KEPRO PRIOR AUTHORIZATION

Presented by Wendy Sprigler RN, Provider and Member Liaison Coordinator

What comes after submission?

TOPICS

- What happens after submitting prior authorization requests
- Pended (Suspended) Prior Authorization (PA)
- Transferring Prior Authorizations between providers
- Retroactive PAs
- PA with Third-Party Liability
- PA Administrative Review and Appeal Process
- Common Denials
- Helpful Links
- Contacting Kepro
- Questions

Kepro®

What happens after submitting prior authorization requests

AUTHORIZATION REVIEWED

- Turn around time: 7 calendar days
- All documentation and criteria/requirements reviewed
- Clinician determines if they can approve request

CLINICIAN UNABLE TO APPROVE REQUEST

- If the clinician cannot approve the PA based on criteria hierarchy the case is sent to a physician to review for medical necessity.
- All submitted documentation is reviewed and a decision is returned to the clinical reviewer.
- The clinical reviewer enters the decision into the case in Atrezzo.

ONCE THE PA REVIEW IS COMPLETED

- Clinician enters the decision in the system
- Extraction file sent to Gainwell; authorization number generated, and letters sent
- If submitted via portal, notice of case status change and letter creation sent
- View/download authorization letter within case (under Attachments-Letters)
- Letters mailed

Pended (Suspended) Prior Authorization (PA)

PENDED PA (PREVIOUSLY REFERED TO AS SUSPENDED)

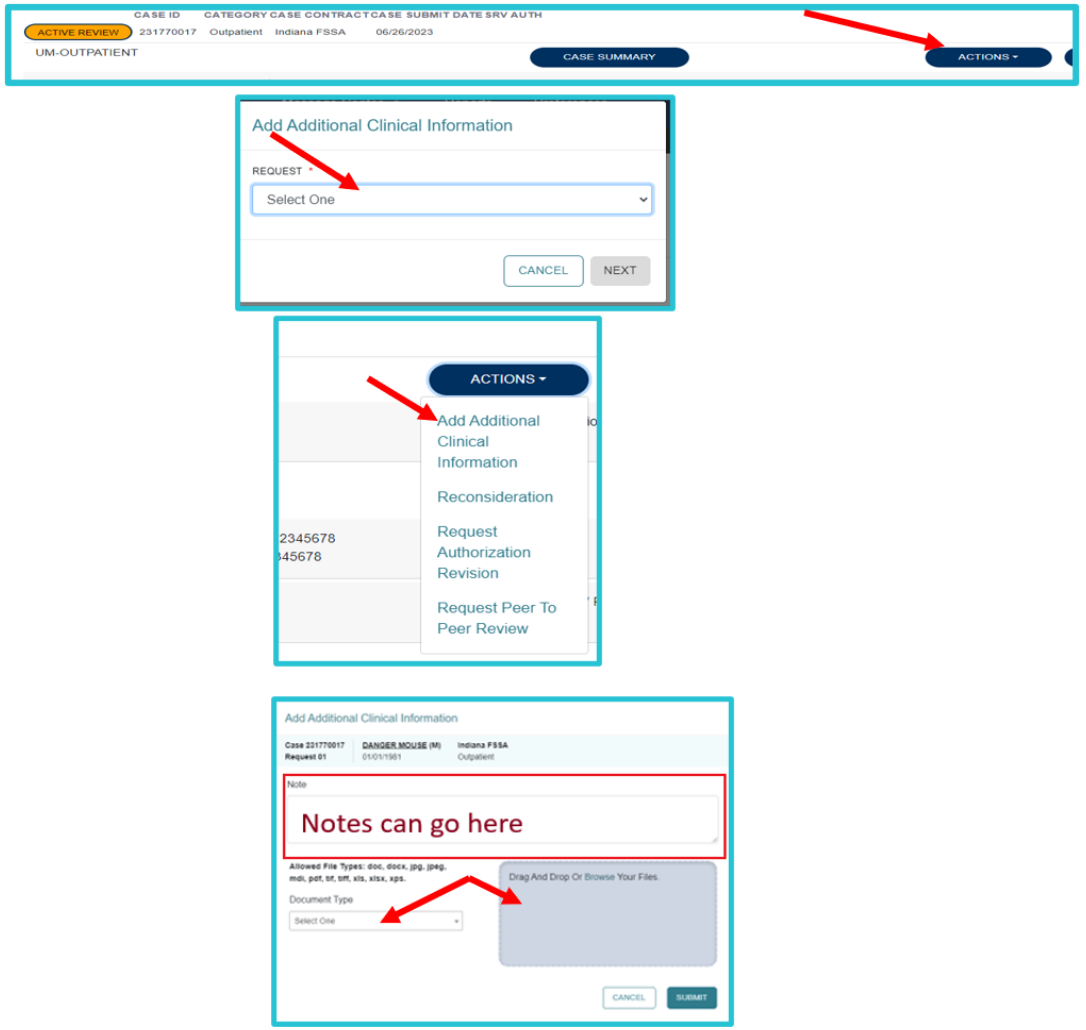
- If requested PA has insufficient information for Utilization Management (UM) team to review, request is pended
- Turn around time clock is stopped
- Clinical will ask you for information that is needed

PA CASE IS PENDED

- If submitted through portal, notification is sent via email and available on portal
- Letter mailed to address on file
- Required clinical information must be submitted via portal or by fax within 30 days
  - ✓ In portal: upload documentation (Actions drop down/ Additional Clinical Information option)
  - ✓ To fax: 800-261-2774
- If information not received within 30 days, request is rejected

ADDING DOCUMENTS TO CASE

- Actions drop down (top right screen)
- Select Add Additional Clinical Information
- Select which request line (i.e., R01, R02), generally the most recent
- Browse for a file or drag and drop it into the box
- Select type of document being uploaded



WHAT HAPPENS NEXT?

- When additional information is submitted, the nurse receives a task to begin the review.
- The case is reviewed for medical necessity.
- Thee turn around time clock is restarted once the additional information is received.
- The reviewer will complete review within 7 total calendar days.

Transferring Prior Authorizations between providers

Kepro®

ASSUMING A PA FROM ANOTHER PROVIDER

- Fax a request to 800-261-2774
- Provide all relevant information including but not limited to:
  - ✓ Member information
  - ✓ Originating provider information
  - ✓ Authorization if available
  - ✓ Procedures on the PA request
  - ✓ Date PA will be assumed
  - ✓ Hospice providers required to submit completed Hospice Provider Request Between Hospice Providers Form

TRANSFERRING OUTSTANDING PA: DURATION

- When member changes eligibility to Fee-For-Service (FFS) coverage, Kepro honors existing PAs for specific durations, whichever comes first:
  - ✓ First 30 calendar days from member's effective date in new plan
  - ✓ Remainder of the PA dates of service
  - ✓ Until approved units of service are exhausted
- **A PA is not a guarantee of payment**

TRANSFERRING OUTSTANDING PA: PROCESS

- Providers should check eligibility before requesting or rendering service
- With any change in Member's assignment to FFS, notify Kepro of any current PA; included supporting documentation to substantiate PA
- Original PA letter must provide Kepro with the following:
  - ✓ Member ID (MID)
  - ✓ Provider's National Provider Identifier (NPI)
  - ✓ Duration and frequency of authorization
- Fax letter with explanation of request: 800-261-2774

Retroactive PAs

RETROACTIVE PA REASONS

- Pending or retroactive member eligibility
- Administrative delays or errors by PA contractor, county, or state
- Services rendered out of state by a provider that is not enrolled as an Indiana Health Coverage Programs (IHCP) provide and become retroactively enrolled
- When requesting a retroactive PA, detailed information and documentation to explain late request is required

RETROACTIVE PA: PROVIDER NOT AWARE OF MEMBER ELIGIBILITY

Retroactive PA may if granted if the following conditions are met:

- Provider's records document that the member failed to inform provider of IHCP coverage
- Provider can provide documentation that reimbursement was continually pursued from member until IHCP eligibility was discovered
- Provider submitted the PA request within 60 calendar days of the date eligibility was discovered

PA with Third-Party Liability

PA FOR MEMBERS WITH THIRD-PARTY LIABILTY (TPL)

- For members with TPL primary insurance, the provider will:
  - ✓ Follow the TPL authorization requirements
  - ✓ Obtain PA from Kepro
- Members with Medicare or Medicare Advantage plan primary insurance:
  - ✓ Covered Medicare services do not require a Kepro authorization
  - ✓ Services not covered by Medicare subject to IHCP PA requirements - PA must be obtained from Kepro

PA Administrative Review and Appeal Process

Kepro

REQUESTING PA RECONSIDERATION

- Request for review within 7 business days of receipt of notification of modification or denial
- Inpatient hospitalizations when member continues to be hospitalized:
  - ✓ Notification of intent to request review must be submitted within 7 business days of receipt of notification of modification or denial
  - ✓ To continue with request, Kepro must receive entire medical record within 45 calendar days of discharge

INITIATING ADMINISTRATIVE REVIEW

Provider must include the following information with the request:

- Summary of request including pertinent reasons for medical necessity
- PA number
- Member name
- IHCP Member ID (MID)

REQUIRED ADMINISTRATIVE REVIEW DOCUMENTATION

- Documentation of medical necessity
  - ✓ Pertinent to case, supports medical necessity
    - No need to duplicate documents already provided
- Submitting provider name, phone number, address
- If submitted via portal:
  - ✓ Enter pertinent reasons for medical necessity in note box
  - ✓ Attach other supporting documents (no form letter)
- Once review is processed, provider and member notified of outcome by letter

3 WAYS TO SUBMIT PA ADMINISTRATIVE REVIEW

- Atrezzo Provider Portal, under Actions tab
  - ✓ Select Reconsideration
  - ✓ Enter a note and add documents
- Fax to 800-261-2774
- Mail to:

  Kepro
  6802 Paragon Place, STE 440
  Richmond, VA 23230

Note: Submitting via other avenues can delay process.

ADMINISTRATIVE HEARING REVIEW PROCESS

- If Administrative Review decision is favorable: authorization effective on the originally requested date
- If decision is to uphold authorization denial: provider may file an appeal within 33 days of adverse decision
- Members can appeal PA decision in writing:
  - ✓ Letter explaining why they think decision is wrong
  - ✓ Letter must include member name and other important info (e.g., date of decision)

REQUEST FOR ADMINISTRATIVE HEARING SUBMISSION

- **Mailed to**:

  Family and Social Service Administration

  Office of Administrative Law Proceedings – FSSA Hearings

  402 W. Washington St, Room E034

  Indianapolis, IN 46204
- **Fax:** 317-232-4412
- **Email:** fssa.appeals@oalp.in.gov

ADDITIONAL APPEAL PROCESS INFORMATION

- As required by statute: if request for hearing is received before effective date of denial/modification, services continue at the authorized level of previous PA
- If appellant is not the member: request must include documentation that appellant has legal right to act on behalf of member is required (e.g., Power of Attorney for Healthcare or legal guardianship papers)

Common Denials

COMMON DENIALS/CASE VOIDS

- Does not meet medical necessity
- Untimely request
- Duplicate request
- Missing document not received within 30 days

Some denials may be avoided by submitting complete documentation in a timely manner

Helpful Links

HELPFUL LINKS

- **Indiana Medicaid FFS provider education**
- **Provider Portal** (preferred method for submission)
- **FSSA forms**

OTHER HELPFUL PROVIDER LINKS

- Indiana Medicaid for Providers
- Indiana Medicaid: Providers: Forms
- Modules for Providers
- Provider Fee Schedules
- IHCP Bulletins

Contacting Kepro

INDIANA AUTHORIZATIONS EMAIL

- Email is for system access, registration, and submissions issues:

  INPriorAuthIssues@kepro.com

- Include:
  - ✓ Detail information about issue
  - ✓ Member ID
  - ✓ Provider ID
  - ✓ Case #
  - ✓ Screen shots of error messages
  - ✓ Any other helpful information to identify problem

***Do not send PHI for case creation or correction**

Kepro

CUSTOMER SERVICE CONTACT INFORMATION

- Phone: 866-725-9991
- Fax: 800-261-2774

Kepro®

QUESTIONS?