PHYSICAL AND OCCUPATIONAL THERAPY UPDATE 2017

KEPRO
INTELLIGENT VALUE

Physical and Occupational Therapy

- Fee for service Medicaid patients can receive up to 20 visits of PT/OT per calendar year without prior authorization-however, prior authorization is recommended for benefit tracking.

- A calendar year is between January 1st and December 31st.

Initial vs. Established

Initial Request

- An Initial request is the first prior authorization request submitted by the provider for that calendar year.
- Initial requests are submitted **BEFORE** the 20 visits have been utilized.
- An initial request is made at the beginning of each calendar year for patients seen in the previous calendar year and still being seen. This is true even if the patient exceeded 20 visits in the previous year.
- If the member has not used their 20 visits for a current calendar year, it is considered an Initial Request.

Established Request

- This should only be used if the member in question has used their 20 visits for the current calendar year.
- If an established request has been initiated before the 20 units have been utilized, the member's benefit of 20 visits without prior authorization can no longer be utilized.
- You can not go back to the 20 visits once the Established request has been initiated.
  - Once an authorization number has been generated, services from that point on will need prior authorization.
- **ALL** Established Requests submitted will be reviewed for medical necessity, regardless of number of visits used without PA.

Initial vs. Established Scenarios

20 visits available

- Jane has come to a PT/OT provider on January 1st for a complaint.
- Jane has yet to use her 20 visits available through her benefit.
- Even if Jane has been a patient of that provider for the last 9 months. Once the new calendar year begins the provider would start the Initial Prior Authorization Request in the C3 system.
- The system will suppress authorization number and the provider can start rendering services.

20 visits utilized

- Jane has been seen by a PT/OT provider and has utilized all 20 visits after January 1st.
- The provider would start an Established Prior Authorization request in the C3 system.
  - Even if the provider cannot see an initial request started in C3, but knows patient has been seen for 20 visits.
    - If an initial request is already approved the system will not allow another to be created for that calendar year.
- The system will generate a billable authorization number when case is completed and approved.

PT/OT Authorization Process

- The Initial requests prior authorization number will be suppressed.
  - This means that no authorization number will be generated and sent to Molina.
  - The system will generate all 0's. (example: 0000000000).
- If an Initial prior authorization request is submitted, even if the member has used all 20 visits this calendar year, no authorization number will be generated it will be suppressed.
  - The provider will have to do a Copy for New Submission/New Request to create an Established request. Once this is submitted, it will be reviewed for medical necessity. If approved, an authorization number will then be generated and sent to Molina. The provider will be able to view this PA as they always have.
- If an Established prior authorization request is submitted before the Initial, it will be reviewed for medical necessity and the member's 20 visits without PA will become unavailable.
  - Once an actual PA is sent to Molina (the claims payer) there must be a PA on subsequent claims for any PT/OT provider.
    - You can not go back to the 20 visits once the Established request has been initiated.

Please choose carefully!

Alternative Benefit Plan

- An authorization number for billing purposes is needed if a Medicaid member is part of the expansion (ABP) and is in transition.
- If an Initial case is requested but later it is found the member has ABP the provider can do a Copy for New Submission/New case to receive an authorization number.
- It is up to the providers to be sure of what type of Medicaid the member has.
- Just keep in mind that Initial authorization requests will not generate a billable authorization number.
- There is no guarantee that the MCO will honor a PT/OT authorization once the member is transitioned, so a new authorization may need to be obtained.

Why should you submit if authorization is not needed for payment?

- Our system can be used for benefit tracking.
- This process helps minimize duplications.
- It can alert you of initial requests that have already been submitted in the C3 system.
- Allows easy submission for established requests using our Copy for New Submission Process (more information can be requested).

Scenarios

- If the member has not used their 20 visits and decided to change providers for the same area/body part-an established request must be submitted.
- If the member has not used their 20 visits and decided to change providers for a different area/body part-an established request must be submitted.
- If the member has not used their 20 visits and is staying with the same provider for a different area/body part-an established request for the evaluation ONLY should be submitted.

Modifications

- **COPY FOR NEW SUBMISSION:** A copy for new submission is requested when a copy for correction cannot be completed due to:
  - Closure of previous authorization request
  - Request is stuck in saved mode and won't submit.
- **MODIFICATION FORM:** Modification forms can be used for modifications to existing authorization for extension of end dates and units only.
- **COPY FOR CORRECTION:** A copy for correction is requested to change or correct services previously authorized. These include but are not limited to:
  - Code Changes
  - Service start dates.
  - Authorization number combination.
  - PLEASE BE SURE TO ADD ALL SERVICE LINES ON THE COPY FOR CORRECTION!!

Request Form

C3 Requesting/Submitting Organization _____ Please list exactly as registered on C3

Address, City, State, Zip _____

C3 Requesting/Submitting Organization NPI _____ Please list exactly as registered on C3

Person Submitting Request _____ Phone _____ Fax _____ Email_____

Referring/Ordering Provider (Per policy the Referring/Ordering Provider must be actively enrolled with WV Medicaid)

Name Do not write "See Above"	NPI Number	
Contact Information	Phone	Fax:

Place of Service/Servicing Provider (Per policy the Place of Service/Servicing Provider must be actively enrolled with WV Medicaid)

Name Do not write "See Above"	NPI Number
Address, City, State, Zip	

Member Medicaid Number _____ DOB_____

Member First Name _____ Last Name _____

Member Address, City, State, ZIP _____

Procedure Type: ☐ PT ☐OT

Patient Status: ☐ New ☐ Established

List Other Retro Reason:

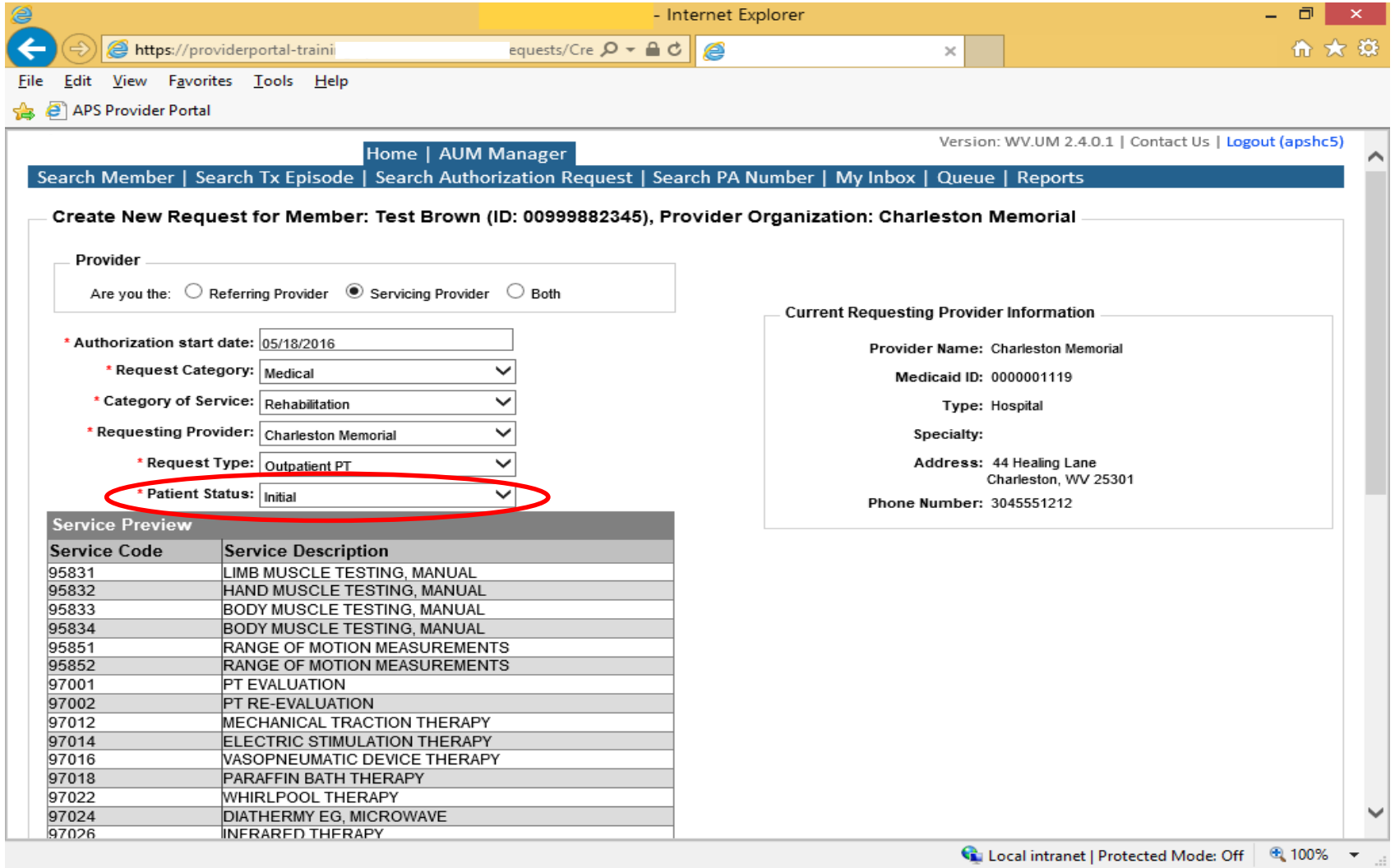
Authorization Type: ☐Prior Authorization

☐Retrospective Request, if applicable list the appropriate reason:

☐Denied by Member's Primary Payer ☐Retrospective Medicaid Eligibility

For Members under age 21, is this request an EPSDT referral? ☐Yes ☐NO **If yes, please submit the most current EPSDT form on file**

Requesting Online



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WEBSITE FOR SUBMITTING AUTHORIZATIONS: HTTPS://PROVIDERPORTAL.KEPRO.COM

WEBSITE FOR ORG MANAGERS TO ADD/MODIFY USERS: HTTPS://C3WV.KEPRO.COM