**INPATIENT Prior Authorization Request**

Inpatient services always require a prior authorization for WV Medicaid. An authorization request is considered prior if submitted within 10 business days of service. Observation stays only do not require a prior authorization, but some services performed during an observation stay may require an outpatient authorization.

To request an Inpatient authorization, Providers will submit via the DDE portal. If you're an employee without a User ID to logon, you can fax the Inpatient form to the fax number included on the form. Please Note: the system will need to be accessed to obtain the status of your request.

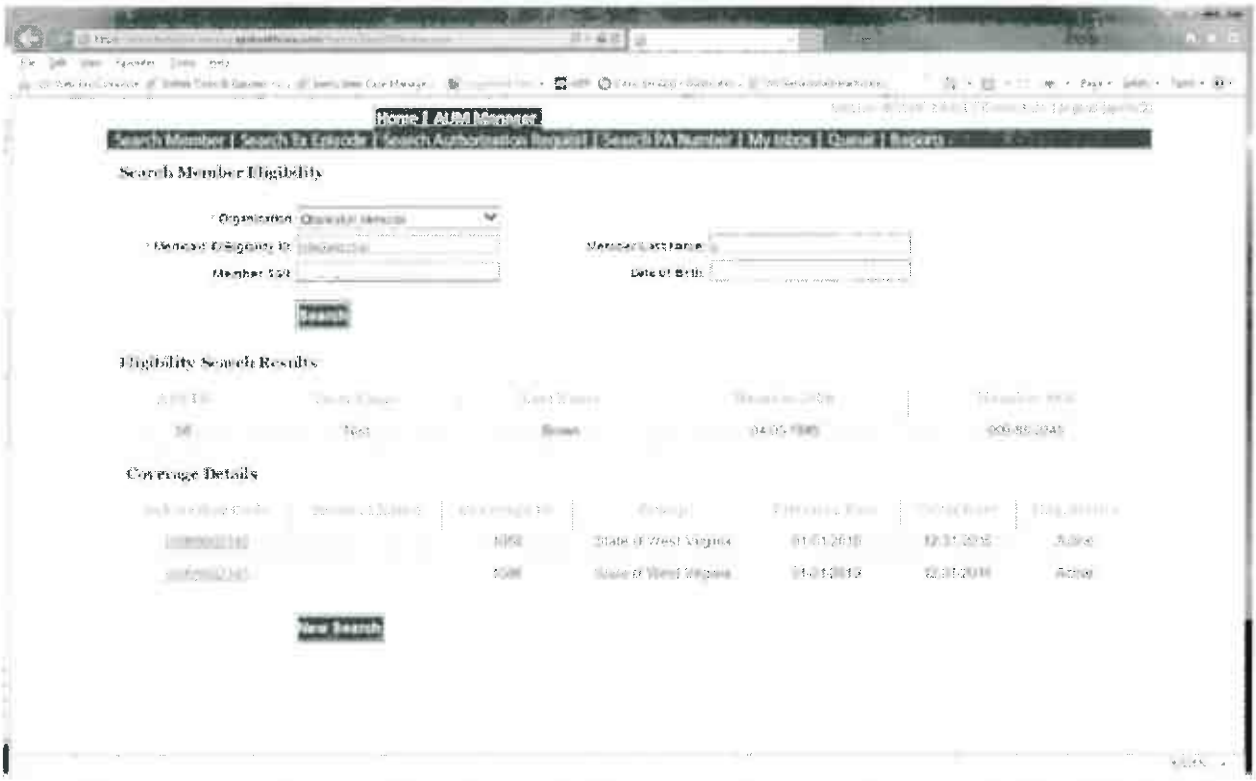
## How to submit an Inpatient Request

Go to https://providerportal.kepro.com and enter you login ID and password

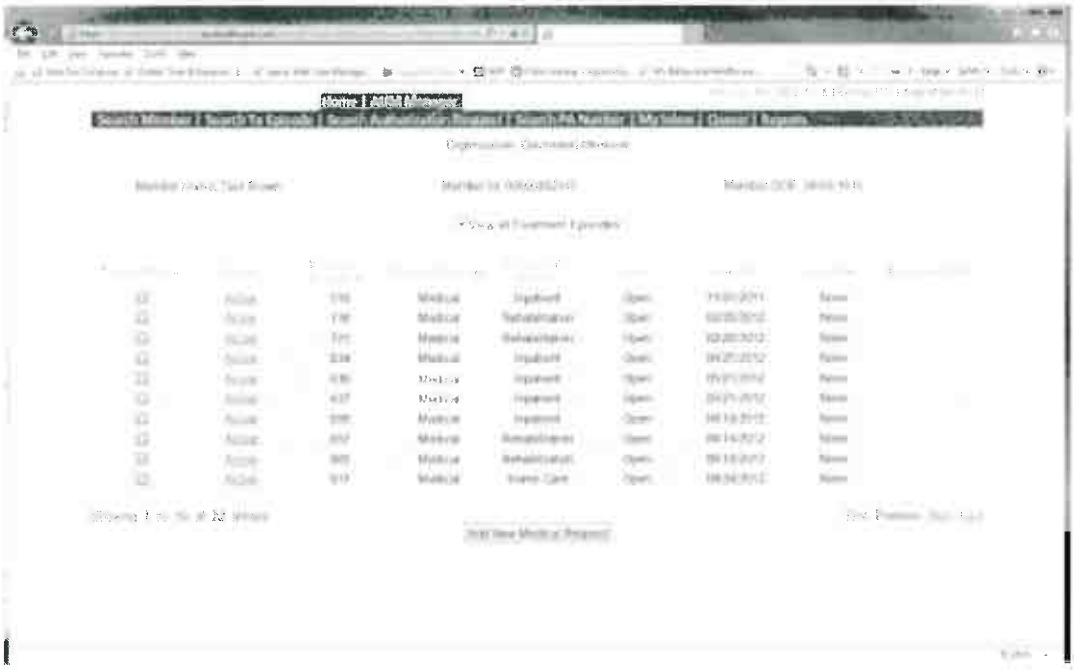

Click on AUM Manager Tab

Click on Search member and enter the WV Medicaid ID number and the member's last name then click Search. (Hint: you can enter the first initial of the last name and click search)

Under "Coverage Details," click on the subscriber code that matches the one you entered on the Search Member screen that has not termed.



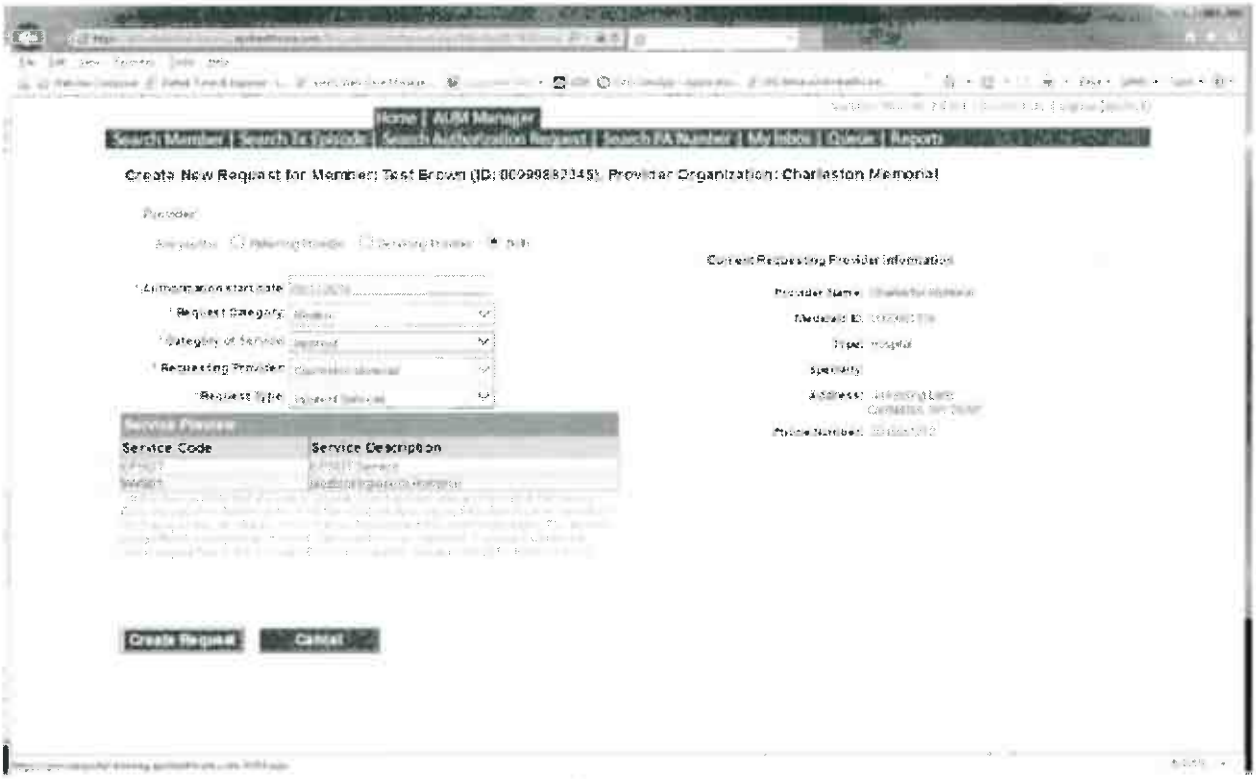

This will bring you to the Treatment Episode Screen which shows all the previous requests for the member. Click on the ADD NEW MEDICAL REQUEST button.



This brings you the Create New Request Screen. Under 'Provider,' you will need to choose rather you are the referring provider, servicing provider or both.

- Referring- Choose if requestor will **NOT** be billing WV Medicaid for requested service.
- Servicing- Choose if requestor **WILL** bill WV Medicaid for requested service
- Both- If you are an office that will be performing and billing for the service, this is the best option to use. (ex. Facility submitting for emergent hospital admission)

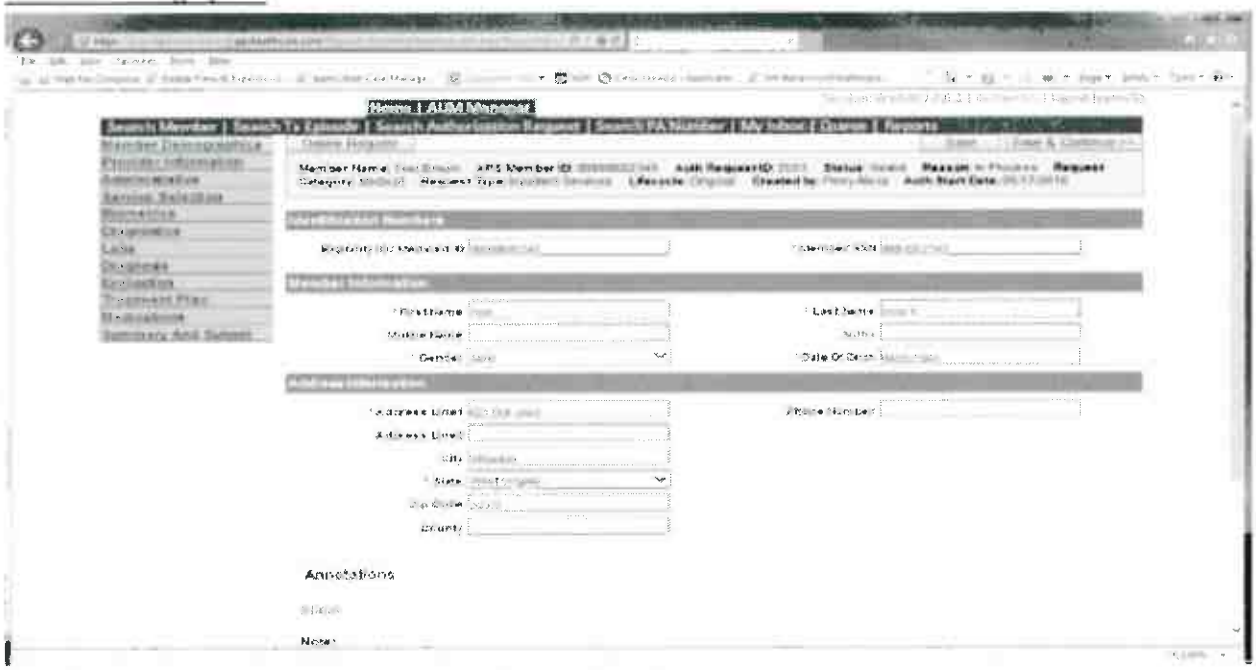
Next, enter the start date (the date the admission), the request category (Medical), the category of service (Inpatient), choose the requesting provider(there will only be a list available if your registration is complete and your provider NPI numbers have been attached), and enter the request type(Inpatient Services) scroll to the end of screen and click "Create Request"




If the member has previous treatment episodes, it will ask you if you want to Attach or Do Not Attach, just choose Do Not Attach. If the member does not have any previous treatments, click Continue

***You are now ready to begin the application.***

## Member Demographics




If the address is not correct, change it and click Save and Continue. If everything is correct, simply click Save and Continue.

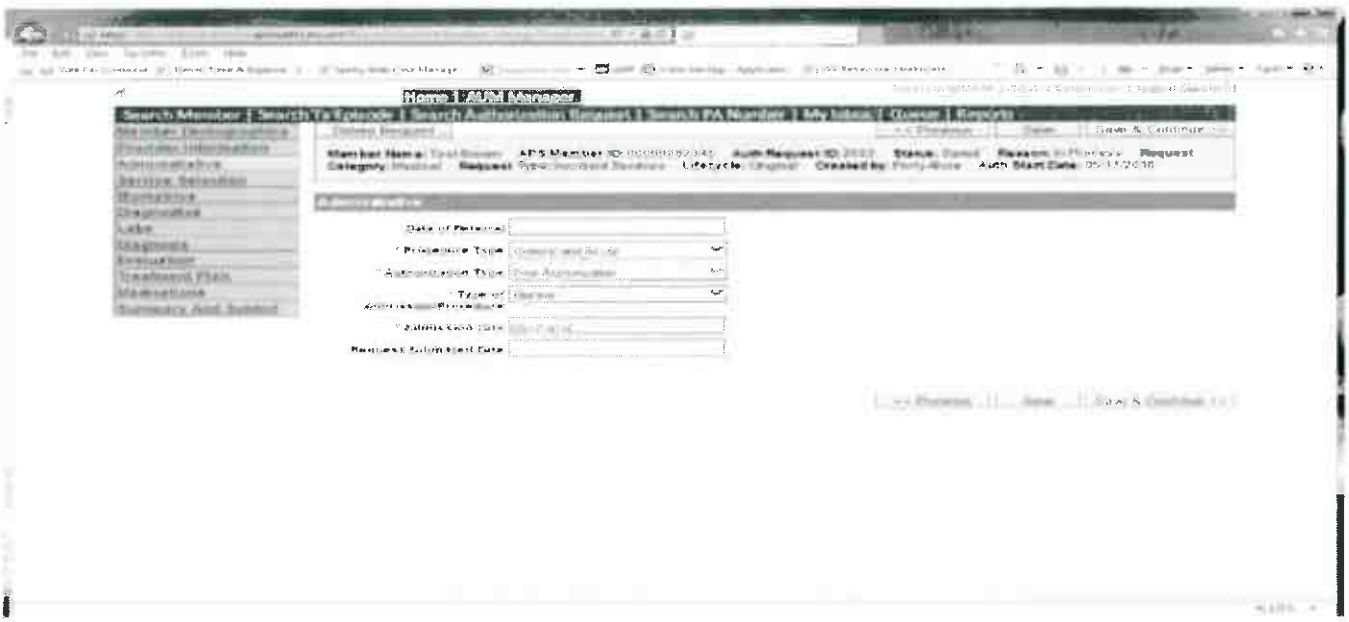
## Provider

This brings you to the Provider Information screen. If you chose that you are the referring provider, this will auto-populate. This information cannot be changed.
If you are the servicing provider, you will need to attach the referring physician information to the request.

To find physician:

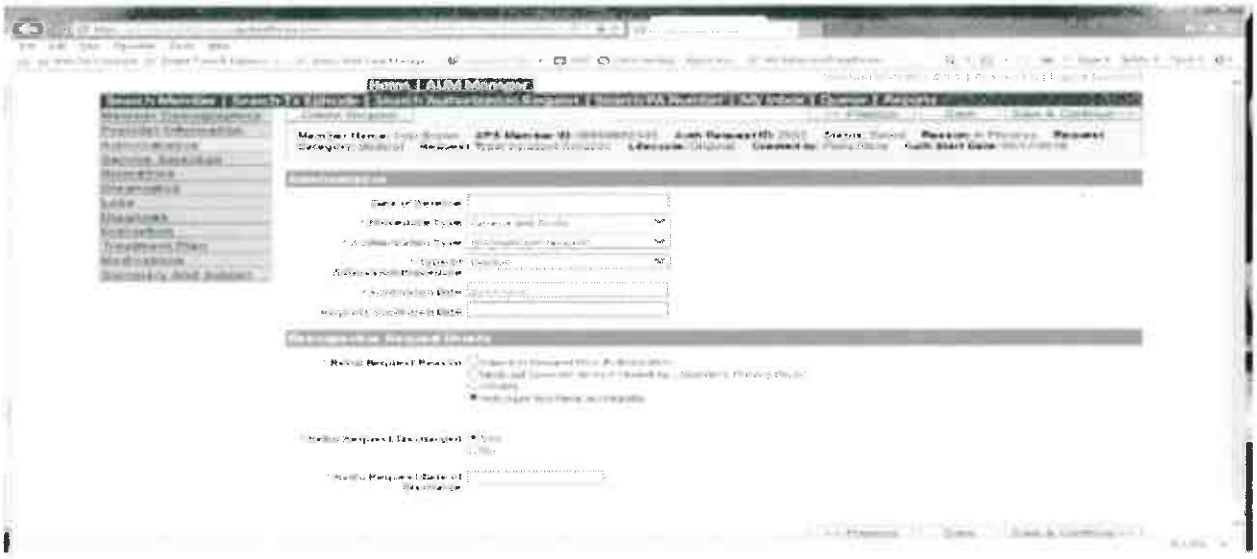
- Click on the Search provider
- Enter the physician's name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR NPI NUMBER.
- Once you have found the physician you are looking for, click the paper clip to attach.
- Enter your direct phone number where you can be reached in the Contact Phone field
- Click Save and Continue.

## Administrative



Answer all questions with the red *, so date of referral is not needed. If your start date is within 10 business days of admission date, the authorization type will be Prior. Please note: If an admission is within 10 business days of the date you are submitting, please choose Prior authorization and not retrospective. This will ensure your request does not pend incorrectly for eligibility to process prior to UM review.

## Administrative

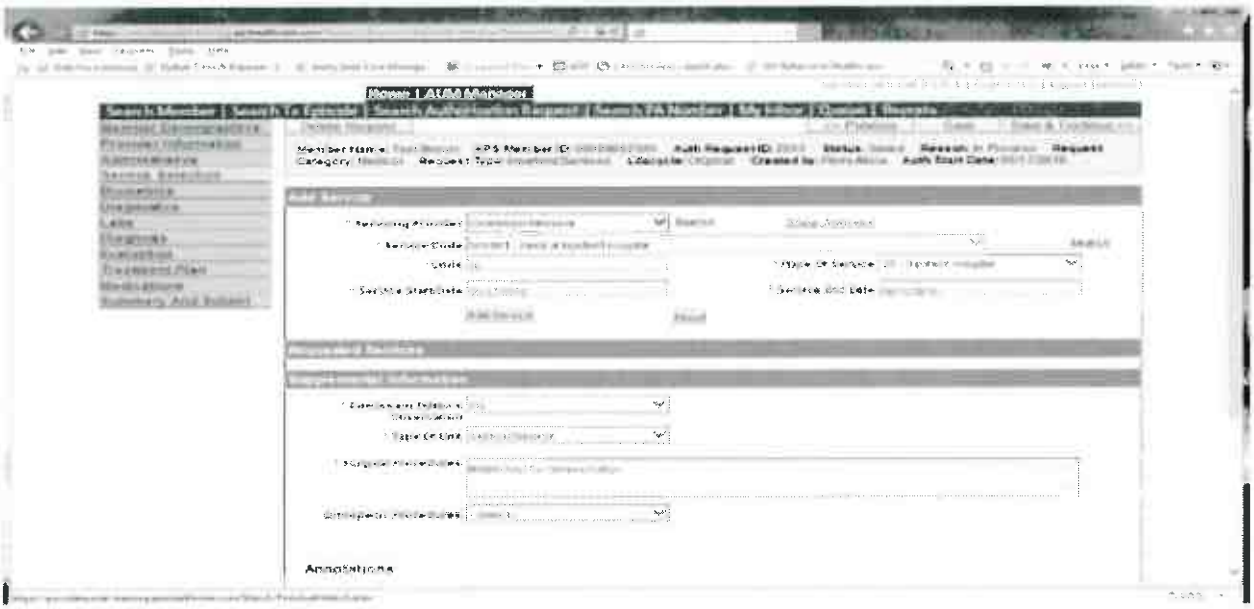


If any other time span, the authorization type will be 'Retrospective Request.' Per BMS policy, there are timelines to request an authorization. If a request is submitted outside of the designated 10 day timeline, a retrospective policy denial letter will be issued. A retrospective reason will need to be selected and there are four options

- Failure to request prior authorization
- Medicaid covered service denied by-Member's primary payer-If this reason is chosen, documentation will need to be provided
- Other: If this reason is chosen, please make sure to provide as much information as possible.
- Retrospective Medicaid Eligibility-Only choose if Medicaid coverage has been backdated to cover date of service.

If member has been discharged, please enter date of discharge.

## Service Selection



If you chose the servicing provider option, this will auto-populate. This information cannot be changed. If you are the referring provider, you will need to attach the Servicing Provider information to the request.

To find Servicing Provider:

- Click on the Search provider
- Enter the name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR NPI NUMBER.
- Once you have found the provider you are looking for, click the paper clip to attach.
- Click Save and Continue.

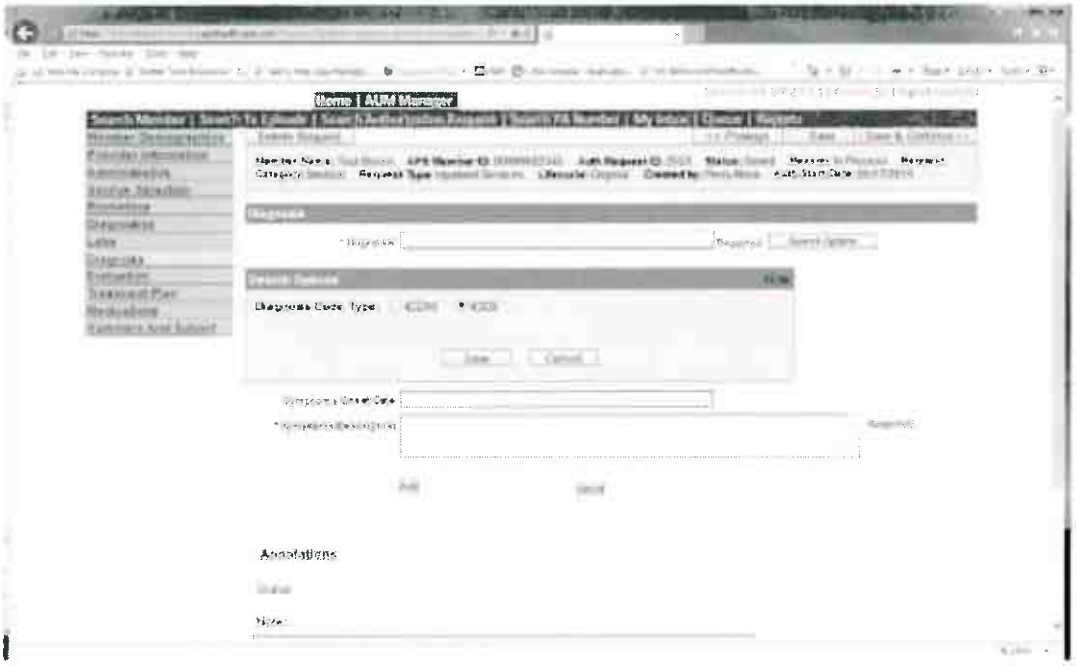
## Service Selection

You are now ready to choose your service code. For inpatient requests, you will choose WVOO1. Please note: If this request is a surgical admission, the surgeon does not need a separate authorization number. If approved, the authorization number needs to be under the facility name only. The units will automatically populate to 30 and you will notice the service end date allows for a 30 day date span. This is because all inpatient authorizations are issued on a 30 day DRG basis. Please do not change service end date. Click ADD SERVICE

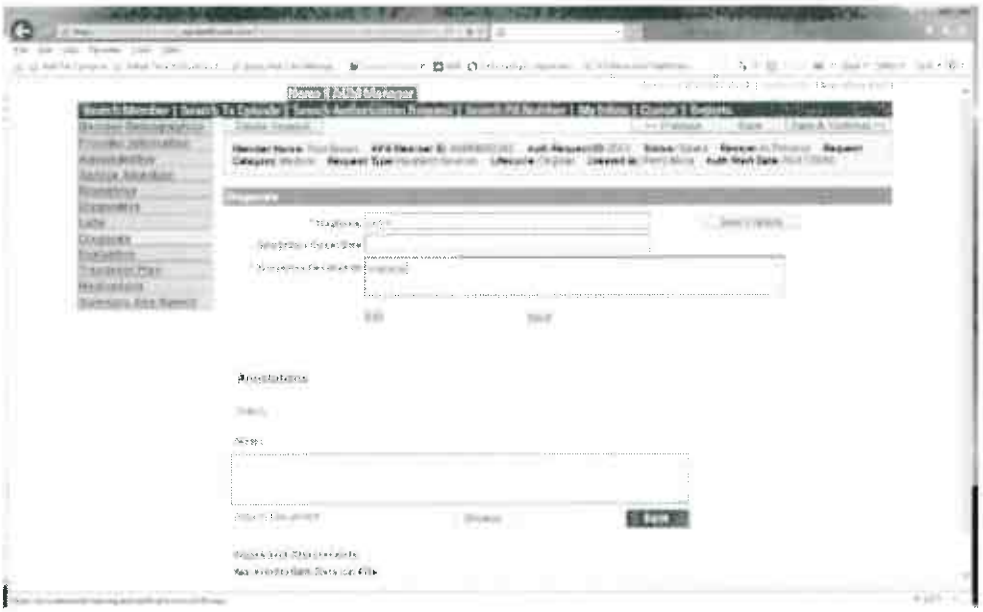
Answer question if admission follows observation. If so, click yes and then enter the date observation began. If no, click no. Enter the CPT code of the surgery in the Surgery Procedures box. If the request is for an orthopedic surgery, click yes to that question and then click Save and Continue.

**Biometrics, Diagnostics and Labs tab do not require information to be entered (no red *) but you can complete information if you choose. Please be sure to click Save and Continue after each screen.**

**Diagnosis**



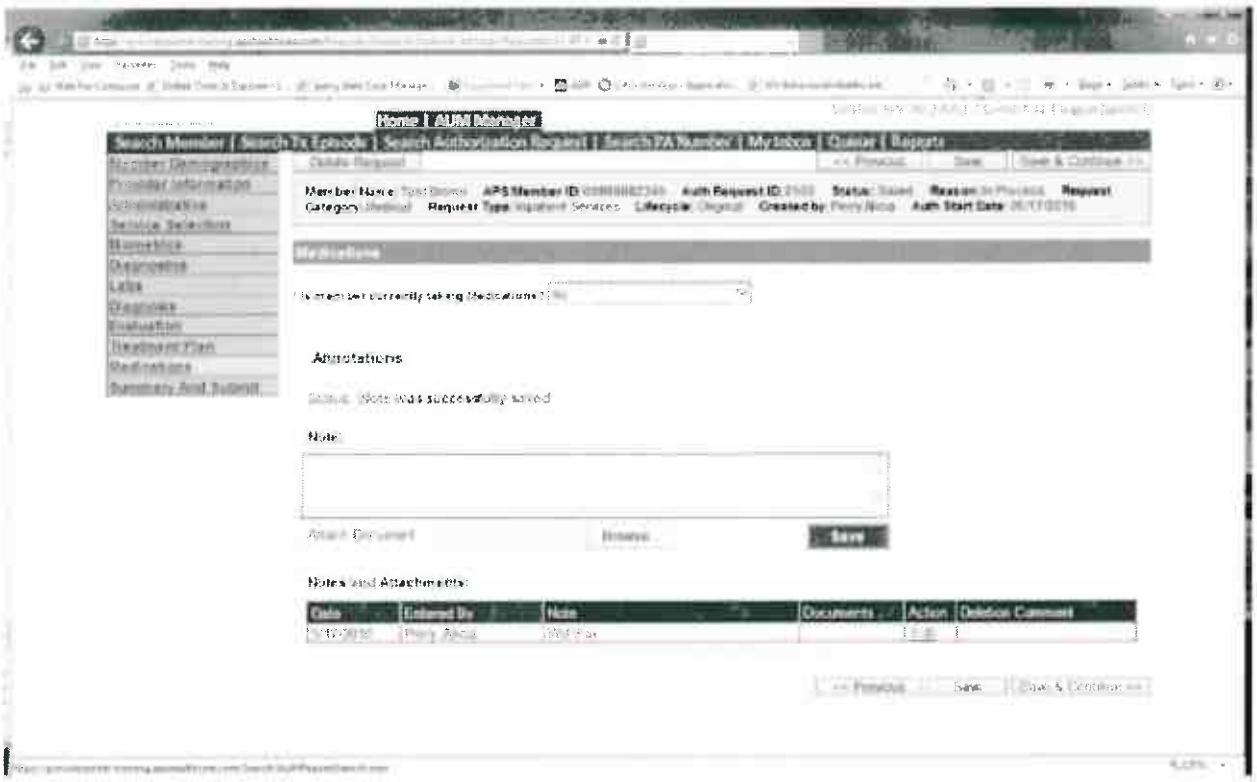
The Diagnosis screen is the next mandatory screen. The diagnosis code should be in the correct format for the date of service submitted. If your date of service requires an ICD-9 diagnosis code, prior to entering the letter and numbers before the decimal, click the search options button, select ICD-9 and click save.



Enter the letter and numbers before the decimal of the diagnosis code, wait for the dropdown list, and choose the code from the list, enter symptoms in the Symptoms box, and click the Add button under the Symptoms box. Do this for as many diagnoses codes you have.

Evaluation and Treatment Plan tabs do not require information to be entered (no red *) but you can complete information if you choose. Please be sure to click Save and Continue after each screen.

## Medications



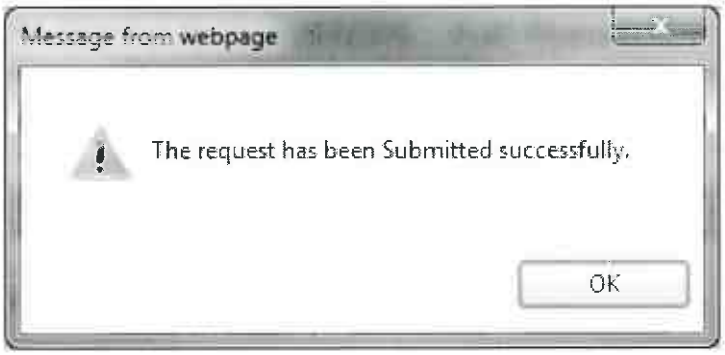

This brings you the Medications screen. This is not a mandatory screen but if you want to list medications, please leave the answer as NO and either copy and paste, or download and attach list in the Annotations/Note sections. If you are going to fax, enter a note in the Annotations/Note Section, WILL FAX, click the blue SAVE button under the notes section. Click Save and continue to the Summary and Submit page.

## Summary and Submit

The Summary and Submit page allows you to scroll the document from the beginning to the end. Look over it to make sure all things have been entered correctly, scroll back up to the top of the page and click SUBMIT in the top left hand corner and NOT the SUBMIT button at the bottom of the request. **Clicking the submit button at the bottom of the page does not allow the submitter to see any errors or warning boxes that require action.**

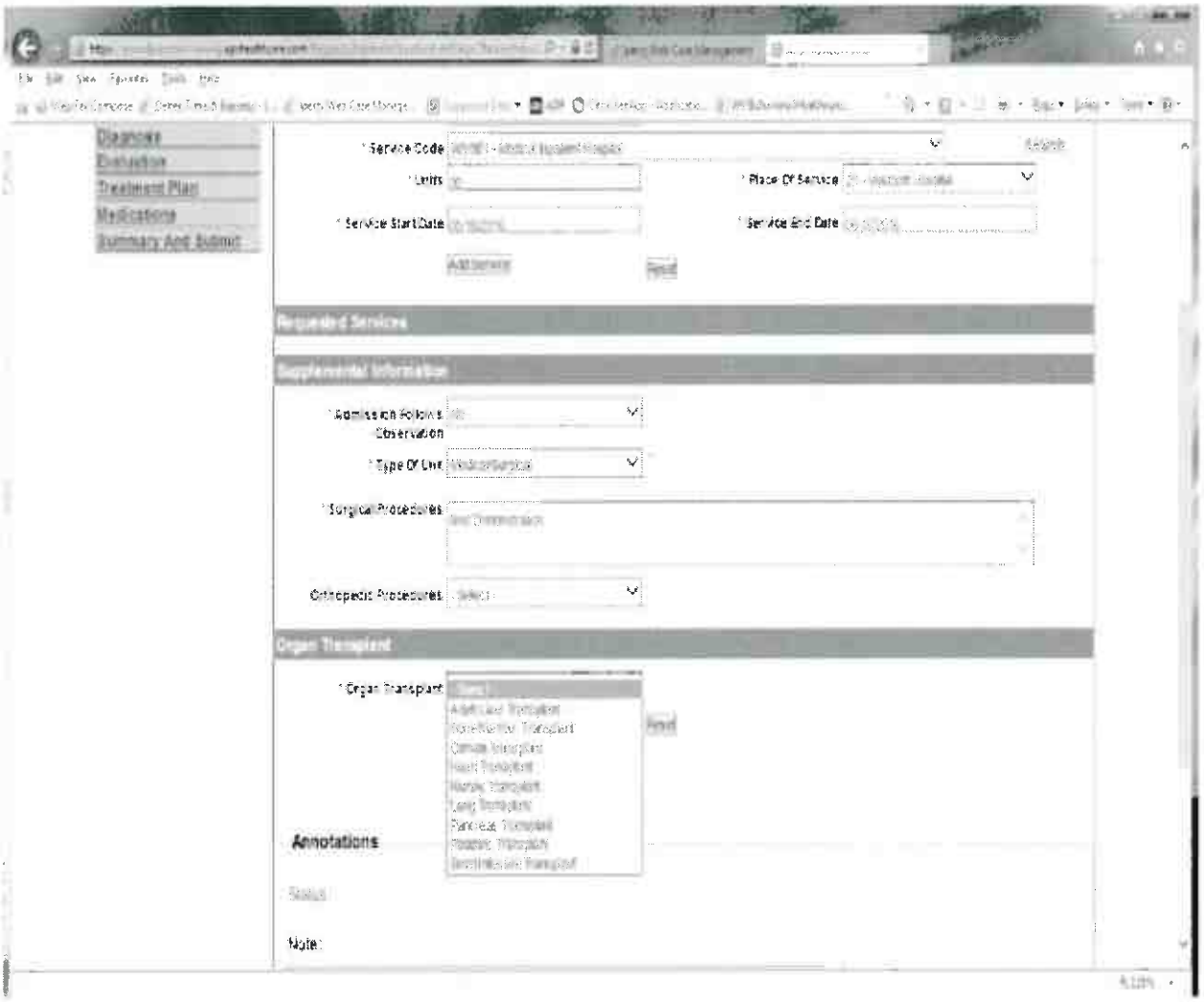
A warning box may be received. If so, c lick continue.

And then Click OK, once the message that your request was successfully submitted has displayed.



Some Inpatient authorization request will be for Organ Transplants, Bariatric Surgery or Orthopedic Surgery. For Bariatric Surgery and Orthopedic Surgery, the providers will indicate and list the CPT codes under the Service Selection Screen.

**For Organ Transplants, the Provider will need to indicate what organ and location.**




Inpatient Rehabilitation under age 21 requires a prior authorization. The authorizations are generally only for 14 day admission. If the Member stay is longer, an authorization request will need to be submitted every 14 days. Please Note: Inpatient Rehabilitation is a NON COVERED benefit for ages over 21.

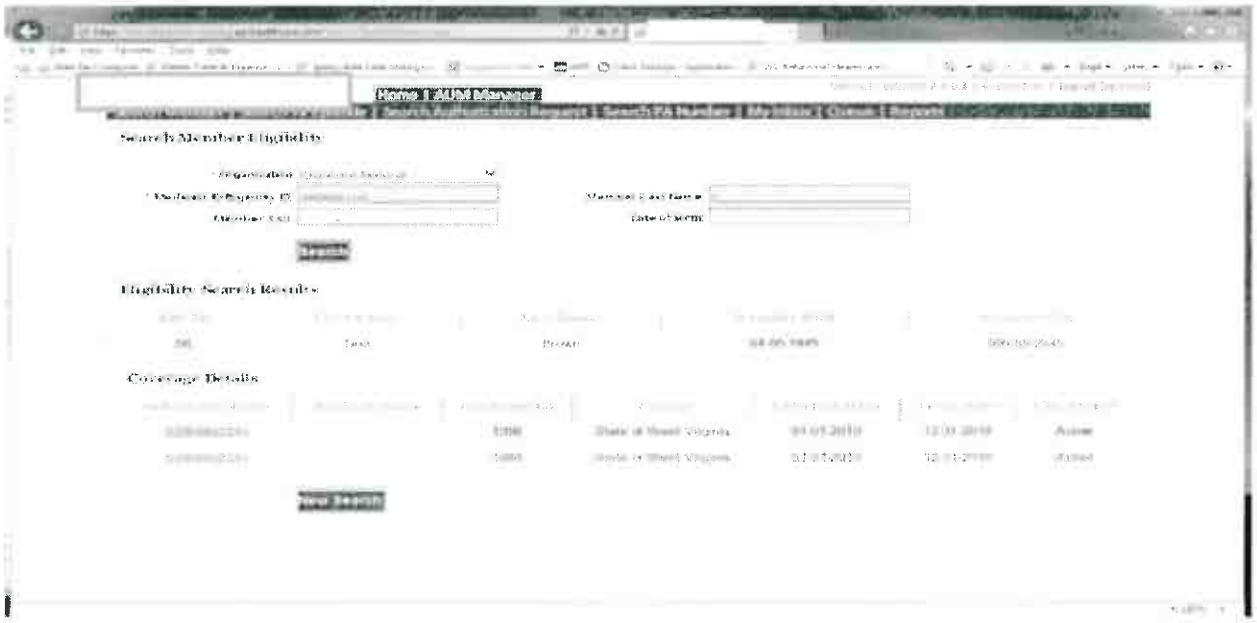
**How to submit an Inpatient Rehab<21 Request**

Go to https://providerportal.kepro.com and enter you login ID and password


**Click on AUM Manager Tab**

Click on Search member and enter the WV Medicaid ID number and the member's last name then click Search. (Hint: you can enter the first initial of the last name and click search)

Under "Coverage Details," click on the subscriber code that matches the one you entered on the Search Member screen that has not termed.

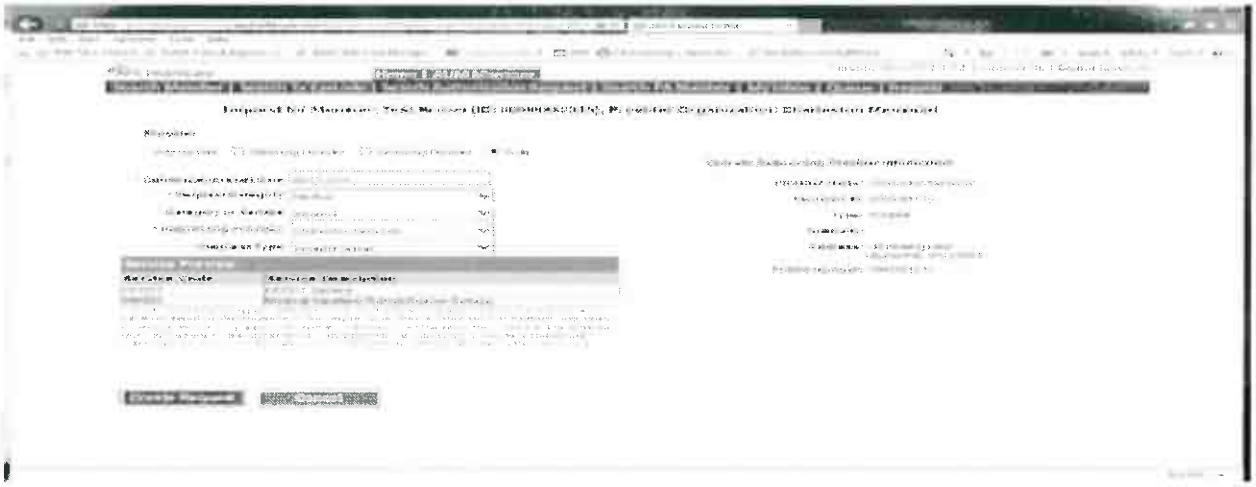


This will bring you to the Treatment Episode Screen which shows all the previous requests for the member. Click on the **ADD NEW MEDICAL REQUEST** button.

This brings you the Create New Request Screen. Under 'Provider,' you will need to choose rather you are the referring provider, servicing provider or both.

- Referring- Choose if requestor will **NOT** be billing WV Medicaid for requested service.
- Servicing- Choose if requestor **WILL** bill WV Medicaid for requested service
- Both- If you are an office that will be performing and billing for the service, this is the best option to use. (ex. Facility submitting for emergent hospital admission)

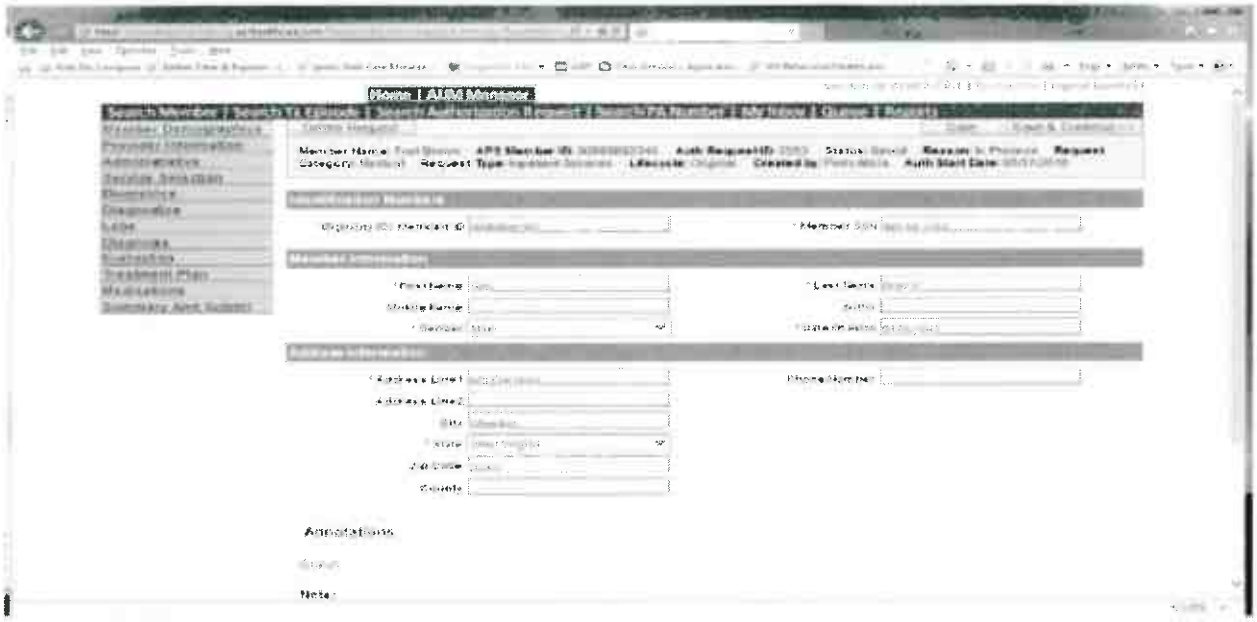
Next, enter the start date (the date the admission), the request category (Medical), the category of service (Inpatient), choose the requesting provider(there will only be a list available if your registration is complete and your provider NPI numbers have been attached), and enter the request type(Inpatient Rehab) scroll to the end of screen and click "Create Request"



If the member has previous treatment episodes, it will ask you if you want to Attach or Do Not Attach, just choose Do Not Attach. If the member does not have any previous treatments, click Continue

***You are now ready to begin the application.***

## Member Demographics



If the address is not correct, change it and click Save and Continue. If everything is correct, simply click Save and Continue.

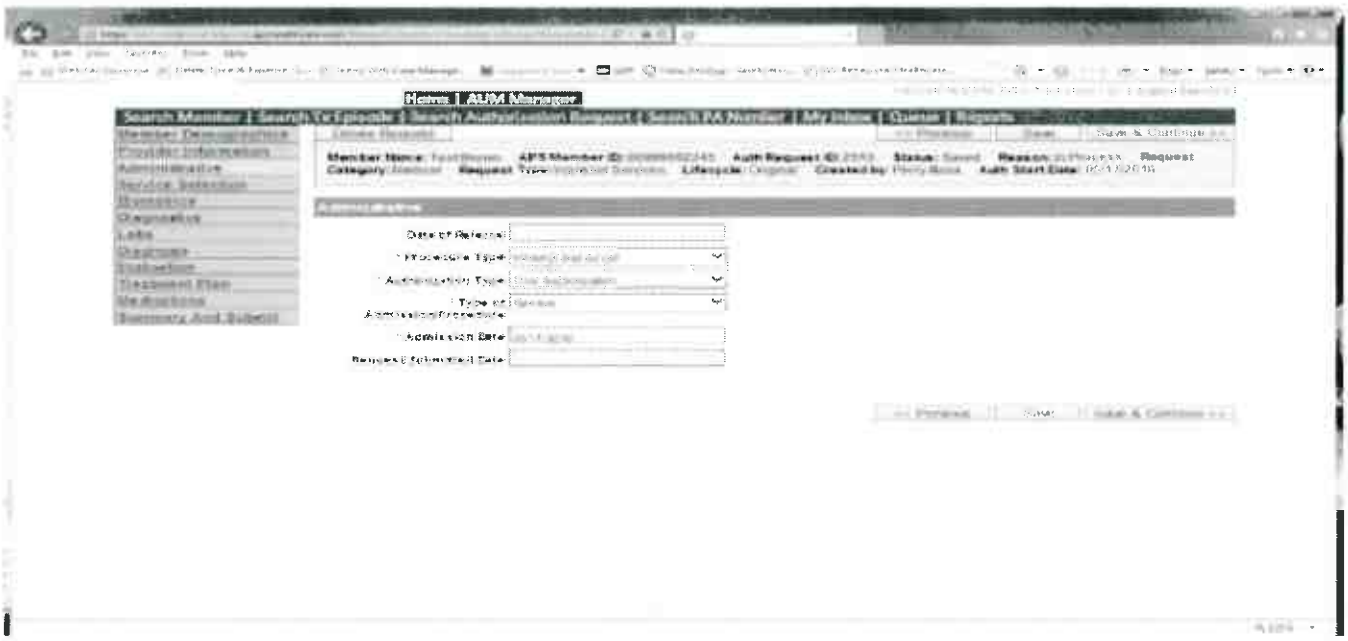
## Provider

This brings you to the Provider Information screen. If you chose the referring provider option, this will auto-populate. This information cannot be changed. If you are the servicing provider, you will need to attach the referring physician information to the request.

To find physician:

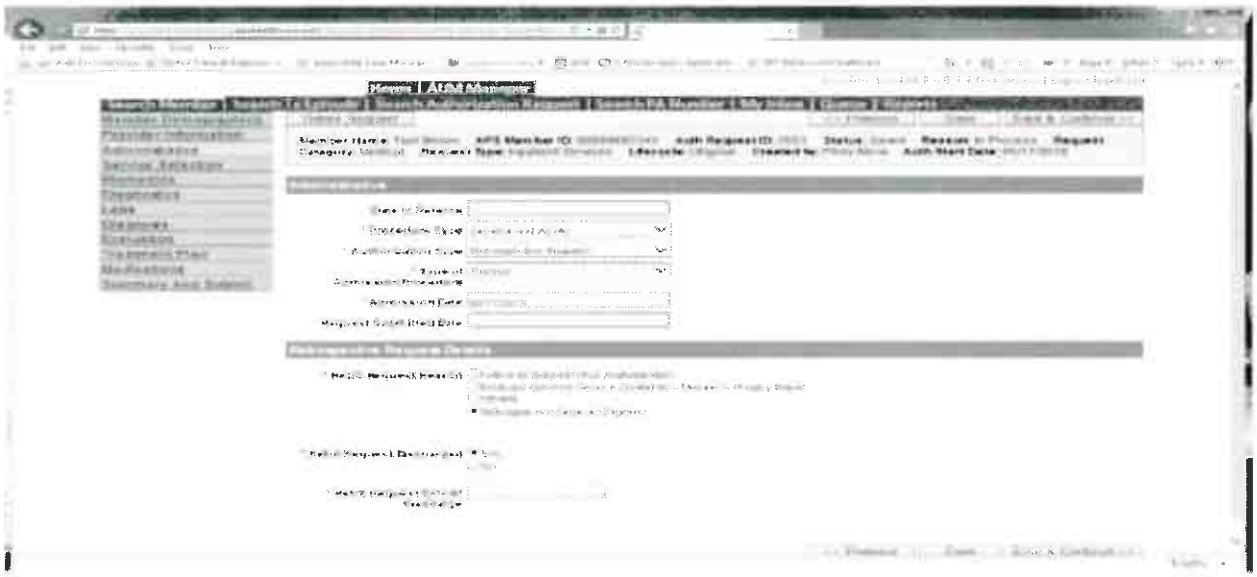
- Click on the Search provider
- Enter the physician's name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR NPI NUMBER.
- Once you have found the physician you are looking for, click the paper clip to attach.
- Enter your direct phone number where you can be reached in the Contact Phone field
- Click Save and Continue.

**Administrative**



Answer all questions with the red *, so date of referral is not needed. If your start date is within 10 business days of admission date, the authorization type will be Prior. Please note: If an admission is within 10 business days of the date you are submitting, please choose Prior authorization and not retrospective. This will ensure your request does not pend incorrectly for eligibility to process prior to UM review.

**Administrative**



If any other time span, the authorization type will be 'Retrospective Request.' Per BMS policy, there are timelines to request an authorization. If a request is submitted outside of the designated 10 day timeline, a retrospective policy denial letter will be issued. A retrospective reason will need to be selected and there are four options

- Failure to request prior authorization
- Medicaid covered service denied by-Member's primary payer-If this reason is chosen, documentation will need to be provided
- Other: If this reason is chosen, please make sure to provide as much information as possible.
- Retrospective Medicaid Eligibility-Only choose if Medicaid coverage has been backdated to cover date of service.

If member has been discharged, please enter date of discharge.

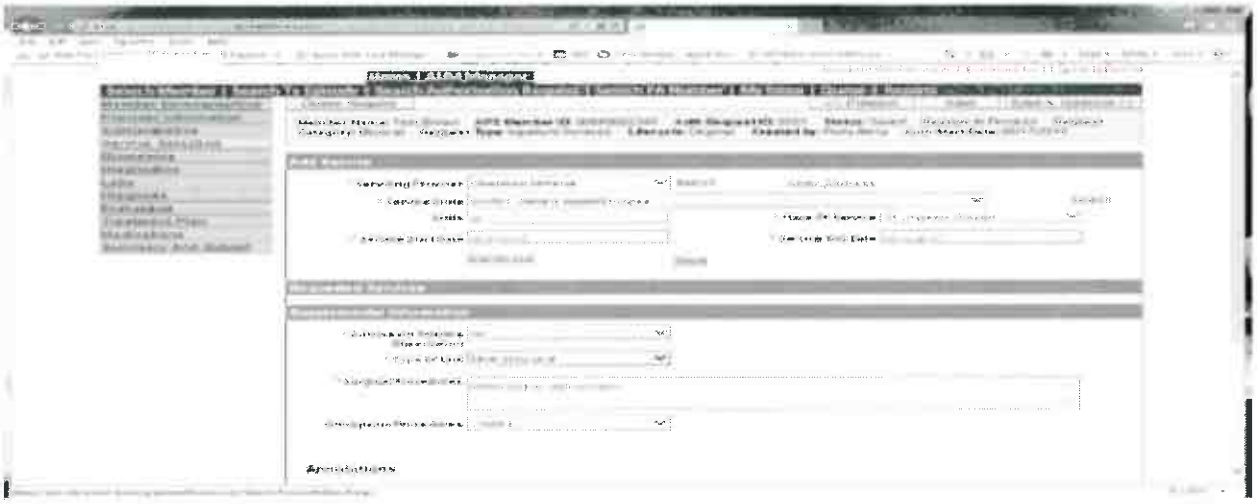
## Service Selection

If you chose the servicing provider option, this will auto-populate. This information cannot be changed. If you are the referring provider, you will need to attach the Servicing Provider information to the request.

To find Servicing Provider:

- Click on the Search provider
- Enter the name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR NPI NUMBER.
- Once you have found the provider you are looking for, click the paper clip to attach.
- Click Save and Continue.

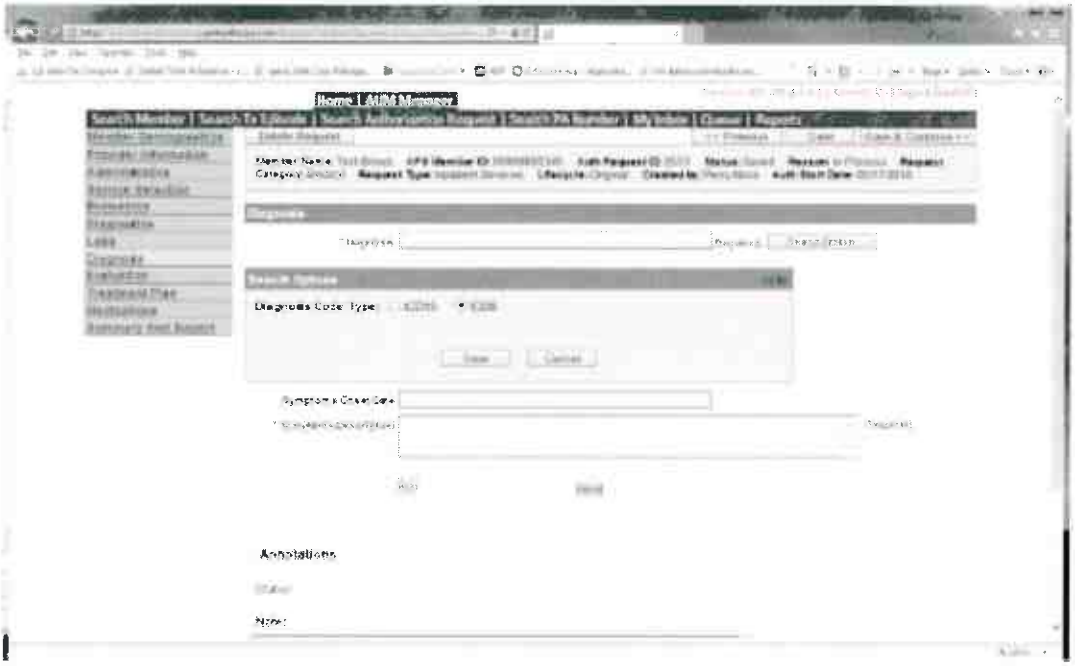
## Service Selection



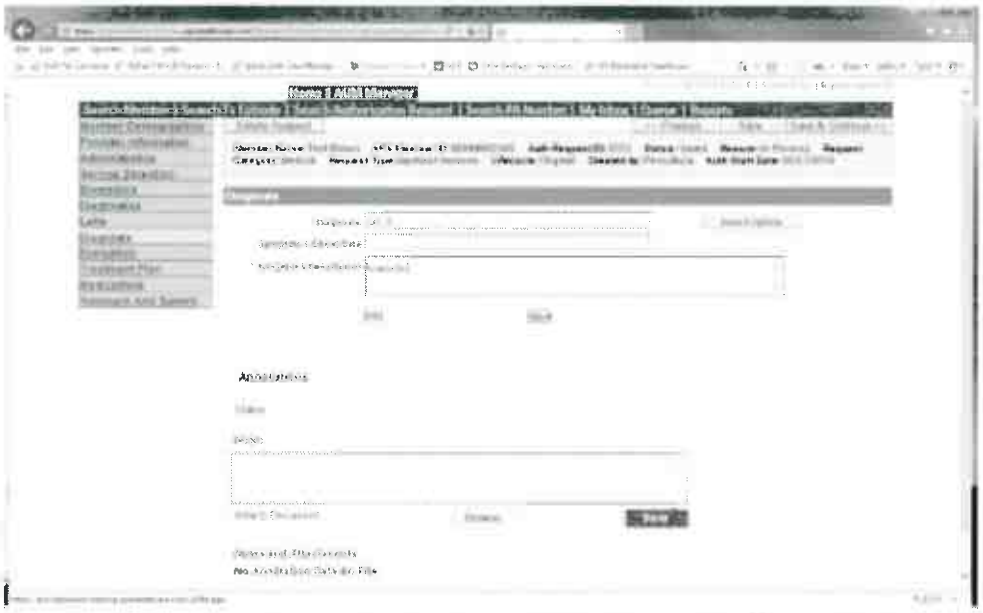
You are now ready to choose your service code. For inpatient rehabilitation requests, you will choose WVOO2. Inpatient Rehabilitation authorizations units automatically populates to 14. This is because all initial inpatient rehabilitation authorizations are only given a 14 day approval. Please do not change service end date. Click ADD SERVICE

Biometrics, Diagnostics and Labs tab do not require information to be entered (no red *) but you can complete information if you choose. Please be sure to click Save and Continue after each screen.

## Diagnosis

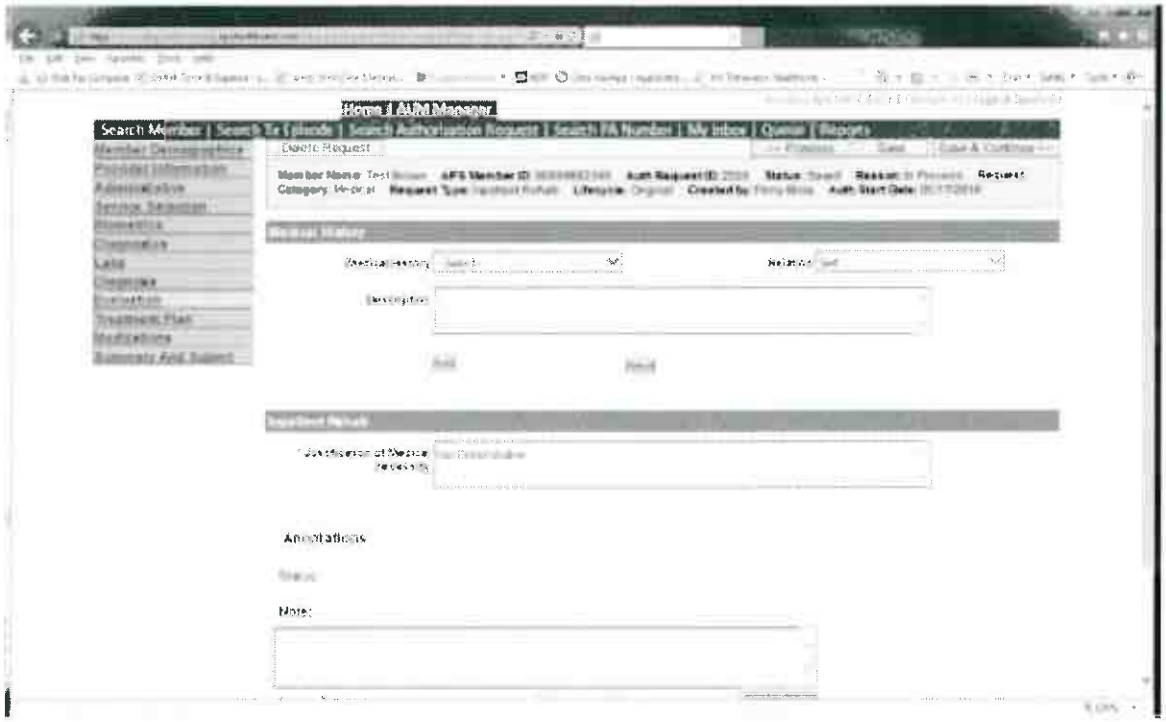


The Diagnosis screen is the next mandatory screen. The diagnosis code should be in the correct format for the date of service submitted. If your date of service requires an ICD-9 diagnosis code, prior to entering the letter and numbers before the decimal, click the search options button, select ICD-9 and click save.



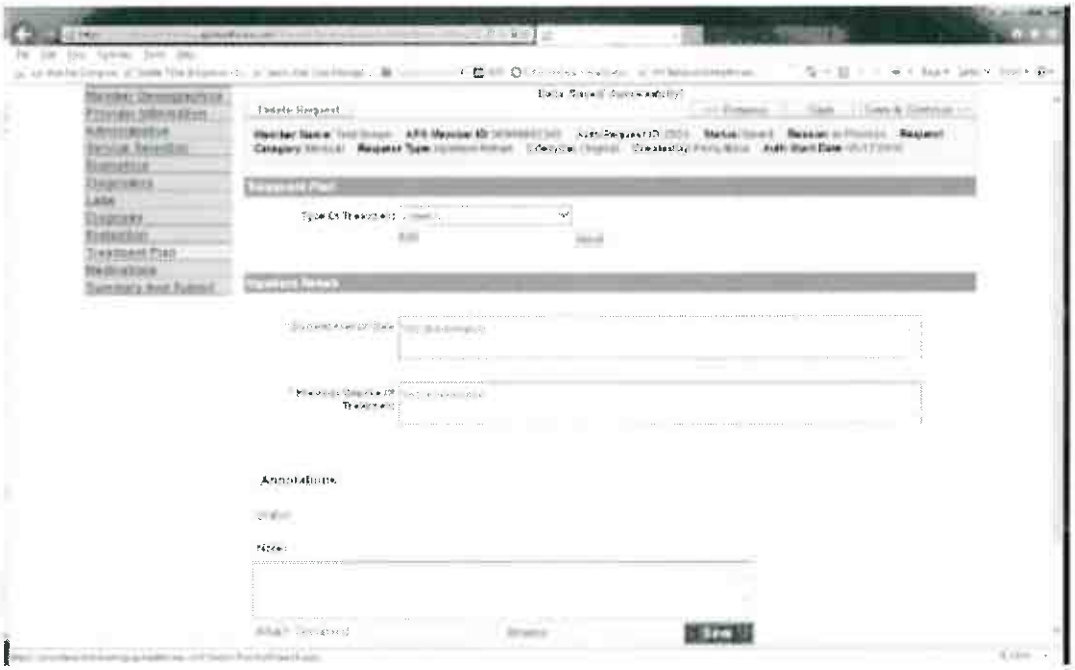
Enter the letter and numbers before the decimal of the diagnosis code, wait for the dropdown list, and choose the code from the list, enter symptoms in the Symptoms box, and click the Add button under the Symptoms box. Do this for as many diagnoses codes you have.

## Evaluation



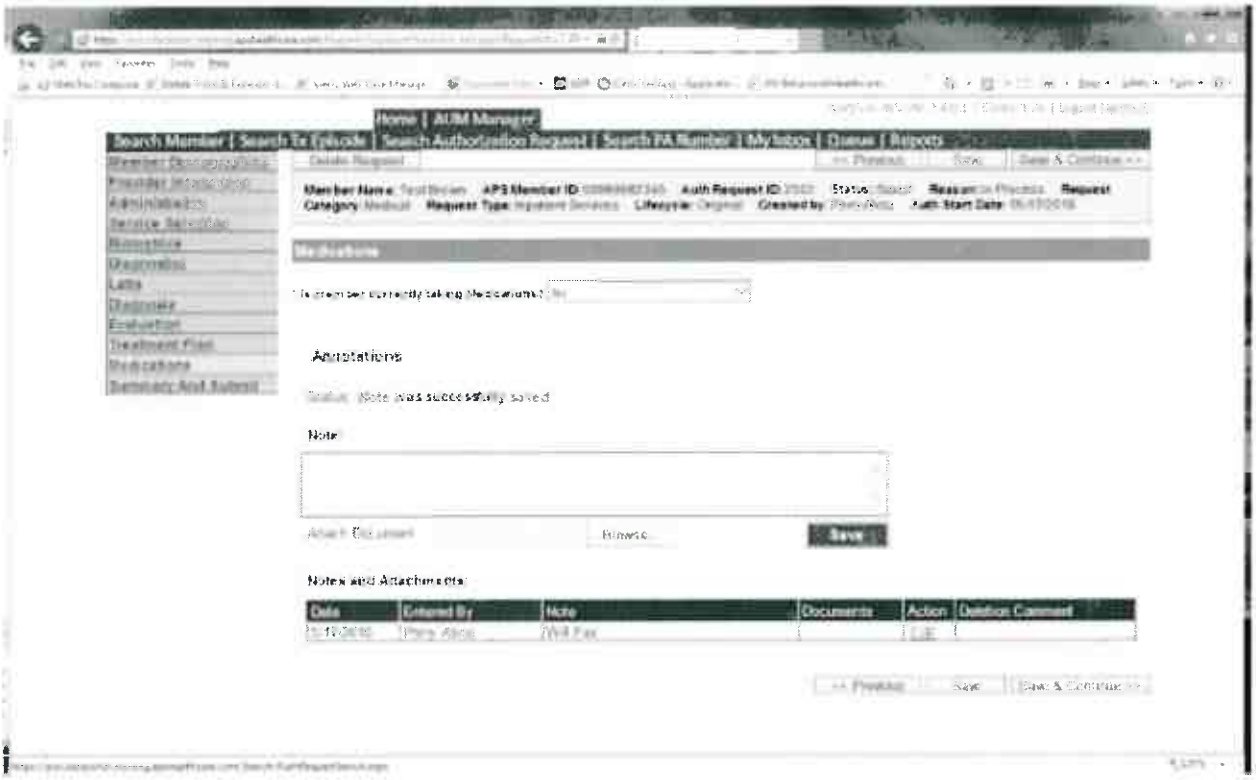

Answer all questions with the red *. The justification of medical necessity will need to be completed. Click Save and Continue

## Treatment Plan




Answer all questions with the red *. The current plan of care and previous course of treatment will need to be completed. Click Save and Continue

## Medications

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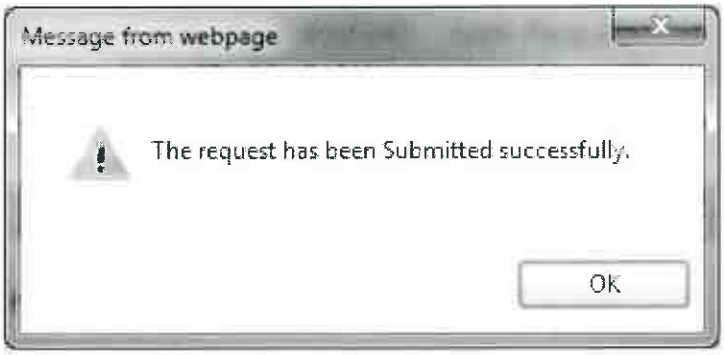
A warning box may be received. If so, click continue.

And then Click OK, once the message that your request was successfully submitted has displayed.



TIPS FOR SUBMITTING INPATIENT REQUEST

- Please remember the facility name has to be attached to the authorization request. Physicians who perform services during an Inpatient admission do not need an authorization and should not be part of your request.
- The diagnosis code submitted should be the Primary code and not the admitting diagnosis code. This is very important to not delay payment of your claim
- If the facility is Active with WV Medicaid, it does not mean that the treating physician is considered active and In-Network with WV Medicaid. If the treating physician is not In-Network and their services will be billed separately, an authorization is required and an OON request form will have to be submitted for review.
- Clinical information is not accepted when faxed alone and must be accompanied by the Inpatient Prior authorization form
- Faxed requests must be completed in its entirety including Provider names and NPI numbers, Diagnosis codes, all boxes checked regarding admission, etc. Our staff will not key from clinical. If the form is not completed correctly, the submitter will receive a fax back form.
- If you receive a fax back indicating that there were issues with your fax, the entire form will need to be resubmitted along with any documentation that could've been sent with the first submission.
- A facility's IQ review does not replace clinical documentation. It is fine to include this with a request but we must receive the appropriate clinical information to conduct a review
- Remember when submitting clinical information to include specific treatments and clinical information relevant to the admitting diagnosis (e.g. Baseline O2 saturation and ABG, if applicable for respiratory issues; IV rates/HR, Vital signs; Neuro checks, assessments, etc. as these are often part of iq criteria and can save the nurse having to call for the information and delaying your result);
- Please be sure to include a clinical contact in case additional clinical information is needed