OUTPATIENT SURGERY REQUEST

There are certain surgical procedures that when performed in an outpatient setting requires prior authorization prior to billing and should be submitted within 10 business days. If a surgery is performed prior to obtaining an authorization, a request can be submitted up to 10 business days after the service. Please note: The request must meet medical necessity and there is no guarantee the procedure will be authorized.

To request an Outpatient Surgery authorization, Providers will submit via the DDE portal. If you're an employee without a User ID to logon, you can fax the Outpatient Surgery Prior authorization request 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.

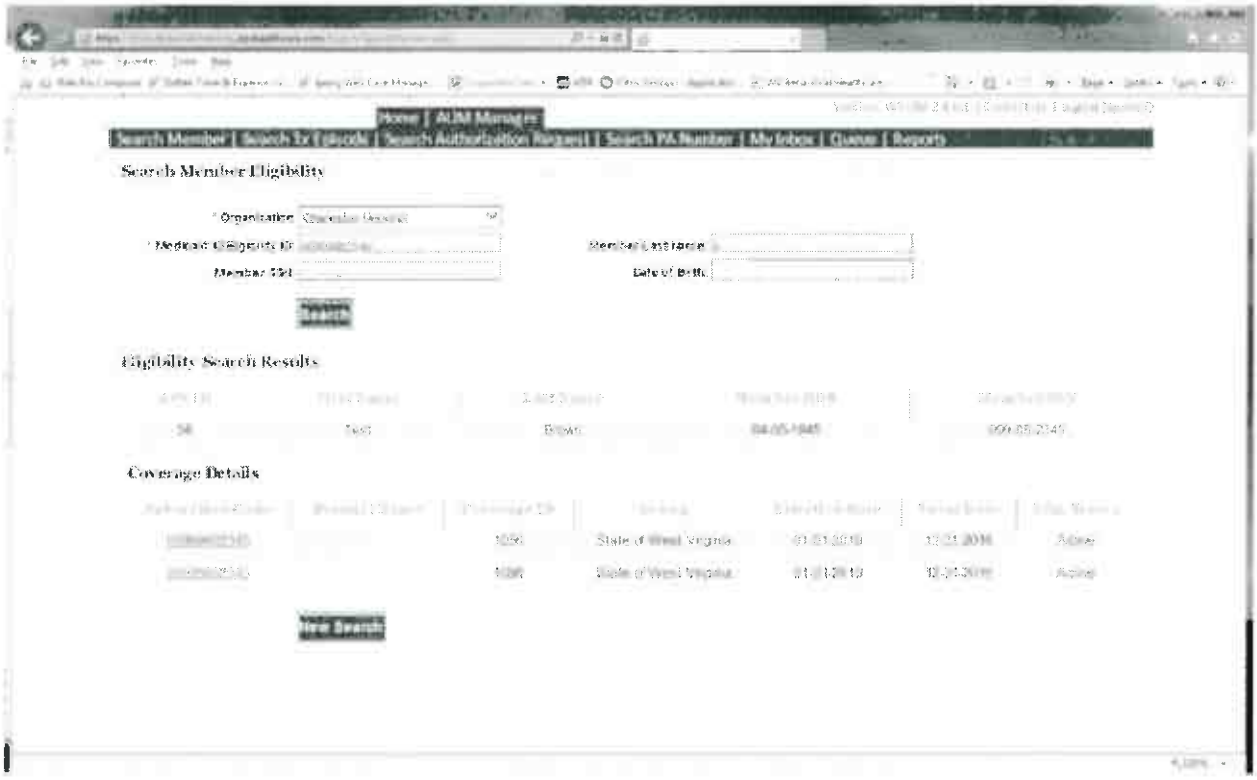
How to submit an Outpatient Surgery Request

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

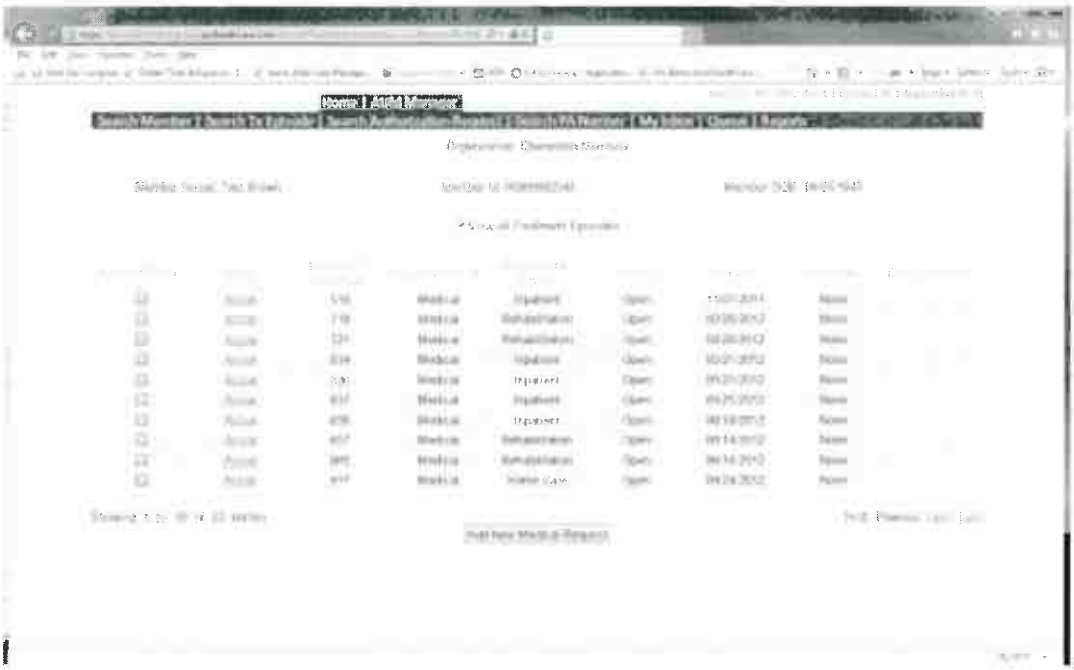
Click on AUM Manager Tab

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.



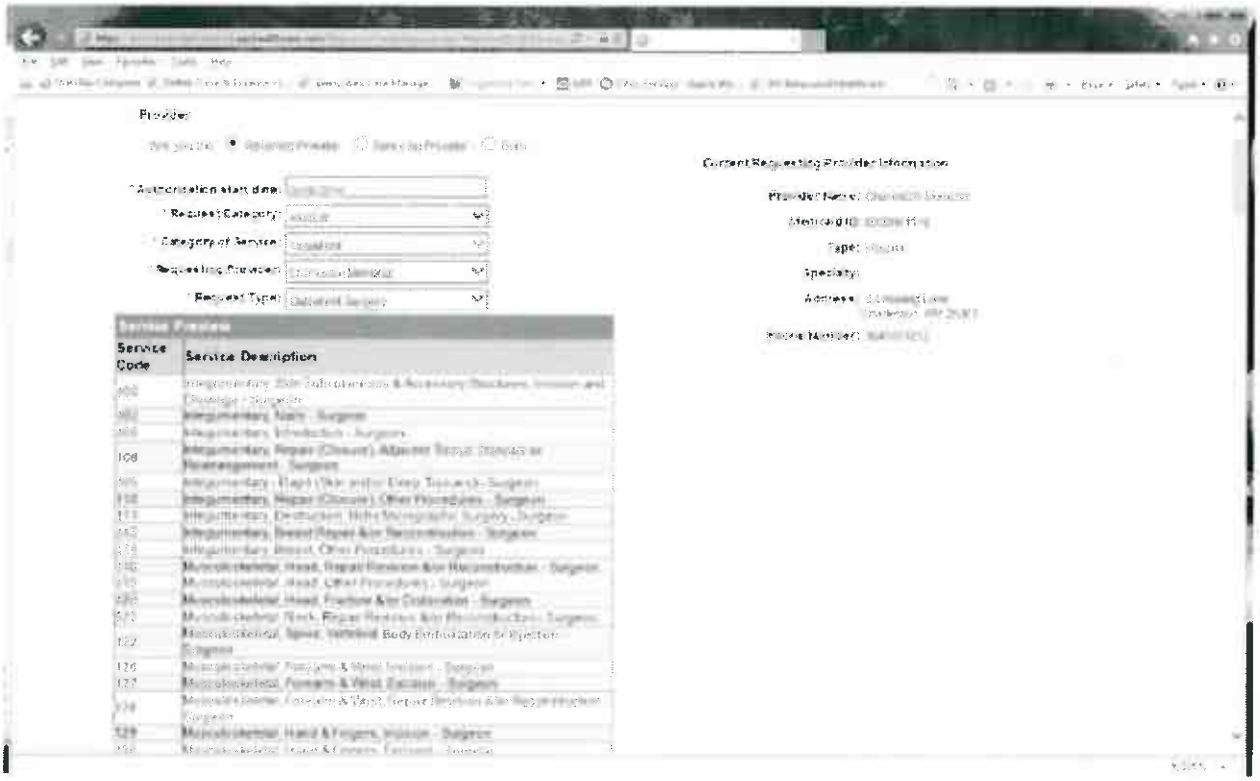
This will bring you to the Treatment Episode Screen which shows all the previous requests for the member. Click on the **ADD NEW MEDICAL REQUEST** button.



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. ***Note: When submitting outpatient request, the referring could bill for services if Surgeon's office.***
- 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.

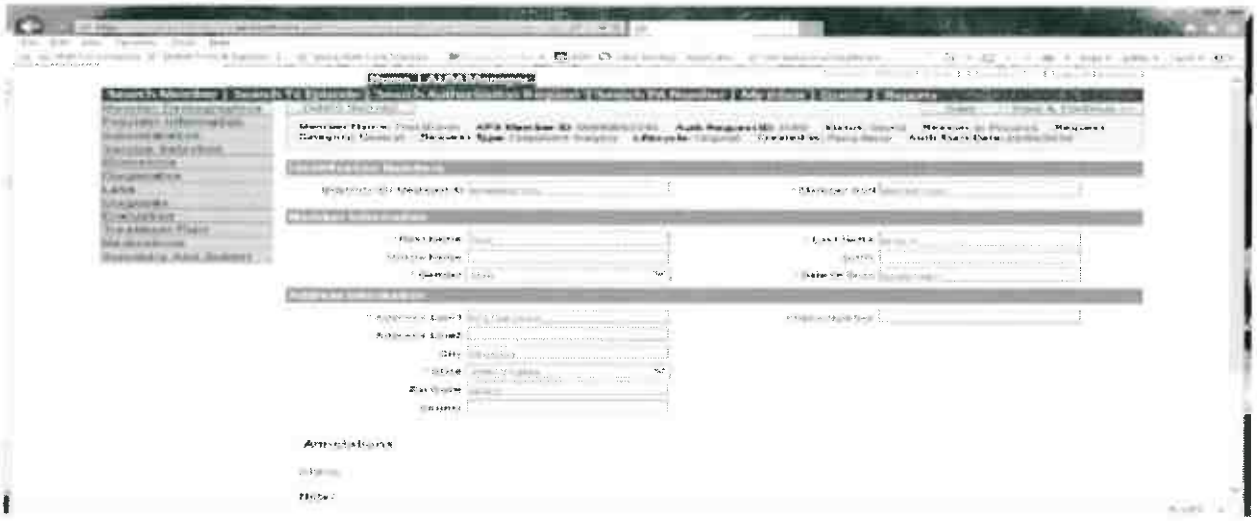
Next, enter the start date (the date of service) .If there is no scheduled date, use the date of service being submitted, the request category (Medical), the category of service (Outpatient), choose the requesting provider(there will only be a list available if your registration is complete and your provider NPI numbers have been attached), and enter the request type(Outpatient Surgery) 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.

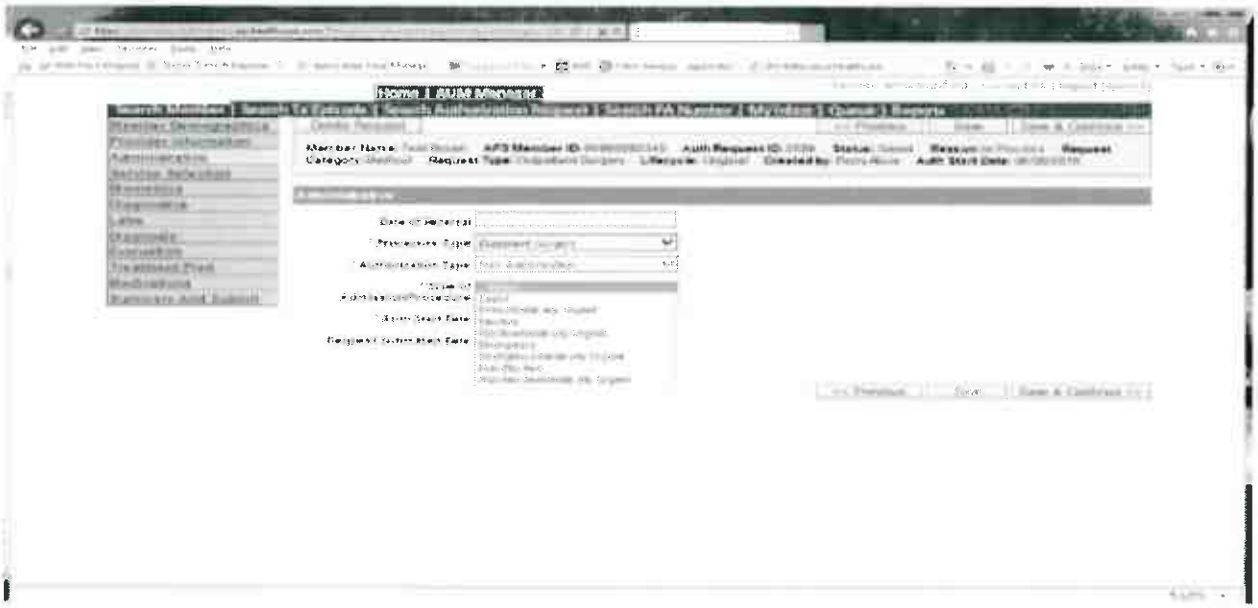
Provider

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 chose the servicing provider option, you will need to attach the referring physician information to the request. To find physician:

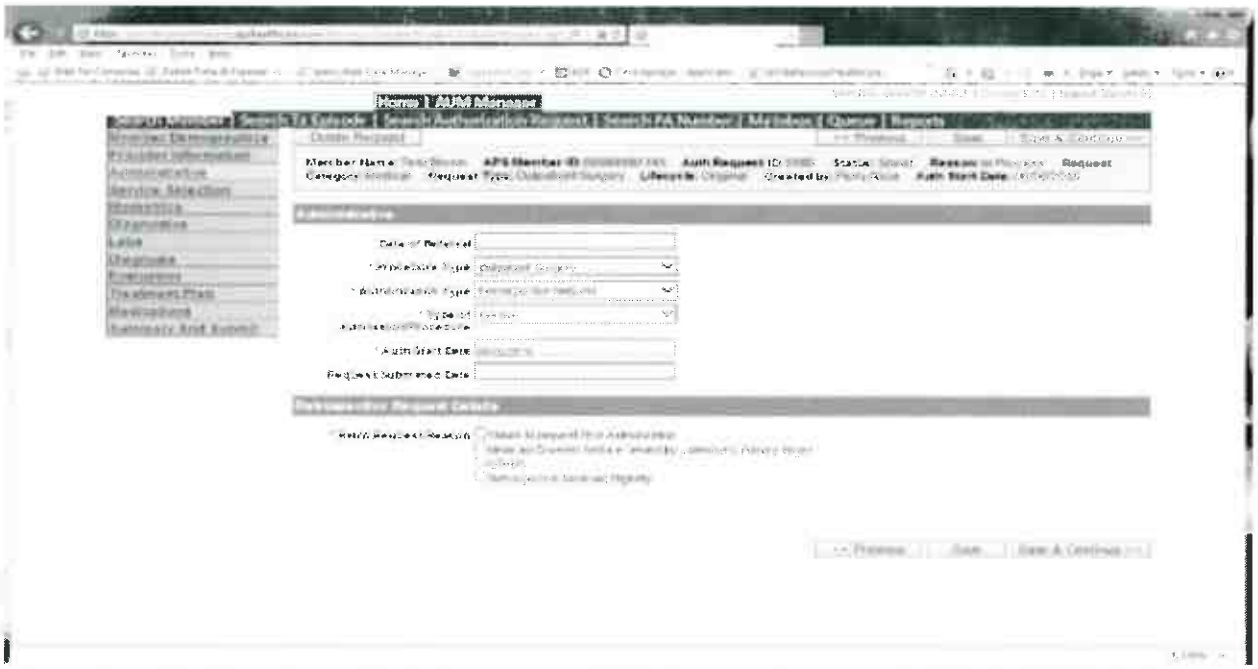
- Click on the Search provider
- Enter the physician's name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI, from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR 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 *. Procedure Type=Outpatient Surgery. Choose Type of Admission/Procedure. ***Please note: Emergency/Medically urgent should only be chosen if it meets BMS definition of medically urgent.*** If the surgical procedure has already taken place and the start date is within 10 business days of admission date, the authorization type will still be Prior.

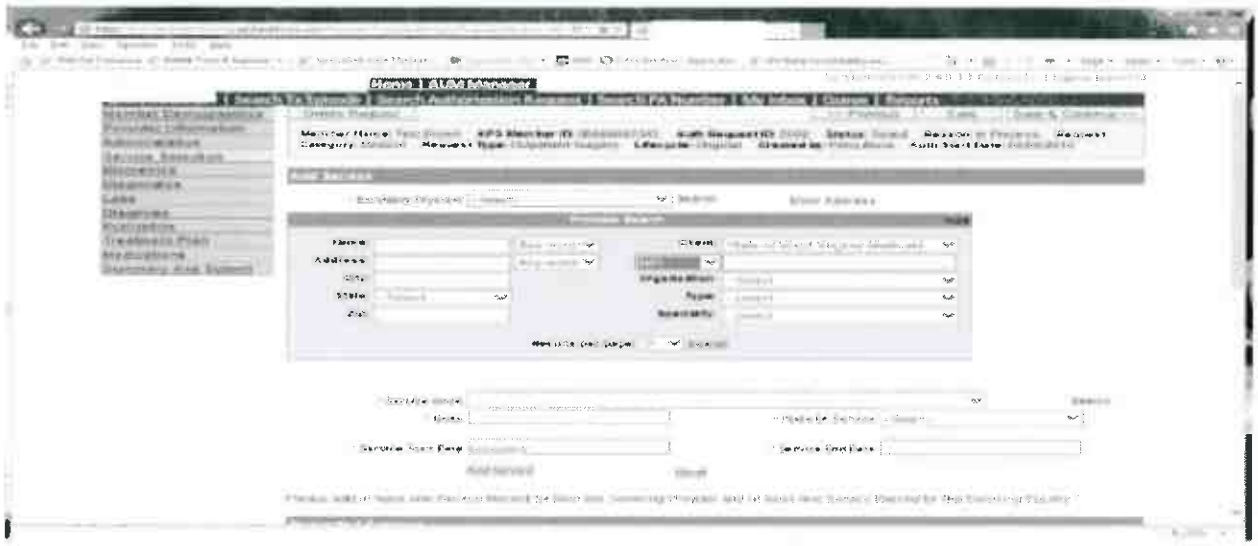
Administrative



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.

Service Selection

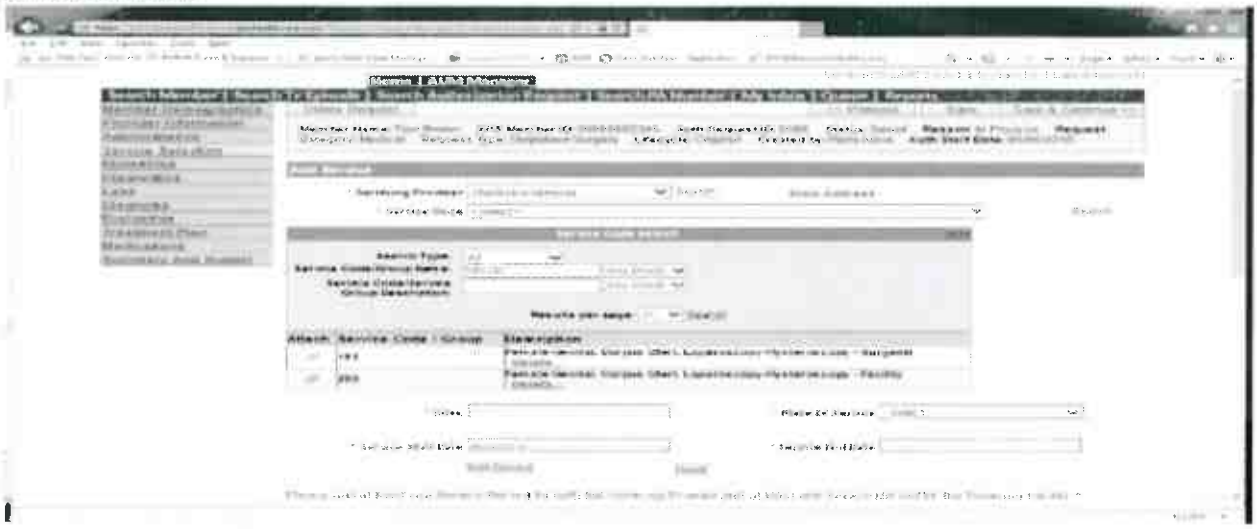


If you chose the servicing provider option, this will auto-populate. This information cannot be changed. If you chose the referring provider option, you will need to attach the Servicing Provider information to the request.

To find Servicing Provider:

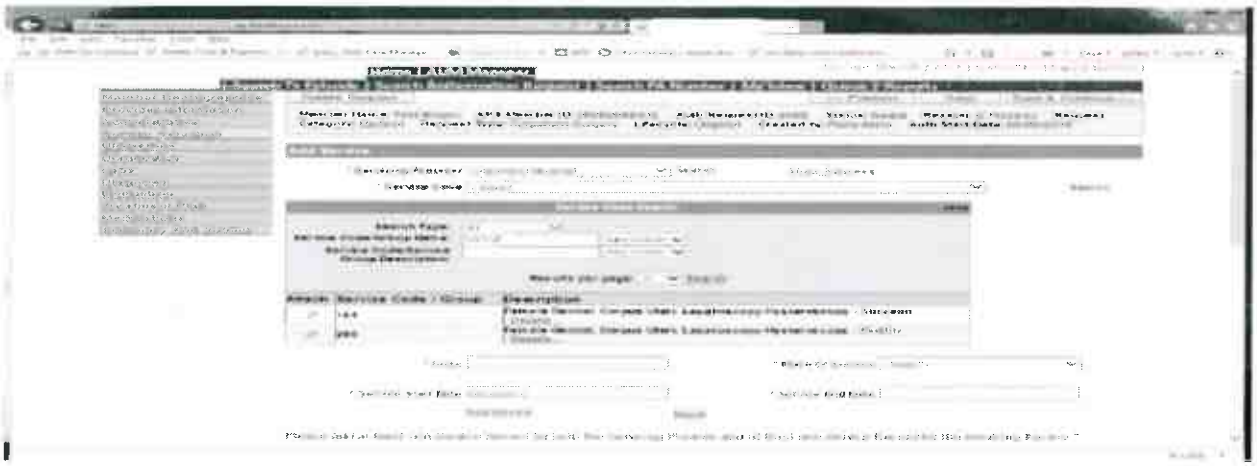
- Click on the Search provider
- Enter the name in the Name field and change Any Words to ALL WORDS and click Search or
- You can select NPI from the dropdown on the right side and enter the NPI number and click search
- DO NOT ENTER ANY OTHER INFORMATION IN ANY OTHER FIELDS. JUST NAME OR NPI NUMBER.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

Service Selection



To find your service code, click the Search link beside Service Code and enter your CPT (procedure) code in the Service Code/Group Name field and click search. The service code that your CPT code falls under will appear, for both the surgeon and facility. All surgeon codes will populate 1 unit and all facility codes will populate 16 units. Make sure if you are the facility, choose the facility codes first then go back to Search Provider, as above, and search for your surgeon. If you are the surgeon's office, choose the code for the surgeon first and then go back and search for the facility. Click ADD SERVICE after each addition. In the description, you can place your cursor over the DETAILS link to make sure that your CPT code is actually in the group that appears. If it is correct, click the paper clip to attach it. The example shows a search for CPT(procedure) code 58558.

Service Selection



Choose the place of service, and click Add Service under the Service Start Date. You have to do this twice, once for the surgeon and once for the facility. Units will auto generate. Please DO NOT change units. If there will be an assistant surgeon, please indicate in the annotation in the annotation box and then click save to save note. The service date span will be 90 days. Please DO NOT CHANGE service end date.

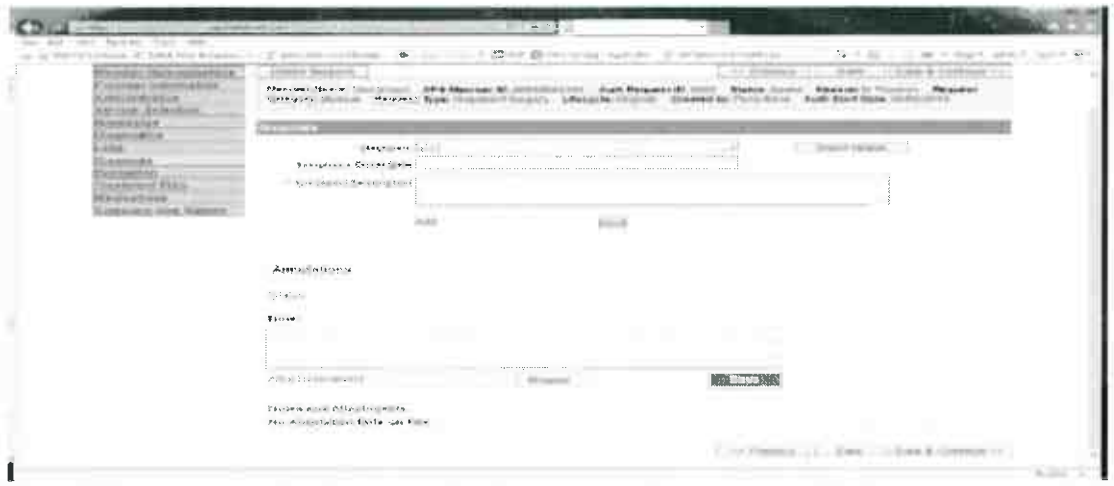
Answer question if admission follows observation. If so, click yes, if no, click no. You would then enter the CPT code of the surgery in the Surgery Procedures box, and if the request is for an orthopedic surgery, click yes to that question and click Save and Continue.

Please document the CPT code being performed in the Surgical Procedure box. If there is just a description entered, this will cause your requests to be pended by the reviewer for the CPT code.

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. ICD-10 diagnosis is required. 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 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. Click Save and Continue

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. Click continue

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

Outpatient Surgery Helpful Tips

- Please update the contact information for your office under the Referring provider section, including extensions in case of questions from the reviewers.
- Do not guess by searching the description given. CPT codes can be searched.
    - Beside the service selection box, there is a blue hyperlink that says search
    - Click search, a gray box will appear
    - Type the CPT code being requested in the first box
    - Click the Search hyperlink in the gray box
    - The code should appear below
- Click the paperclip to select the service code
- For each surgical code there must two lines in the service selection screen, one for the surgeon and another for the facility.
- Document CPT code being performed. OP Surgery codes are in bucket lists but some have different criteria.
- Double check the services selected by clicking details under the service selection.
- Include units for Botox
- Include the facility, as well as the surgeon.
- Indicate if the request is for bilateral.
- The Master Code list contains CPT and HCPCS codes that require a prior authorization and is available to providers. Please check the list first to determine if the procedure requires a prior authorization. If you do not have a copy of the MCL (master code list), it can be downloaded here: http://KEPROhealthcare.com/publicprograms/west_virginia/WV_Medical_Prov.htm
- Code changes need to be submitted within 10 business days of the procedure.
- Be sure diagnosis code is appropriate (example: ICD-9 prior to 10/01/2015 and ICD-10 after 10/01/2015).
- If clinical is being faxed, please document in an annotations box.
- When faxing additional documentation be sure to include the Authorization Request ID on the coversheet. Elective procedures require the clinical documentation to support the elective procedure: exam findings, labs, imaging, previous interventions etc.
- The requested surgery should correlate to the patient diagnosis and clinical documentation. For example, a request for a hysterectomy for a diagnosis of epilepsy where 100 pages of documentation is provided related to the member's epileptic history and various health issues does not correlate. The documentation submitted should be relevant to the request and support the medical necessity of the request.