NEWS FLASH

SENIOR Preferred (HMO)

Update to Part B Therapies, Effective January 1, 2018

May 15, 2018

As of January 1, 2018, Senior Preferred requires prior authorization for all therapies exceeding $2010 ($2010 per calendar year for OT and for combined PT/ST.) The processes currently in place will not change. You can find updated documents online at https://www.seniorpreferred.org/for-providers. Be sure to pass this along to all staff as appropriate.

Instructions for Completion of Part B Prior Authorization

- Complete all fields of Prior Authorization forms. Incomplete forms will result in significant delays for decisions or a denial of service.
- Sign and date form with legible signature.
- Forward signed order or plan of care or MD / NP / PA progress note documenting need for additional therapy.
- Attach daily treatment notes.
- Please see Prior Authorization Process document on our website for more detailed information.

Please visit seniorpreferred.org under the Provider tab to access all therapy forms.

Prior Authorization Process for Senior Preferred (HMO) Part B Therapy Visits

Outpatient Medicare Part B Senior Preferred therapy (PT, OT and ST) more than the Medicare threshold of $2010 will require prior authorization. The threshold will apply to the 2018 calendar year for OT services and for combined PT and ST services.

All therapy claims will be entered into a database on the Senior Preferred Provider Portal/My Plan Tools. The database will be available for review to determine when services rendered by all network providers of therapy services are at the threshold for the calendar year. Accuracy of portal dollars depends upon timely billing submissions. Prior authorization forms and certified treatment plans will be reviewed to insure all components are completed (for coding, see below). This policy addresses therapies given at a frequency of one to three times per week.

Senior Preferred reserves the right to audit documentation at any time to evaluate compliance with Medicare regulations.

YOU WILL RECEIVE A COMMUNICATION FROM SENIOR PREFERRED (HMO).

Please follow the instructions outlined below for submission of Prior Authorization forms.

1. Complete all demographic fields at the top of the form including -
   - Date form is completed
   - Requesting provider name
   - Therapist's NPI number
   - Therapist's phone and fax numbers,
   - Discipline requested,
   - Date form is completed
   - Member's name, health plan ID number, date of birth and date of illness or injury.
2. Enter name of provider (MD/PA/NP)
   - Enter prescribing therapy.
   - Fax a copy of **the original signed order** for therapy (must have original legible signature) OR the **signed treatment plan** (original legible signature or Medicare compliant electronic signature required).
   - Enter the date of the last face-to-face exam by the provider prescribing therapy.
3. Enter medical diagnosis with code. The medical diagnosis may be -
   - A symptom(s).
   - Updated at time of report on 10th day of treatment.
   - If code not readily available, we can get it from first status report or coder may contact Senior Preferred Customer Service with information when available.
4. Enter date of evaluation. Therapy may be given on this day.
5. Enter number of therapy visits requested.
6. Enter number of therapy visits per week and the number of weeks being requested.
7. If request is for more therapy for same illness, utilize "Additional therapy visits requested", and complete times per week for weeks.
   - This will not require a new treatment plan if the request for additional therapy is made within 60 days of the last therapy visit.
   - If a request for additional therapy is made greater than 60 days following the last therapy session, a new treatment plan and prior authorization will be required.
8. Complete "significant improvement has been made" only if you request additional therapy visits. Leave blank on initial requests.
9. Complete rehab potential.
10. Indicate if records are available in Epic and provide the date of the initial treatment plan.
11. If your therapy evaluation is confidential (under glass in Epic), you will need to print and fax to Senior Preferred.
    - If you do not have an electronic record, you will need to print and fax to Senior Preferred.
    - All initial evaluations should be typewritten and signed by the attending MD/NP/PA.
12. Sign and date the form prior to sending to Senior Preferred.

Additional Instructions (many similar to past documentation as required by Medicare)

1. Moving forward treatment plans must be Medicare compliant regarding acceptable signatures (see below).

The Evaluation Form

2. The Evaluation form (containing Physician/Provider Certification) states that the services are reasonable and necessary to treat the member's condition.

What to include in the evaluation

3. The evaluation should include -
   - Your typewritten treatment plan including the type, frequency and duration of PT, OT, or ST, diagnosis, goals and functional assessments, and your signature.
   - Only licensed skilled therapists can make clinical judgments and certify / recertify a plan of care with their signature.
   - New or significantly modified treatment plans will require certification. The treatment plan must have an original signature from an MD / PA / NP or an acceptable electronic signature that necessitates the MD / NP /PA review prior to signing.
   - **Signature** means a legible identifier of any type acceptable per policies in Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4 concerning signatures.
     - **Therapy may not proceed without a valid signature on the treatment plan.**
     - **A "Signature on file" does not meet signature requirements and will not be accepted as a valid signature.**
     - **Initial evaluations submitted with "signature on file" will be asked to submit an attestation statement or signature log from the requesting MD / PA /PA. Upon receipt of an attestation statement or signature log, the treatment plan will be considered.**
   - **Use of an order for care of a physician / non-physician practitioner**. Per the Medicare Benefit Manual, Chapter 220, Section 220.1.1 **– Care of a Physician / Non-physician Practitioner** – Although there is no Medicare requirement for an order, when -
     - documented in the medical record,
     - an order provides evidence that the patient both needs therapy services and
     - is under the care of a physician or non-physician practitioner.

     Use of an order is prudent to determine that a physician / non- physician practitioner is involved in the member's care and available to certify the plan.

     Senior Preferred will accept a documented note from an MD / NP / PA that therapy is advised and ordered when -
     - Included within the progress note from a clinic / nursing home visit OR a signed order for therapy containing an original legible signature from the MD / PA / NP; OR
     - A treatment plan with an original legible signature or an acceptable signature/initials over a typed or printed name from the MD / PA / NP. A signature log or attestation statement is acceptable if

accompanied by an illegible signature. (Epic electronic signatures are acceptable if they can be verified upon review.)

Updated reports every 10 days

4. A licensed therapist providing therapy services will need to submit an updated report once every 10 treatment days. Templates are available for use and may be electronically submitted or faxed to Senior Preferred.
   - These reports should include progress, changes in goals and functional reporting.
   - You may send date of 10th treatment day progress report if available in Epic. This document should contain evidence that a licensed skilled therapist has regularly re-evaluated the condition and adjusted the exercise program.
   - This is NOT a new prior authorization. It is intended to monitor a member's progress in therapy.

Documentation

1. Reasonable and necessary documentation should minimally include the following -
   - Expectation of improvement within a reasonable and predictable amount of time with clearly defined time frame.
   - Restoration/maintenance potential in relationship to the extent and duration of therapy. Improvement is evidenced by successive objective measurements whenever possible.
   - Illness/injury/loss of ability is amenable to therapy services which will restore function to the point of reasonable independence, excluding permanent deficits that are unable to be restored.
   - A maintenance program designed for the member with instructions to the member, supportive personnel and/or family members.
   - Please refer to LDC L33631 and L33580 for additional details related to Medical Necessity as defined by Medicare.
2. Requests for additional therapy should identify unmet goals, barriers or reasons for unmet goals, number of visits per week x number of weeks for additional therapy, documentation of active participation by the member and functional improvement. There should be additional documentation that the physician/NP/PA has periodically reviewed therapy services being provided.
3. A discharge report should be sent at the time a member's therapy is completed. If the threshold amount is hit ($2,010) a medical necessity review will take place at the Health Plan. Medicare does not cover packaged or predetermined therapy services or programs. Senior Preferred will not cover such programs.
4. Senior Preferred will do a review at the time the $2,010 dollar threshold is hit.
   - A maximum of 10 additional treatment days will be allowed if approved.
   - You may continue to provide services utilizing appropriate modifiers.
   - Additional review will be required for those members needing ongoing therapy.
   - Senior Preferred utilizes Local Coverage Determinations for therapy and Apollo guidelines.
5. Additional documentation may be requested during the review process. Providers are encouraged to provide 10th day treatment notes

for those members with a continued need for therapy services.

6. Senior Preferred will request recoupment of dollars spent for therapy if services are evaluated as being unreasonable / unnecessary.
7. Members who have recently experienced a significant stroke or traumatic brain injury will require more intensive and prolonged therapies. Senior Preferred will work with therapy providers to insure that therapies ordered by rehabilitation physicians are not interrupted during the review process.
8. Incomplete prior authorizations will not be processed and will be returned.

Examples of unreasonable / unnecessary therapy services as described in the Local Coverage Determination for the state of Wisconsin:

- Services that do not require the skills of a therapist are not considered to be reasonable or necessary therapy services, even if they are performed or supervised by a therapist, physician, or non-physician provider.
- Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction in function which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. For, example, therapy may not be covered for a fully functional patient who developed temporary **weakness** or **debility** from a brief period of bed rest following abdominal surgery, UTI, etc. It is reasonably expected that as discomfort reduces and the patient gradually resumes daily activities, function will return without skilled therapy intervention.
- Therapy to improve recreational or athletic performance is not covered.
- If a patient's limited ability to comprehend instructions, follow directions, or remember skills that are necessary to achieve an increase in function is so severe as to make functional improvement very unlikely, rehabilitative therapy is not required, and therefore, is not covered.
- Regarding lymphedema management: conditions reversible by exercise or elevation of the affected area are not covered; dependent edema related to congestive heart failure or other cardiomyopathies is not covered.
- Please see LCD L33631 for guidelines addressing specific modalities and non-covered indications.
- Therapies given at a rate of 5 days per week are not addressed in this policy. Please refer to member's Medicare Part A benefits.