



Blue Care Network Speech Therapy Utilization Management Guide & Frequently Asked Questions

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Speech Therapy Utilization Management Guide

Introduction

The information contained in this guide serves as an orientation and reference guide to eviCore's Clinical and Administrative Policies and Procedures. Be sure to read the guide and share it with your staff.

eviCore complies with all applicable state and federal laws and regulations. The information contained herein does not supersede any applicable state or federal law or regulation, and should not be interpreted as such.

Submitting the Initial Treatment Plan Form

The referring physician must obtain an initial authorization for speech therapy services through Blue Care Network. Approved referrals authorize the initial evaluation. You are required to submit Treatment Plans (authorization requests) in order to receive reimbursement for covered services beyond the initial evaluation. To request authorization for visits, report your clinical findings from the evaluation in the appropriate sections of the Treatment Plan form. Begin your requested treatment plan with the date of the initial visit.

We strongly encourage you to submit the Treatment Plan with a copy of the initial Speech/Language Evaluation, including standardized assessment scores if applicable, within two (2) business days of the first visit. Prompt submission will assist in the timely evaluation of your request and notification of the review determination.

We accept Treatment Plans submitted by fax, or by mail. If your authorization request is received before 5:00 PM in your time zone, it is considered received on the same day as you transmitted it to us. If your authorization request is received after 5:00 PM in your time zone, it is considered received on the next business day. Mailed authorization requests could result in a delayed determination due to postal delivery times.

These same procedures apply when physicians refer patients back to you for a new condition. For each episode of care, submit a new Treatment Plan form with updated clinical findings within two (2) business days.

Required Fields on the Treatment Plan Request

Clear and complete Treatment Plans will speed the processing of your authorization requests. Please be sure the following information is complete on your Treatment Plan before you submit it:

- › Patient name
- › Patient date of birth (must be included in addition to patient's age)
- › Patient health plan ID number
- › Name of health plan/insurance carrier
- › Provider name and Tax ID Number
- › Dates, including:
 - › Date of submission
 - › Date of first treatment/visit
 - › Date objective findings were obtained
 - › Date of onset of the patient's condition

- › Diagnosis codes (specific ICD codes and diagnosis descriptions)
- › Proposed Treatment Plan schedule - including “From” and “To” dates
- › Number of visits anticipated

Key Elements for Clinical Review of Treatment Plans

When a Treatment Plan is received, we will validate the presence of an initial authorization for the therapy services with Blue Care Network and review the case for medical necessity and/or clinical appropriateness. Clinical review decisions are based on key data provided with the Treatment Plan. It should be noted that uncomplicated cases requiring fewer visits do not require as detailed clinical information as complicated cases requiring more visits. Critical data impacting the review determination made by the clinical peer reviewers include:

- › Age
- › Mechanism of onset
- › Date of onset
- › Subjective complaints
- › Pain intensity levels
- › Objective findings (such as, standardized assessment scores, informal assessment)
- › Co-morbidity issues (medical complications)
- › Complicating factors
- › Functional limitations
- › Clinical diagnosis(es)
- › Proposed plan of treatment
- › Treatment goals

The clinical peer reviewers use the submitted clinical information in conjunction with our proprietary Clinical Practice Guidelines to decide the number of visits to authorize for each request. These Clinical Practice Guidelines are available to you through our secure provider portal at www.LMhealthcare.com.

Treatment Plans that present a clear clinical picture (e.g., subjective complaints are validated by the objective findings), and that are accompanied by a consistent diagnosis better support the necessity for the requested treatment frequency.

Treatment is typically authorized in thirty (30) day increments, not to exceed the patient’s benefit limit for the episode. Authorization in these timeframes allows the clinical peer reviewers to assess the patient’s response to treatment. If additional care is required beyond the initial thirty (30) day Treatment Plan authorization, you must submit a new Treatment Plan for ongoing or concurrent care.

Concurrent (Ongoing) Treatment Requests

When additional care is required after the expiration of an authorized Treatment Plan, a new Treatment Plan reflecting the patient’s current status, with updated standardized assessment scores and treatment goals is required. Please note that in order to establish the need for ongoing care, the patient record must document significant lasting benefit from previous treatment.

If you know that a patient will require ongoing treatment, we suggest that you submit the new request a few days to one week prior to the expiration date of the existing authorization.

To assist with the review, you may include a copy of all progress notes for treatment rendered since your last submission. This documentation allows the clinical peer reviewer to assess your patient’s clinical improvement and can provide additional support for ongoing services. If you sent progress notes with a previous request, you only need to send the new progress notes.

Retrospective Treatment Request

Retrospective authorization requests are those where all requested visits for a member have already occurred. Please note the following policies pertinent to retrospective authorization requests.

- › You are required to include a copy of all applicable documents (i.e. Treatment Plan, examination findings, progress notes) for the services you provided.
- › eviCore will provide a review determination within the timeframe required by applicable regulations.
- › eviCore will not process retrospective authorization requests as expedited or urgent requests.

Requests for Additional Information

If we cannot make a decision regarding a request for treatment due to the lack of information on the form, we will send you a "Request for Information" letter. The letter will describe the information required, and the length of time you have to submit it. If we do not receive the requested information within the designated time period, your authorization request may be denied. If you receive a denial, you will be provided with instructions on how to appeal the decision.

When you submit information, attach a copy of the "Request for Information" letter you received. If a copy of the letter is not attached, be sure that you note the following on your documentation to avoid processing delays:

- › Case Reference Number
- › Patient name
- › Patient date of birth
- › Patient ID number
- › Practitioner name and Tax Identification Number
- › Corrected Treatment Plan form, if applicable

Note that if you resubmit a corrected Treatment Plan authorization request for any reason, be sure to write the word "CORRECTED" or "RESUBMITTED" across the top. And, if applicable, write the case Reference Number on the form.

Notification of Review Determinations

We will provide you with written notifications of clinical review determinations via a faxed letter. We will notify members by a separate mailed letter.

When we approve your request for authorization in its entirety, we will send you a notification letter identifying the number of visits and treatment period approved. The letter will also include information on how to submit a new Treatment Plan should additional care be necessary.

When the number of visits and/or services requested on a Treatment Plan is modified or denied, written notification will include the following:

- › Number of visits approved and the treatment period during which such visits may be used.
- › Clinical reasons for the decision.
- › Instructions for requesting a copy of the Clinical Practice Guideline used in a decision.
- › Instructions for contacting the clinical peer reviewer to discuss a modification or denial.
- › Instructions for appealing a determination, including your right to submit additional information.
- › Time limits for submitting an appeal request.

If the number of visits you requested is modified, and you agree with the clinical rationale, provide treatment up to the number of visits authorized. If you determine that the patient will require additional care beyond the treatment period authorized, submit a new Treatment Plan about one week prior to the expiration date. Refer to the Concurrent (Ongoing) Treatment Requests section for more information.

Access to Clinical Peer Reviewers

eviCore uses licensed speech therapists and medical physicians to render review determinations. You may request a peer-to-peer discussion about Treatment Plan denial or modification determinations. Within one (1) business day of the request, a clinical peer reviewer will be available to you. To request such a peer-to-peer discussion, please call Customer Service. A representative will help connect you with a clinical peer reviewer.

Authorization Request Follow-Up Process

We will process authorization requests as dictated by applicable state and federal regulatory requirements. To check the status of your requests, login to the provider portal at www.LMhealthcare.com or call our Customer Service Department.

Duplicate Treatment Plan Authorization Request Forms

Please do not resubmit your Treatment Plan unless you have verified that we did not receive your original submission. Submission of duplicate forms will create delays in processing.

Date Extensions of Existing Authorizations

To extend the expiration date of an existing authorization, submit a request for a date extension. An extension may be necessary due to unforeseen delays, such as your patient's inability to attend all scheduled visits. If approved, date extensions will not exceed the benefit period for the patient's episode. Date extensions are typically processed within 2-5 business days.

To Submit a Date Extension Request

Submit a Date Extension Request form on-line by logging on to the provider portal.

Or, fax a Date Extension Request form. Remember to include the original start date and the new end date with your submission, along with your reason for the request.

Complete Medical Records

Patient documentation serves as a permanent record that supports the treatment provided to your patients and allows for the reimbursement of that treatment. Good record keeping becomes especially important when establishing the medical necessity of the services you provide. Complete medical records include the following important elements:

- › Must be legible with standard abbreviations, or a key to the unique abbreviations used.
- › Patient name and/or identification number must be present on each page of the file.
- › Complete medical history.
- › Detailed description of subjective complaints.
- › Detailed description of your objective examination findings.
- › Description of any diagnostic testing, and the resultant findings.
- › Working diagnosis or set of diagnoses.
- › Treatment plan, including goals of treatment, frequency/number of visits, types of services planned, and expected time frame for improvement and discharge from care.

- › If necessary, your referral of the patient to another practitioner and the clinical rationale for this decision.

Clinical Practice Guidelines

The Clinical Practice Guidelines provide clinical decision support tools necessary for clinical peer reviewers to render medical necessity review determinations. The Clinical Practice Guidelines have been developed systematically, and are based on current peer-reviewed scientific evidence, consensus peer evaluation, and generally recognized professional standards. Development involves input and direction from applicably licensed practitioners with current knowledge and experience in the clinical principles and standards of care under review. This includes clinical peer reviewers, clinical/medical directors, practitioner advisory committee members, and/or outside content experts.

The Clinical Practice Guidelines used for making authorization and review determinations are reviewed annually by a peer-review committee of participating practitioners. The review criteria are subject to further review by multi-disciplinary Utilization Management and Quality Improvement Steering Committees.

All services provided by practitioners must be delivered in accordance with the professionally recognized standards of care and practice, as reflected in the Clinical Practice Guidelines. Clinical criteria are used to establish medical necessity and to determine services covered and reimbursable under a member's benefit plan. We recognize that some practitioners provide services that are within their scope of practice, but do not meet the care parameters defined in the clinical criteria, or a member's benefit plan. We acknowledge that our Clinical Practice Guidelines are a subset of the professional practices provided within the practitioner community.

Appropriate Utilization

Through case management, the clinical department oversees and monitors patient care, ensuring that each patient receives effective, quality care resulting in a positive outcome. Accordingly, the clinical department affirms that:

- › Clinical peer reviewers render authorization decisions based on the appropriateness of care and services.
- › Clinical peer reviewers are not compensated in any way for denying, limiting, or modifying care.
- › No incentive is provided to the clinical peer reviewers or consulting committee members to encourage modification or denial of requested care.
- › Review decisions and determinations are not arbitrary. All information submitted on a Treatment Plan authorization request, or other means of clinical documentation, is reviewed. Decisions are based on established Clinical Practice Guidelines, scientific evidence, and research literature.

Speech Therapy Provider FAQs

1. How do clinical peer reviewers decide on the number of visits they authorize?

Clinical peer reviewers use the clinical information submitted for review and proprietary Clinical Practice Guidelines to decide the number of visits authorized for each request. Clinical peer reviewers take into account the complexity and severity of a member's condition when rendering a clinical review. As such, severe, complicated cases requesting high numbers of visits require more detailed clinical information to establish medical necessity than mild, uncomplicated conditions requesting few visits. Please see the Utilization Management Guide for a detailed description of the authorization process.

2. Will these procedural changes affect my patients' coverage?

No. Changes in your authorization procedures do not affect patient coverage.

3. When am I required to submit a Treatment Plan authorization request form?

For patients you are actively treating during this transition, request authorization beginning with the first visit after any approval granted by BCN expires. For any new patients who present on or after the eviCore UM program effective date, submit the Treatment Plan to request authorization after the initial evaluation.

4. If a patient has existing authorizations in the BCN system, do I have to send a new request for services that BCN already authorized beyond the eviCore UM program effective date?

No. BCN is honoring treatment plans that have already been processed and approved by BCN. For example: You requested authorization on 7/15/08 for 20 visits from 7/17/08 through 9/17/2008, and BCN approved 20 visits from 7/17/08 through 9/17/08. Continue to utilize the existing approved treatment plan from BCN until that authorization is exhausted.

Follow eviCore's authorization requirements for any unauthorized services falling on or after the eviCore UM program effective date.

5. Where can I obtain Treatment Plan forms?

Treatment Plan forms are available on eviCore's secure provider portal at www.LMhealthcare.com.

6. Can I call in an authorization?

Requests for authorization must be faxed utilizing eviCore's Treatment Plan form to (888) 565-4225.

In cases of an emergency, requests are considered urgent if the standard review process could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or in the opinion of a practitioner with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Contact eviCore for such services at (877) 531-9139.

7. How do I submit authorization requests to eviCore for therapy services?

Fax the Treatment Plan form to eviCore at (888) 565-4225.

8. Who do I direct questions to about my authorization request?

Check the status on-line through eviCore's secure portal or call eviCore for inquiries about your authorization request at (877) 531-9139. Your approved or denied authorization can also be found in BCN's on-line system through WebDenis.

9. Who do I call to verify Member Benefits?

Member benefits for therapy can be verified by following the normal BCN process for eligibility of benefits. The BCN options available include:

- › Web-DENIS (Dial-in Eligibility Network Information System)
- › CAREN (automated telephone system)
- › BCN's Provider Inquiry

10. Where do I submit claims?

There is no change in the claims process. Continue to submit claims directly to BCN.

11. Can I include DME supplies on an authorization request to eviCore?

You may document that a patient requires specialized DME equipment; however, DME supplies will not be authorized by eviCore. Follow the normal BCN process for all DME.

12. How do I appeal services not approved as medically necessary?

The review determination letters provided by eviCore include appeal information. Follow the information provided to you in this letter.

Contact Us

Provider Portal

www.LMHealthcare.com

Email

info@LMHealthcare.com

Phone

(877) 531-9139

Fax

(888) 565-4225

Address

eviCore healthcare
1610 Arden Way, Suite 280
Sacramento, CA 95815

Office Hours

8:30 am to 5:00 p.m. EST