



PT/OT/ST Transition

March 2019

3/15/2019

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Introduction

Nebraska Total Care is moving to transition management of the therapy program away from NIA and the Post-Service, Pre-Payment process back to a prior authorization process for all services.

Why: This change is being made in response to provider feedback that the NIA process has been administratively burdensome and less desirable than prior authorization processes that preceded it and will also clearly identify for providers what services are authorized.

When: Prior authorization will be required for dates of service 4/1/2019 forward. For members in a current, active course of care Nebraska Total Care will begin accepting authorization requests on 3/18/19.

Introduction

Who: All participating providers will be required to obtain prior authorization for all members in therapy services. All non-participating providers continue to need an authorization for all services.

Claims for authorized services will continue to be submitted to Nebraska Total Care. All therapy claims must still contain the appropriate modifier when submitted to the health plan and failure to include a specialty modifier (GN, GO, GP), may result in the inability to process your claim.

Authorization Processes

Both initial and continued treatment authorizations should be submitted to Nebraska Total Care using the revised [Outpatient Treatment Request \(OTR\)](#) form that can be found on our website under the Physical Health Forms section.

Revisions to the form include:

- Discharge Plan/Transition Plan: Must include discharge plan or plans to transition to home program including date
- Ordering Physician: Must include name, address, phone and fax #'s
- Attestation for new treatment onset

The OTR form can be submitted via fax or the provider portal. Please submit your clinical documentation in support of services to be rendered when submitting the OTR form.

Authorization Processes

A complete submission for prior authorization for therapy services includes, at a minimum the following:

- Fully completed OTR form
- Therapy evaluation that is signed and dated by the treating therapist
- Prescription for therapy that lists the treating diagnosis(es), type of therapy, name of referring physician clearly indicated, referring physician's address, phone and fax numbers and has an accepted signature (MD,DO,APRN, DPM)

Authorization Processes

The first five (5) PT/OT/ST visits* for a member in a new course of treatment during the fiscal year (7/1-6/30) will require only notification to the health plan via the OTR form in order to be authorized.

- *The initial 5 visits is per member for the fiscal year, not per provider.

For the sixth service visit and beyond an authorization with OTR form and supporting clinical is required (prior to services being rendered).

Authorization Processes

Failure to submit OTR notification to Nebraska Total Care for the first five sessions will result in claim denials for no authorization.

For members in a current course of active treatment, the five initial sessions requested via notification does not apply. Those members require prior authorization and Nebraska Total Care will begin accepting requests for dates of service 4/1/19 forward starting on 3/18/19.

Providers are responsible for identifying if the first five sessions requested are the first five for a member starting a new course of treatment for a new condition/injury in the fiscal year.

Please be aware that providers will need to continue to ensure that the member has not exhausted his/her PT/OT/ST benefit and/or has a restorative benefit prior to providing services

Authorization Processes

Therapy benefit limits for adults are 60 combined therapy visits for the fiscal year and are expected to be rehabilitative.

Therapy benefits for youth do not have an identified quantitative limit and are able to be restorative with an expectation of transition to a home program as appropriate.

Authorization Turn Around Time (TAT) is up to 14 days for outpatient services, however, Nebraska Total Care strives to complete these as quickly as possible and our current authorization TAT for services is under 2 days if clinical information is submitted with the request.

Clinical Reviewers

Our clinical review staff works as part of Nebraska Total Care's utilization management team and consists of a team of physical, occupational, and speech therapists, all employed by Nebraska Total Care.

This Nebraska Total Care staff development will promote consistent points of contact for provider authorization staff and the ability to know the members and their course of care is a benefit of the move to this type of program management.

Adverse Determination Processes

Nebraska Total Care conducts prior authorization reviews done by licensed and qualified utilization management staff. Prior authorization requests can be denied for lack of medical necessity or when the service is not covered by Nebraska Medicaid. When a review completed by a utilization management staff member leads to an authorization denial, providers have the following opportunities to further pursue authorization approval for the requested coverage.

Adverse Determination Processes

Providers can request a peer to peer review with a Nebraska Total Care Clinician.

- The Utilization Management staff will schedule the peer to peer process at the provider's request; peer to peer discussions will be managed by the Nebraska Total Care reviewing clinician to the extent possible and should be completed within 14 days from notification
- Upon completion of the peer to peer review, the Nebraska Total Care Clinician who conducted the peer to peer review will recommend to approve, modify or deny coverage for the service requested
- The peer to peer review is an opportunity to bring forth additional clinical information and as a basis for rationale for a service to demonstrate medical necessity

Adverse Determination Processes

Regardless of the completion of a peer to peer discussion, members or providers acting on behalf of the member can submit an appeal of coverage denial through submission of a written request.

- Additional medical records and clinical documentation not previously submitted can be attached to appeal requests to support medical necessity of the service requested for authorization
- When appealing an authorization denial, the appeal request can be received verbally from the member but must be followed up in writing from the member before review can occur
- Providers must obtain a signed Member Authorized Representative form from the member to act on their behalf/as their representative in the appeal process

Adverse Determination Processes

When an appeal determination results in upholding the original denial of requested coverage, members and providers acting on the member's behalf have the right to request a state fair hearing. Providers must have written authorization from the member to act on the member's behalf in the state fair hearing process.

- The appeal process through Nebraska Total Care must be exhausted prior to request for a State Fair Hearing
- The resolution of any appeal not resolved wholly in favor of the member by Nebraska Total Care may be addressed through the state fair hearing process
- Nebraska Total Care complies with the final determination rendered through a State Fair Hearing and the decision in these matters is then considered final

Retro Authorizations

To request retro-authorization:

Provider will submit a retro-authorization request through the standard authorization request channels (fax, portal)

Provider explicitly identifies in the submission that they are making a retro-authorization request

Nebraska Total Care Utilization Management will receive the request and,

- Determine if it has been made timely based on plan notification of eligibility
- If the authorization request is timely, the retro authorization will be reviewed against Medical Necessity Criteria
- If the authorization request is not timely, it will be administratively denied

Retro Authorizations

For retro-authorizations that are not approved upon review, appeal rights apply.

Nebraska Total Care will not retroactively review for authorization of routine services except with documentation of valid circumstances, for example:

- Services authorized by another payer who subsequently determined the member was not eligible for the services or was not eligible with the payer at the time the services were rendered
- Member received retro-eligibility from the Department of Health and Human Services, Division of Medicaid and Long-Term Care
- Services occurred during a transition of care period between two Heritage Health Managed Care Organizations

Nebraska Total Care will not accept retro authorizations for failure to request an authorization prior to rendering of services.

Contact Information

Authorization Fax Number: 1-844-252-4644

Nebraska Total Care Utilization Management Department
Phone Number: 1-844-385-2192

Customer Service: 1-844-385-2192, TDD/TTY: 1-844-307-0342, Relay 711.

Questions

Q/A