Outpatient Prior Authorization Request Form
DMAS/KePRO

KePRO/DMAS now require any Medicaid Provider submitting Prior Authorizations using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9 digit zip code. If you do not know your 9 digit zip code then please visit: http://zip4.usps.com/zip4/welcome.jsp

Submit fax request for prior authorization to: 1-877–OKBYFAX (877-652-9329)
Requests may be submitted up to 30 days prior to schedule procedures/services, provided Enrollee is eligible.

1. ☐ **Initial** ☐ **Recertification** ☐ **Change** ☐ **Cancel** **Recert: Enter previous PA#. Change or Cancel: enter PA# to be changed or canceled. PA #**

2. **Date of Request (mm/dd/yyyy)** / /	3. **Review Type (check one if applicable)** ☐ Retrospective Prepayment Review (Date notified of eligibility / /) ☐ Retroactive MCO disenrollment

4. **Enrollee Medicaid ID Number** (12 digit Number):	5. **Enrollee Last Name**:	6. **Enrollee First Name:**	7. **Date of Birth** (mm/dd/yyyy): / /	8. **Gender:** ☐ Male ☐ Female

9. a. **NPI/API/Requesting Service Provider Name & ID Number:** b. **9 digit Zip Code (Mandatory)**	10. **Treatment Setting** ☐ Outpatient ☐ Provider's Office ☐ Home ☐ Intensive Outpatient	11. **Primary Diagnosis Code/ Description: (enter up to 5)** 1. 2. 3. 4. 5.

12. a. **NPI/API/Referring Provider Name and ID Number:** b. **9 digit Zip Code** *(Mandatory)*	13. **PA Service Type:** ☐ 0050 Outpatient Psych ☐ 0092 Orthotics (EPSDT) ☐ 0100 DME ☐ 0204 Outpatient Rehab	☐ 0450 MRI ☐ 0451 CAT ☐ 0452 PET ☐ 0500 Home Health

14. **Severity of Illness (See instructions pertaining to each PA service type):**
15. **Intensity of Services (See instructions pertaining to each PA service type):**
16. **Additional Comments (See instructions pertaining to each PA service type):**

DMAS 363
10/08/09

Outpatient Prior Authorization Request Form
DMAS/KePRO

Number	17. HCPCS/ CPT/ Revenue Code	18. Code Description	19. Modifiers (if applicable)	20. Units Requested	21. Actual Cost per Unit	22. Frequency	23. Total Dollar Requested	24. Dates of Service	
								From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
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25. **Contact Name:**									
26. **Contact Telephone Number:**									
27. **Contact Fax Number:**									

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Additional Information

14. Severity of Illness:
15. Intensity of Services:
16. Additional Comments:

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INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

www.dmas.kepro.org
www.dmas.virginia.gov

This FAX submission form is required for outpatient Prior Authorization Review, Concurrent Review and Retrospective Review. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on KePRO forms can be entered. Do **not** send attachments or non-KePRO forms.

If KePRO determines that your request meets appropriate coverage criteria guidelines the request will be "tentatively approved" and transmitted to the DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by the DMAS Fiscal Agent will be sent to you via U.S. mail process and will be available to providers registered on the web-based program iEXCHANGE (http://dmas.kepro.org) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS' Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous preauthorization would be a recertification request.
   - **Change**: a change to a previously approved request; the provider may change the quantity of units, dollar amount approved (DME) or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may not submit a "change" request for any item that has been denied or is pended.
   - **Cancel**: Use to cancel all or some of the items under one preauthorization number. An example of canceling all lines is when an authorization is requested under the wrong enrollee number.
2. **Date of Request:** The date you are submitting the prior authorization request.
3. **Review Type:** Place a √ or **X** in the appropriate box. Please refer to the Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the services being requested. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
4. **Enrollee Medicaid ID Number:** It is the provider's responsibility to ensure the enrollee's Medicaid number is valid. This should contain 12 numbers.
5. **Enrollee Last Name:** Enter the enrollee's last name exactly as it appears on the Medicaid card.
6. **Enrollee First Name:** Enter the enrollee's first name exactly as it appears on the Medicaid card.
7. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
8. **Gender:** Please place a √ or **X** to indicate the sex of the patient.
9. **a. NPI/API Requesting/Service Provider Name and ID Number:** Enter the requesting/service provider name and ID number, national provider identifier or atypical provider identifier.

b. 9 digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.

10. **Treatment Setting:** Place a √ or **X** to indicate the place of service. Outpatient Psych: Mark "Outpatient".
11. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s). You can enter up to 5 descriptions and ICD-9 codes.
12. **a. NPI/API Referring Provider Name and ID Number:** Enter the referring provider name and ID number, national provider identifier or atypical provider identifier for the provider requesting the service.

    b. 9 digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted,
13. **PA Service Type:** Place a √ or **X** to indicate the category of service you are requesting. Orthotics: If enrollee is under 21 check "Orthotics (EPSDT)".
14. **Severity of Illness (Clinical indicators of illness including abnormal findings)*:**
    - One of the most important blocks on the form is the Severity of Illness. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.
    - Provide the clinical information of chief complaint, history of present illness, pertinent past medical history (supportive diagnostic outpatient procedures), abnormal findings on physical examination, previous treatment, pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities to substantiate the need for service and level of service requested. (Always include dates, types & results [with dimensions/% as appropriate]).
    - Service Type specific instructions:

Outpatient Psych	List all symptoms and behaviors supporting the need for outpatient psychiatric treatment. Clinical documentation should address safety risks (immediate or potential), level of functioning, adequacy of support system and social factors. For continued treatment, include clinical findings within the last five visits and progress towards treatment goals. Clinical updates should describe treatment compliance and any related changes to the individual's psychosocial and medical status.
DME	Provide all of the information listed in Section II of the CMN.
Home Health -Rehab	Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.
Home Health –Skilled Nursing	Describe specific orders for nursing.
Rehab	Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.

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15. **Intensity of Services (Proposed/Actual monitoring and therapeutic services)*:**
    - This is another critical area of the form. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.
    - This field must include the treatment plan for the patient. List the services, procedures, or treatments that will be provided to the patient.
    - Service Type specific instructions:

Outpatient Psych	Identify the treatment modality (i.e. individual, family, or group), number and frequency of sessions and anticipated duration of treatment.
DME	Provide all of the information listed for each line item in Section III and IV of the CMN. Include all items and not only those that require preauthorization. (If there is no begin service date, list the physician's signature date that is below Section III on pg. 1 and on pg.2 of CMN if applicable.
Home Health	Describe long term and short term goals with achievement dates.
Home Health –Skilled Nursing	Specific description of goals and achievement dates; Specific description of procedures, especially if requesting comprehensive visits; If requesting ongoing comprehensive visits, specify why goals have not been accomplished.
Rehab	Identify if the plan of care is a 60-day plan of care (acute) or an annual plan of care (non-acute); Describe the long term and short term goals with achievement dates; Documentation of meeting program goals.

16. **Additional Comments:** This area must be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the Regulations, DMAS Manual, and InterQual criteria (see PA chapter in the DMAS Manuals).

Outpatient Psych	Confirm: psychosocial assessment completed; substance abuse and/or medication evaluations completed (if needed); and plan of care designed, signed, and dated by a Licensed Mental Health Provider (LMHP). Indicate where the service is being provided (Mental Health Clinic, provider's office, home, or nursing home).

17. **HCPCS/CPT/Revenue Code:** Provide the HCPCS/CPT/Revenue procedure code.
    NOTE: ***NEW* Starting July 1, 2009, Private Rehab (Provider Type 057) and CORF (Provider Type 019) providers will be required to submit request for Outpatient Rehab services utilizing CPT Codes in place of current Revenue codes. See Attachment "A" at end of document for list of Correct CPT codes. Refer to 5/27/2009 Medicaid Memo.**
18. **Code Description:** Provide the HCPCS/CPT/Revenue procedure code description. For NEOP, provide the type of scan and location.
19. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. DME providers enter modifier as appropriate based upon the Durable Medical Equipment and Supplies Listing/Appendix B found in the DMAS DME provider manual information.

20. **Units Requested**: Based on physician's orders, plan of care, or CMN provide the number of services/visits requested. Knowledge of InterQual/DMAS criteria will be extremely helpful. DME providers: Only identify the number of units necessary in excess of the established allowable for the time span requested. For example, if 2 cases of diapers are allowed per month and 3 cases are used per month, the overage is 1 case per month. If a timeframe of 6 months is requested by the From and Thru date, then the total Units Requested for the time frame is 6 cases. Place numbers only in the Units Requested block. Units requested as 2/2 months or 100/box/month or 7 days cannot be keyed and will be rejected.

    NOTE: ***NEW* Starting July 1, 2009, Private Rehab (Provider Type 057) and CORF (Provider Type 019) providers will be required to submit request for Outpatient Rehab services utilizing CPT Codes in place of current Revenue codes. See Attachment "A" at end of document for assistance with correct Unit submission. Refer to 5/27/2009 Medicaid Memo.**

21. **Actual Cost per Unit or Usual and Customary (DME providers only)**: Enter information in this column for codes identified in Appendix B as individual consideration (IC) or usual and customary. For IC, enter actual cost per unit less any incentives/discounts or reductions received from the manufacturer. For items identified in Appendix B as usual and customary, enter the provider's usual and customary charge to the generic public. The provider must retain documentation supporting this dollar amount.
22. **Frequency:** Enter Frequency usage of Service requested
23. **Total Dollars Requested (DME providers only)**: Enter the dollar amount requested for items listed as usual and customary or IC in the appendix B of the DMAS DME provider manual. In the Appendix B, each code is listed with a set fee, as usual and customary or IC. The Total Dollars Requested is the total for all units requested in that line. For items listed as usual and customary enter your usual and customary charge to the general public. For items listed as IC enter the dollar amount requested. The provider must retain documentation supporting verification of cost (a manufacturer's invoice, brochure with cost information from the manufacturer, cost estimate on letterhead from the manufacturer, etc.) This cost is per unit of the item being requested, e.g. 1ea, 1 pair, or 1 box of 100.
24. **Dates of Service**: Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date.
25. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
26. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
27. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject.

*__Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information.__

The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the enrollee's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

Attachment A

Revenue Code prior to and on June 30, 2009	Procedure Code effective on and after July 1, 2009	Procedure Code Description
0421	97110	Therapeutic procedure (PT), each 15 min. **Note**: unit = 15 minutes
0423	97150	Therapeutic procedure(s) (PT), group **Note**: unit = a group session
0424	97001	Physical therapy evaluation **Note**: unit = an evaluation
0431	97530	Therapeutic activities (OT), each 15 min **Note**: unit = 15 minutes
0433	S9129	Therapeutic procedure(s) (OT), group **Note**: unit = a group session
0434	97003	Occupational therapy evaluation **Note**: unit = an evaluation
0441	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual **Note**: unit = one treatment session
0443	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group (2 or more individuals) **Note**: unit = one treatment session
0444	92506	Evaluation of speech, language, voice, communication, and/or auditory processing **Note**: unit = an evaluation