Prior Authorization of Physical Therapy, Occupational Therapy and Speech Therapy

Provider Orientation Session for Humana Healthy Horizons® in Kentucky

LC18636KY0822 (HUMP18636)

Humana Healthy Horizons in Kentucky is a Medicaid product of Humana Health Plan Inc.

Agenda

- Program Overview
- Submitting Requests
- Prior Authorization Outcomes, Special Considerations and Post-decision Options
- Provider Portal Overview
- Additional Provider Portal Features
- Provider Resources
- Q & A

Program Overview

Humana Healthy Horizons Prior Authorization Services

Applicable membership:	Prior authorization applies to the following services:	Prior authorization does NOT apply to services performed in:
• Medicaid	• Outpatient • Elective/Non-emergent	• Emergency rooms • Inpatient stays

It is the responsibility of the **treating/ordering provider** to request prior authorization approval for services.

Prior Authorization Program

Prior authorization is required for:

- Physical therapy
- Occupational therapy
- Speech therapy

To find a list of Current Procedural Terminology (CPT) codes that require prior authorization through eviCore, please visit: https://www.evicore.com/resources/healthplan/humana/Kentucky.

Prior Authorization Program

Fundamental Approach

- Clinical reviewers evaluate clinical information to determine whether services meet medical necessity criteria.
- Providers are encouraged to request authorization before care is delivered to ensure payment for services rendered.
- A request can be made as early as **7 calendar days** prior to requested start date.
- eviCore will review retro requests up to **2 business days** after services were rendered.

Prior Authorization Program

Clinical Philosophy

- Support patient-centered care founded on best available evidence.
- Promote functionally oriented and measureable treatment programs.
- Focus on skilled, medically necessary treatment interventions.
- Empower patient independence.
- Eliminate practice variation that cannot be explained or justified.

Prior Authorization Program

Goals

- Authorize medically necessary services which require the skills of a licensed professional.
- Promote evidence-based practice.
- Identify and review treatment interventions where evidence does not support use.
- Provide evidence-based guidelines to support authorization decisions and educate practitioners.
- Decrease or eliminate unexplained practice variation and unnecessary visits.
- Manage costs efficiently so members continue to receive **quality care** and **skilled services.**

Prior Authorization Program

Medical Necessity

- The services must be specific and effective treatment for the condition.
- The condition is expected to improve significantly in a reasonable and generally predictable time period. Therapy duration should be reasonable and not without end.
- The amount, frequency and length of the services must be reasonable under accepted standards of practice.
- The medical benefit is designed to allow therapy to return the patient to essential activities of daily living.
  - It was **not** designed to allow continued therapy to return to recreational or athletic activities.
  - It was **not** designed to cover therapy for the purpose of improving or maintaining general fitness.

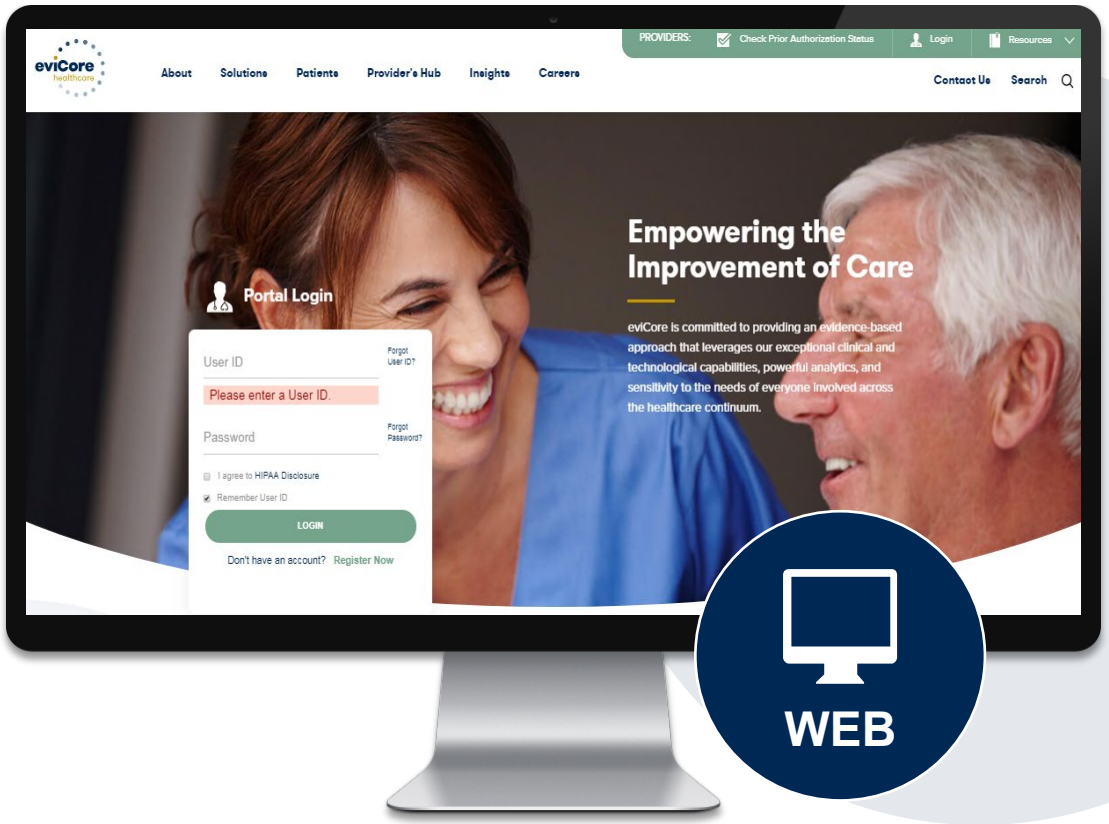
You can view the therapy guidelines here: https://www.evicore.com/provider/clinical-guidelines.

Submitting Requests

Methods to Submit Prior Authorization Requests

eviCore Provider Portal (preferred)

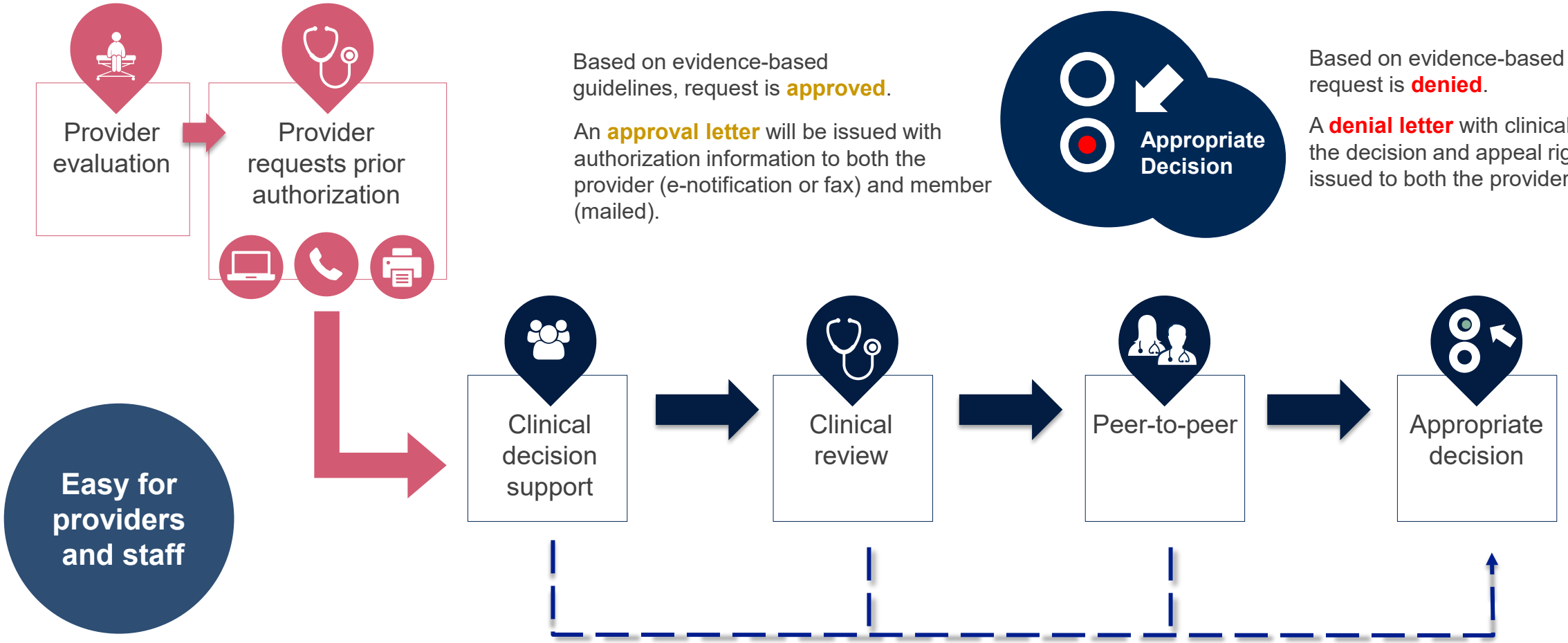
- **Saves time**: Faster process than phone authorization requests.
- **Available 24/7**: You can access the portal any time and any day.
- **Save your progress**: If you need to step away, you can save your progress and resume later.
- **Upload additional clinical information**: No need to fax supporting clinical documentation—upload documents to the portal to support a new request or when additional information is requested.
- **View and print determination information**: Check case status in real time.
- **Dashboard**: View all recently submitted cases.
- **E-notification**: Opt in to receive email notifications when there is a change to case status.
- **Duplication feature**: If you are submitting more than one prior authorization request, you can duplicate information to expedite submissions.



Phone Number:
866-672-8115
Monday through Friday,
7 a.m. – 7 p.m.

Fax Number:
855-774-1319
PA requests are accepted via fax and can be used to submit additional clinical information.

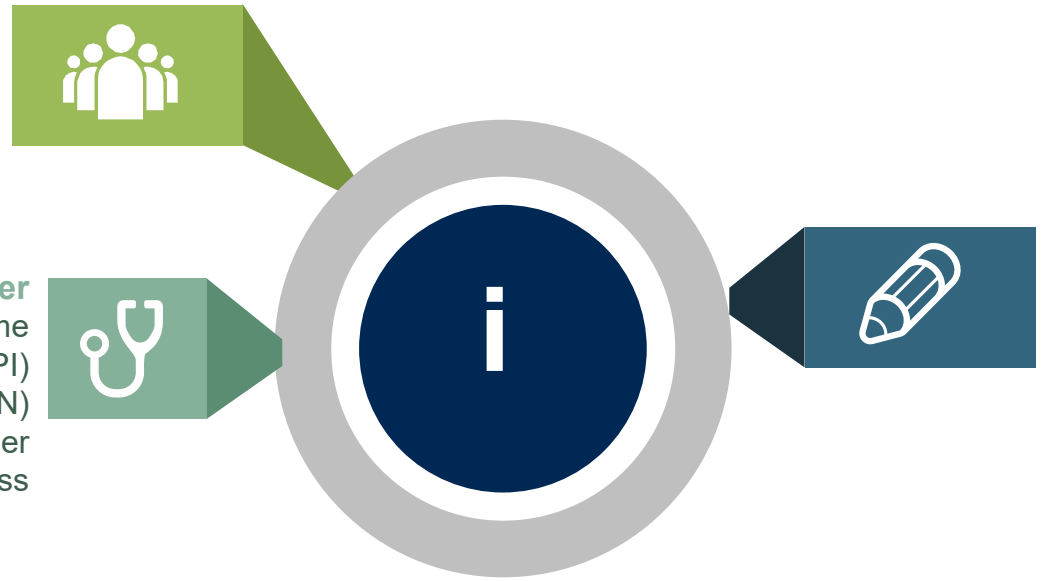
Utilization Management – The Prior Authorization Process



Information Required for Request

Member
Member ID
Member name
Date of birth (DOB)

Rendering Provider
Provider name
National provider identifier (NPI)
Tax identification number (TIN)
Fax number
Street address



Requests
Select MSMPT, MSMOT or MSMST for requested services

The appropriate diagnosis code for the working of differential diagnosis

If clinical information is needed, please supply:

- Patient's subjective complaints, objective examination findings and level of function
- Information from Treatment Request Clinical Worksheet
- Information should be current
- Office notes will be requested as needed

Insufficient Clinical – Additional Documentation Needed

Additional Documentation to Support Medical Necessity

If all required documentation is not received during the case build, or the submitted information is insufficient for eviCore to reach a determination, the following will occur:

A hold letter will be faxed to the requesting provider requesting additional documentation.	The provider must submit the additional information to eviCore.	eviCore will review the additional documentation and reach a determination.
The hold notification will inform the provider about what clinical information is needed as well as the date by which it is needed.	Requested information must be received within the timeframe as specified in the hold letter, or eviCore will render a determination based on the original submission.	Determination notifications will be sent.

Prior Authorization Process

When requesting authorization before treatment begins:

- Complete your initial evaluation, then submit for prior authorization within **2 business days**. The initial evaluation **does not** require prior authorization.
- Start date should be the **first day of treatment** (date of initial evaluation or visit following if treatment was not provided during the initial evaluation visit).
- When requesting ongoing or continuing care, you can submit up to **7 calendar days** prior to the next start date for authorization.
- Notification requires submission of the following information:
  - Patient demographics
  - Provider demographics
  - Minimal clinical information
    - Type of condition
    - Is the request post-surgical?
      - If yes, date of surgery?
- If prior care, questions will be asked to determine if this is a new condition.

Prior Authorization Process

How to request additional visits:

- Additional visits may be requested as early as **7 calendar days** prior to the requested start date.
- You will be asked to submit current clinical information.
- Clinical information should be **current**. Recommended timeframes:
  - Adult and non-developmental pediatric patients = **14 calendar days**
  - Developmental pediatric patients = **30 calendar days**
- Use the appropriate **clinical worksheet** as a guide.
- If condition is complex or the worksheet does not capture aspects of the condition you want to convey, this information can be given as “additional information” via upload, fax or text box summary.
- The **start date** will be the first date you need additional visits to begin.

Prior Authorization Process – Important Concepts

Overlapping Requests

- Request for more visits within the existing approved time period.
- Information you provide should explain why the visits could not be spread over the approved period.
- Review to determine if additional visits are medically necessary.

Authorization Extensions

- Providers can request a 30-day authorization extension.
- Provider must request extension prior to the original authorization's expiration date.
- Date extension can be requested via the online portal.

Prior Authorization Process – Important Concepts

Authorization decisions include:

- Visits
- Approved time period

Example: 6 visits from Jan. 1, 2022, to Jan. 31, 2022

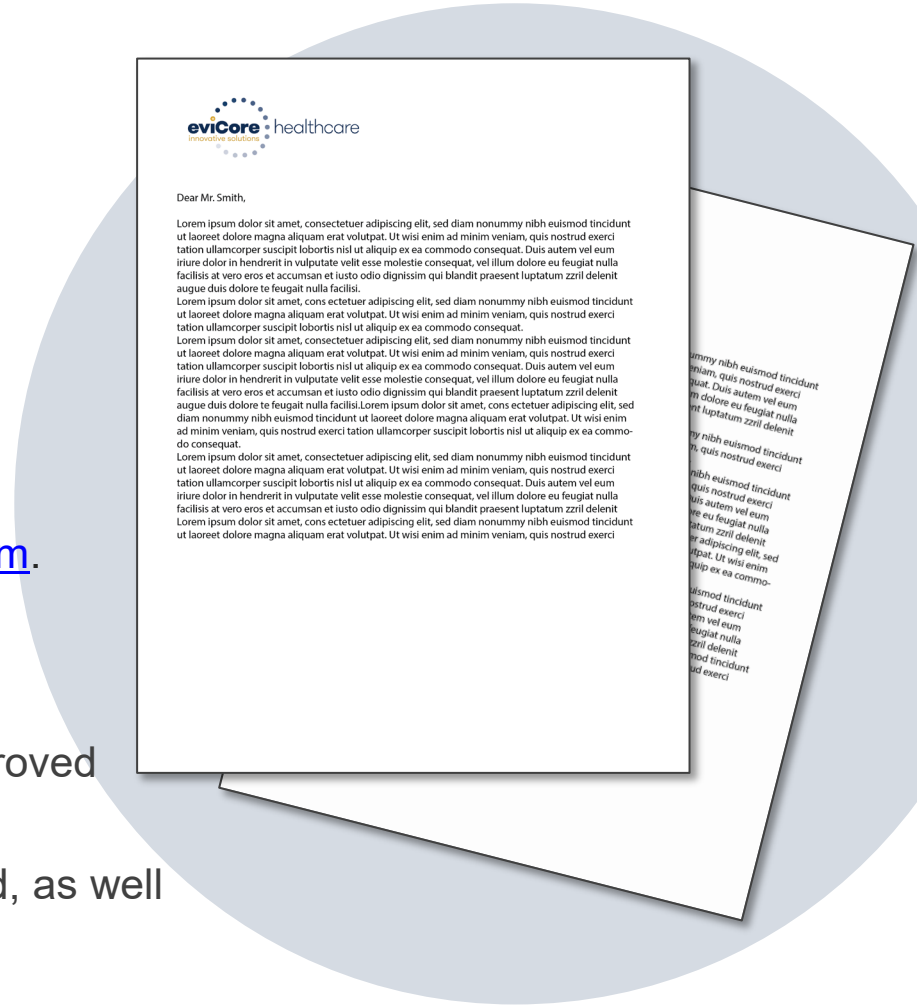
Spread the visits over the approved period to prevent a gap in care.

Prior Authorization Outcomes, Special Considerations and Post-decision Options

Prior Authorization Outcomes

Approved Requests

- All authorization requests are processed within **2 business days** of receipt.
- Authorizations are valid for:
  - Adult and non-developmental pediatric—**60 calendar days**
  - Developmental pediatric—**80 calendar days**
- Authorization letters will be faxed to the treating and ordering provider.
- Web-initiated cases will receive e-notifications when a user opts to receive.
- Members will receive a letter by mail.
- Approval information can be printed from the eviCore portal at www.eviCore.com.



Partially Approved Requests

- In instances when a specific number of visits are requested, some may be approved and some denied.
- In these instances, the determination letter will specify what has been approved, as well as post-decision options for denied visits.

Prior Authorization Outcomes

Denied Requests

- Based on evidence-based guidelines, if a request is determined as not medically necessary, a notification with the rationale for the decision and post-decision/appeal rights will be issued.
- Denial letters will be faxed to the ordering provider and rendering facility.
- Members will receive a letter by mail.

PLEASE NOTE: The determination letter is the ***best*** immediate source to determine what options exist on a case that has been denied.

Special Circumstances

Retrospective (Retro) Authorization Requests

- eviCore will review retro requests up to **2 business days** after services were rendered.
- Authorization requests submitted beyond **2 business days** and up to **90 calendar days** after the date of service will be subject to the retro criteria. If retro criteria are met, then the case will be reviewed for medical necessity. If criteria are not met, then the request will be administratively denied.
- Retro authorization submission with request made after the date of service, when prior authorization is required but not obtained, is allowed in the following circumstances:
  - Service is related to another service that received prior approval and was performed; the new service was not needed when the original prior-authorized service was performed.
  - Need for the new service was determined at the performance of the original prior-authorized service.
  - Humana Healthy Horizons in Kentucky-covered patients determined to be retroactively eligible for Medicaid. (Retroactive Medicaid coverage is a period of up to three months prior to the application month.)

Urgent Prior Authorization Requests

- Can be initiated on provider portal or by phone.
- Case is reviewed and a determination is made within **24 hours**.

Post-decision Options

When Request is Determined as Not Medically Necessary

Based on evidence-based guidelines, request is determined as **not medically necessary**.

A denial letter is issued to the member, provider and site, with clinical rationale for the decision and appeal rights.

Post-decision Options

My case has been denied. What's next?

- Providers are often able to utilize post-decision activity to have a case reviewed for overturn consideration.
- Your **determination letter** is the best immediate source to determine what options exist on a denied case. You also may call us at **866-672-8115** to speak to an agent who can assist with advising which option is available and provide instruction on how to proceed.

Post-decision Options

Additional Clinical

- Additional clinical information can be submitted in writing without the need for a provider to participate.
- Must be requested within **5 business days** of the determination.

Peer-to-peer Review (verbal)

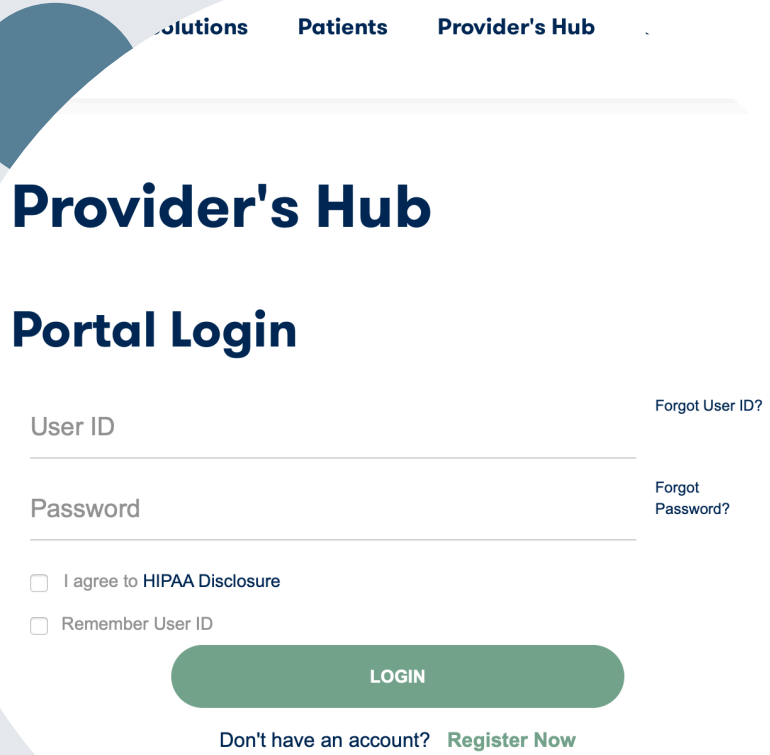
- If a request is denied and requires further clinical discussion for approval, we welcome requests for clinical determination discussions from referring or treating providers. In certain instances, additional information provided during the consultation is sufficient to satisfy the medical necessity criteria for approval.
- A peer-to-peer review must be requested within **5 business days** of the determination.
- Peer-to-peer reviews can be scheduled at a time convenient for your provider by logging into eviCore's provider portal at www.eviCore.com.

Appeals

- eviCore is not delegated for appeals processing for Humana Healthy Horizons KY Medicaid enrollees**.** Please refer to your determination letter for instructions on filing an appeal with Humana Healthy Horizons.

Provider Portal Overview

Portal Compatibility

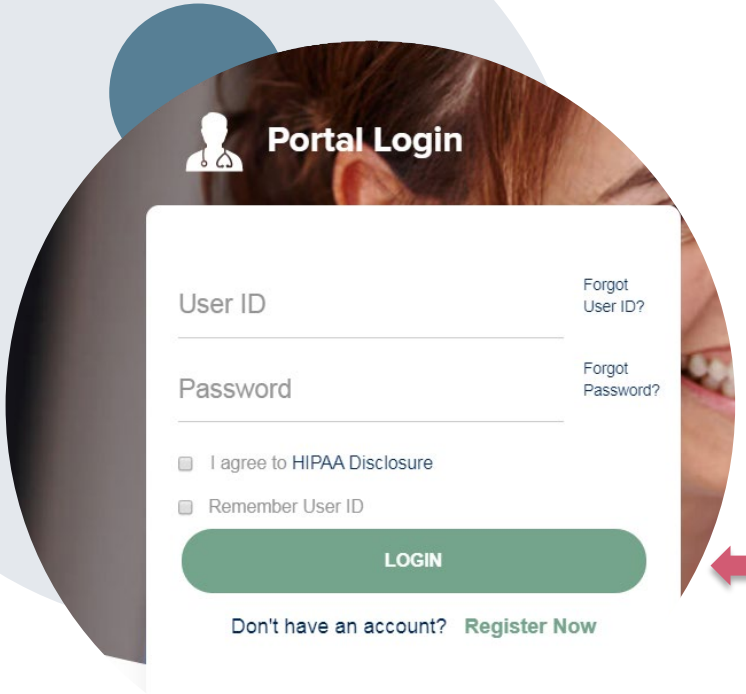


The eviCore.com website is compatible with the following web browsers:

- Google Chrome
- Mozilla Firefox
- Microsoft Edge

Note: You may need to disable pop-up blockers to access the site.

eviCore healthcare Website



Visit www.evicore.com

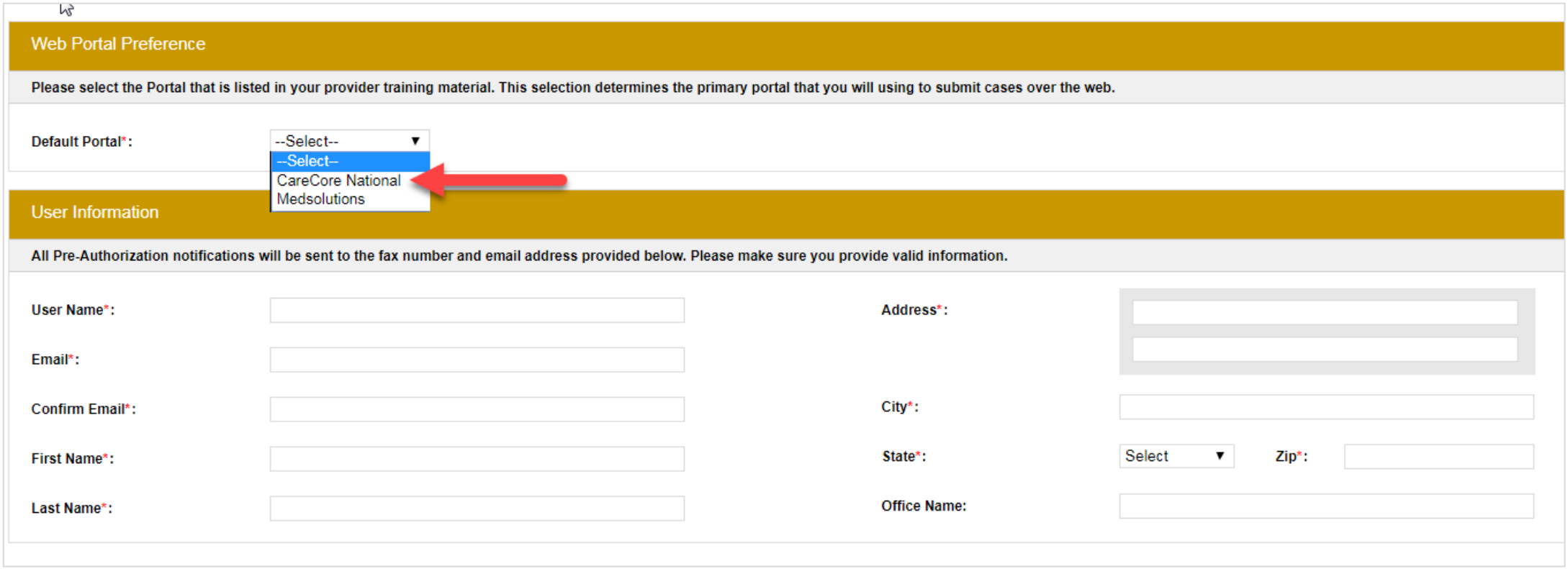
Already a user?

If you already have access to eviCore's online portal, simply log in with your user ID and password and begin submitting requests in real time!

Don't have an account?

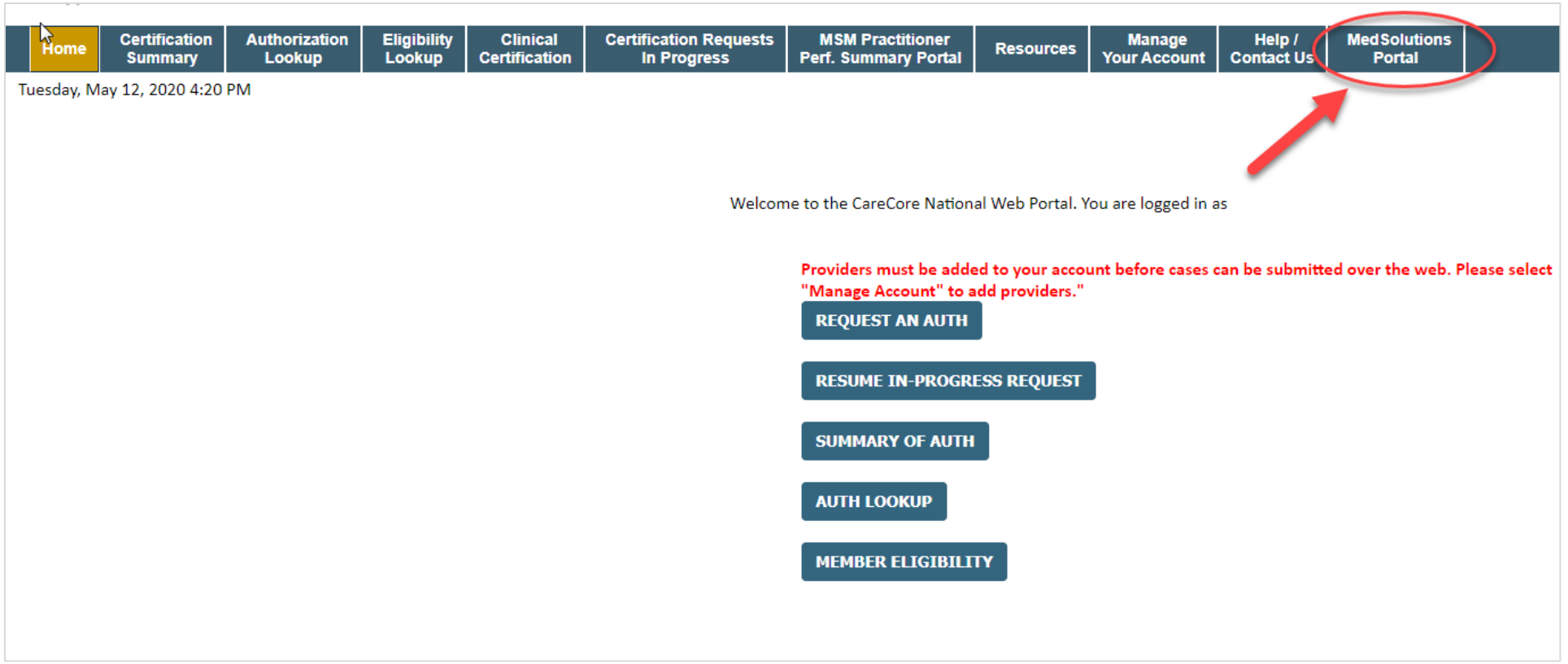
Click **"Register Now"** and provide the necessary information to receive access today!

Creating An Account



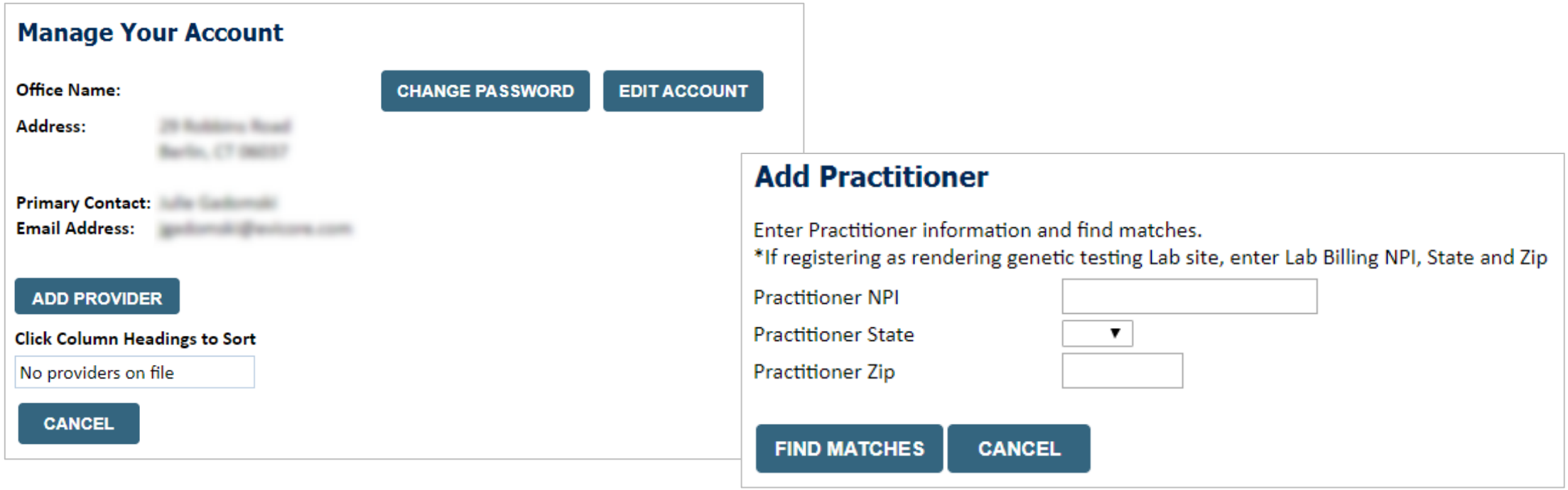
- Select CareCore National as the Default Portal, complete the User Information section in full, then select Submit Registration.
- You are immediately sent an email with a link to create a password. Once you create a password, you are redirected to the login page.

Welcome Screen



Note: You can access the MedSolutions Portal at any time without providing additional login information. Click the MedSolutions Portal on the upper right corner to seamlessly toggle between the two portals.

Add Practitioners

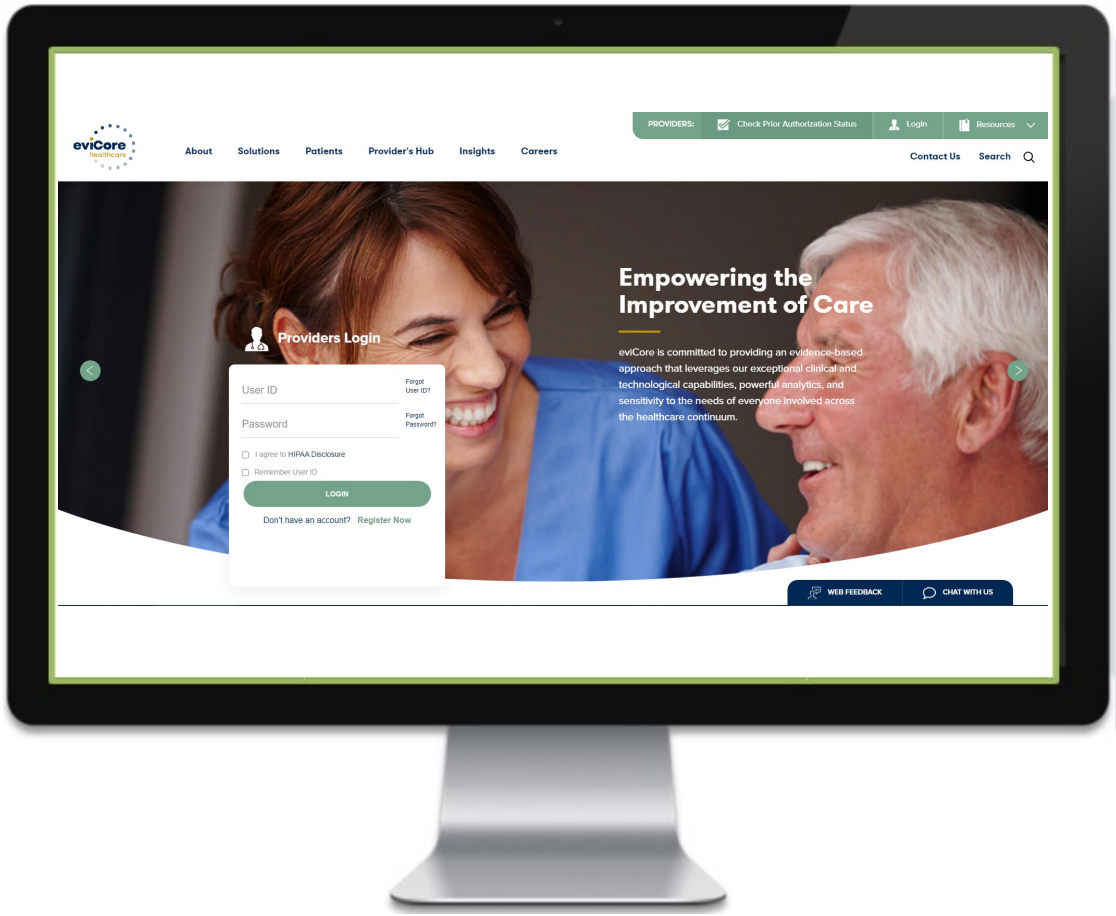


- Select the **Manage Your Account** tab, then **Add Provider**.
- Enter the NPI, state and ZIP code to search for the provider.
- Select the matching record based upon your search criteria.
- Once you select a practitioner, your registration will be complete.
- You also can select **Add Another Practitioner** to add another provider to your account.
- You can access **Manage Your Account** at any time to make any necessary updates or changes.

Portal Demo

The eviCore online portal is the quickest, most efficient way to request prior authorization and check authorization status.

Click for Portal demonstration.



WEB

Additional Provider Portal Features

Portal Features

Certification Summary

- Allows you to track recently submitted cases

Authorization Lookup

- You can look up authorization status on the portal and print any correspondence.
- Search by member information or by authorization number with ordering NPI.
- Review post-decision options, submit appeal and schedule a peer-to-peer.

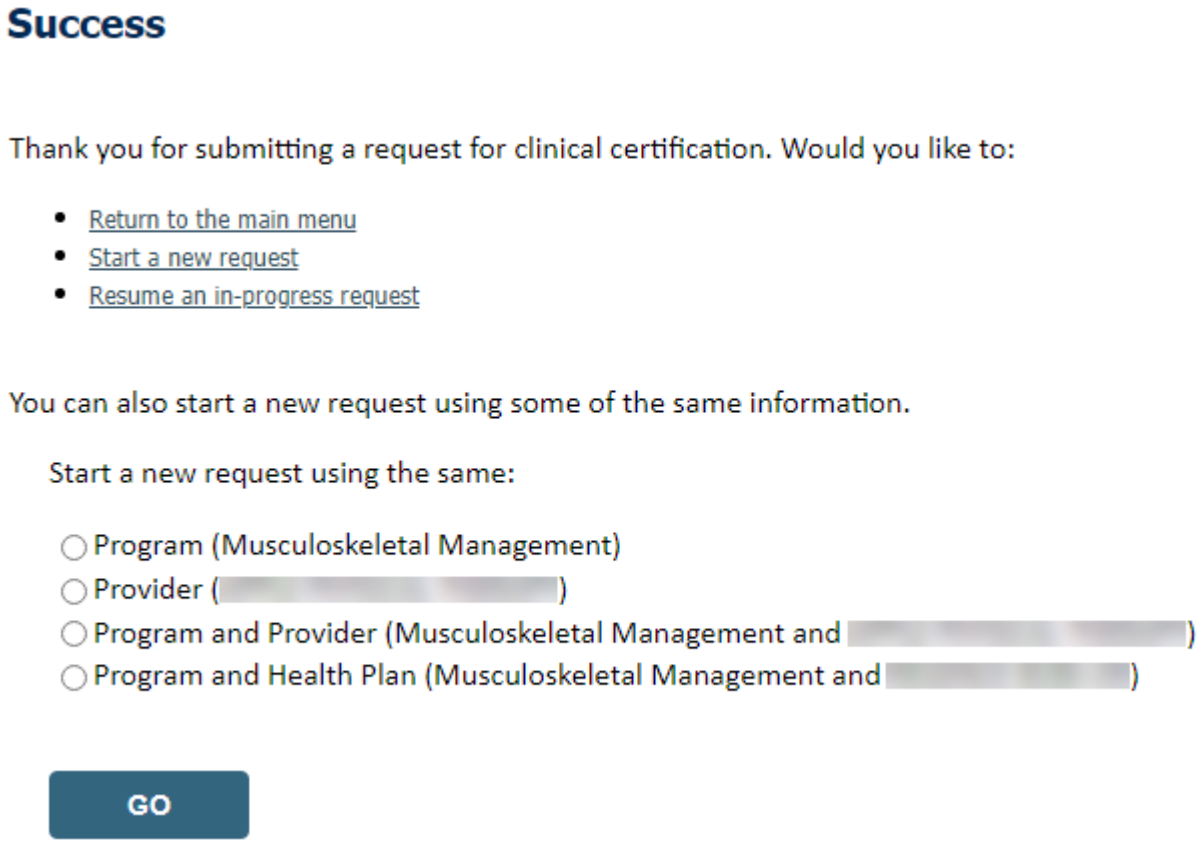
Eligibility Lookup

- Confirm if member requires prior authorization.

Clinical Certification

- You can begin an authorization request.

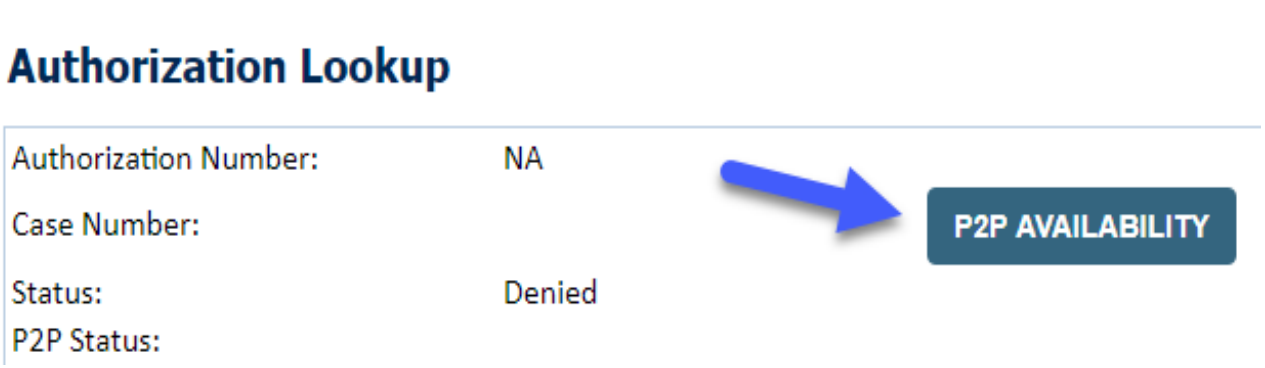
Duplication Feature



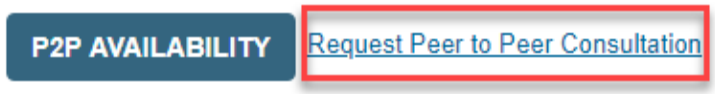
- Duplication feature allows you to start a new request using the same information.
- Eliminates entering duplicate information
- Time saver!

How to Schedule a Peer-to-peer Request

- Log into your account at www.evicore.com.
- Perform Authorization Lookup to determine the status of your request.
- Click on the “P2P Availability” button to determine if your case is eligible for a peer-to-peer conversation:

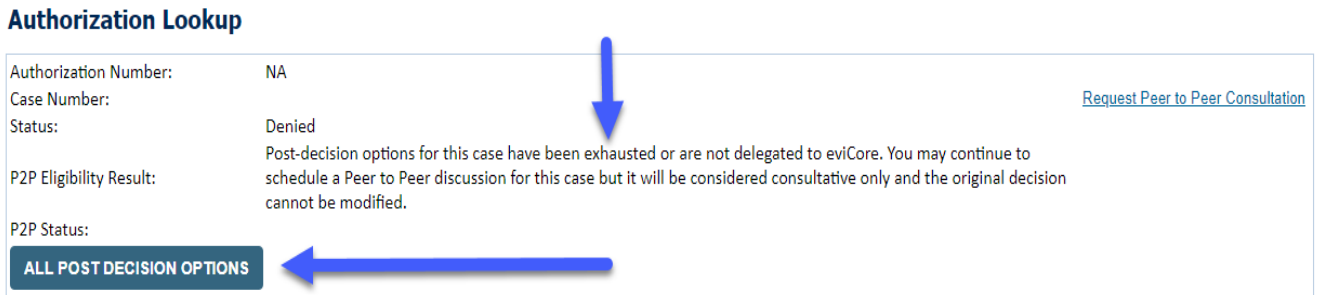


- If your case is eligible for a peer-to-peer conversation, a link will display that allows scheduling without additional messaging.



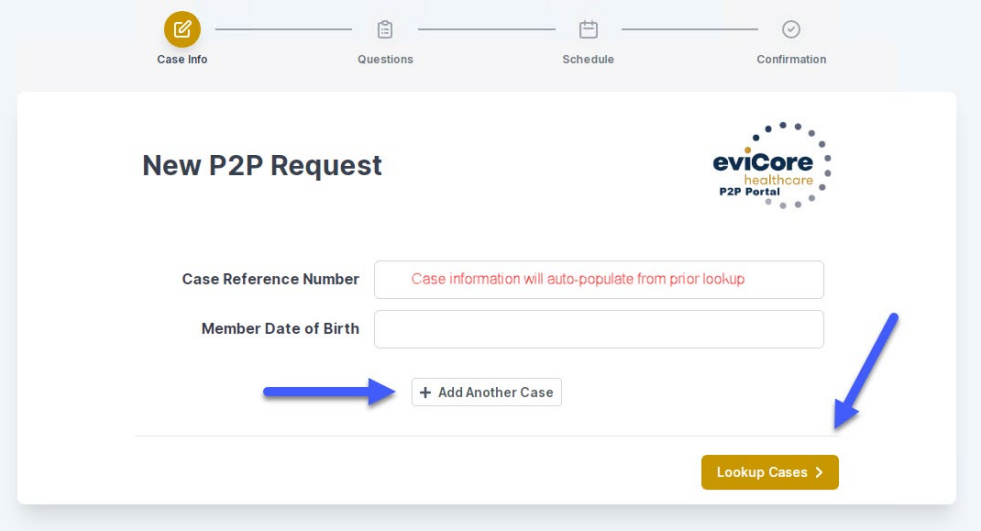
How to Schedule a Peer-to-peer Request

Pay attention to any messaging that displays. In some instances, a peer-to-peer conversation is allowed, but the case decision cannot be changed. When this happens, you can still request a Consultative Only Peer-to-Peer. You also may click on the “All Post Decision Options” button to learn what other action may be taken.



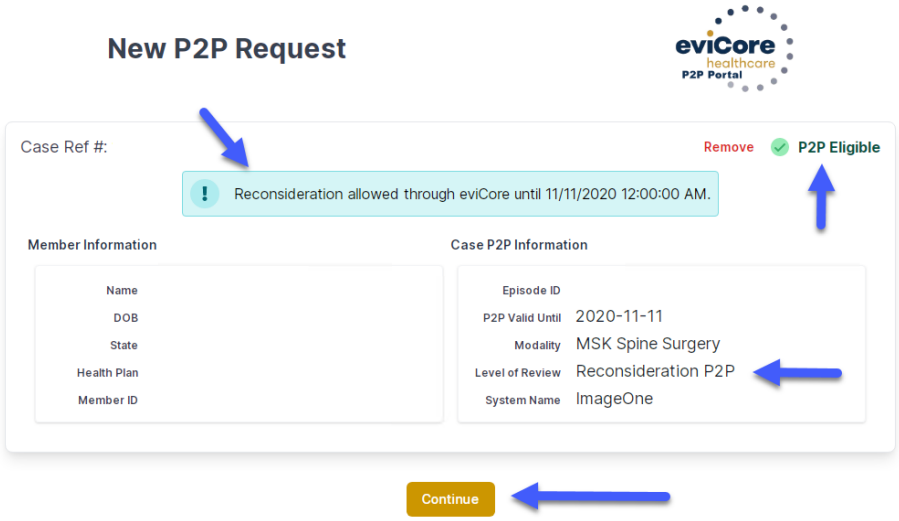
Once the “Request Peer-to-Peer Consultation” link is selected, you will be transferred to our scheduling software via a new browser window.

How to Schedule a Peer-to-peer Request

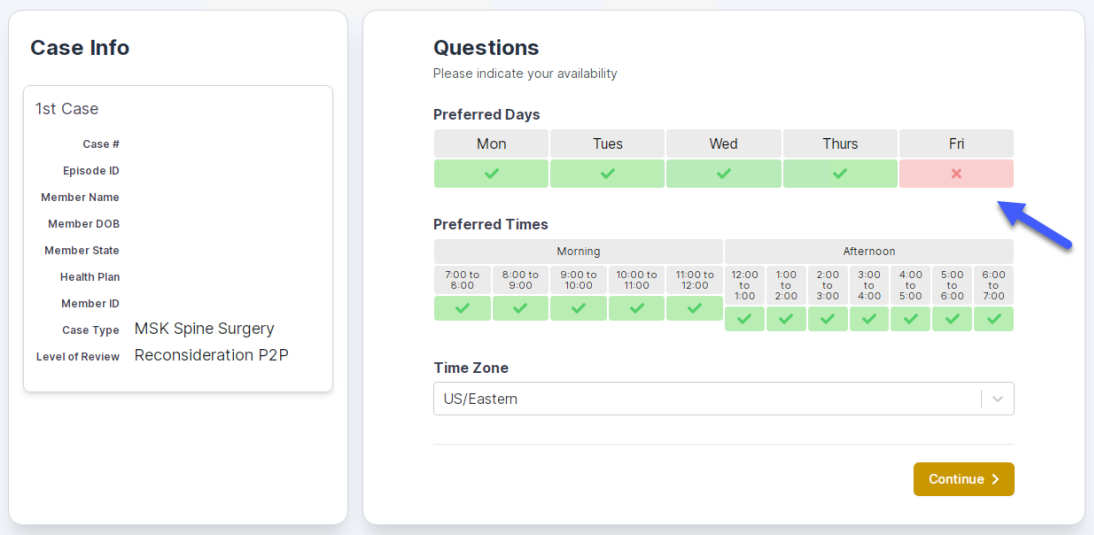


- On first login, you will be asked to confirm your default time zone.
- You will be presented with the Case Number and Member Date of Birth (DOB) for the case you just looked up.
- You can add another case for the same peer-to-peer appointment request by selecting “Add Another Case.”
- To proceed, select “Lookup Cases.”

- You will receive a confirmation screen with member and case information, including the Level of Review for the case in question. Select Continue to proceed.

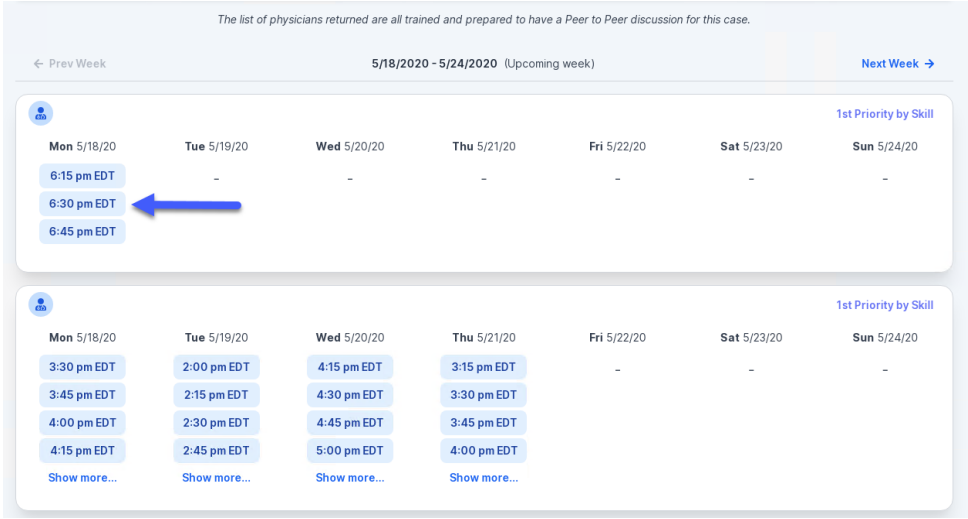


How to Schedule a Peer-to-peer Request



You will be prompted to identify your preferred days and times for a peer-to-peer conversation. All opportunities will be listed automatically. Select any green check mark to deselect the option and then select Continue.

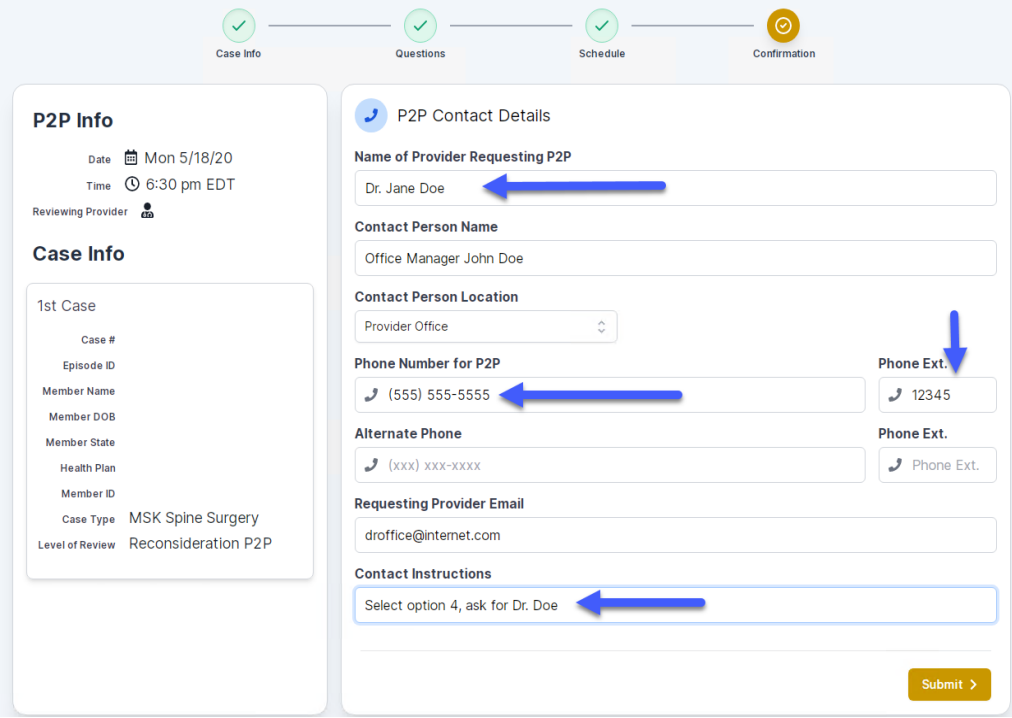
You will be prompted with a list of eviCore physicians/reviewers and appointment options per your availability. Select any of the listed appointment times to continue.



How to Schedule a Peer-to-peer

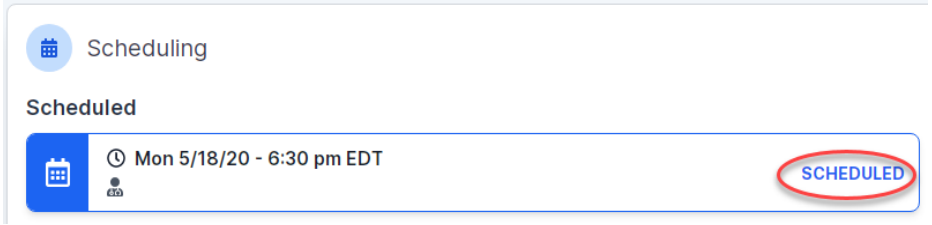
Confirm Contact Details

- Contact Person Name and Email Address will auto-populate per your user credentials.



- Be sure to update the following fields so that we can reach the right person for the peer-to-peer appointment:
  - Name of Provider Requesting P2P
  - Phone Number for P2P
  - Contact Instructions

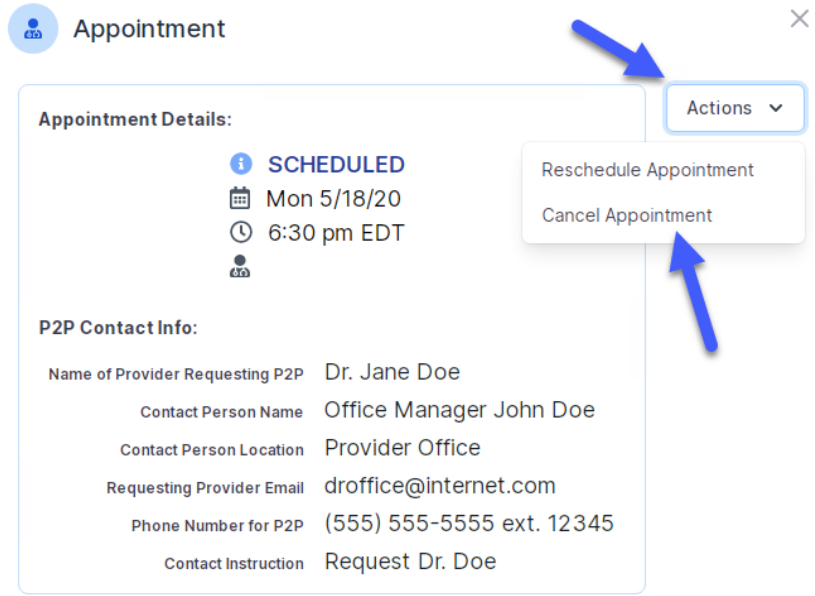
- Select Submit to schedule appointment. You will be presented with a summary page containing the details of your scheduled appointment.



Canceling or Rescheduling a Peer-to-peer Appointment

To cancel or reschedule an appointment:

- Access the scheduling software per the instructions above.
- Go to **My P2P Requests** on the left pane navigation.
- Select the request you would like to modify from the list of available appointments.
- Once opened, select the schedule link. An appointment window will open.
- Select the **Actions** drop-down and choose the appropriate action.
  - If choosing to reschedule, you will have the opportunity to select a new date or time as you did initially.
  - If choosing to cancel, you will be prompted to input a cancellation reason.



- Close browser once done

Provider Resources

Dedicated eviCore Teams

Call Center

- Phone: 866-672-8115
- Representatives available 7 a.m. to 7 p.m.

Web Support

- Live chat
- Email: portal.support@evicore.com
- Phone: 800-646-0418 (Option 2)

Client & Provider Operations Team

- Email: clientservices@eviCore.com (preferred)
- Phone: 800-646-0418 (option 4)
- Eligibility issues (member or provider not found in system)
- Transactional, authorization-related issues requiring research

Provider Engagement

- **Merritt Senters** – Regional Provider Engagement Manager
  - Email: Merritt.Senters@eviCore.com
  - Phone: 615-468-4000, ext 29917
  - Regional team that works directly with the provider community

Provider Resource Website

Provider Resource Pages

eviCore's Provider Experience team maintains provider resource pages that contain client- and solution-specific educational materials to assist providers and their staff. The provider resource page includes, but is not limited to, the following educational materials:

- Frequently asked questions
- Quick reference guides
- Provider training
- Current Procedural Terminology (CPT) code list

To access these helpful resources, please visit

https://www.evicore.com/resources/healthplan/humana/Kentucky.

Provider Newsletter

Stay Updated With Our Free Provider Newsletter

eviCore's provider newsletter is sent out to the provider community with important updates and tips. If you are interested in staying current, feel free to subscribe:

- Go to eviCore.com.
- Scroll down and add a valid email to subscribe.
- You will begin receiving email provider newsletters with updates.

Provider Resource Review Forums

The eviCore website contains multiple tools and resources to assist providers and their staff during the prior authorization process.

We invite you to attend a **Provider Prior Authorization Online Portal Tips and Tools** session to help you navigate www.eviCore.com and understand all the resources available on the Provider's Hub. Learn how to access:

- eviCore's evidence-based clinical guidelines
- Clinical worksheets
- Check-status function of existing prior authorization requests
- Search for contact information
- Podcasts and insights
- Training resources

How to register for a Provider Resource Review Forum?

You can find a list of scheduled **Provider Prior Authorization Online Portal Tips and Tools** session on www.eviCore.com → Provider's Hub → Scroll down to eviCore Provider Orientation Session Registrations → Upcoming.

Thank You!