KEPRO
INTELLIGENT VALUE

Utilization Management Contractor

Provider Manual

for

Intellectual/Developmental Disabilities Waiver

UMC- I/DD Waiver- Provider Manual Table of Contents

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Introduction

KEPRO is a Quality Improvement Organization designated by the Centers for Medicare and Medicaid Services. KEPRO is an organization with unequaled experience with utilization management and prior authorization across the spectrum of health and human services. KEPRO brings 35 years of federal and state medical review and quality improvement experience, along with a background in Medicaid behavioral health, intellectual/developmental disabilities, waiver program management and state-funded programs.

KEPRO is an integrated care management and quality improvement organization serving both public and commercial health care markets.

KEPRO's Mission Statement

To advance the quality and efficiency of health care through integrated care management solutions tailored to the needs of our customers and stakeholders.

KEPRO's Vision Statement

To be an industry leader, known for our exceptional suite of products and services, our highly skilled professionals, and delivery of credible, measurable results to our customers and stakeholders.

Our Role

KEPRO is the contracted Utilization Management Contractor (UMC) for the WV Department of Health and Human Resources (DHHR) Bureau for Medical Services (BMS). In this capacity, KEPRO administers specific fee-for-service programs operations for the Bureau. All policies and procedures are approved by the State prior to implementation.

I/DD Waiver Program

The I/DD Waiver Program is a long-term care alterative, which provides services that enable individuals to live at home rather than receiving facility care. The program provides home and community-based services to West Virginia residents who are medically and financially eligible to participate.

As the UMC, KEPRO is responsible for the day-to-day operations and oversight of the I/DD Waiver program. This includes processing applications, conducting the medical evaluations for re-evaluations of waiver participants, managing enrollment, reviewing requests for prior authorization, providing training and technical assistance managing the Centers for Medicare and Medicaid Services (CMS) reporting and conducting reviews of services provided.

KEPRO I/DD Waiver Contacts

To reach KEPRO, please use any of the following contacts.

KEPRO
1007 Bullitt Street, Suite 200
Charleston, West Virginia 25301

Administrative Phone Number:	304-343-9663
I/DD Waiver Toll Free:	866-385-8920
Fax:	866-521-6882
Email Address:	WVIDDWaiver@kepro.com

KEPRO website: http://wvaso.kepro.com

I/DD Waiver CareConnection© web portal: https://WVLTC.kepro.com

KEPRO staff are available by phone 8 a.m. to 5:00 p.m., Monday through Friday.

Initial Application Processing

KEPRO manages and tracks initial applications for the I/DD Waiver program. Within 2 days of receipt of an initial application, KEPRO will key the request into the CareConnection© system and contact the applicant/legal representative to request they choose an Independent Psychologist (IP) to complete their Individual Psychological Evaluation (IPE) which will be used to determine initial medical eligibility. Upon receipt of their chosen IP, KEPRO will refer the member's case to the IP through the CareConnection© system. The IP will then document their attempt to contact the member for scheduling the IPE and document the appointment date and time within the system. This comprehensive system allows for seamless transition between the KEPRO, Medical Eligibility Contract Agent (MECA) and IP functions.

Once the IPE is complete, the IP will upload the assessment into the system for review by the MECA who will determine whether the applicant is medically eligible for I/DD Waiver services. The MECA then tracks their decision within CareConnection© which prompts KEPRO to create an authorization (when applicable) and the appropriate Notice of Decision Letter which is sent to the applicant/legal representative.

Managed Enrollment

Those applicants determined medically eligible will be placed on the I/DD Waiver Managed Enrollment List which is maintained within the I/DD Waiver CareConnection© system. When a funded slot becomes available, KEPRO will prepare correspondence to the eligible applicant/legal representative informing them they will be contacted for a functional assessment and instructing them to obtain financial eligibility at their local DHHR. Only after the member is determined both medically and financially eligible will KEPRO enroll the new program member.

Annual Functional Assessment

KEPRO will track attempted/successful contacts and appointments in CareConnection©. Experienced staff (Service Support Facilitators) will conduct the Annual Functional Assessment at least 30 calendar days prior to the member's Anchor Date. Data from the assessment will be input into CareConnection©, an individualized budget will be established and MECA can use the data/assessments to determine continued medical eligibility for I/DD Waiver services.

The Annual Functional Assessment will also include a component of education. A Service Support Facilitator will educate the potential program member/legal representative and his/her chosen respondents about their choice for service delivery model (traditional or self-directed), their choice of Service Coordination providers, available services, an option for Waiver services or for those provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). KEPRO will review the program's approved Handbook during each assessment and answer questions and/or refer the member to an applicable resource contact. KEPRO will use the Structured Interview, Inventory for Client and Agency Planning (ICAP) and the appropriate version of the Adaptive Behavior Assessment System for purposes of data necessary for the MECA to determine medical eligibility and for KEPRO to develop an individualized budget.

KEPRO makes every effort to complete assessments within timeline. When an assessment cannot be completed within timeline due to unforeseen circumstances, such as inclement weather or member cancellation, all attempted contacts/attempted appointments are tracked in the CareConnection© system.

Individualized Waiver Budgets

The KEPRO unbiased independent assessments are the foundation to collecting necessary data elements which are compared to global claims and statistically evaluated for relevance to those claims. Ultimately a needs-based individualized budget is produced and made available for each I/DD Waiver program member.

Upon receipt of to the total amount of I/DD Waiver program funds available for the program from the Bureau, KEPRO will adjust the algorithm to produce future budgets that are within the total available program funds. In the event that a program member's needs change, KEPRO can accommodate a new budget amount (upon request/approval from the Bureau), or authorizations for services in excess of the individual budget amount through the negotiation process. The budget will be made available to the Service Coordination Agency or the fiscal/employer agent for self-directing members through the CareConnection© system.

Education, Training, and Technical Assistance

KEPRO Provider Educators (PEs) conduct activities to support efforts to improve the provision of I/DD Waiver services. In addition, KEPRO helps assure quality outcomes are achieved through deliberate, focused training and evaluation of the I/DD Waiver system.

Ongoing and specific feedback is provided to agencies in order to assist them in improving both their documentation practices and their utilization management structures. Relative to documentation practices, providers receive on-site technical assistance/trainings, feedback from chart reviews, and consultative reports that may be utilized as tools to enhance agency performance. In the utilization management arena, providers receive a systems analysis which allows for ongoing/continuing growth in developing needed structures to assure improved outcomes. As program performance data are analyzed over time, providers are educated on the results and attend training that assists in improving utilization management structure.

Training & Technical Assistance

Training and technical assistance are designed to meet providers' needs and may be delivered via face-to-face instruction or via web meeting. A sample of topics includes:

- Person-centered Planning
- Appropriate Use of Service Codes
- Service Coordination
- System for Data Submission
- Use of the WV I/DD Waiver CareConnection©
- Requesting Prior Authorization for Services
- Budget/Service Negotiation
- Best Documentation Practices
- Individual Program Plan (IPP) Development
- Alternative/Complementary Services
- Mechanisms to Assure Staff Competency
- Utilization Management

KEPRO Provider Educators are also accessible by phone or e-mail for providers to contact regarding questions or issues about the program.

Provider Trainings

KEPRO offers training in venues designed to meet the needs of providers. Training topics are identified through KEPRO staff observation, consultation score results, provider input, and stakeholder recommendations through the Quality Improvement Advisory (QIA) Council process. Training modules are developed through research and consultation to address the targeted areas. Training gatherings may include lecture, panel discussion, question and answer sessions, and/or small group discussions or may be individualized for a specific provider.

KEPRO trainings may be statewide, regional, or provider specific. To accommodate the needs of a wide range of providers, trainings on some topics may be open to all interested parties (subject to facility limitations), while others may be offered by invitation only. While every effort will be made to provide adequate advance notice to providers, some training may require a short planning timeframe to address pressing concerns and meet the needs of providers. Training announcements will include the training topic, learning objectives, target population, date, time, location, and continuing education information. Training information may be provided through phone calls, mailings, email, fax and/or website posting. A training module or topic objective will be established for all trainings, along with a roster of participants and completed evaluations. KEPRO works with various licensing/credentialing boards to gain approval for continuing education credits.

New Provider Orientation

The provider orientation program is KEPRO's first step in the development of long-lasting partnerships with providers. New Provider Orientation is offered to assure that new providers develop effective utilization management and other skills needed to successfully provide services to I/DD Waiver members.

Focused Training

In addition to statewide and regional trainings, KEPRO also provides focused or specialized trainings. Trainings are tailored to meet the specific needs of providers. It is recommended that providers take advantage of these on-site trainings by allowing access to front-line staff. Focused or specialized trainings can assist providers as they seek to improve their performance in areas that have a direct impact on the actual day-to-day processes staff members encounter.

Feedback

In accordance with the KEPRO Quality Improvement Plan, stakeholder input is solicited through a variety of means to ensure that the training provided is based on identified needs and is clear, relevant, beneficial, and of high quality. Satisfaction surveys are requested for all training sessions. The results of the training surveys are reviewed for future training needs and for internal quality improvement. Consultation scores are reviewed monthly to identify and target further training issues. Additionally, the Quality Improvement Advisory Council process provides ongoing stakeholder input into the development of quality provider training.

Technical Assistance

KEPRO is dedicated to providing responsive technical assistance to West Virginia's Title XIX MR/DD Waiver providers. KEPRO is available for consultative technical assistance, which is scheduled around the consultation process, or general technical assistance that is available on both a scheduled or nonscheduled/as-needed basis. Providers are encouraged to utilize technical assistance provided through KEPRO. All technical assistance is available by telephone, written communication, or face-to-face communication, and all technical assistance activities are tracked.

Consultative Technical Assistance

Each provider agency is assigned an KEPRO Provider Educator, so that in-depth understanding of each provider's quality improvement needs can be developed. With this knowledge, Provider Educators provide customized technical assistance to providers on issues regarding service provision, utilization management, and the registration/prior authorization process.

Consultative technical assistance is centered on the consultation process and follows pre-set timelines. The Exit Interview, or Exit TA, is provided at the end of the on-site review and involves a summation of the initial findings of the consultation/review.

- To request any type of technical assistance, contact KEPRO at (304) 343-9663.

Review Criteria

KEPRO has been administering the Inventory for Client and Agency Planning since 2005 and the Adaptive Behavior Assessment System since 2011. These assessments, in conjunction with the Structured Interview and the Extraordinary Care Assessment (both developed by KEPRO) comprise the Annual Functional Assessment.

During the Annual Functional Assessment, KEPRO will provide stakeholder education including choice of providers, choice of service delivery model, choice of Waiver or institutionalization.

This education and assessment will be conducted face-to-face and the assessment findings will be the basis for determining the member's level of functioning in the following areas as currently required for program eligibility: Self-care; receptive or expressive language; learning; mobility; self-determination; and capacity for independent living –and- to determine the member's Waiver budget.

Quality Assurance Activities

KEPRO is committed to promoting delivery of quality services to I/DD Waiver program members. To that end, quality assurance activities are conducted with providers, members, and other stakeholders.

Provider Self-Reviews

To ensure compliance with Centers for Medicare and Medicaid (CMS) Quality Assurances, each year, providers are required to submit a self-review of services provided to I/DD Waiver recipients. With the self-review, agencies will report on compliance for the following Quality Assurances:

Quality Assurance—Qualified Provider: Agencies will report on the qualifications of 100% of staff who were employed at any time during the assigned review period by following the instructions provided with the self-review tool. Data on the following requirements must be reported:

- Confidentiality Training,
- Member Rights Training,
- Training on Recognition/Reporting of Abuse/Neglect/Exploitation,
- Infectious Disease Control Training,
- CPR Training,
- First Aid Training,
- Training in Health and Welfare (specific to person who receives services) and
- Training in Person-Centered Support (specific to person who receives services).

Quality Assurance—Service Plan: Agencies will report on the service plans of 10% sample of persons served by the agency at the beginning of the review period. The sample will be representative of ages and living settings of individuals served by the agency, as well as of the services provided by that agency; it will be identified by KEPRO and included with the agency's notification of the due-date and review period. Data on the following requirements must be reported:

- Service Plan Reflects Assessed Need,
- Service Plan Reflects Desired Outcomes,
- Service Plan Reflects Identified Health and Safety Risks,
- Service Plan is Updated Annually and Revised as Needed,
- Service Plan Reflects Type, Scope, Duration, Amount, and Frequency of Services Specified in the Service Plan,

- File Contains Signed and Current Freedom of Choice Form Designating Chosen Service Delivery Model and
- File Contains Signed and Current Freedom of Choice Form Designating Chosen Service Coordination Agency.

Quality Assurance—Health and Welfare: Agencies will report on the health and welfare requirements of the same sample used to report service plan data. Data on the following requirements must be reported:

- Staff Criminal Background Checks with Satisfactory Results,
- Office of Inspector General (OIG) List of Excluded Individual Checks with Satisfactory Results,
- Acknowledgement of Person Who Receives Services on Reporting Abuse/Neglect/Exploitation,
- IMS Critical Incidents Resolved within Timelines,
- IMS Critical and Abuse/Neglect/Exploitation Incidents Followed-Up On within Timelines and
- Behavior Support Plans Involving Restrictive Interventions Approved by Human Rights Committee.

Agencies are notified at least 90 days in advance of the date their review is to be submitted to KEPRO, as well as of the time period for which they are to provide information. KEPRO will disseminate a self-review tool that providers will use to report their findings, as well as an affidavit that must be signed by executive leadership to attest to the accuracy of the report.

On-Site Provider Reviews and Validation

In keeping with the requirement to ensure compliance with Centers for Medicare and Medicaid (CMS) Quality Assurances, each year, KEPRO will conduct annual on-site reviews with provider agencies. KEPRO Provider Educators conduct reviews of provider documentation practices and provider utilization management processes. Technical assistance is offered as needed so that improvements can be attained and sustained. The ultimate goal of the review process is to assist providers in achieving positive outcomes for individuals and families through the services provided. Within a consultative atmosphere, providers are given an optimal opportunity to succeed in meeting the documentation standards set forth by WV-DHHR.

During the on-site review, KEPRO will review a 10% selection of the qualified providers reported upon in the agency-submitted self-review. The purpose of this review is to validate the information provided by the agency. In addition, KEPRO will validate the service plan/health and welfare sample submitted via the self-review and will review an additional 10% of files of persons who receive services. The additional files will be requested the first day of the review.

Schedule/Notification to Providers: KEPRO will notify providers in advance of their review Anchor Date. Reviews will occur within a 60-day period around that Anchor Date. For example, an Anchor Date of August 1st indicates the provider review will occur any time between July 1 and August 31. Upon arrival, KEPRO will provide a list of program members and staff that will comprise the review sample.

The Review: Ensuring a productive and accurate review will require provider assistance before, during, and after. A work area that is conducive to maintaining confidentiality and that includes electrical outlets and internet access should be made available. In addition, the provider should ensure that KEPRO has access to files of all staff and persons who receive services.

Upon arrival, KEPRO Provider Educators will conduct an introduction in order to provide any needed clarification and for identification of agency staff who will serve as the point of contact during the review. Providers are invited to meet with the reviewers throughout for technical assistance.

During the review, Provider Educators will review the selected files for compliance in the following areas:

- Qualified Provider,
- Health and Welfare,
- IPP Compliance,
- Utilization Management,
- WV Incident Management System,
- Individual Services Provided,
    - Direct Care,
    - Service Coordination,
    - Behavior Support Professional,
    - Registered Nurse,
    - Licensed Practical Nurse.

In addition to the on-site review of files of staff and persons who receive services, KEPRO will conduct interviews with staff and satisfaction surveys with persons who receive services. Visits of each agency-operated day service and a percentage of licensed residential sites will also be conducted, in order to evaluate compliance with the CMS Integrated Settings Rule.

According to agency preference, daily exits can be conducted or one exit can be conducted at the conclusion of the review. At the exit(s) findings will be discussed, and technical assistance will be conducted and/or scheduled. Providers are encouraged to include clinicians in the exit meeting(s).

Recommendations for Disallowance: Certain deficiencies identified require recommendation for disallowance. Disallowances are recommended when services are provided by unqualified staff

or when services are delivered that are invalid. BMS and the Office of Program Integrity (OPI) will make a final determination regarding disallowances.

After the Review: If there are no disallowances, within 30 days of the conclusion of the review, the BMS I/DD Waiver Program Manager will forward the following:

- Final Review Report: identifies issues found during the review,
- Final Disallowance Report: will indicate there are no disallowances and
- Plan of Correction: if applicable, with completion instructions and due-date.

If there are disallowances, the provider agency will receive via secure email a letter from KEPRO as well as the following:

- Draft Review Report: identifies issues found during the review,
- Draft Disallowance Report: instructions on provision of required claims data will be provided. The agency may also include comments related to the recommendations for disallowance and
- Plan of Correction: with completion instructions and due-date.
-

For those providers whose review results in recommendations for disallowance, KEPRO, BMS, and OPI will meet to discuss the provider's comments and approved Plan of Correction. Any changes made based on provider comments will be included in the final disallowance report, which will be forwarded, along with a final review report, by BMS.

Follow-Up Plan of Correction: Six months following the review, KEPRO will select a sample of individuals, dependent upon the results of the review, for follow-up. This follow-up will consist of a review of the provider's approved Plan of Correction to evaluate compliance with policy and follow-through on the plan.

Quality Improvement Advisory (QIA) Council

The QIA Council is the focal point of stakeholder input for the I/DD Waiver program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The role of the QIA Council is to advise and assist BMS and KEPRO in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses the CMS Quality Assurances as a guide to:

- Recommend policy change,
- Recommend program priorities and quality initiatives,
- Monitor and evaluate policy changes,
- Monitor and evaluate the implementation of priorities and quality initiatives,
- Serve as a liaison between the I/DD Waiver and interested parties and
- Establish committees and work groups consistent with its purpose and guidelines.

The Council membership is comprised of persons who either formerly or currently receive I/DD Waiver services or their family members, service providers, advocates, and other stakeholders. Applications for the Council, which meets quarterly, can be found at this link: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/Pages/QIA-Council.aspx

Participant Experience Survey

KEPRO staff conduct the Participant Experience Survey with a representative sample of program participants annually. These surveys are scheduled and conducted by an KEPRO Consumer/Family Educator and the results are compiled, analyzed, and presented to BMS with recommendations for program policy and quality.

Complaints

KEPRO receives, reviews, tracks, and/or investigates complaints submitted by providers, persons who receive services, or other stakeholders related to services of program participants. A consistent procedure is followed in responding to complaints and reporting to BMS on trends and outcomes.

Complaints can be received either verbally, or in writing via mail, email, or fax. Upon receipt of a formal complaint, KEPRO will track the complaint and request any information needed for follow-up. As appropriate, technical assistance and referrals will be provided, or an investigation may be conducted.

The complainant is informed that providers are required to have a grievance/complaint procedure and information will be requested regarding what steps have been taken to resolve the complaint at the agency level. Though complainants are encouraged to attempt to resolve the issue at the agency level first, it is not required in order to file a formal complaint. Anonymous complaints may be made, and KEPRO will follow-up, including conducting an investigation if needed, to the extent possible with the information provided.

When an investigation is conducted, KEPRO will notify the provider, as long as doing so will not compromise the integrity of the investigation. Formal complaints are responded to in writing within 2 business days; however, an anonymous complaint will not be considered formal in nature. Complaints will be handled in the least restrictive manner necessary.

As appropriate and required, referrals to appropriate protective services entities will be made.

WV Incident Management System (IMS)

KEPRO monitors the IMS daily to ensure that agencies have followed-up with incidents within timelines. If it is found that agencies have not followed-up as required, KEPRO will contact the agency to request follow-up and provide technical assistance as necessary. In the event that it is noted as a significant issue with a particular provider, KEPRO will offer training and technical assistance to the agency in an effort to remedy the issue.

Authorization, Negotiation and Appeals

KEPRO staff review requests for prior authorization and make determinations regarding: Whether the member's health and safety has been addressed by the team, whether requested services are within policy parameters and, whether requested services are within the member's individualized budget.

Prior Authorization Process

With few exceptions, I/DD Waiver services require prior authorization before they can be delivered to recipients. Requests for prior authorization are submitted by the Service Coordinator (SC) to KEPRO via the I/DD Waiver CareConnection©. At the member's Inter-disciplinary Team (IDT) meeting, the team determines the number of necessary units of each service and the SC submits a request for those services in CareConnection©.

Within 48 hours of the request, the KEPRO Registration Coordinator will conduct a review and make one of the following determinations:

1. The request can be **approved**—if the request is approved, an authorization number is provided in CareConnection©.
2. The request must be **closed**—a request cannot be approved and must be closed if approval would cause the budget or service limits to be exceeded, if necessity for the service(s) is not demonstrated, and/or a request for documentation has not been responded to within 10 days.
3. Additional **information** is needed—if additional information, such as required documentation or clarification is needed, the SC will be notified via a documentation request in CareConnection©.

Crisis Services and Crisis Site Person Centered Support services can be provided without a prior authorization for up to 72 hours. This is to allow the IDT to address crises immediately; the SC must submit a request for authorization as soon as it can be done.

It is important to note that KEPRO does not deny requests for service. Only the Bureau for Medical Services (BMS) has latitude to deny I/DD Waiver requests. Any request that is closed by KEPRO can be appealed via second level negotiation thereby requesting a BMS review and decision.

Second Level Negotiation

Second level negotiation requests are submitted to KEPRO. Upon receipt, KEPRO tracks the request and reviews it for accuracy. If the request requires additional information, KEPRO will notify the SC of the specific documentation and/or clarification needed. If no additional information is needed, KEPRO forwards the request to BMS.

Upon receipt of the completed second level negotiation request, BMS will either approve the request, deny the request, or contact the provider to negotiate. If BMS approves the request, KEPRO will notify the provider and facilitate approval of the requested units of service. In the event the request is denied, KEPRO will provide a Notice of Denial to the person who receives services via mail and will attach that Notice to CareConnection©. **Authorized units of service will be modified to reflect the approvable units**

per the Notice of Denial. If BMS negotiates and reaches an agreement with the individual, KEPRO will facilitate approval in CareConnection© of the agreed-upon units of service.

Medicaid Fair Hearing

Medicaid recipients may request Medicaid Fair Hearing any time a denial or reduction in eligibility or service occurs. The Notice of Denial sent at the conclusion of unsuccessful second level negotiation will include a request for Medicaid Fair Hearing and instructions on requesting a hearing. If the recipient wishes to request Medicaid Fair Hearing, he or she will submit the request to the Board of Review according to the instructions in the Notice of Denial.

A "stay" can be granted, meaning the individual can receive the previously approved level of services until a hearing decision is received, if the Board of Review receives the request for hearing within 13 days of the date on the Notice of Denial. If the individual wishes to receive a stay, the SC should contact KEPRO to verify eligibility for the stay and to request authorization of the previously approved level of services.

If the Board of Review receives the request for hearing within 90 days of the date on the Notice of Denial, but after 13 days, a hearing will be scheduled, however, a stay will not be available.

Individuals who choose to pursue Medicaid Fair Hearing may seek legal counsel; if this occurs, they are required to notify the Board of Review, who will in turn notify BMS. BMS will also secure legal representation at that time. Note that if legal counsel is secured, all communication must occur between attorneys.

BMS, or BMS counsel if applicable, will attempt to schedule a pre-hearing conference once the Scheduling Order for the Medicaid Fair Hearing has been received by all parties. The pre-hearing conference is a mechanism by which BMS and the individual are able to negotiate again. If the pre-hearing conference results in successful negotiation, the individual will withdraw the hearing. If an agreement cannot be reached, the hearing will take place as scheduled.

The Medicaid Fair Hearing is a formal proceeding at which BMS and the individual will present testimony to a hearing officer regarding the reduction or denial that has occurred. The hearing, which will be recorded, may be held via telephone, video-conference, or in person at BMS, per the individual's choice. The hearing officer does not render a decision immediately following the hearing. Rather, he/she will review the recording of the hearing and provide a written decision to the parties within 90 days date of the Notice of Denial. The hearing officer will either decide to:

- **Uphold** BMS' decision: the hearing officer agrees with BMS' original decision to deny the request, or
- **Reverse** BMS' decision: the hearing officer does not agree with BMS' original decision to deny the request and finds in favor of the person who receives services.

In the event BMS' decision is upheld, the individual may request that the decision be reviewed by the Board of Review. If a satisfactory outcome is not achieved with that review, the decision can be appealed

via State Circuit Court; if the Circuit Court upholds the decision it can be appealed via the State Supreme Court.

Fraud, Waste, Abuse Referral

KEPRO is contractually obligated to report any suspected fraud, waste, and abuse to BMS' Office of Program Integrity (OPI).

For Additional Information

Bureau for Medical Services

350 Capitol Street, Room 251
Charleston, WV 25301
Phone: 304.558.1700
Fax: 304.558.4398
Website: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/Pages/default.aspx

Utilization Management Contractor

KEPRO
1007 Bullitt St., Suite 200
Charleston, WV 25301
Phone: 866.385.8920
Fax: 866.521.6882
Email: WVIDDWaiver@kepro.com
Website: http://wvaso.kepro.com

Fiscal Employer Agent (Personal Options)

Public Partnerships, LLC (PPL)
Phone: 877.908.1757
Efax: 877-567-0071
Website: http://www.publicpartnerships.com/programs/WestVirginia/WVIDD/index.asp

Claims Processing

Molina Medicaid Solutions
For Providers: 888.483.0793
For Members: 304.343.3380
Fax: 304.348.3380
Website: https://www.wvmmis.com/default.aspx

West Virginia Protective Services

Phone: 800.352.6513
Website: http://www.dhhr.wv.gov/bcf/Services/Pages/default.aspx

Office of Health Facility Licensure and Certification (OHFLAC)

408 Leon Sullivan Way Charleston,
WV 25301
Phone: 304.558.0050
Fax: 304.558.2515
Website: http://ohflac.wv.gov/

Change Log

Date	Change
1/31/2017	Section: Quality Assurance Activities, On-Site Provider Reviews and Validation Updated Language: *Schedule/Notification to Providers:* KEPRO will notify providers in advance of their review Anchor Date. Reviews will occur within a 60-day period around that Anchor Date. For example, an Anchor Date of August 1st will mean the provider review will occur any time between July 1 and August 31. Upon arrival, KEPRO will provide a list of program members and staff that will comprise the review sample. Rationale: Language updated to reflect current process effective 1/1/2017 with "new" review tool.