Rehabilitation Solution

Blue Cross NC
Provider Training

Objective

Effective December 1, 2024, Carelon Medical Benefits Management (Carelon) will manage outpatient (including professional and home) rehabilitation services reviews for Blue Cross North Carolina commercial members through the Rehabilitation Program. Our objective today is to help you understand what this means to you and your practice.

Agenda:

- Rehabilitation Solution overview
- Program resources
- Order request demonstration (if time permits)
- Q & A

Program overview

Carelon Rehabilitation Solution

The Carelon Rehabilitation Program uses evidence-based clinical practice guidelines and a focused clinical appropriateness review process to ensure the appropriate rehabilitative services, at the appropriate place of service, for the appropriate duration.

Our goal is to assist in maximizing the member's functional improvement, while at the same time, enhancing and simplifying the provider's experience in the delivery of care.

Therapy treatment plans are reviewed against Carelon's clinical appropriateness guidelines to help ensure that care aligns with established evidence-based medicine and services codes that do not warrant skilled care are not approved within the episode of care.

Our solution is powered by experts

Kerrie Reed, MD

National Medical Director, Rehabilitation and BJPP

Responsible for developing clinical strategy and supporting provider engagement and growth.

Disha Patel PT, DPT

Senior Clinical Architect Rehabilitation and MSK

Responsible for clinical design.

Yvonne Sullivan PT, MPT, ATC

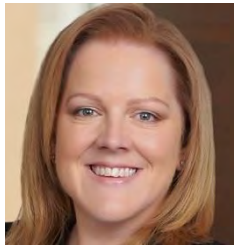
Solution Director, Rehabilitation

Responsible for outreach, education, and client implementations.

Melissa Peeler

Staff VP/GM MSK and Surgical Suite

Responsible for business strategy and design.



Katherine Starnes

Senior Solution Director, Rehabilitation

Responsible for solution strategy and performance.

Our clinician reviewers' specialties:

- Physical therapy
- Occupational therapy
- Speech therapy
- Physiatry
- Internal medicine
- Orthopedics
- Pediatrics
- Chiropractic

Effective date for the Rehabilitation Program

Contact center and provider portal open

Program effective date

Contact center and provider portal is available for prior authorization requests with dates of service rendered on or after December 1, 2024. Prior authorization requests cannot be submitted more than 30 days in advance of a date of service.

Submitting an order request

Carelon provider portal

- www.providerportal.com through single sign on with the Blue e website.
- The Blue e website should be utilized to initiate therapy requests: https://bluee.bcbsnc.com/providers/web/login
- Available 24 hours/day, 7 days/week except for maintenance on Sundays from 12 to 6 p.m. CT
- Provider portal support team: 1-800-252-2021

Carelon contact center

- Dedicated toll-free number: **1-866-455-8414**
- Contact center hours: Monday to Friday from 8:00 am – 5:00 pm ET.
- Voicemail messages received after business hours will be responded to the next business day.

*Carelon call center is closed on the following holidays: New Year's Day, Martin Luther King Jr Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving and Christmas Day

Services requiring prior authorization

Physical and Occupational therapy

Supervised modalities

Constant attendance modalities

Therapeutic procedures

Adaptive equipment training

Work hardening treatment

Wound care and lymphedema treatment

Other therapy services

Speech language therapy

Speech fluency

Speech sound production

Language comprehension and expression

Oral and pharyngeal swallowing function

Auditory processing

Prior authorization not required from Carelon

Members with the following clinical condition:

- BCNC Commercial members with a primary diagnosis of Autism Spectrum Disorder/Pervasive Development Delay, therapy services do not require authorization when focused on the primary diagnosis (primary ICD-10 codes: F84.0, F84.2, F84.3, F84.5, F84.8, or F84.9).

CPT service codes

Procedure codes:

- Vary by line of business and may be managed by the local health plan.
- Carelon Rehabilitation microsite page @ https://providers.carelonmedicalbenefitsmanagement.com/rehabilitation/.
- Qualified providers of therapy services including chiropractors rendering in scope therapy services in the BCNC Commercial market, will be managed by Carelon.

Determinations:

- Carelon authorizes therapy services in visits.
- Carelon adjudicates codes under a main treatment grouper, and a set of adjunctive service codes are separately reviewed.
  - Providers should begin by entering one treatment CPT code from the main treatment grouper on the request. Main treatment codes operate on a grouper CPT code concept.
  - Providers should enter all adjunctive CPT codes on the request. Due to varying clinical evidence, these codes require additional review per the *Carelon Clinical Guidelines*.
- Questions regarding procedure codes not in scope for the Rehabilitation Solution will be referred to the health plan.
- Determinations will be made on the main treatment grouper as well as each adjunctive CPT code entered for the request. This may result in a mixed outcome, under the same authorization.

What is the purpose of therapy?

Benefits and criteria may be different based on the documented purpose of therapy treatment. The visits determined to be medically necessary are based on the clinical details documented on the request by the provider.

Rehabilitative

Rehabilitative care improves, adapts and restores functions impaired or lost as a result of illness, injury or surgical intervention.

Habilitative

Habilitative care helps to develop and/or improves skills that are currently not present and/or assist in the development of normal function.

Maintenance

Maintenance care preserves present level range, strength, coordination, balance, pain, activity, function and/or prevents regression of the same parameters. Maintenance care begins when a treatment plan's therapeutic goals are achieved, or additional functional progress is not apparent or expected.

Clinical appropriateness review

Clinical scope

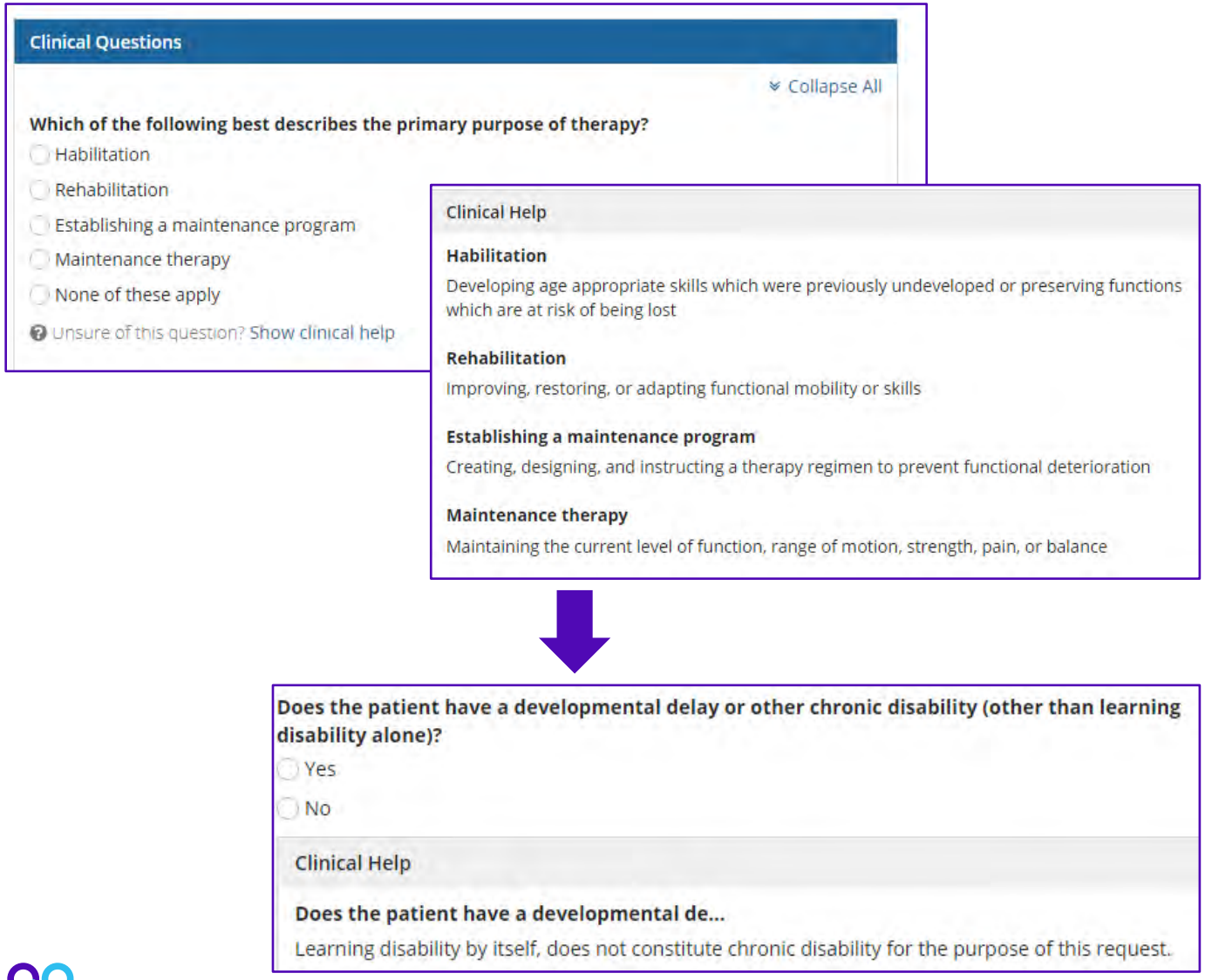
(Rehabilitative and Habilitative)

Therapy treatment requests are reviewed against clinical appropriateness guidelines to help ensure that care aligns with established evidence-based medicine and that service codes that do not warrant skilled care are not approved within the episode of care.

- Primary treatment diagnosis
- Confirmation of developmental delay or other chronic disability
- Acuity and complexity of the condition as well as the expected duration of the care plan
- Functional outcome tool(s) or milestone assessment with baseline score(s)
- Conditions that may impact therapy or comorbidities
- Recent surgery
- Response to treatment or mitigating factors
- Attainment or objective progression on care plan's functional goals
- Review of clinical documentation

*For a printable list of the clinical factors for each therapy discipline and therapy type please visit the *Order Request Checklist* resource on the Rehabilitation microsite at https://providers.carelonmedicalbenefitsmanagement.com/rehabilitation/.

Habilitative purposes of therapy an in-depth look



In the clinical section of a Physical Therapy, Occupational Therapy or Speech Therapy prior authorization request, users are asked to document the *primary purpose of therapy*.

Clinical help text defines *Habilitative* services as, those which develop age-appropriate skills which were previously undeveloped or preserving functions which are at risk of being lost.

In addition to documenting a primary purpose of therapy of Habilitation, users are also asked to document if the member has a developmental delay or other chronic disability.

Please note the documentation of a developmental delay or chronic condition can based on the physician's diagnosis of that member or the therapist's evaluation of the member using standardized assessments.

Place of service settings

Outpatient clinical settings, including professional and home

- POS 11 – Office
- POS 12 – Home
- POS – 49 Independent clinic
- POS – 02 Telehealth provided other than in the patient's home (when covered)
- POS – 10 Telehealth provided in patient's home (when covered)
- POS – 22 Outpatient hospital

We closely manage members' episodes of care

An episode of care is the managed care provided for a specific injury, surgery, condition, or illness during a set time period.

Episodes of care may have multiple prior authorization requests:

- Carelon will provide an authorization with a visit allocation and valid timeframe for requests meeting medical necessity.
- If a member needs additional skilled therapy after the initially authorized number of visits, their provider can create a second treatment request in the portal.
- Because both requests are treating the same medical condition, they're considered the same episode of care.
- The provider will answer clinical questions about the member's progress so we can make a medical necessity determination.
- The treatment request submission cycle can continue until medical necessity is no longer met, the member is discharged from therapy, or a benefit limit has been reached (when applicable).

Episode of care workflow

Requests are staged for the member's episode of care based on the initial evaluation date entered and the previous requests determination.

1 INITIAL EVALUATION

Prior authorization is not required for the initial evaluation codes, or any treatment codes rendered at the initial evaluation date of service.

Should the provider choose to enter an evaluation request, they may.

Answering, "No" to the question, "Has an initial evaluation been performed", will result in a 1-visit authorization to render treatment on the initial evaluation date of service.

2 INITIAL TREATMENT REQUEST

Prior authorization is required for subsequent treatment visits following the initial evaluation date of service.

If skilled care is required, an initial treatment request should be submitted.

- Requests must be submitted within 2-business days.
- No clinical documentation required.
- Medical necessity attestations, clinical complexity questions including initial functional tool score, surgery and comorbidities.

Real-time approval on the portal or through the call center with visit allocation and valid timeframe, if medical necessity criteria are met (with code exceptions).
Customized allocations based on level of functional impairment, surgery, comorbidities and complexity/severity.

3 SECOND TREATMENT REQUEST

If the member still requires skilled therapy and has remaining functional goals in the plan of care, the provider may submit additional treatment requests.

- Requests must be submitted within 2-business days.
- No clinical documentation required.
- Updated functional tool score and goal attainment, along with mitigating factors or changes to the treatment plan (if poor progress).

Real-time approval on the portal or through the call center with visit allocation and valid timeframe, if medical necessity criteria are met (with code exceptions).
Customized allocations based on objective functional improvement, functional goal attainment, and remaining functional goals.

4 ADDITIONAL TREATMENT REQUESTS

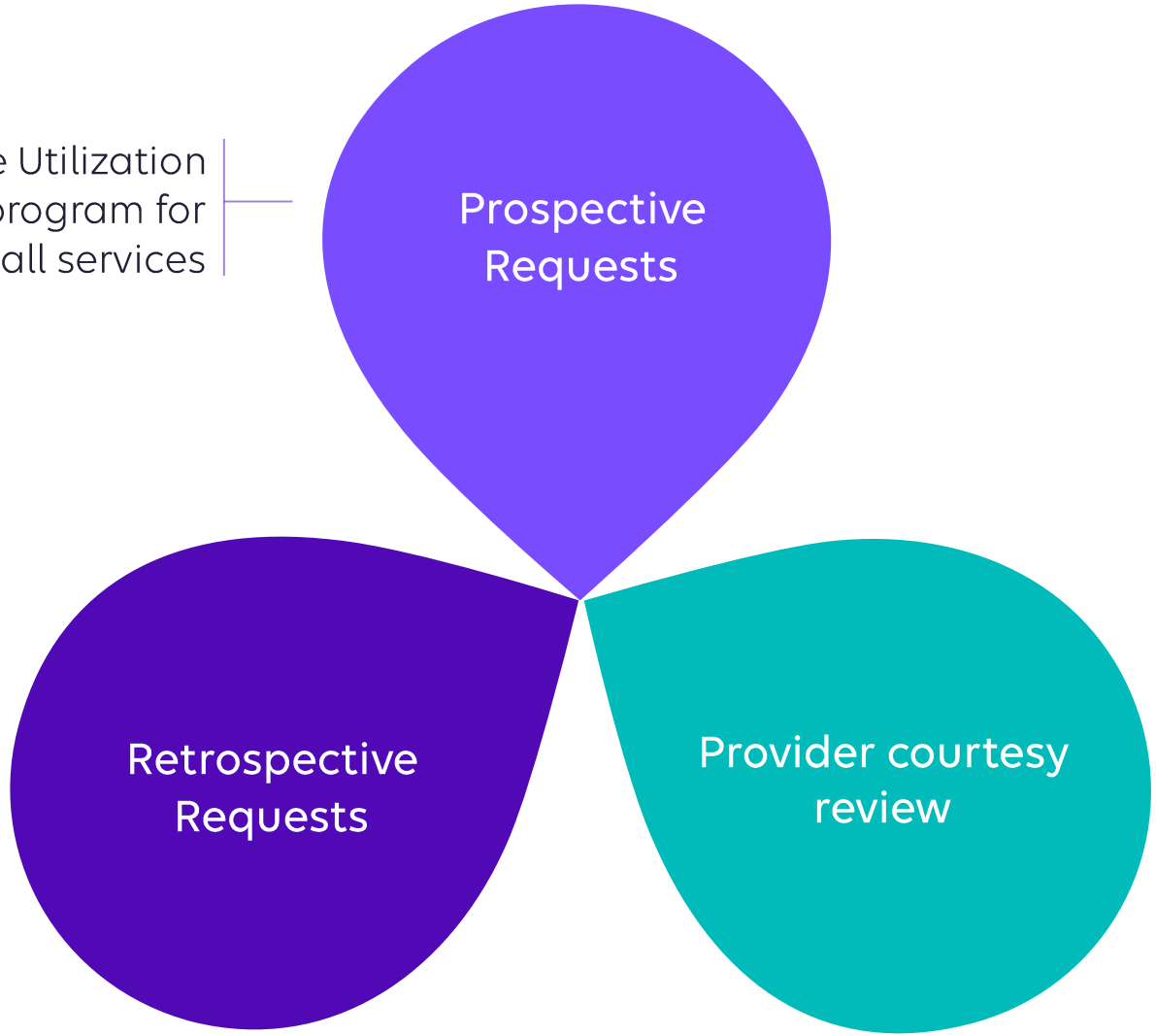
If the member still requires skilled therapy and has remaining functional goals in the plan of care, the provider may submit additional treatment requests.

- Requests must be submitted within 2-business days.
- Clinical documentation is required for review by a Carelon clinician.
- Request is reviewed for progress on functional goals, remaining SMART functional goals, ongoing skilled need within an expected timeframe.

Medical necessity review by a Carelon clinician within mandated turnaround time
Customized allocations based on objective functional improvement, functional goal attainment, and remaining functional goals.

Provider initiated requests

Prospective Utilization Management program for all services



Retrospective reviews within 2 business days of the date of service that requires prior authorization.

Carelon will perform provider courtesy review for Blue Cross NC therapy requests with an adverse determination within 180 days.

Post determination options

Cases with an adverse determination may have the following options based on the market and line of business.

Peer to Peer Discussion

- Providers can request a peer-to-peer conversation with an Carelon clinician at any stage in the request process.
- A peer-to-peer can be initiated through the Carelon call center.
- The provider has the option to schedule the peer-to-peer at a convenient time, if necessary.

Provider Courtesy Review (PCR)

- Provider courtesy review can be initiated on prospective therapy cases within 180 days of the adverse determination date.
- The turnaround time for PCR is 7 calendar days.
- The PCR process allows the provider to upload additional documentation that may impact the request's determination.
- PCR process can be initiated by the servicing provider on the portal, by phone, or fax.

Health Plan Appeal

- Providers who have exhausted the post determination options or have received an adverse determination on a case that is not eligible for the available post-determination options, can appeal through the health plan.
- An appeal can be initiated through the health plan following the steps outlined on the denial letter.

Case adjudication

The valid timeframe for a therapy prior authorization request is dependent on the number of visits determined to be medically necessary for the request.

Evaluation Requests:

- Physical Therapy and Occupational Therapy “evaluation request” valid timeframe is 15 days from the start date of service entered for the request
- Speech Therapy valid timeframe is 30 days from the start date of service entered for the request

Treatment Requests:

- Timeframes vary based on the number of visits determined to be clinically appropriate for the request or state mandate
- Valid timeframes can range between 30 days (1 month) – 274 days (9 months)

Date of service change or valid timeframe extension:

- If a date of service changes and is outside of the valid timeframe of the authorization; then a new request should be submitted through Carelon.
- If the servicing provider is unable to render the authorized therapy treatment visits within the valid timeframe for the request, a new prior authorization request through Carelon should be submitted.

Case closure rules

Case turn-around time

Non-Urgent

- Requests shall close within 3 business days

Urgent

- Requests shall close within 72 hours

Preparing for the program go-live

Which Blue Cross NC members require prior authorization?

Included lines of business (products):

- Commercial (FLF/IND) members

Excluded lines of business (products):

- Medicare Advantage
- Commercial Self-Insured (ASO)
- State Health Plan
- Federal

Please contact the health plan to verify prior authorization requirements for members who are not found within the Carelon system. If the health plan confirms eligibility, they may contact Carelon to have the member manually added into the Carelon system.

Program resources

Post go-live training resources for providers and their employees

Carelon OFFERS

QUARTERLY SOLUTION Q&A SESSIONS

For all health plan providers

CARELON PROVIDER PORTAL HELP DESK

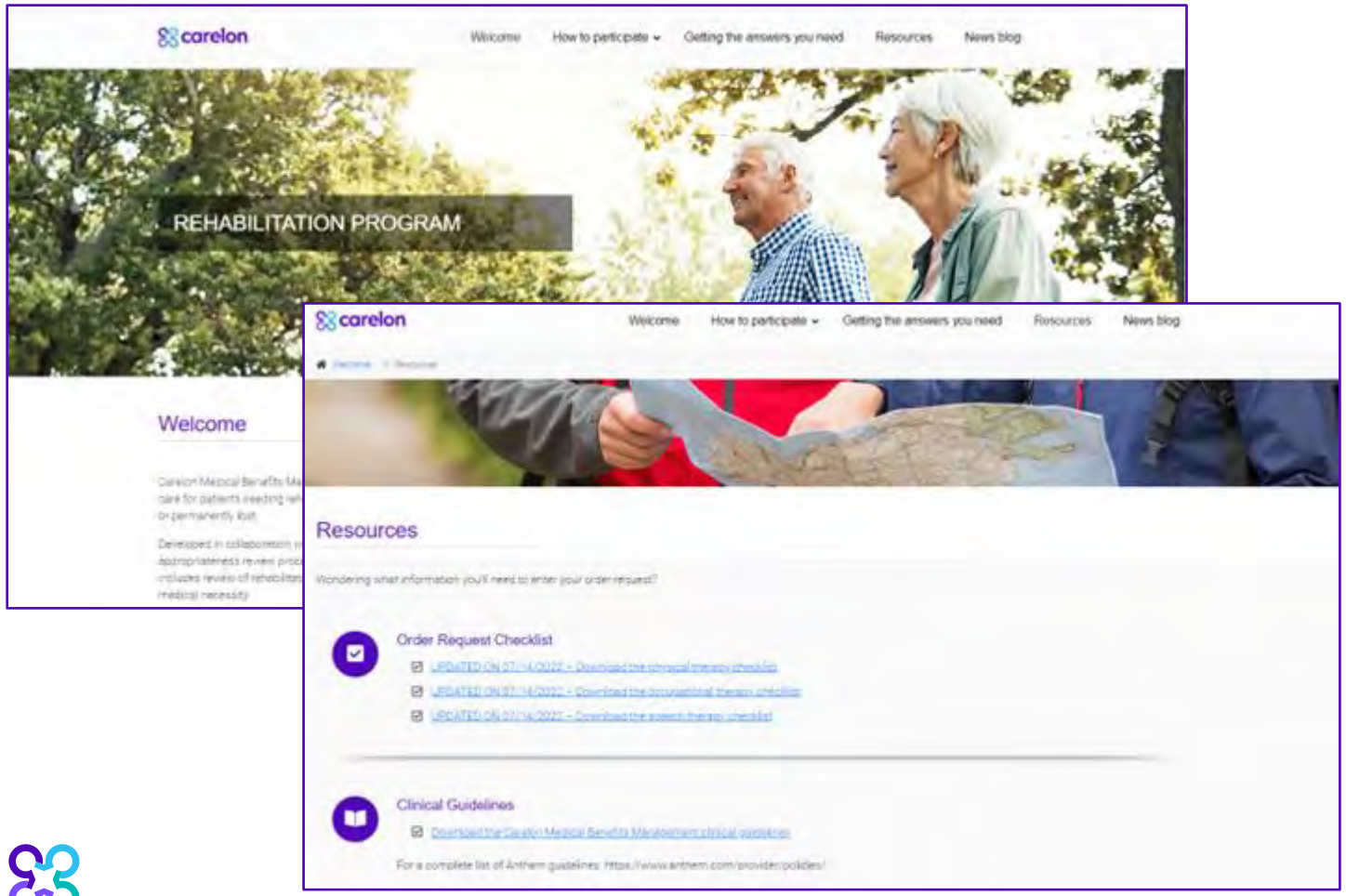
Micro training tutorials on the order request process. How to videos for starting an order request, checking order status, managing providers and user profile, and viewing order history.

PROVIDER MICROSITES

Helpful information such as checklists, FAQs, etc.

Provider microsite

https://providers.carelonmedicalbenefitsmanagement.com/rehabilitation/



Providers can visit the microsite for:

- Order request checklists
- Functional outcome tool and score value lists
- Rehabilitation Solution FAQ's
- Link to the Carelon Clinical Guidelines
- Updated Rehabilitation Solution CPT code list for Blue Cross NC requests
- Portal support team – 1-800-252-2021

Provider training

REHABILITATION SOLUTION PROVIDER TRAINING SESSIONS

SOLUTION TRAINING DATES

- Wednesday, October 2, 2024 @ 12:00 ET
- Wednesday, October 16, 2024 @ 12:00 ET
- Wednesday, October 30, 2024 @ 12:00 ET
- Wednesday, November 6, 2024 @ 12:00 ET

Questions: rehabprogram@carelon.com

Rehabilitation Solution
Order Request Demonstration

Note: Carelon maintains the confidentiality of all protected health information. All data displayed is fictional and any resemblance to real persons is purely coincidental.

Questions?

Rehabilitation Program provider website:
https://providers.carelonmedicalbenefitsmanagement.com/rehabilitation/

Rehabilitation Program Email:
RehabProgram@Carelon.com

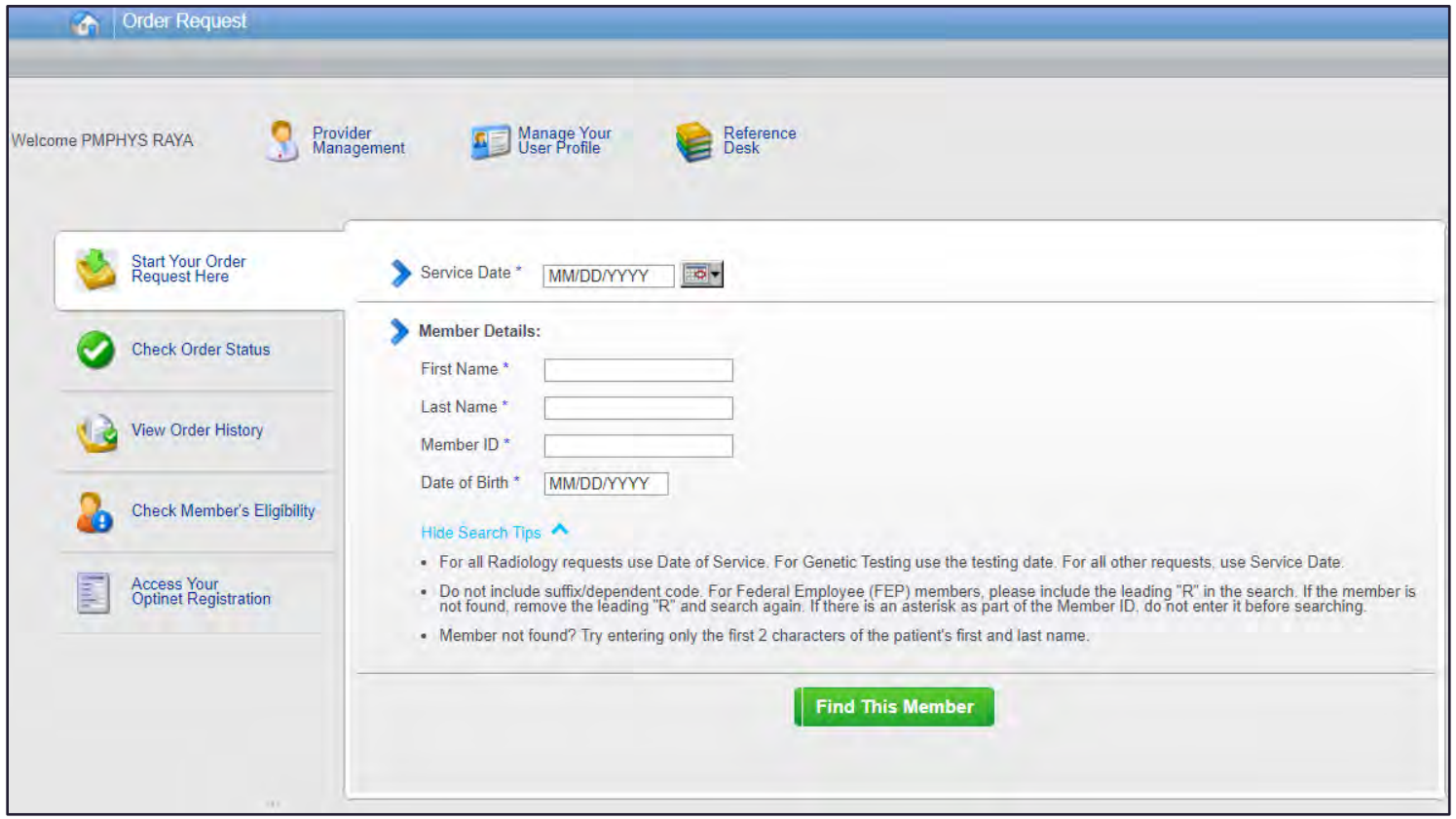
Thank you!

Appendix

Rehabilitation Solution
Order Request Demonstration

Note: Carelon maintains the confidentiality of all protected health information. All data displayed is fictional and any resemblance to real persons is purely coincidental.

Start your order request



To start an order request, enter the "Date of Service" field on the provider portal homepage.

A member search is completed by providing the following:

- Member First Name
- Member Last Name
- Member ID (without the prefix)
- Member Date of Birth

Select "Find this member"

From this landing page the user may also:

- Check Order Status
- View Order History
- Check Member's Eligibility
- Provider Management
- Manage Your User Profile
- Reference Desk

Missing member process

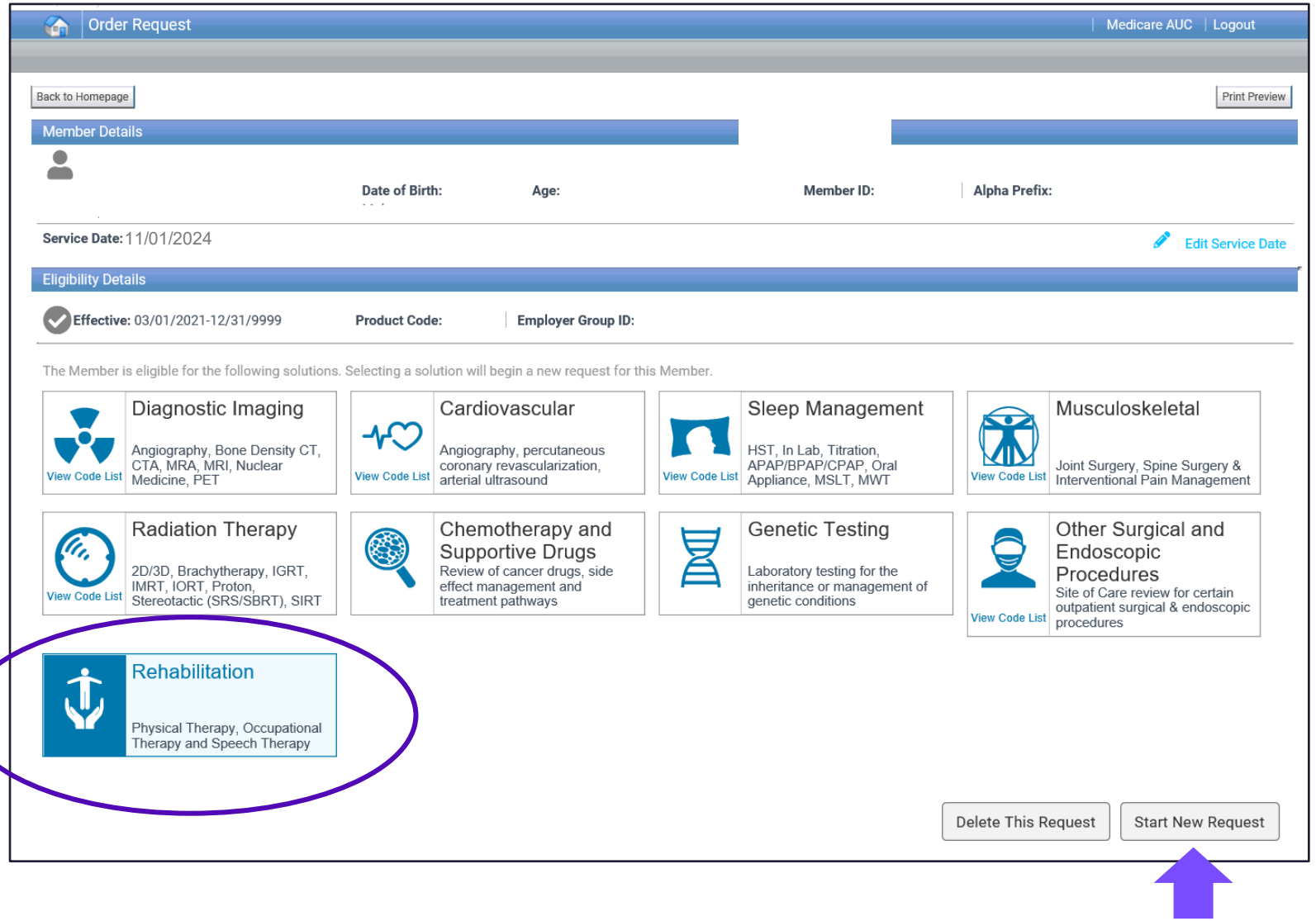
1. The provider comes to Carelon to submit a request for authorization and the member cannot be found.
2. The provider will be notified via messaging to check the member details and re-attempt the search.

   The member currently does not require authorization from Carelon based on membership file details received from the health plan.
3. The provider may contact the health plan to verify eligibility or contact Carelon for assistance.

   A 3-way call can be performed with the health plan to manually add the member and assist with the prior authorization.
4. Specific member information will need to be supplied to Carelon from the health, in order to manually add the member.

   If necessary, the next member file from the health plan to Carelon will include the updated member record.

Order type selection



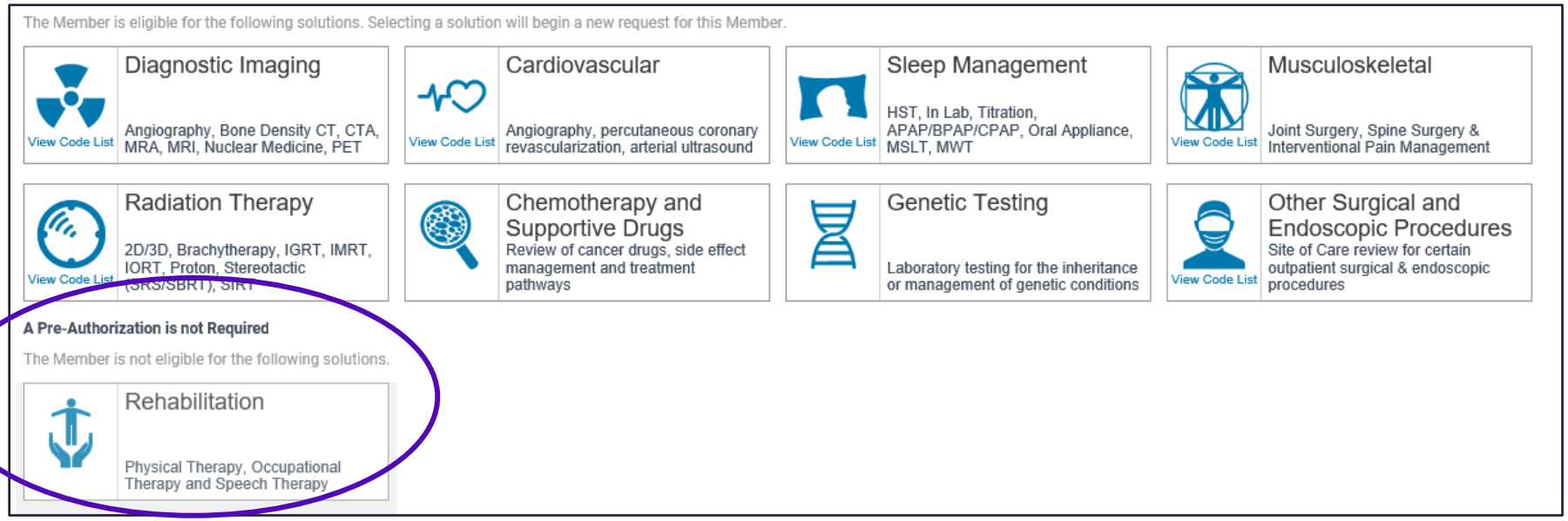
On the order type screen, select "**Rehabilitation**" and then select the "**Start New Request**" button.

Note: only programs that are currently managed by Carelon for the selected member will display on the order type selection screen.

Note: If you encounter an "Our Apologies" error, please follow the steps below to update your Carelon user profile.

1) From the home page, select "Manage your user profile"
2) Select "User Information"
3) Update all missing/required fields in your user profile.
4) Select "Save"
5) Select the "home icon" to return to the homepage and submit a request.

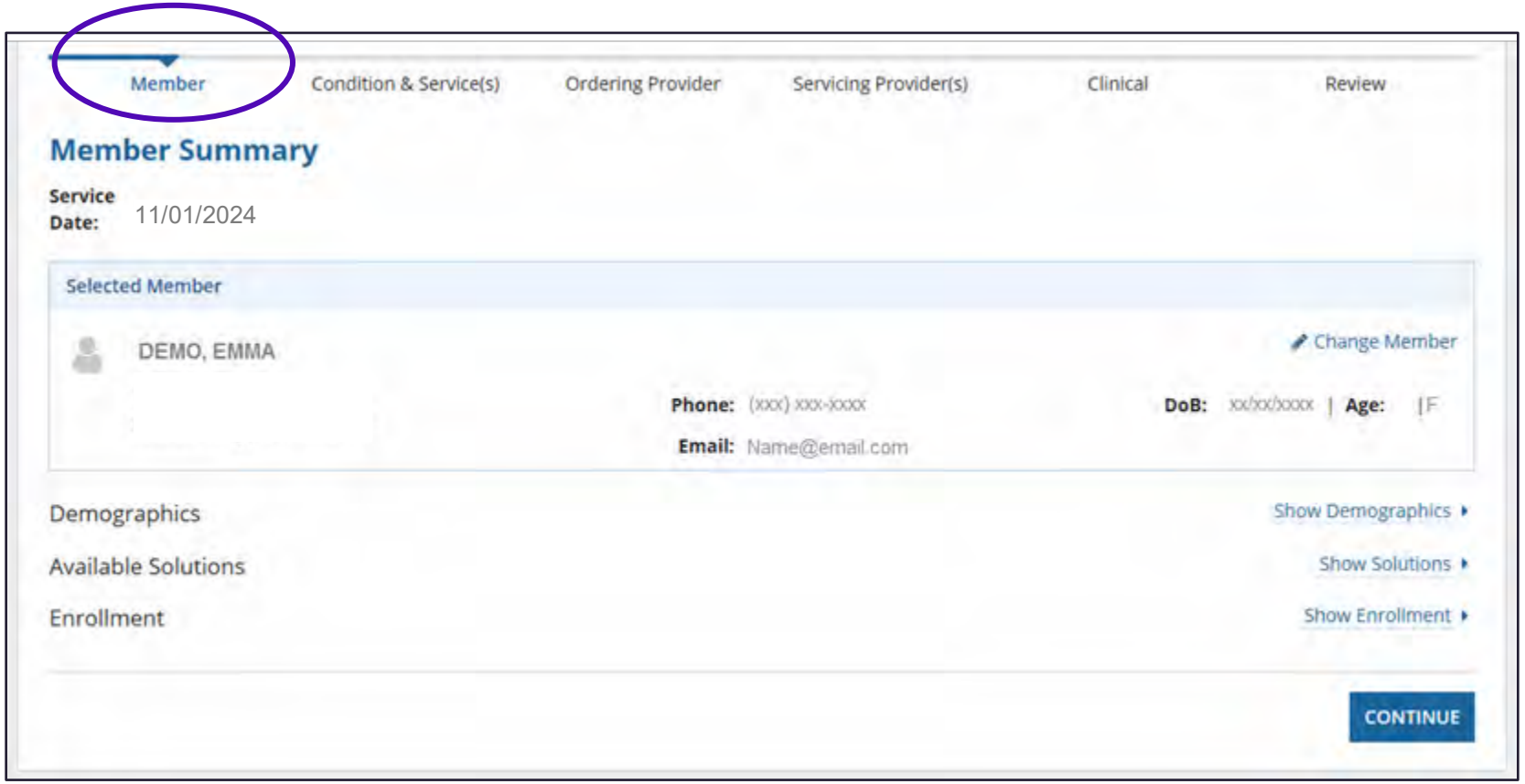
Prior authorization not required through Carelon



If a prior authorization is not required from Carelon based on the membership file received from the health plan, the system will display the tile under “A prior authorization is not required from Carelon” section or a Rehabilitation tile will not be displayed.

*See missing member slide for next steps if eligibility for the Carelon Rehabilitation Program is confirmed by the health plan.

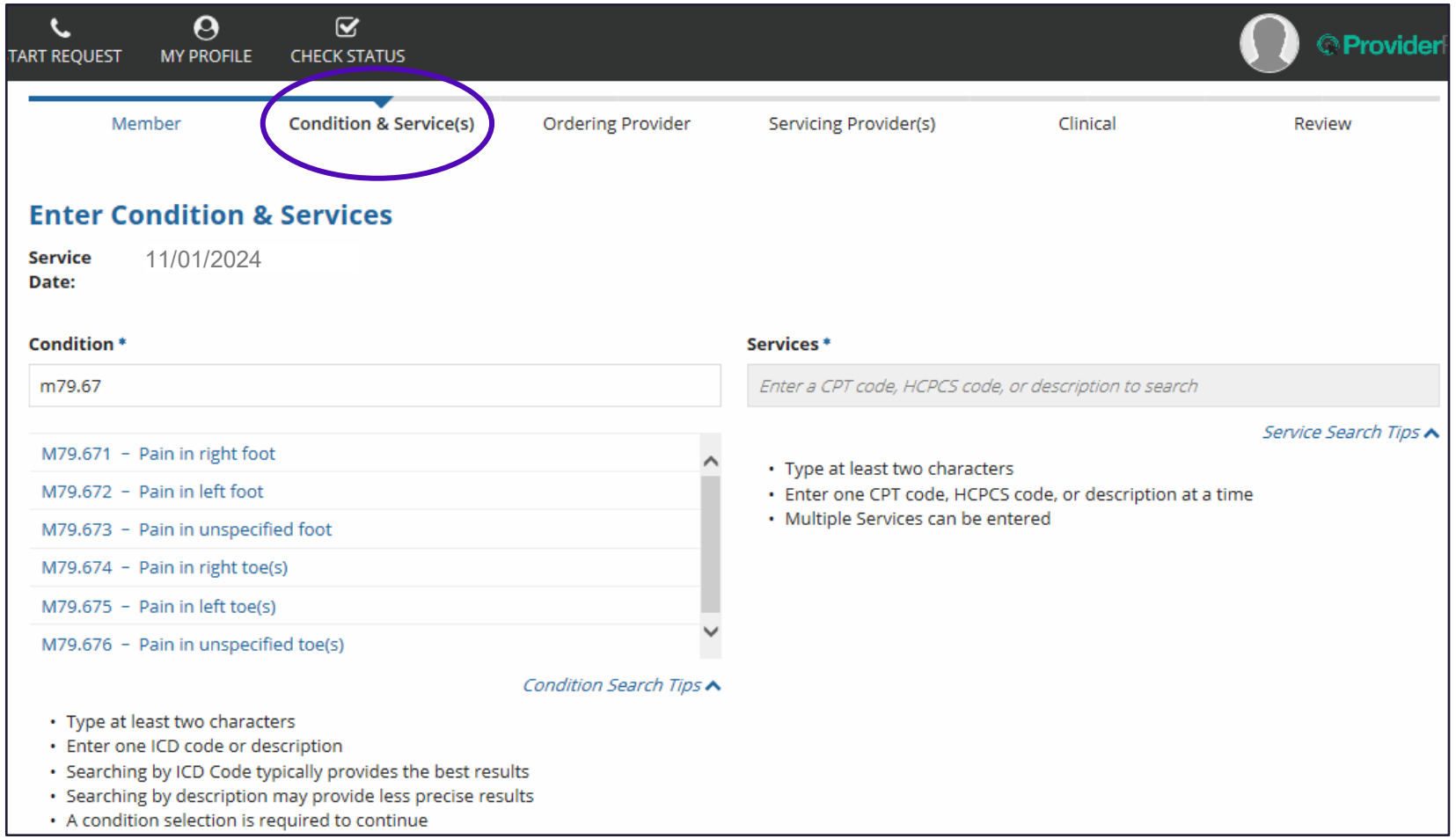
Review member information



If the member is not the correct member, select "**Change Member**".

If the member is correct, select "**Continue**" to move forward with the request.

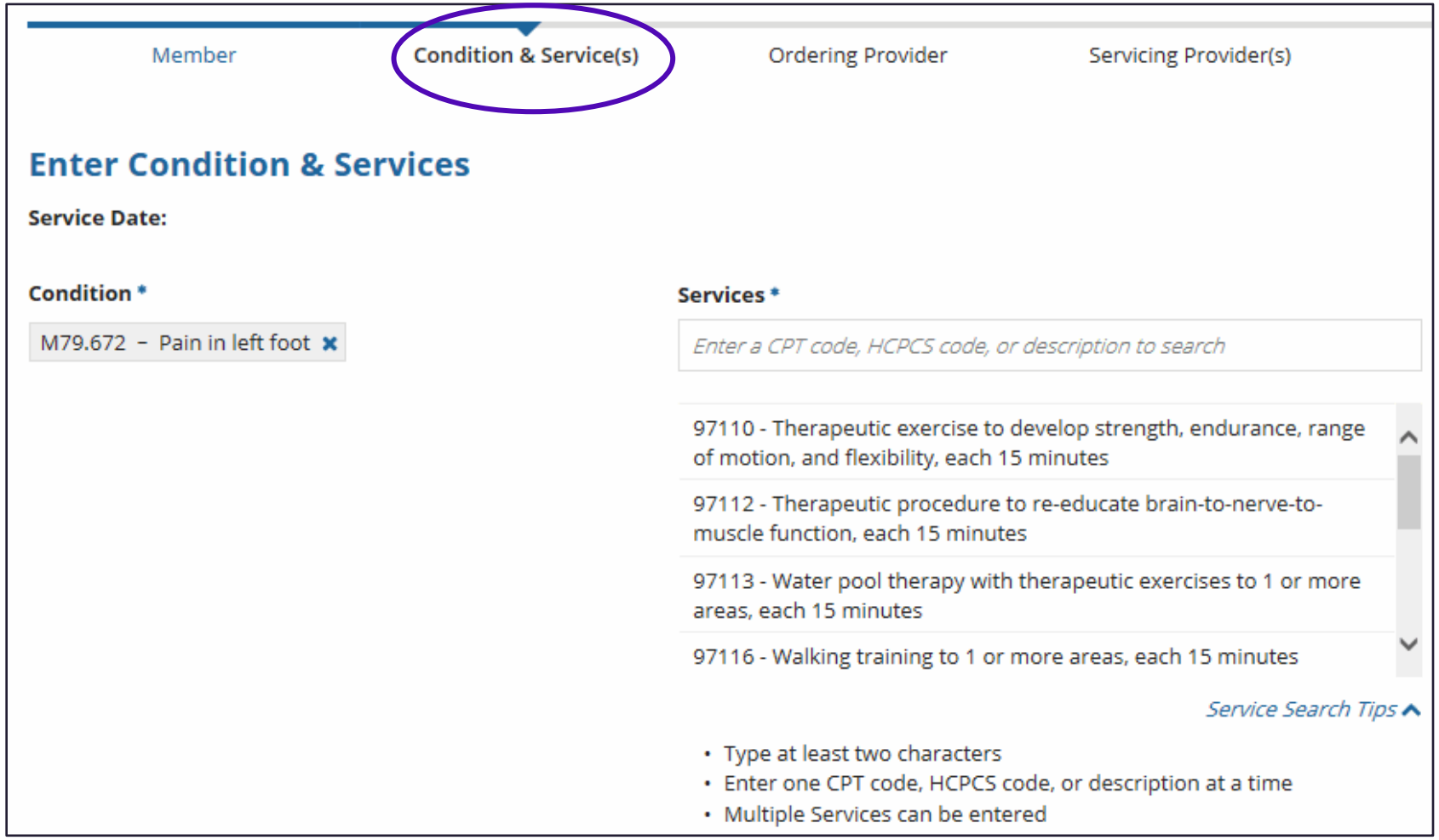
Select primary diagnosis



Search for the primary ICD-10 diagnosis by the description the or ICD-10 code.

The diagnosis could be the ICD-10 code provided by the ordering/referring physician or if the user is in a direct access state, the ICD-10 code that the therapist is allocating for the member.

Select service(s)



Enter the CPT code services.

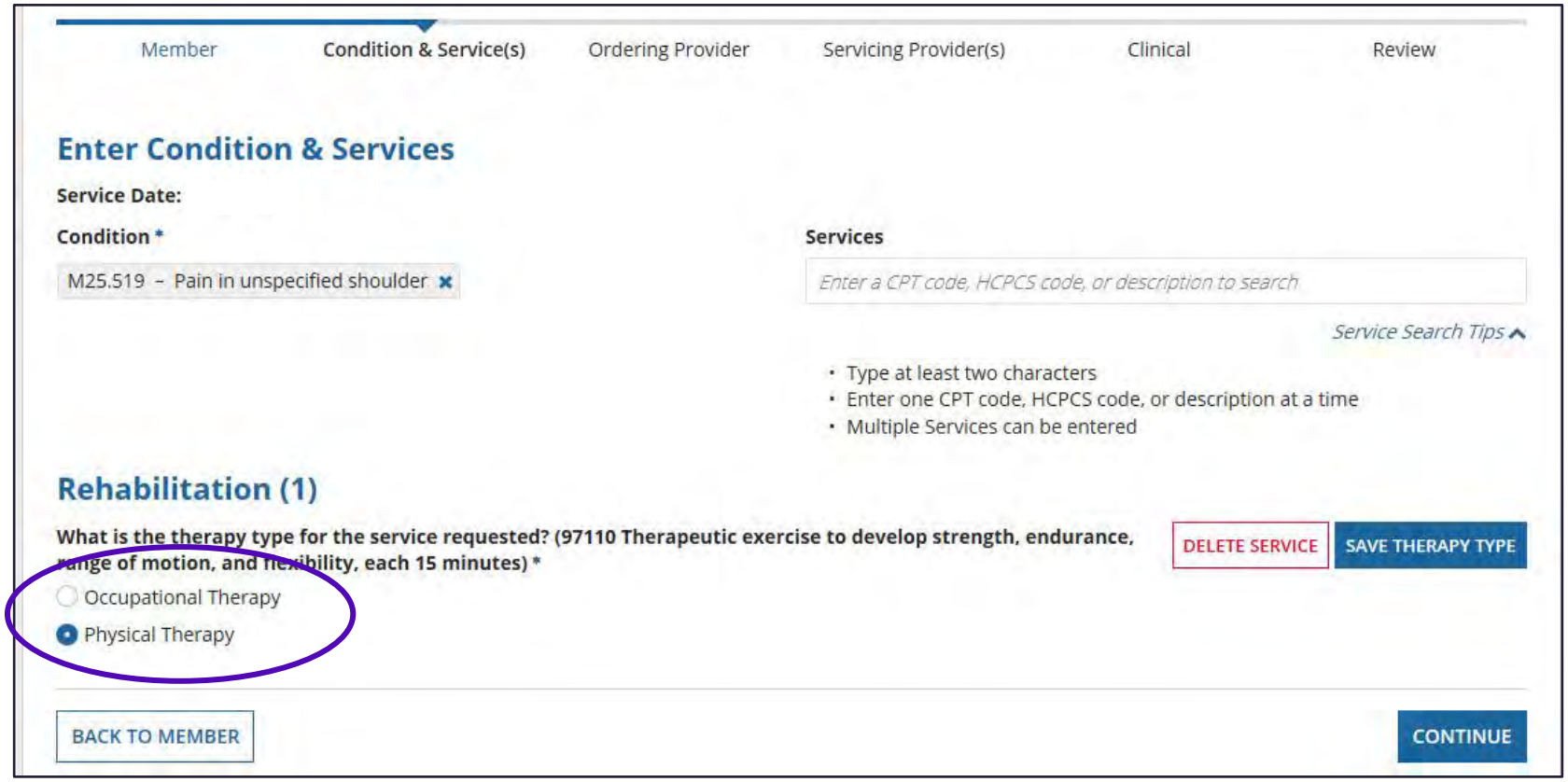
Search for services by the description or the CPT code.

The CPT codes are organized in two ways:

- Main treatment codes utilize a grouper concept
- Adjunctive treatment CPT codes, do not utilize a grouper concept

Begin by entering one CPT code from the main treatment grouper into the request.

Identify the therapy type



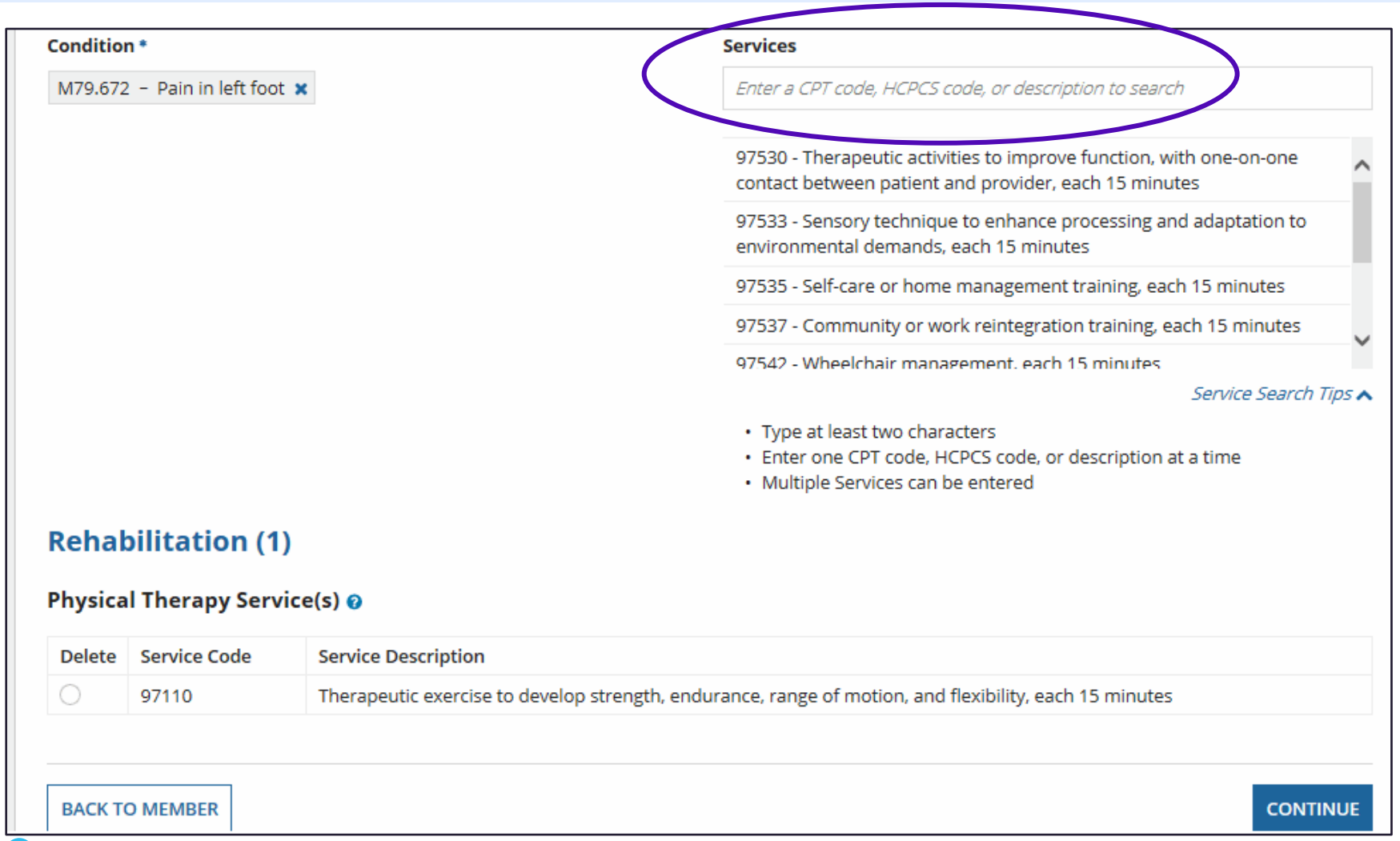
When the selected CPT code exists in more than one therapy discipline, the system will prompt the user to document the therapy they are requesting.

The therapy discipline selected should match the modifier providers submit on claims to the health plan.

- PT: GP Modifier
- OT: GO Modifier
- ST: GN Modifier

The user will select "**save therapy type**" and "**continue**".

Select additional services



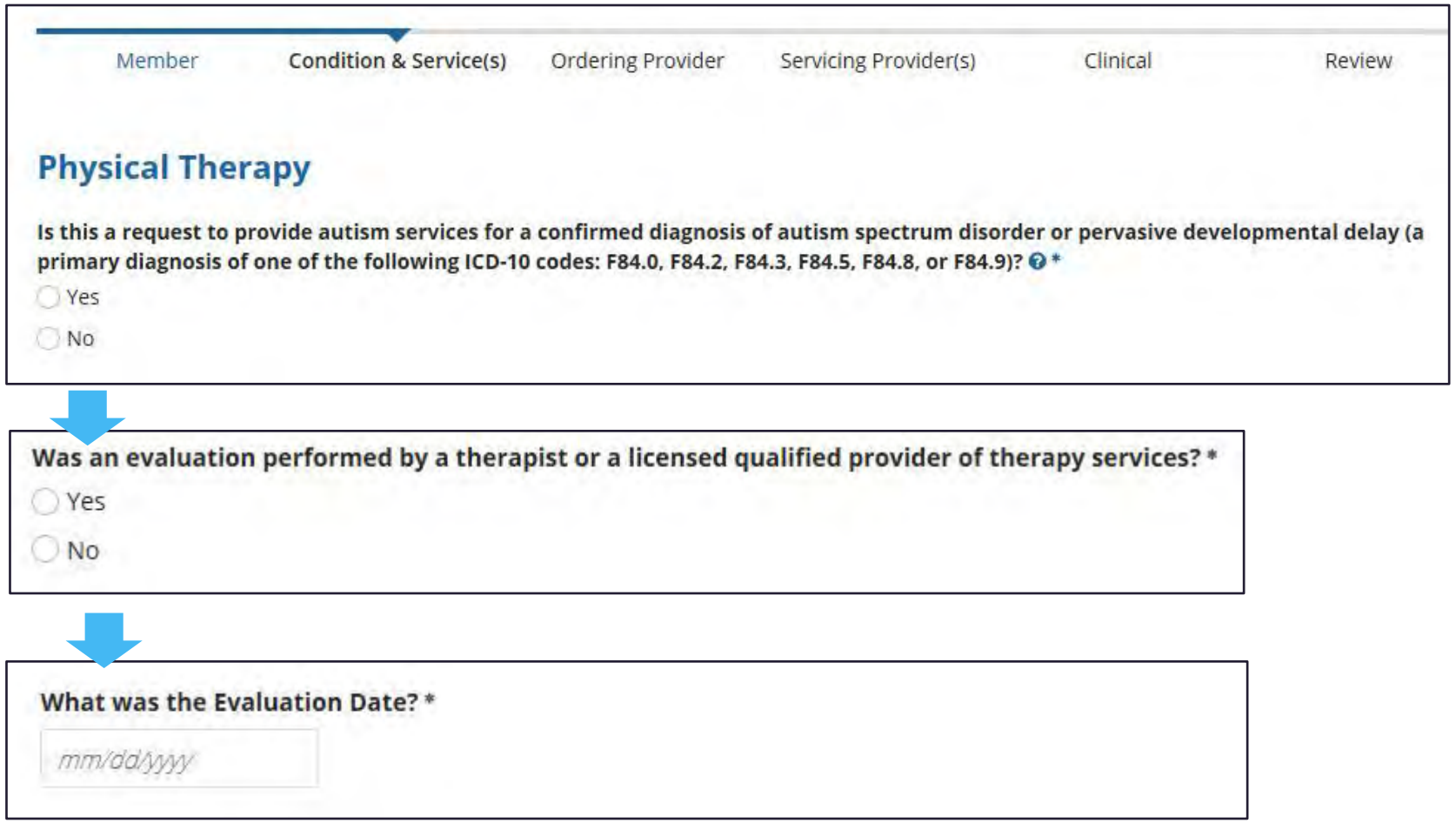
After saving the therapy type the CPT service field becomes active again.

The user should enter all the adjunctive treatment CPT codes for the episode of care.

The adjunctive CPT codes can be searched for by the description or the CPT code.

Once all the CPT codes have been entered the user will select "**continue**" to move forward with the request.

Enter the episode of care metrics



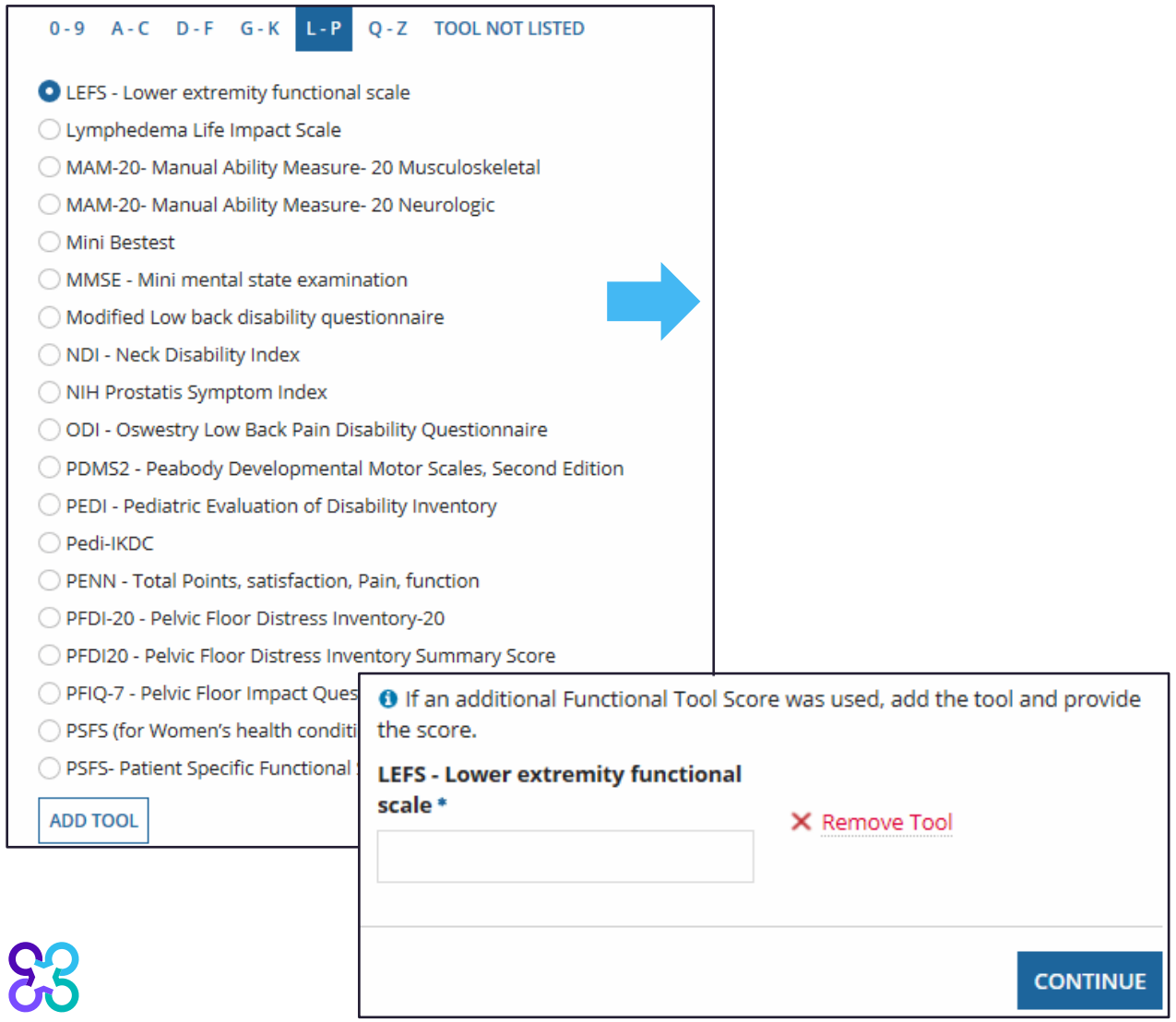
Next, the user will enter the episode of care metrics.

Document if the request is to provide services for a confirmed diagnosis of Autism Spectrum Disorder or Pervasive Developmental Delay as specified by the listed ICD codes.

Document if an initial evaluation has been performed. Note: A "**No**" answer will provide the facility with 1 visit to perform the initial evaluation, and any treatment rendered at the initial evaluation.

If an initial evaluation was performed, enter the initial evaluation date. Note: The initial evaluation date should be kept consistent for each request throughout the episode of care for the member.

Episode of care entry (continued)



Next the user will document the functional outcome tool utilized in the plan of care.

Up to two tools can be selected for multiple diagnoses or body parts being treated.

Select the functional outcome tool from the drop-down list prior to manually entering the same tool, as scoring will not be allowed on a manually entered tool.

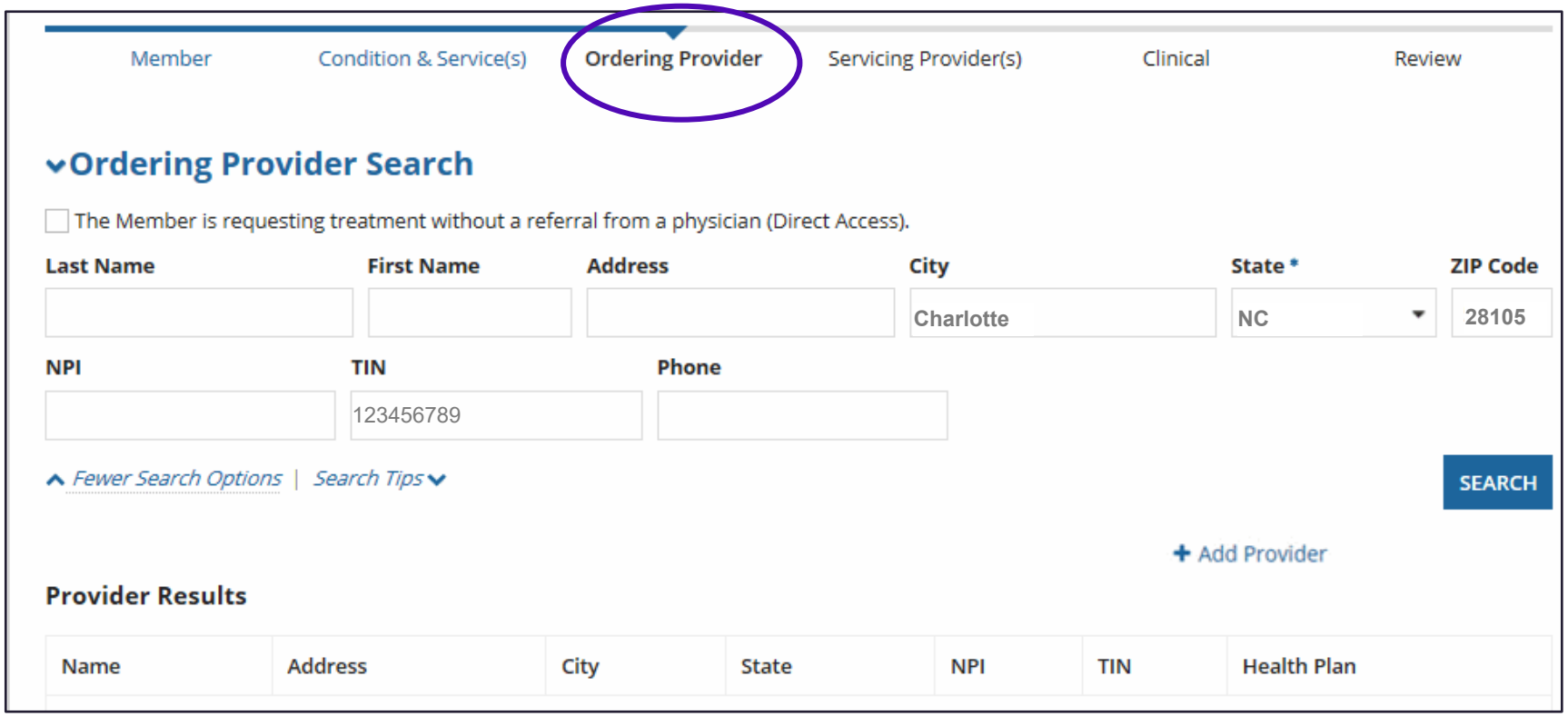
Once you find your tool, select "**Add tool**"

Document initial/baseline score for the tool. Note: Requests that required an initial or baseline score will require an updated tool score on subsequent requests. Also, some tools do not require a score.

Select "**Continue**" once completed.

If you do not find your tool, please select "Tool not listed" and enter the name of your tool. Note: a score will not be collected.

Select ordering provider



Next, the user will search for the ordering provider.

Some requests and markets allow a direct access option. To initiate a direct access request, click the direct access box.

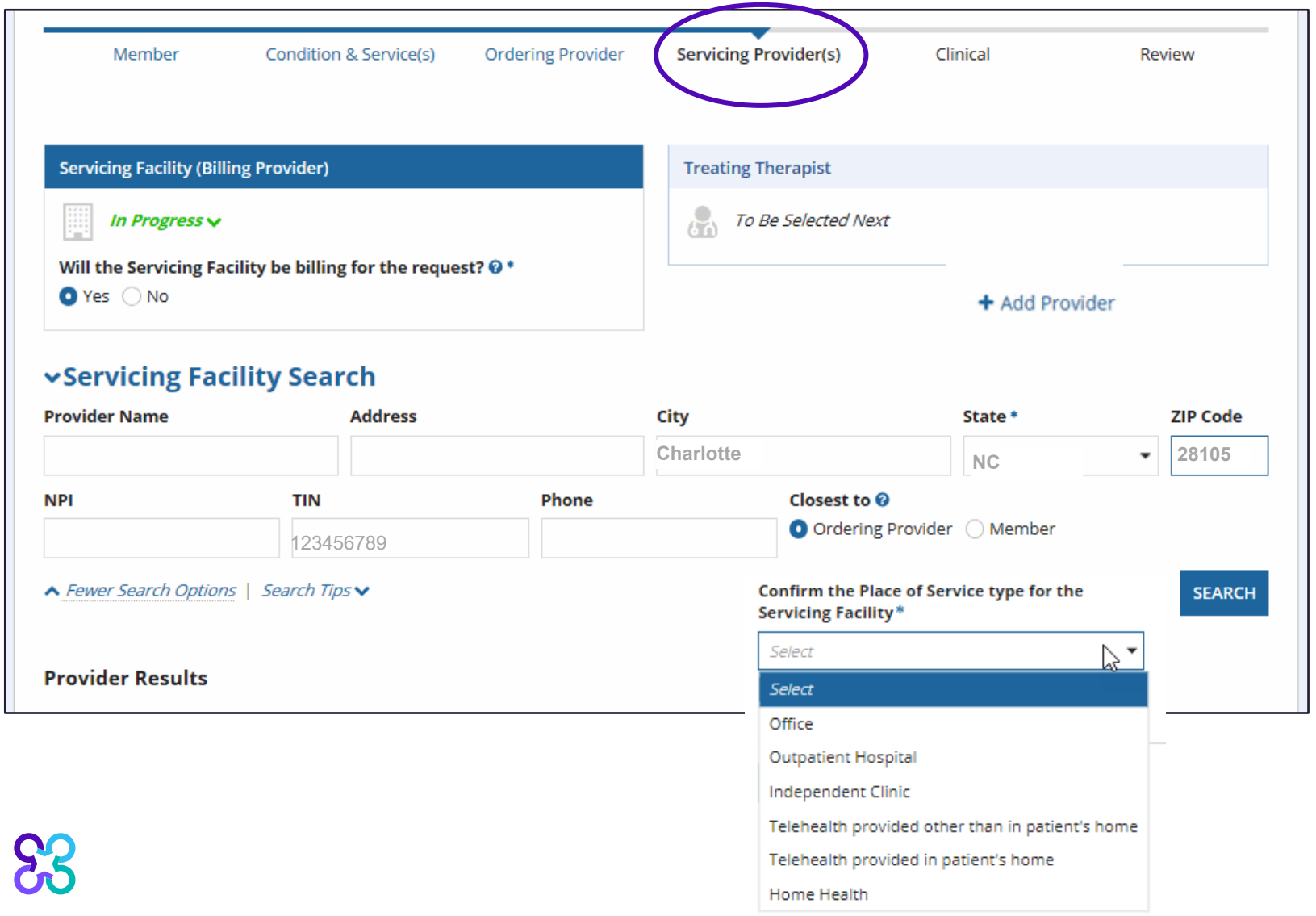
When searching for a provider, the less information entered the better. The city, state, and zip code are required fields. Carelon suggests searching utilizing the TIN/NPI, city, state, and zip code.

Select "**search**" and select the provider if found in results.

If provider is not found, the user can manually add the provider, utilizing the "add provider" link. Note: manually added providers will show as out-of-network.

If a manual add is not allowed for a health plan the user will be messaged with next steps.

Select facility and place of service



Next the user will identify who is the servicing facility/billing entity for the request (e.g., the facility or the individual treating therapist).

Search for a servicing facility utilizing the TIN, city, state and zip code. When searching for a facility, the less information entered the better.

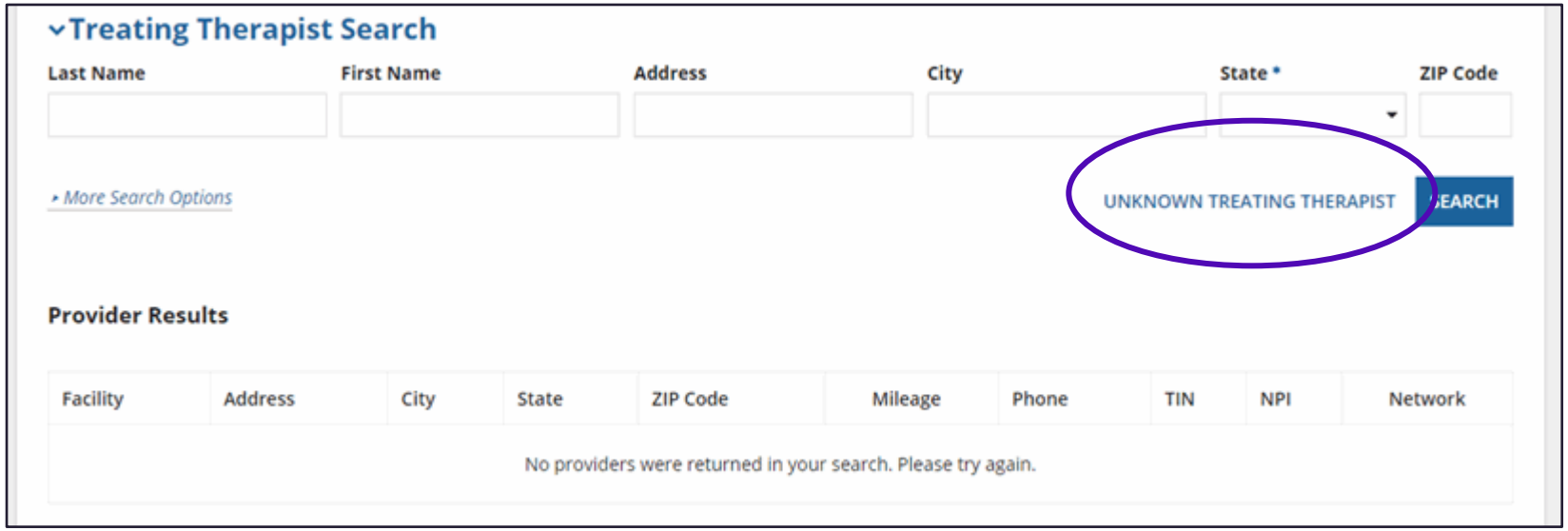
Select the facility from the search results.

If provider is not found, the user can manually add the provider, utilizing the "add provider" link.

If manual add is not allowed for a health plan the user will be messaged with next steps.

Next the user will select the place of service designation for the outpatient therapy services.

Select treating therapist



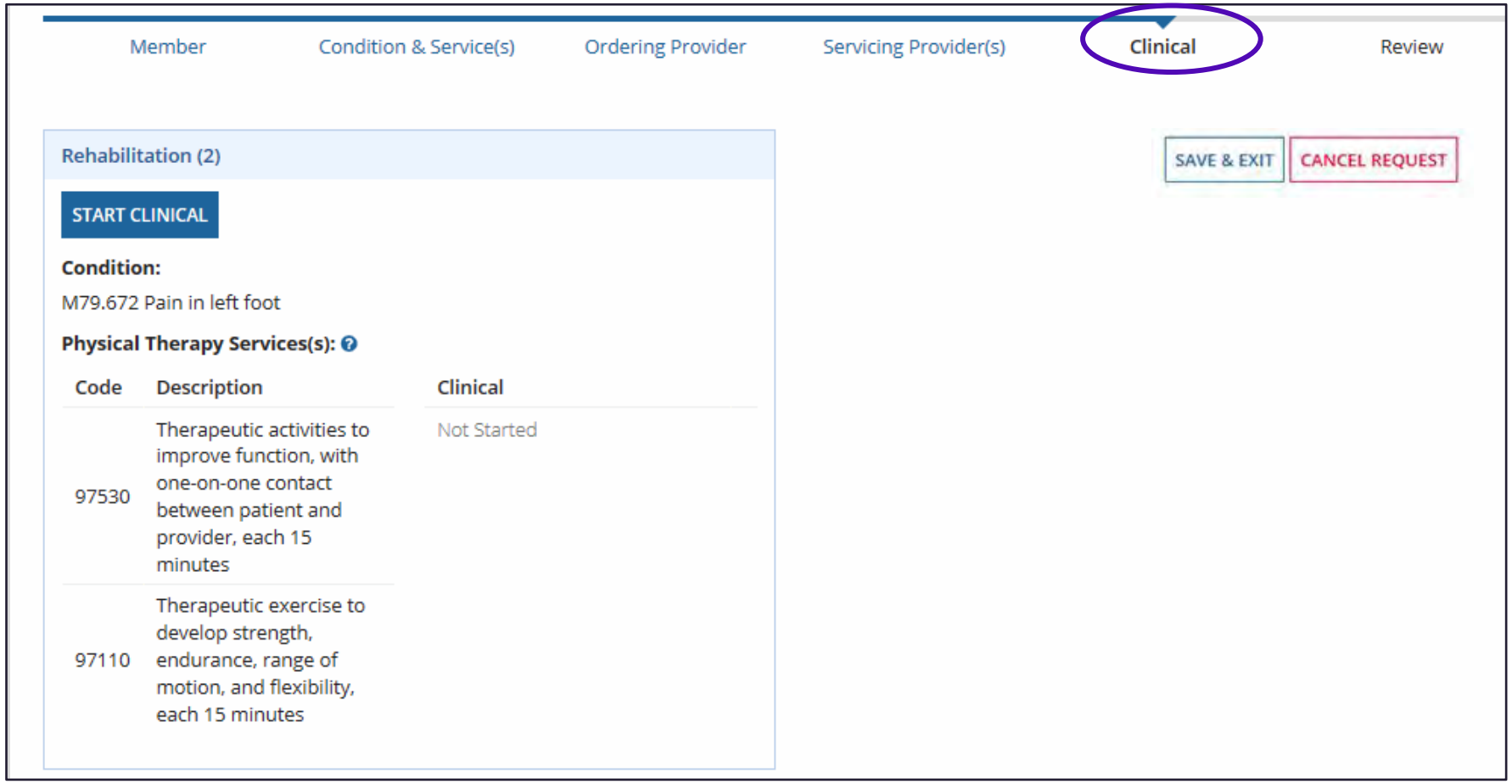
Next, the user will select the treating therapist if they are the billing entity.

If the servicing facility record is selected as the billing entity, the treating therapist field is optional. The user should select "**unknown treating therapist**".

If the servicing facility is not selected as the billing entity for the request and it will instead be billed through the individual treating therapist, these fields are mandatory.

Search for the treating therapist using the NPI, city, state and zip code.

Start the clinical entry

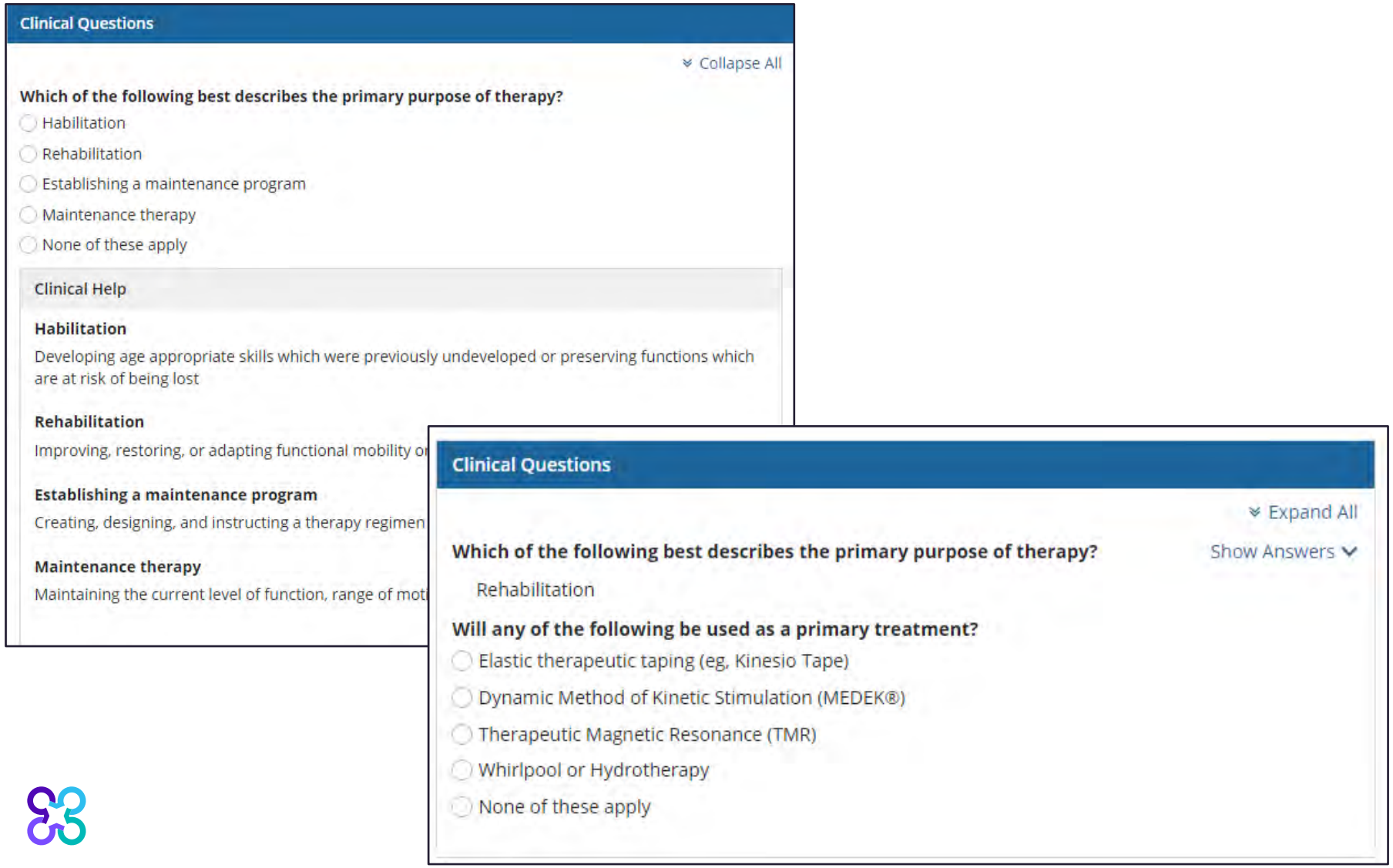


Based on the member's clinical scenario and whether it is an initial or subsequent treatment request, the user will need to answer some clinical questions.

Please reference the provider microsite "*Order request Checklists*" for a complete list of the clinical details required. Review the checklist document with clinicians and office staff who may be entering the prior authorization request for the facility.

Select "**Start clinical**" button

Clinical entry (continued)

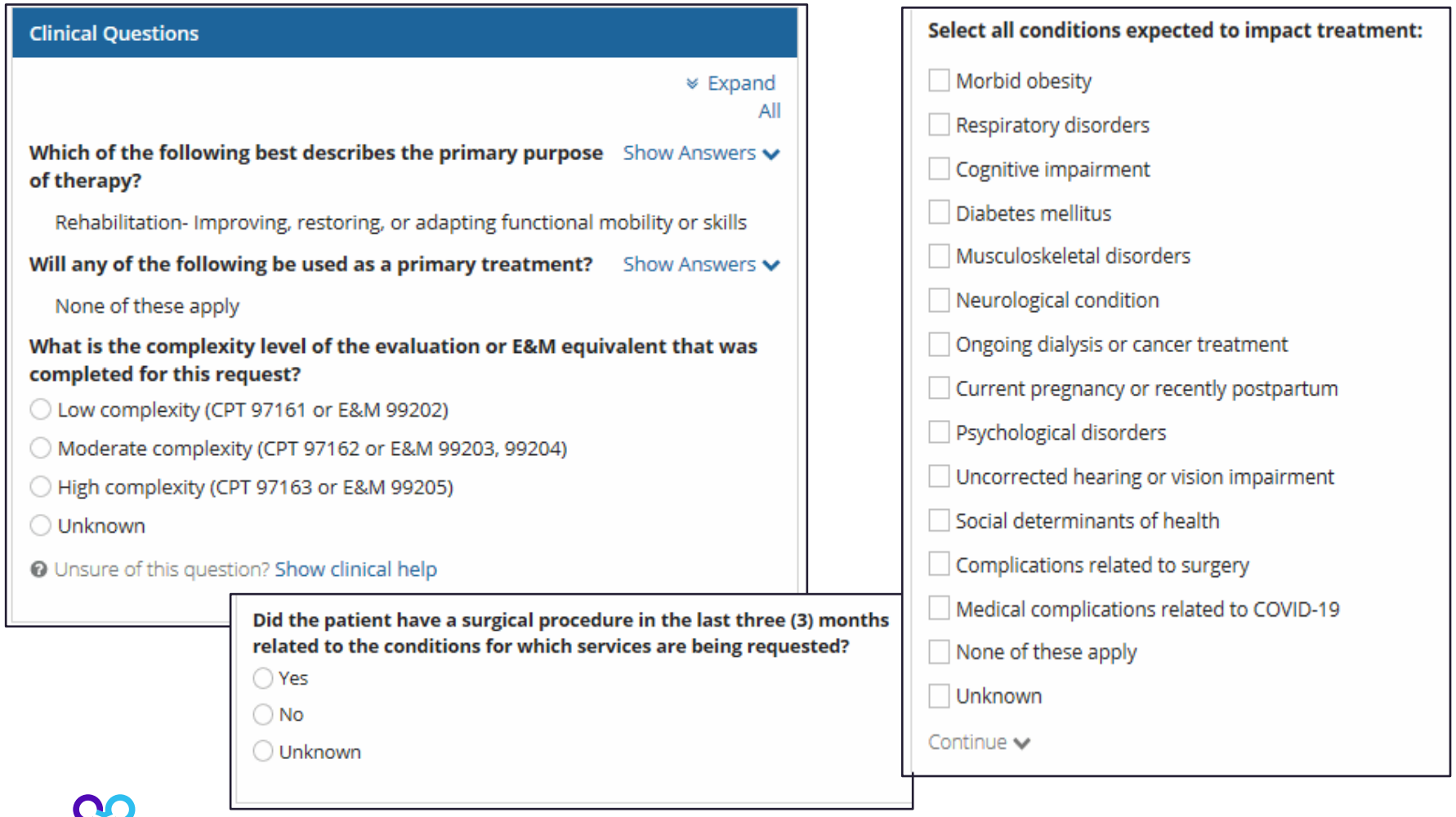


The user will be asked to document the primary purpose of therapy for the request.

Based on the answer, the next clinical question will be displayed

In this example, the user is asked if any of the following treatments will be used as a primary treatment.

Clinical entry (continued)

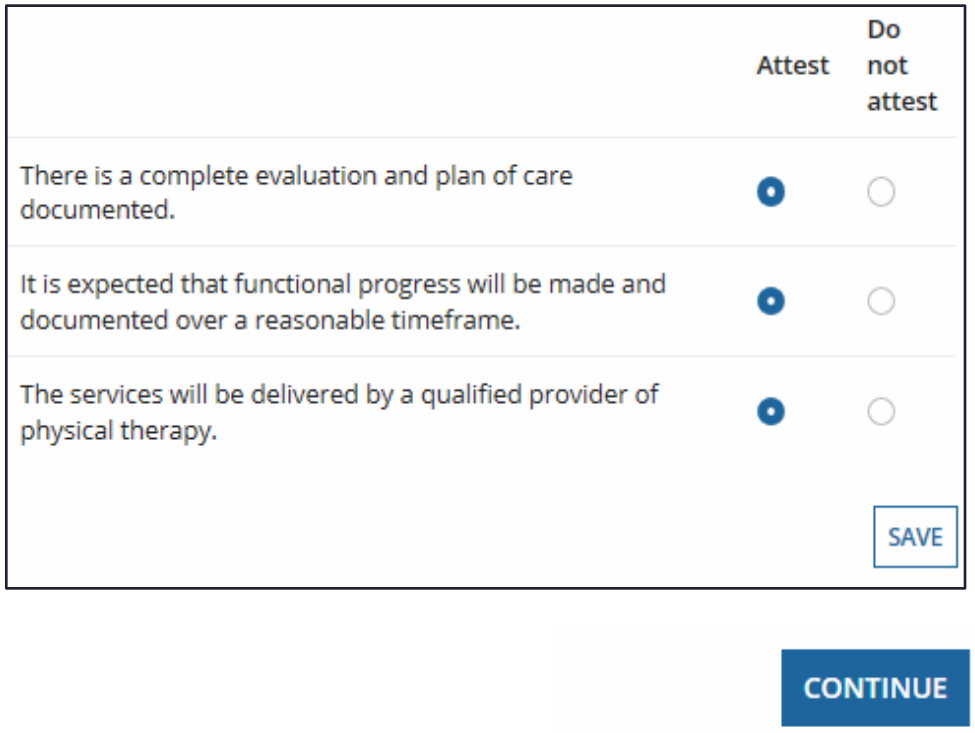


Based on the answer to the previous clinical question, the next clinical question will be displayed.

This may include but is not limited to:

- The complexity level of the initial evaluation for the request.
- The acuity of the condition and the expected length of duration.
- If the patient has had a surgical procedure in the last three months related to the diagnosis.
- And comorbidities or conditions expected to impact treatment.

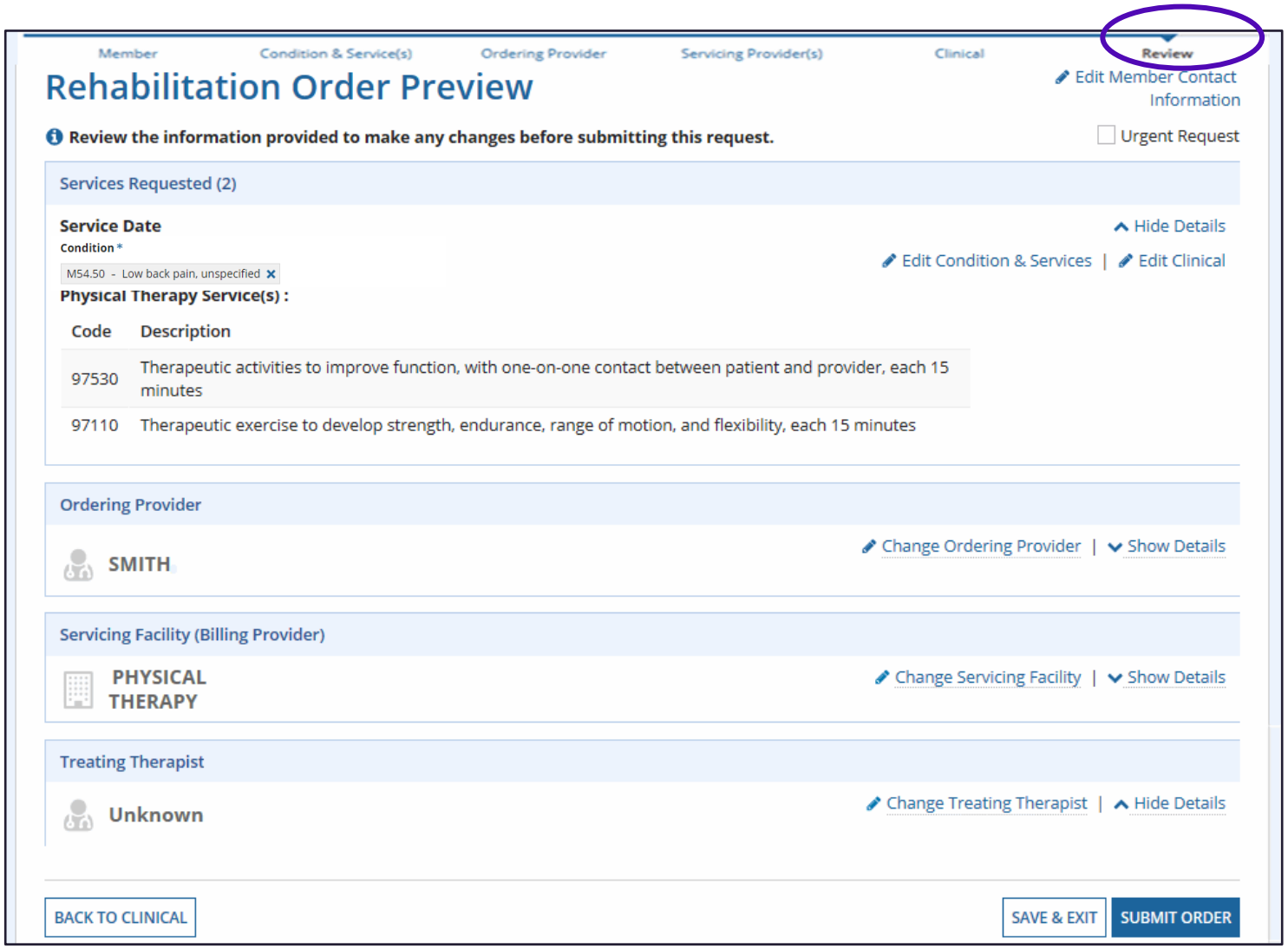
Clinical entry (continued)



Depending on case stage, the user may be asked to compete a clinical attestation.

Once the answers to the clinical questions have all been answered and "**Save**" has been selected, The user will select "**Continue**".

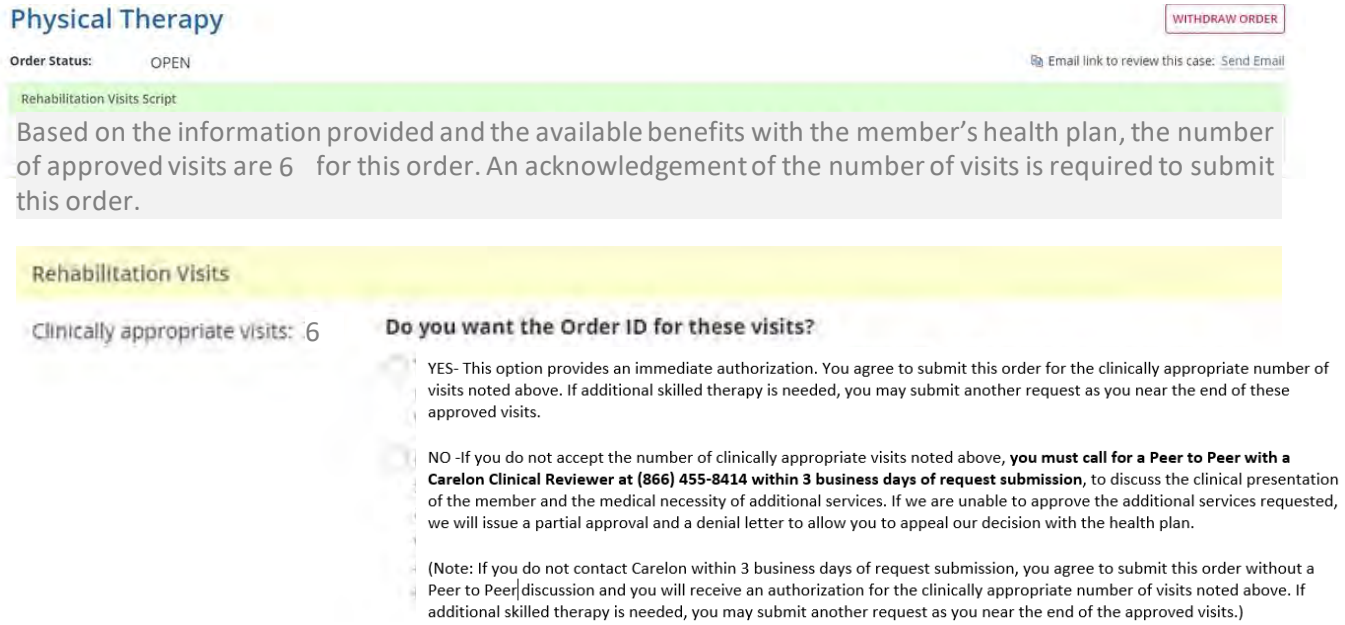
Review collected information



The order preview screen allows the user to review the requests' information prior to submission and make any necessary modifications.

Select the "**submit this request**" button once the user has verified all the information.

Additional Visit Request Capability



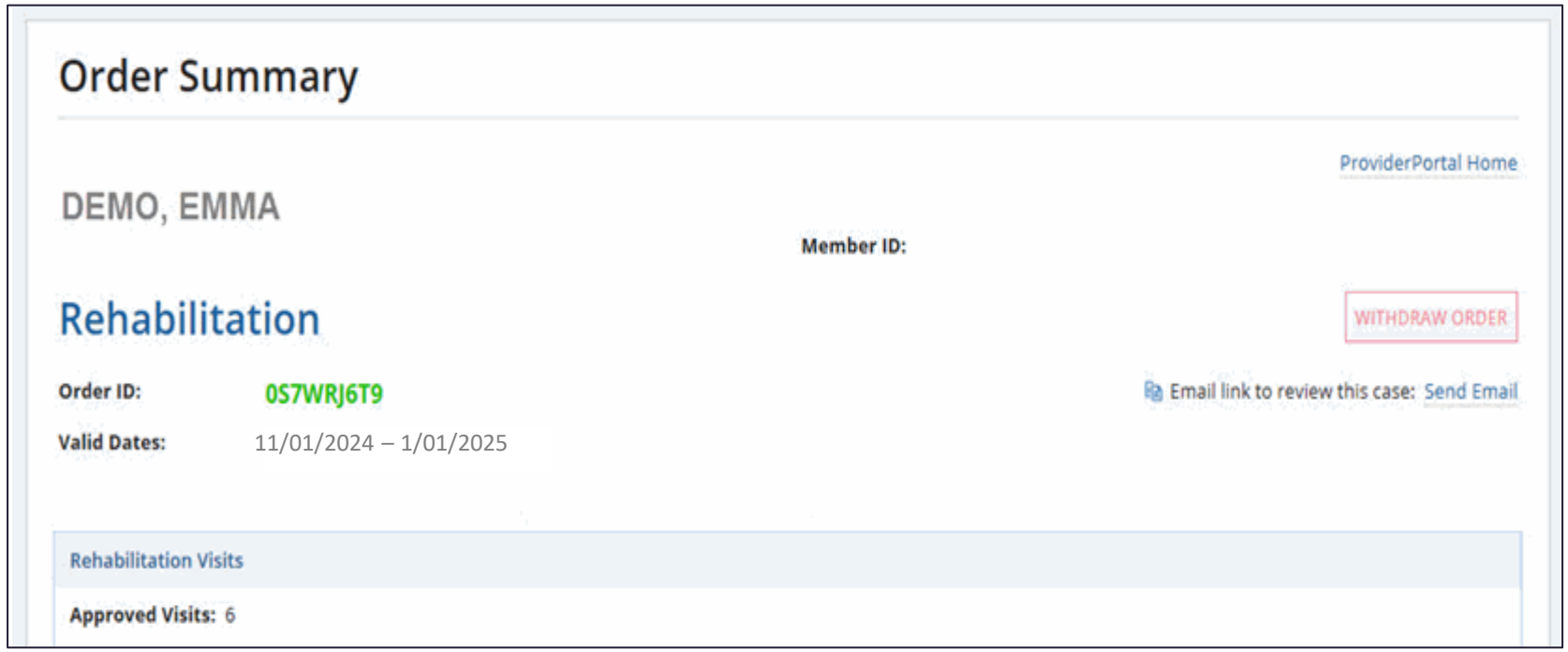
Therapy requests that meet clinical criteria will receive a response with an order tracking number, and the number of visits determined to be clinically appropriate.

The provider is given the following options:

- **Yes-Accept the visits:** This option provides an immediate authorization. You agree to submit this order for the clinically appropriate number of visits noted above. If additional skilled therapy is needed, you may submit another request as you near the end of these approved visits.
- **No-Not accept the visits:** If you do not accept the number of clinically appropriate visits noted above, **you must call for a Peer to Peer with a Carelon Clinical Reviewer at (866) 455-8414 within 3 business days of request submission**, to discuss the clinical presentation of the member and the medical necessity of additional services. If we are unable to approve the additional services requested, we will issue a partial approval and a denial letter to allow you to appeal our decision with the health plan.

(Note: If you do not contact Carelon within 3 business days of request submission, you agree to submit this order without a Peer to Peer discussion and you will receive an authorization for the clinically appropriate number of visits noted above. If additional skilled therapy is needed, you may submit another request as you near the end of the approved visits.)

Order request determination

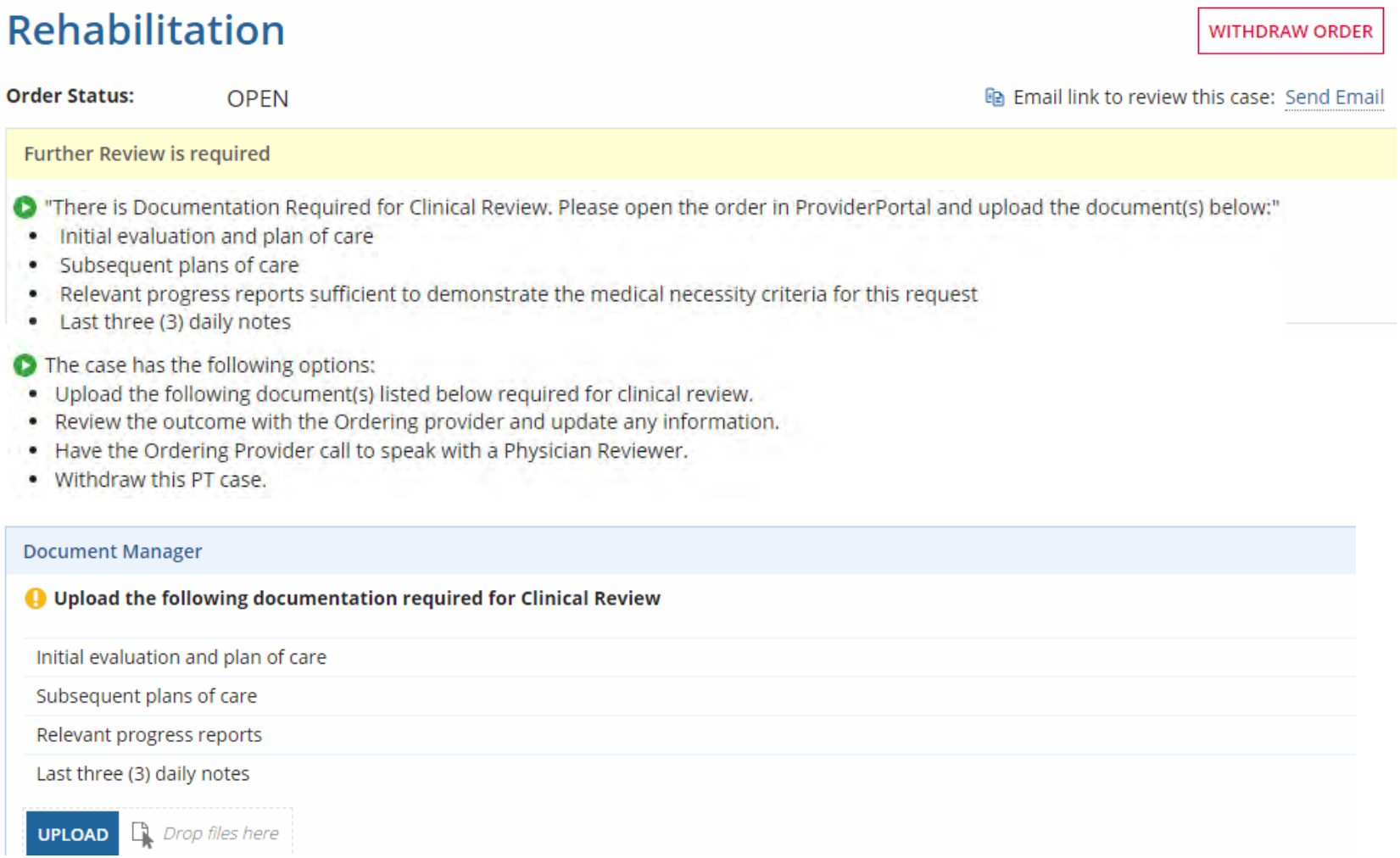


After accepting the visits, the provider will receive the Carelon order number and the prior authorization valid timeframe.

Note: The number of approved visits for this request may not be the total number of visits needed under the treatment plan. Providers can always return to request additional visits if the member requires additional skilled therapy.

If the request does not meet criteria, it will be sent for clinical review. The provider can contact Carelon to discuss the request at any time.

Clinical documentation required



When documentation is required, typically at the recurring request, the system will indicate that clinical upload is needed.

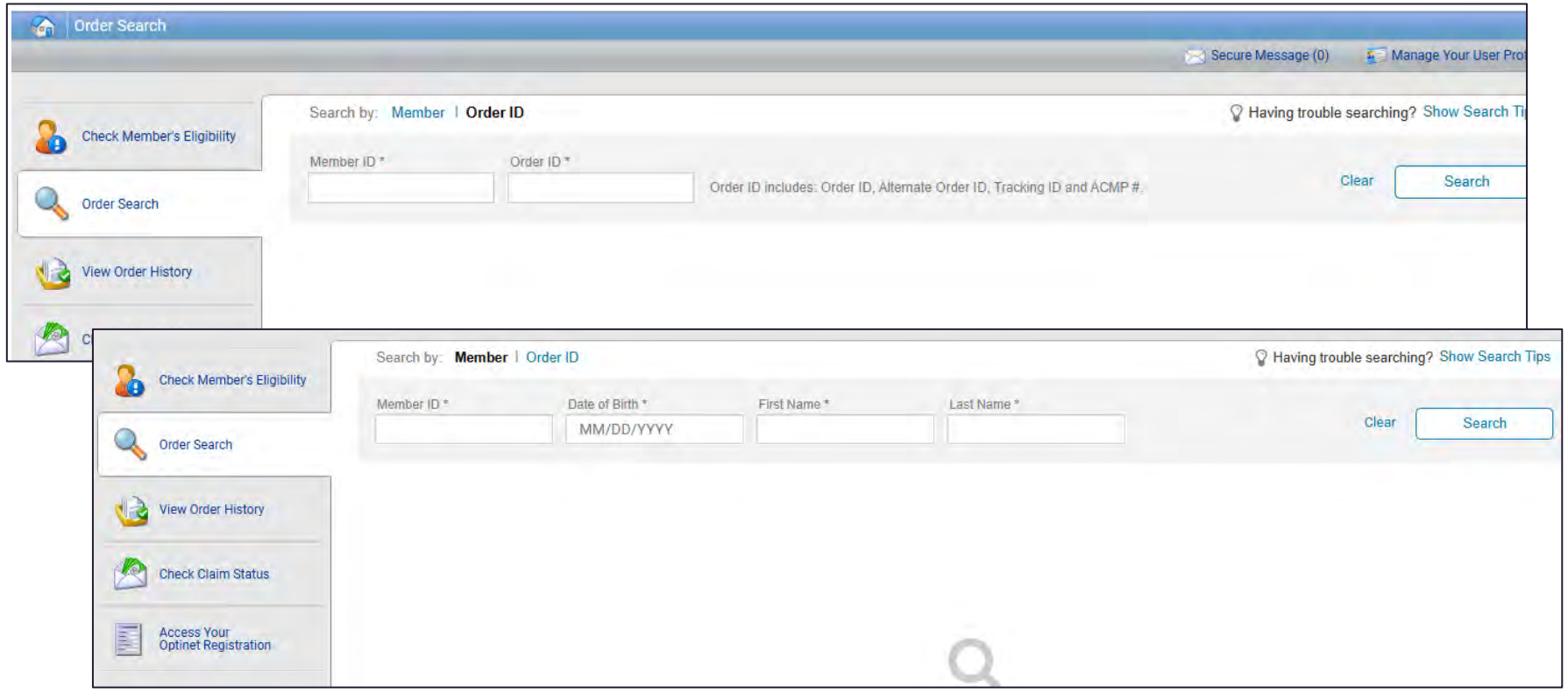
The list of requested documents can be found in the document manager.

Once the provider has uploaded the requested documents there is nothing further for the provider to do until a determination is made.

If the member is returning to the facility and the provider has not received a determination, they may call Carelon and ask that the request is reviewed live. If the provider cannot hold, they may request a same day call back from Carelon once a determination has been made.

If the provider has additional questions, they may call Carelon for a peer-to-peer discussion.

Viewing a case determination or case history



If the user needs to stop and finish the request later, select the "**Save and Exit**" button at any time and utilize "**Order Search**" to find the saved case.

After submitting a prior authorization request, the user will be able to view the request determination by selecting "**Order Search**".

Users can search by "**Order ID**" with the required fields or via "**Member**" with the required fields.