

1. Q. What educational materials does BCN use to indicate outpatient rehabilitation benefits? How do these materials show that treatments must be based on medical necessity and that there may be a difference between the limits of the member's benefits and the visits that are approved?

A. All new members get a member handbook with a customized benefit summary. In addition, BCN Customer Service representatives give information to members on their benefits and how authorization works, as follows:

- If the member has a benefit based on the number of visits, the visits approved during clinical review may differ from the member's benefit limits. For example, a member may have a 60-visit benefit but that this doesn't guarantee approval of a request for all 60 visits by BCN or eviCore healthcare. Approval is based on whether the visits are medically necessary.
- If the member has a benefit based on a specific number of days, all medically necessary visits need to be completed by the end of the benefit period. The benefit period count starts with the date of the first treatment. For example, a member with a 60-calendar-day benefit may receive medically necessary care from June 18, 2017 to August 17, 2017. The benefit is exhausted after August 17, 2017.

Note: Some members have a benefit that gets renewed — for example, after surgery.

2. Q. BCN or eviCore may authorize the evaluation and treatment dates at the same time — on the same date and in the same authorization request. If the claim shows an evaluation date that occurs before the date of the first treatment visit, how are these dates handled when the claim is received? (Providers are told that the benefit start date is the date of the first treatment visit.)

A. All therapy services, including both the evaluation and treatment visits, must be covered by a date span specified in the authorization request. Providers should enter both the evaluation and the treatment visits on the same authorization request. For each service, providers can enter a date span that starts on a different date. In addition:

- If the evaluation is provided before the date the treatment starts, the date span for the evaluation can start earlier than the date span for the treatment visits. That way, the evaluation that occurs earlier than the treatment visits can be accommodated on the same authorization request as the treatment services.

Note: Contact eviCore at 1-877-531-9139 if either the evaluation date or the treatment start date needs to be changed.

- If evaluation and treatment start on the same date, the start date of the authorization (as requested by the provider) is the start date of the member's benefit for that service.

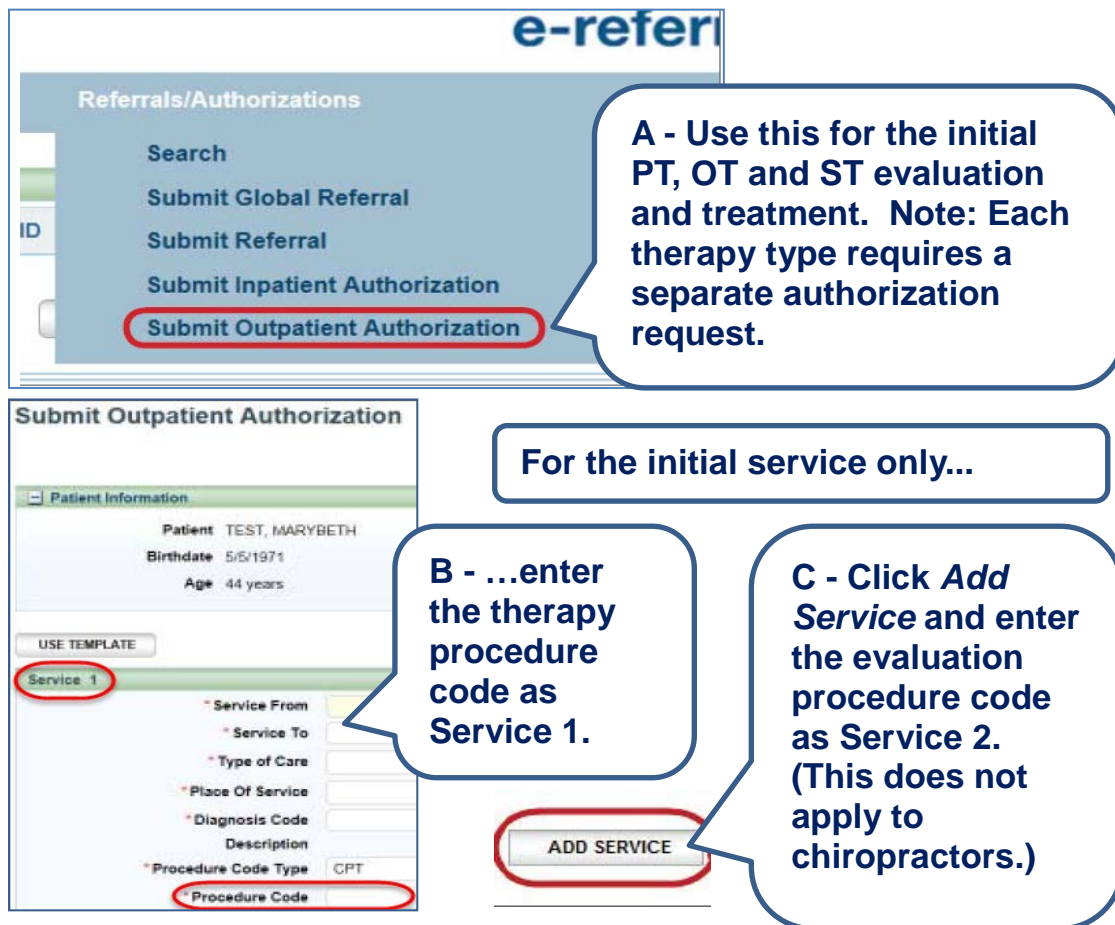
If the claim for the evaluation shows a date of service that is before the authorization's start date, the claim is pended; it isn't automatically denied. Instead, BCN Claims staff typically contact BCN's Utilization Management department and arrange for the start date on the evaluation line to be moved back. The date span on the modalities line, however, remains unchanged. This way, the evaluation claim can be paid and the member is afforded the full date span for his or her treatments.

3. Q. How should the requests to authorize the therapy evaluation and treatment procedures be entered in to the e-referral system?

A. The therapist can enter the evaluation date and the treatment start date in to the e-referral system as two separate procedures. On the evaluation line, enter one day (for the date of the member's evaluation), then enter the therapy treatment start date and extend it for 60 days. See below.

Note: Chiropractors providing physical therapy services should submit the dates for treatment only. Enter the treatment start date. Then enter a treatment end date that is 60 days after the start date. In addition, chiropractors must submit separate requests to authorize physical therapy services (select *97XXX codes) or manipulation services.

Also, submit authorization requests under either the independent therapist's ID number or the facility's ID number. Don't use a group ID number for authorization requests.



e-referral

Referrals/Authorizations

- Search
- Submit Global Referral
- ID
- Submit Referral
- Submit Inpatient Authorization
- Submit Outpatient Authorization**

A - Use this for the initial PT, OT and ST evaluation and treatment. Note: Each therapy type requires a separate authorization request.

Submit Outpatient Authorization

Patient Information

Patient: TEST, MARYBETH
 Birthdate: 5/5/1971
 Age: 44 years

USE TEMPLATE

Service 1

- * Service From
- * Service To
- * Type of Care
- * Place Of Service
- * Diagnosis Code
- Description
- * Procedure Code Type: CPT
- * Procedure Code**

For the initial service only...

B - ...enter the therapy procedure code as Service 1.

C - Click Add Service and enter the evaluation procedure code as Service 2. (This does not apply to chiropractors.)

ADD SERVICE

To save time and avoid delays or pends, submit the initial authorization requests with the correct codes:

Physical therapy –
 *97110 for treatment (Service 1)
 *97161, *97162 or *97163 for evaluation (Service 2)

Occupational therapy –
 *97535 for treatment (Service 1)
 *97165, *97166 or *97167 for evaluation (Service 2)

Speech therapy –
 Evaluation only (Service 1):
 *92521 through *92524
 Do not enter Service 2.

4. Q. Can members opt out of reporting some of their rehab visits to BCN? Example: A BCN member may need treatments beyond a 60-calendar-day time frame; intervals of treatment may be needed throughout the year. Some families with children would prefer using benefits for treatment during the summer and want to opt out of reporting visits during the other times of the year.

A. Members must report *all* outpatient rehab visits. Reporting some visits and not others isn't an option.

5. Q. What can providers do to limit their financial liability when they know one of the following? That -

- **Authorization won't be given.**
- **The member's benefits don't include the services they provide.**
- **The member is about to or has exhausted his or her benefits.**
- **The member chooses to opt out of reporting visits to BCN.**

A. Guidelines for providers are outlined in the "Exclusions and limitations" section of the [BCN Advantage chapter](#) of the *BCN Provider Manual*. These guidelines apply to members with BCN HMO (commercial) or BCN Advantage coverage.

6. Q. Do providers need to submit functional limitation G codes for BCN Advantage members like they do for Original Medicare members?

A. For dates of service on or after Jan. 1, 2019, you don't need to report the nonpayable functional limitation G codes and their applicable modifiers.

For dates of service prior to Jan. 1, 2019, you must report the nonpayable functional limitation G codes and their applicable modifiers when billing outpatient physical, occupational and speech therapy services for BCN Advantage members. Functional assessment reporting codes submitted in conjunction with therapy services are used to gather data on Original Medicare claim submissions. There is no payment for these services.

Report the modifiers for the nonpayable G codes as secondary modifiers and not as primary. Modifiers reported as primary will cause an error in our payment system and the claim will be denied.

Here's an example showing how to report these codes and modifiers correctly:

- **Report as primary:** In the line item, report the BCN Advantage modifier for the type of therapy (physical, occupational or speech) along with the G code.

04/12/2017	04/12/2017	0420	TPM	G8991GP	1	\$0.00	E11622
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- **Report as secondary:** In the "Additional Modifiers" box, report the required Centers for Medicare & Medicaid Services modifier.

