

# Prior Authorization of PT/OT/ST Outpatient Therapy Services

On behalf of Indiana Medicaid

Acentra HEALTH

# Agenda

**Prior Authorization Requirements and Provider Responsibilities**

**Physical and Occupational Therapy**

**Speech Language Pathology Therapy**

**Prior Authorization Review Process and Outcomes**

**Atrezzo Updates and Reminders**

**Post Submission Actions**

**Provider Resources and Q&A**

# Prior Authorization (PA) Submission Requirements

## Submitting via Portal

**Submitting requests through the portal is the preferred PA method**

- The portal Case Wizard provides step-by-step guidance through the case submission process and prompts you if there are any issues.
- Communicate with clinical reviewers using case Notes.
- Allows you to have multiple accounts assigned under your login.

## Submitting via Fax

- Prior Authorization Request Form:
  - Member Identification number
  - Provider NPI both “Requesting” and “Rendering” (if different)
  - CPT or HCPCS; along with dates of service (DOS)
  - Diagnosis code
  - Form must be signed
- Submit all relevant documentation at the time of submission

## Submitting via Phone

- Provider must provide all the information from the Prior Authorization Request Form over the phone.
  Then submit all relevant documentation either via portal, fax or mail.

*__Abbreviations__ National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) and Dates of service (DOS).

# Timely Submissions

- Notification of initial Therapy requests must be received within 48 hours from delivery of services.

- If the initial request is received past 48 hours, and the request does not qualify as a retrospective review (all dates in past), then the certified start date can only be authorized from the date received.

- When requesting continuation of services, the request must be received prior to services being rendered.

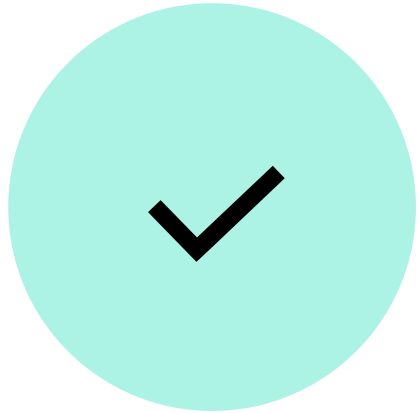
# Provider Responsibilities

**MEMBER ELIGIBILTY**

- Check eligibility, to ensure you submit the PA to the correct vendor.

**PRIOR AUTH REQUIRED?**

- Use the IHCP Fee Schedules to check if codes require a PA.



**FORMS AND DOCUMENTS**

- Complete all required forms for documents for submission. Please check for signatures.

# Therapy Covered Benefits

- The IHCP covers the following:
  - **Rehabilitative therapy** services for members under 21 years of age when determined medically necessary. For members 21 years of age and older, the IHCP covers rehabilitative therapy services for no longer than two years from the initiation of the therapy, unless a significant change in medical condition requires longer therapy.
  - **Habilitative therapy** services for members under 21 years of age on a case-by-case basis, subject to prior authorization. Important Note: Habilitative therapy is not a covered service for members 21 years of age and older.

# Submission Requirements

- The prior authorization (PA), via any submission method, must be requested and have all documentation submitted within 2 business days from the initial evaluation date
- For ongoing services, the prior authorization must be submitted prior to services being rendered
- Providers must attach a current plan of treatment and progress notes (for continued service) indicating the necessity and effectiveness of therapy to the PA request and make this documentation available for audit. **(cannot be older than 90 days)**
- IHCP requires written evidence of physician involvement and personal patient evaluation to document acute medical needs. (signed physician order)
- PT/OT units requested must match those noted on the plan of care (1 unit = 15 minutes)
- ST units requested must match those noted in the plan of care (1 unit = 1 visit)

# Physical and Occupational Therapy Services

# Therapy Non-Covered Services

**Therapy non-covered services include:**

- Therapy rendered for diversional, recreational, vocational or avocational purposes; for the remediation of learning disabilities; or for developmental activities that can be conducted by nonmedical personnel.
- Educational services, including, but not limited to, the remediation of learning disabilities, are not considered habilitative therapy and are not covered.
- IHCP does not separately reimburse for ongoing evaluations.
- IHCP does not authorize requests for therapy that duplicate other services provided to a member.

**Non-covered services specific to occupational therapy:**

- General strengthening exercise programs for recuperative purposes
- Passive range-of-motion services (as the only or primary mode of therapy)
- Occupational therapy psychiatric services

# Order Requirements

## Occupational Therapy Orders

- Therapy must be ordered by a qualifying provider:
  - Physician (doctor of medicine or osteopathy)
  - Podiatrist
  - Advanced practice registered nurse
  - Optometrist
  - Physician assistant
  - Chiropractor
  - Psychologist

## Physical Therapy Orders

- Therapy must be ordered by a qualifying provider:
  - Physician (doctor of medicine or osteopathy)
  - Podiatrist
  - Advanced practice registered nurse
  - Dentist
  - Physician assistant
  - Chiropractor
  - Psychologist

# PT/OT Modifier Requirements

**The following codes MUST have modifier with prior auth request that will match claim submission (GP or GO):**

- 92610 Evaluation swallowing function
- 97014 Application of electrical stimulation to 1 or more areas, unattended by physical therapist
- 97035 Application of ultrasound to 1 or more areas, each 15 minutes
- 97110 Therapeutic exercise to develop strength, endurance, range of motion, and flexibility-each 15 minutes
- 97112 Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
- 97113 Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes
- 97116 Walking training to 1 or more areas, each 15 minutes
- 97140 Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
- 97530 Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
- 97535 Self-care or home management training, each 15 minutes

**Indiana Medicaid: Providers: Code Sets**

# Speech Language Pathology Services

# Speech Therapy Non-Covered Services

- Evaluations and reevaluations are limited to three hours of service per evaluation.

- Group therapy is covered only in conjunction with, not in addition to, regular individual treatment.
  - The IHCP will not reimburse for group therapy as the only or primary means of treatment.

- The IHCP does not reimburse separately for speech pathology services provided by a nursing facility or a large private or small ICF/IID.
  - These services are included in the facility's established per diem rate.

# ST Order Requirements

- IHCP requires written evidence of physician involvement and personal patient evaluation to document acute medical needs.

## Speech Therapy Orders

Speech Therapy must be ordered and signed by a qualifying provider:

- Physician
- Nurse practitioner
- Clinical nurse specialist
- Certified nurse midwife
- Physician assistant

# Speech Therapy Unit/Modifier Requirements

- Speech Therapy codes are requested as 1 unit per visit.
  - Speech Therapy is 1 unit / per 1 visit
- Procedure Codes 92607 & 92608 – Eval of speech gen device-only - **No PA required**
- Unlike Physical and Occupational Therapy, there are no required modifiers on Speech Therapy prior authorization requests
  - Important Note: HM is a claims only modifier (not to be used on the PA request)

*For the full list of covered procedure codes, refer to IHCP List of* Therapy Services Codes

# Review Process

# Prior Authorization Review Process

**After submission of a request, one of the following actions will occur:**

1. **<u>Approval</u>**: Request met criteria either at nurse review level or medical director review.

   PA requests, via portal, may be immediately approved through Rules Driven Authorization process if all criteria has been met.

2. **<u>Pended request for additional information</u>**: Information is requested for determination that was not included with the original submission.

# Prior Authorization Review Process Cont.'

3. **<u>Administrative Denial</u>**: Denial of services due to:
   - Untimely Request
   - Requested information not received

4. **<u>Medical Necessity Denial</u>**: Physician has determined that medical necessity has not been met. The Physician may partially approve or fully deny a request.

# Tips to Reduce Pends and Denials

- Include all required forms and service specific documentation and verify:
  - ✓All required forms are filled out completely and contain proper signatures, as required.
  - ✓The request has not been previously submitted.
  - ✓The member is not receiving services from a different provider.
  - ✓The service does not fall under IHCP exception list (Fee Schedule/PA not required).
  - ✓The units requested match the units/visits on the plan of care.
  - ✓Provide any missing documentation within 7 calendar days of Acentra Health pend, requesting additional information.

**Therapy PA Checklist**

# Administrative Review/Reconsideration

- If an administrative denial or medical necessity denial is issued, the provider can request an Administrative Review (also known as Reconsideration). The provider MUST submit a request for administrative review to Acentra Health within ***7 business days plus 3 calendar days*** of the date provided on the initial adverse determination letter.

- To request an administrative review:
  - Request from the “actions” drop down in the Provider Portal.
  - Fax written request
  - Provider manual contains details of what is required to initiate an administrative review: https://www.in.gov/medicaid/providers/files/modules/prior-authorization.pdf

# Peer to Peer

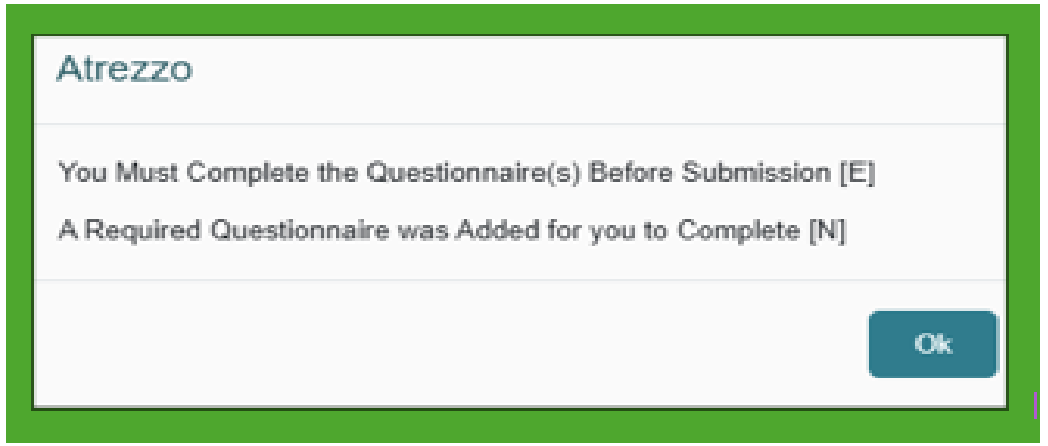
- Providers may request a Peer to Peer on a medical necessity adverse determination. Requests for peer to peer must be completed within ***7 business days plus 3 calendar days*** of the date provided on the initial adverse determination letter.

- To request an administrative review:
  - Request from the “actions” drop down in the Atrezzo portal. Provide the ordering provider’s full name, phone number, and three dates and times of availability.
  - Call Customer Service at 866-725-9991
  - Once an agreeable date and time have been identified, a representative will contact the provider (via telephone) with the confirmed date and time.  A note will also be placed in the case that is visible to the provider.

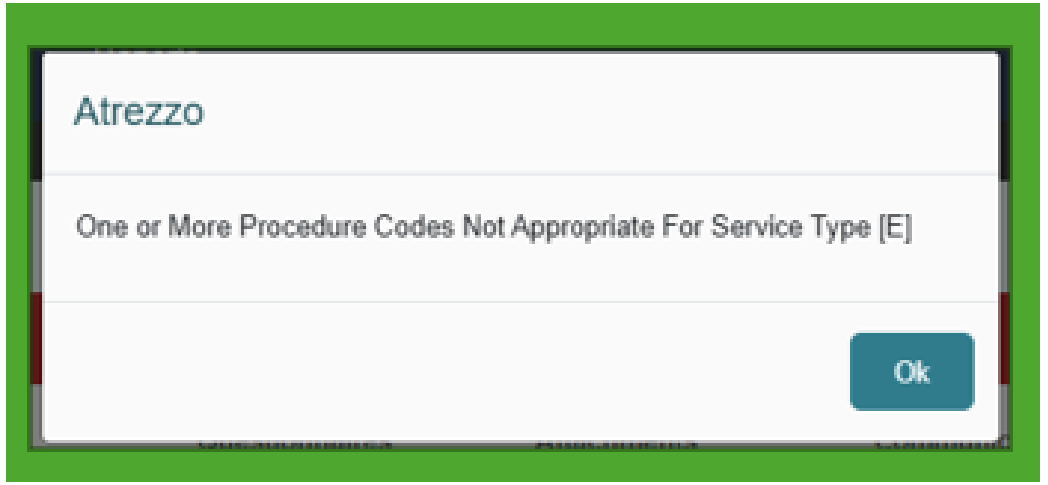
# Atrezzo Updates and Reminders

# Pop Up Reminders/Warnings

A reminder will pop up when submitting a Physical Therapy PA to complete the questionnaire prior to submitting.

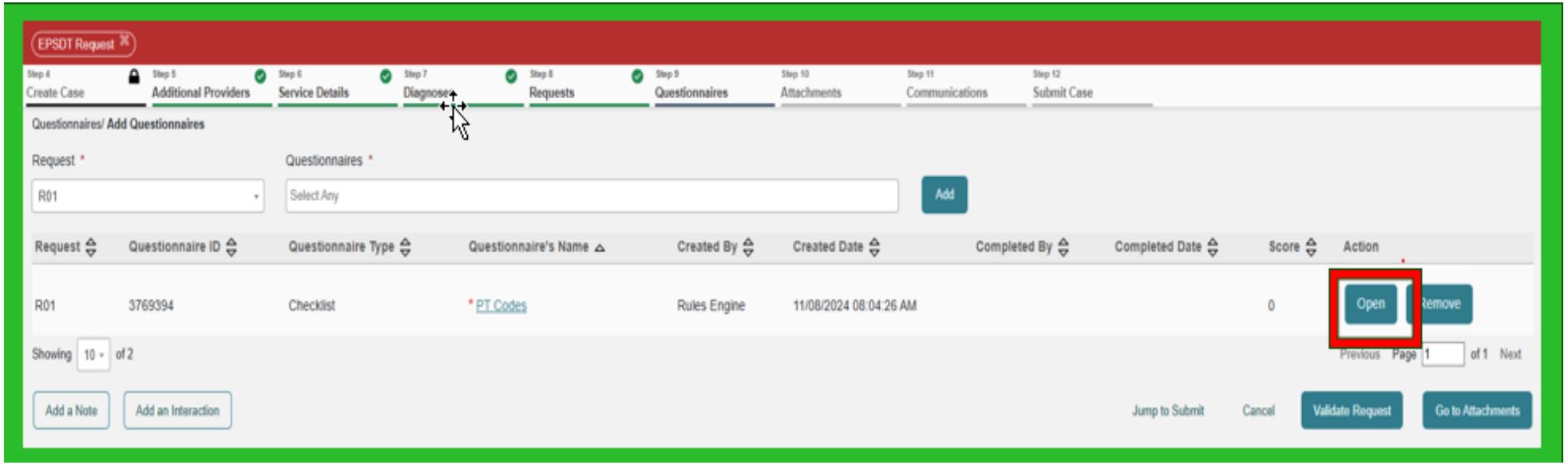



A warning message will populate if the code does not require a Prior Authorization, if one or more codes are not appropriate for service type (outside service type selected), etc.



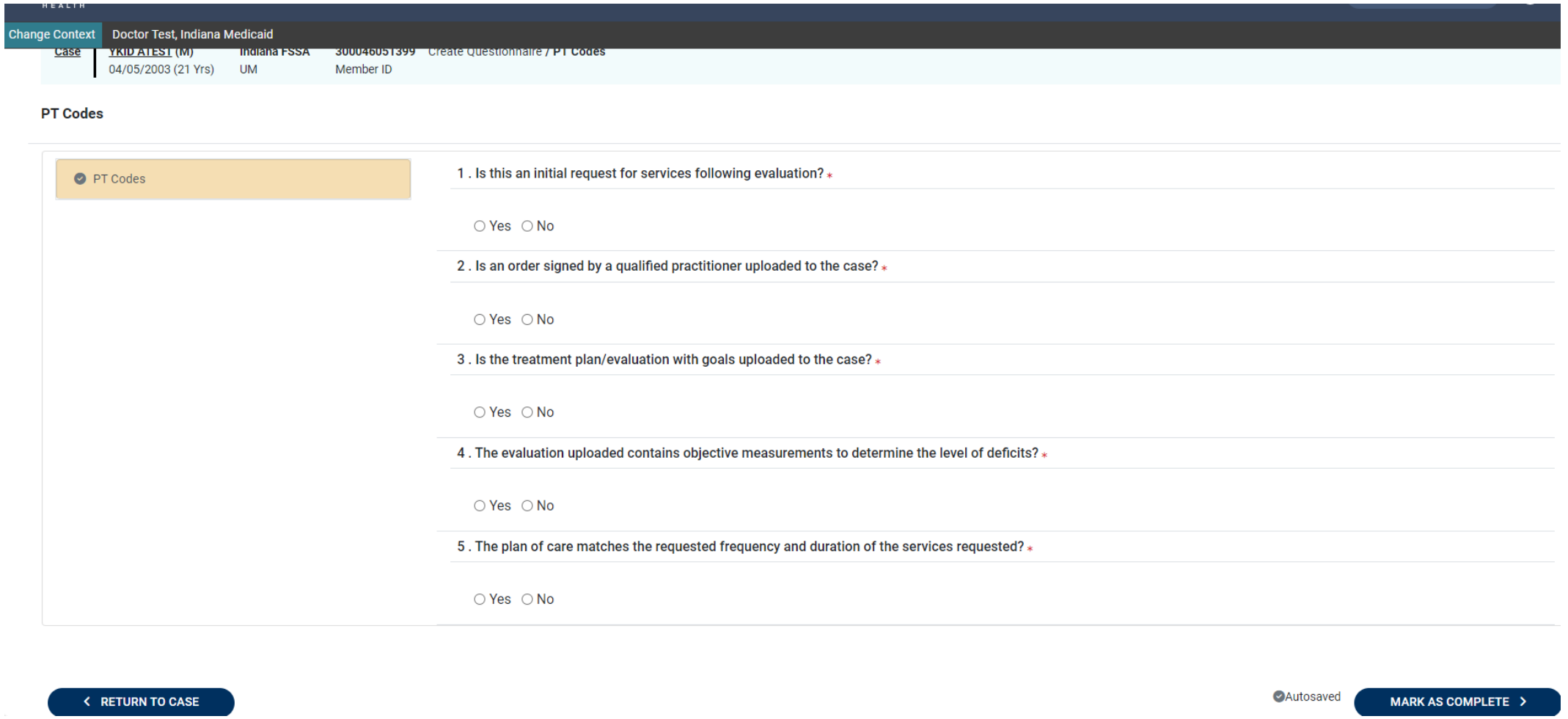
# The Questionnaire Section Example

On the questionnaire section, the PT codes questionnaire will be populated. Click the Open button to answer the questions.



# Answering the Questionnaire

The questions should be answered based on the documentation in the member's chart.



# Important Update

# Authorization Revision Request

The following require a prior authorization revision request to be submitted:

- Requests to move units from one code to another will continue to be an Authorization Revision Request.
- If no additional units are needed but the end date needs to be extended, this would also be an Authorization Revision Request.
- Requests to increase services in an existing authorization date span is appropriate when supporting documentation of medical necessity is submitted along with the Authorization Revision Request.

# Action for Authorization Revision Request

# Assuming a PA From Another Provider

- Fax a request on the **Authorization Revision Request form** to 800-261-2774 or call customer service at 866-725-9991.

- Provide all relevant information including but not limited to:
  - Member information
  - Originating provider information
  - Authorization number
  - Procedures on the PA request
  - Date PA will be assumed

# Transferring Outstanding PAs

**Providers should check eligibility before requesting or rendering service.**

- When a member changes eligibility to Fee-For-Service (FFS) coverage from another vendor, Acentra honors existing PAs for specific durations, whichever comes first:
  - ✓ First 90 calendar days from member's effective date in new plan.
  - ✓ Remainder of the PA dates of service, OR
  - ✓ Until approved units of service are exhausted.

- Original PA letter must be submitted to Acentra with the following:
  - ✓ Member ID (MID).
  - ✓ Provider's National Provider Identifier (NPI).
  - ✓ Duration and frequency of authorization.

- Fax a letter with explanation of request to Acentra Health: 800-261-2774.

# Provider Resources

- **Provider Education and Training materials** (Videos, Handbooks, Quick Guides and FAQs) are located at: https://inmedicaidffs.acentra.com/training-and-education/

- **Provider Communication and Support email**: INPriorAuthIssues@Acentra.com

  *Provider registration assistance. Prior Auth submission issues. Assistance with account.*

- **Dedicated Customer Support Line  Call us at 866-725-9991**

  *Request a clinical call back. Check case status. Reset Log In. Submit prior auth requests.*

# Conclusion and Q&A

**Thank you for your time!**

**Provider Relations Assistance:** INPriorAuthIssues@acentra.com.

**Provider education website:** Training & Education - Indiana Medicaid FFS (acentra.com).

**Acentra Health Customer Service:** **Phone: 866-725-9991**

**Fax: 800-261-2774**