Prior Authorization Process for Quartz Medicare Advantage Part B Therapy Visits

What Part B therapies require a prior authorization?

For the 2020 calendar year, outpatient Medicare Part B therapy services that are more than the 30-visit limit will need a prior authorization. This requirement applies to physical, speech, and occupational therapy services.

Tracking and documenting Part B therapy visits

Quartz Medicare Advantage reserves the right to audit documentation at any time to assess compliance with Medicare regulations.
Using this database means:

- You can review the database to check therapy services rendered by all network providers are at the threshold for the calendar year.
- Accuracy of portal visit count depends upon the timely submission of billings.
- We can review prior authorization forms and certified treatment plans to ensure all components are completed (for coding see below).

Submitting Prior Authorization forms

Please follow the instructions outlined below when submitting a Part B Therapy prior authorization form.

1. Complete all demographic fields at the top of the form such as:
    - Date form is completed
    - Ordering provider name
    - Therapist's NPI number
    - Therapist's phone and fax numbers
    - Discipline requested
    - Member's name, health plan ID number, date of birth, and date of illness or injury.
2. Enter provider prescribing therapy information such as:
    - Name of the provider (MD/PA/NP)
    - Send/fax a copy of the original signed order for therapy (must have an original legible signature) to (608) 881-8397; OR
    - The signed treatment plan (original legible signature or Medicare compliant electronic signature required)
    - Enter the date of the last face-to-face exam
3. Enter medical diagnosis with code. The medical diagnosis may be a symptom(s).
    - Diagnosis may be updated at the time of the report on the tenth day of treatment.
    - If code is not readily available, we will obtain from the first status report or the coder may contact Customer Service with information when available.
4. Enter the date of the evaluation. Therapy may be given on this day.
5. Enter the number of therapy visits requested that are beyond the 30-visit limit.

6. Enter the number of therapy visits per week and the number of weeks being requested.
7. Indicate if records are available in Epic and provide the date of the initial treatment plan. If your therapy evaluation is confidential (under glass in Epic):
    - You will need to print and fax it to Quartz Medicare Advantage at (608) 881-8397.
    - If you do not have an electronic record, you'll need to print and fax it to Quartz Medicare Advantage.
    - Attending MD/NP/PA needs to type and sign all initial evaluations.
8. Sign and date the form before you send it to Quartz Medicare Advantage.

Additional instructions for complying with Medicare's documentation requirements –

1. Moving forward treatment plans must be Medicare compliant regarding acceptable signatures (see 3 below).
2. The evaluation form (containing physician/provider certification) states that the services are reasonable and necessary to treat the member's condition.
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.
    - New or significantly modified treatment plans will require certification.
        - Only licensed skilled therapists can make clinical judgments and certify/recertify a plan of care with their signature.
        - The treatment plan must have an original signature from an MD/PA/NP or an acceptable electronic signature, which necessitates the MD/NP/PA review before signing.
    - Upon receipt of an attestation statement or signature log, the treatment plan will be considered. Therapy may not proceed without a valid signature on the treatment plan.
    - SIGNATURE means a legible identifier of any type acceptable according to policies in Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4 concerning signatures.
        - "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.
4. 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. The 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.
    - Quartz Medicare Advantage 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.

5. 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 Quartz Medicare Advantage. These reports should include progress, changes in goals, and functional reporting.
    - You may send the date of tenth 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 as a way to monitor a member's progress in therapy.
6. Reasonable and necessary documentation should minimally include the following:
    - The expectation of improvement within a reasonable and predictable amount of time with a clearly defined time frame.
    - Restoration/maintenance potential in relation 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 LCD L33631 Outpatient Physical and Occupational therapy Services. LCD L33580 Speech-Language Pathology for additional details related to Medical Necessity as defined by Medicare.
7. Requests for additional therapy should identify Unmet goals; barriers or reasons for unmet goals; the number of visits per week times number of weeks for additional therapy; and documentation of active participation by the member and functional improvement. Additionally, there should be documentation that the physician/NP/PA has periodically reviewed therapy services being provided.
8. A discharge report should be sent at the time a member's therapy is completed. If the number of visits has hit the 30-visit limit, a medical necessity review will take place at Quartz.
9. Quartz Medicare Advantage will do a review at the time the 30-visit limit is met.
    - A maximum of 10 additional treatment days will be allowed if approved.
    - You may continue to provide services utilizing appropriate modifiers.
    - An additional review will be required for those members needing ongoing therapy.
    - Quartz Medicare Advantage utilizes Local Coverage Determinations for therapy and Apollo guidelines.
10. Additional documentation may be requested during the review process. Providers are encouraged to provide tenth-day treatment notes for those members with a continued need for therapy services.
11. Quartz Medicare Advantage will request the recoupment of dollars spent on therapy if services are evaluated as being unreasonable/unnecessary.
    - Medicare does not cover packaged or predetermined therapy services or programs.
    - Quartz Medicare Advantage will not cover such programs.
12. Members who have recently experienced a significant stroke or traumatic brain injury will require

more intensive and prolonged therapies. Quartz Medicare Advantage will work with therapy providers to ensure that therapies ordered by rehabilitation physicians are not interrupted during the review process.

13. Incomplete prior authorizations will not be processed and will be returned.
14. The LCD for PT/OT outpatient therapy will be followed to determine medical necessity and recommended visits allowed such as vestibular therapy of five visits or less.

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 the 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, the 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 five days per week are not addressed in this policy. Please refer to member's Medicare Part A benefits.

We're here to help

If you have questions, please –

- **Call:** Customer Service at (800) 394-5566 or TTY 711.
- **Email:** CustomerService@QuartzBenefits.com.