Nebraska Total Care

PT/OT/ST Prior Authorization Requirements
Frequently Asked Questions

No.	Question	Answer
1	What are the ages and benefit limits for adult and child therapy?	**Adults (Age 21 and Older):** NMAP covers a combined total of 60 therapy sessions (physical therapy, occupational therapy and speech therapy visits) per fiscal year (July 1- June 30th). Services must be: Restorative therapy with a medically appropriate expectation that the client's condition will improve significantly within a reasonable period of time. **Child:** NMAP covers therapy services for individuals from birth to age 20. Services must be - Reasonable and medically necessary for the treatment of the client's illness or injury; or Restorative therapy with a medically appropriate expectation that the client's condition will improve significantly within a reasonable period of time.
2	What is the maximum treatment span duration that may be approved for on-going services?	The treatment span and number of visits that may be approved is based on medical necessity and the member's progress. • **Adults (Age 21 and Older):** The maximum span that will be approved for members 21 and over is 90 days • **Child:** The maximum span that will be approved for members 20 and under is 6 months. For 6 month authorizations, the documentation requirements remain the same. Providers are expected to be in compliance with the governmental regulations for completing re-evaluations and updates to their Plan of Care (POC). Decision on what meets medical necessity criteria will be based on the documentation submitted at the time of the request. You will not need to resubmit updated plans of care or orders during your authorization period unless there is a change of condition and more visits are needed
3	If a pre-authorization request is missed, how many days does a provider have to send in the request without having to do an appeal?	A pre-authorization should be completed prior to the onset of services. Nebraska Total Care does not do retro-authorizations except under extenuating circumstance such as: • Member was retroactively enrolled in Medicaid. • Member is transitioning from one managed care organization to another and in a continuity of care period, etc. • Nebraska Total Care will do a 2 business day look back for all initial start of care requests for therapy only. This does not apply to continuation of care requests. Nebraska Total Care would start the authorization of services with the date the request was received and claims for prior dates would deny. Providers would then have to follow the appeals process.

No.	Question	Answer
4	What clinical information needs to be submitted with the Outpatient Medicaid Authorization and PT/OT/ST form to demonstrate medical necessity?	Generally speaking it is any documentation to support that the services are necessary for the treatment of their condition or injury and demonstrates that functional improvement and progress is being made in a reasonable period of time. This may include: • **Completed Outpatient Medicaid Authorization and PT/OT/ST form available on the website.** Tips for completion: ○ Requesting Provider = Referral Source (MD, DO, DPM, PA, NP). Please include fax number of referral source. ○ Servicing Provider = Therapy provider ○ Total Units/Visits/Days = Number of **visits** requested. ○ Ensure that the visits requested do not exceed the therapy plan of care and/or the prescription. • **Therapy plan of care signed by the therapist, that should include, as applicable:** ○ Evaluation and/ or progress note ○ Objective findings to support need for skilled therapy ○ Number of visits received ○ Standardized testing with specific scoring report ○ Adherence to home program ○ Updated goals that are Specific, Functional, and Measurable that supports continued need for skilled therapy vs transition to home program ○ Baseline and current progress on all functional goals ○ Updated treatment frequency / duration • **Valid referral signed by Referral Source, or physician signed therapy plan of care.** ○ Valid referral should be dated, signed by accepted referral source, and have a diagnosis pertinent to requested therapy. ○ Referrals for those under 21 are limited to 6 months in duration, unless a shorter time frame is specified by the referring provider. Referrals for those 21 and over are limited to 12 months, unless a shorter time frame is specified by the referring provider.
5	How does the eval plus 12 work for new episodes of care for 4/4/2022 through 6/30/2022?	Effective April 4, 2022, Nebraska Total Care will update the PT/OT/ST authorization processes for Medicaid Services as follows: For all Nebraska Total Care Medicaid members we will allow the first 12 sessions, per discipline, for a new episode of care to be administratively authorized to expedite services and allow for immediate access to care. There are no changes to our evaluation auth processes, and the evaluation remains a distinct service not included in these 12 initial sessions. Evaluations continue to be able to be billed on the same day as services. • **Admin Authorization may be called in by the provider, sent in via fax or via the provider portal with the required Medicaid OTR forms until June 30, 2022.** • For services beyond the first 12 sessions, providers will submit authorization requests with clinical information via the same processes that have historically been in place. If you have questions, please contact Provider Relations.

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6	How does the eval plus 12 work for new episodes of care beginning 7/01/2022?	For all Nebraska Total Care Medicaid members we will allow the first 12 sessions, per discipline, for a new episode of care to be administratively authorized to expedite services and allow for immediate access to care. There are no changes to our evaluation auth processes, and the evaluation remains a distinct service not included in these 12 initial sessions. Evaluations continue to be able to be billed on the same day as services. • **Effective July 1, 2022, the above processes to support administrative authorization will be retired. At that time our systems will be set up to enable the first 12 sessions, per discipline, for new episodes of care to be done without any administrative authorization.** • For services beyond the first 12 sessions, providers will submit authorization requests with clinical information via the same processes that have historically been in place. If you have questions, please contact Provider Relations.
7	If a member has PT, OT and ST on the same day does that count as one session towards the benefit limit?	No, it would count as three.
8	Can providers extend the authorization time frame if a patient does not utilize all of the visits that were approved in a 60 day period?	You would need to call in as it may depend on the reason why those visits were not utilized during the initial date span. Medical necessity would still be a consideration for extending dates. If granted, this would be on a one-time basis for up to 30 days.
9	What start date do we need to use when requesting authorization?	The first date needed for authorization would be the first day of treatment rendered, pending timely receipt. An evaluation with treatment on the day of evaluation is considered the first visit and would require an authorization. For requests outside of eval plus 5 and eval plus 12, all authorization requests need to include items listed in question 4.
10	Can providers bypass the 5 visit authorization and proceed to a full clinical review for the amount of visits we feel will be needed?	Absolutely.
11	Do we need to send a hard copy of the MD order as often we do not receive that until later?	You may document a verbal order on the Outpatient Medicaid Authorization PT/OT/ST form that is submitted on the initial request only, but you must send in the written copy with any subsequent requests and keep on file for audit purposes. The information regarding the verbal order must include: • The referring provider's name • Date the verbal order was given The person that took the verbal order

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12	Explain how evaluations are counted and do they require prior authorization?	An evaluation does not require a prior authorization (for a child or adult) for PAR providers. An evaluation only (without treatment on the same day) does count in the 60 visit limit for adults. Nebraska Total Care does not require prior authorization for 2 PT, 2 OT, and 2 ST evaluation codes every plan year. Re-evaluation codes do not require prior authorization but do count towards the 60 visit limit for our adult members.
13	Do you require the evaluation revenue code on claims for therapy, such as 424 for PT, etc. so you know it is an actual eval?	Only if it billed on a UB form (facility) and not on a HCFA.
14	If we have a Nebraska Total Care member walk in for services, like making a splint or home program, can we provide the services and fax in the information for the authorization same day as evaluation/ treatment?	Yes, if it is for a new course of treatment. You would submit a completed Outpatient Medicaid Authorization PT/OT/ST form and verification of an MD order.
15	Can we start providing services before we get approval back on our request?	If this is for on-going services (not the initial 5 or 12) you may run the risk of the services not being approved. You are encouraged to get the request submitted as early as possible prior to services being provided. Per NCQA a standard review needs to be completed with 14 calendar days.
16	Can the patient be seen for 2 PT cases concurrently? 2 different injuries, 2 different doctors, so we would have 2 separate cases.	These occasions should be far and few between and two encounters for the same discipline on the same day should not occur (i.e., 2 PT visits on the same day). There may be unusual situations where there is only one office capable for providing a specific specialty therapy (such as for treatment of lymphedema or pelvic floor rehab) and that should be clearly communicated on the Outpatient Medicaid Authorization PT/OT/ST form. Both providers are responsible for tracking the number of sessions towards the member's benefit limit so that one provider does not end up with claims denied for exceeding the benefit limit.
17	If a patient was being seen at another clinic and have used their 5 visits, they then have an initial evaluation at our clinic. Do they get another 5 as it is a new patient?	If the member has not used their Evaluation plus 5 limits for the plan year they may be eligible for another Eval plus 5. Please call the prior authorization line for more information.

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18	Do multiple modalities count as one visit, if done on the same day?	Multiple modalities performed by one discipline would count as one visit. Example: If physical therapy did gait training, mobilization, ice, and instruction in home program on the same day, it would count as one visit or session. However if more than one discipline treated the member on one day, each discipline treating the member would count as a visit/session towards the benefit limit. Example: Physical Therapy and Occupational Therapy provides services on same day, it would count as 2 visits or sessions.
19	Regarding the home treatment plan, what if you are new into the treatment and do not have a definitive date for transition to a home program? What should we put on the Outpatient Medicaid Authorization PT/OT/ST form?	The plan for discharge should begin on the day of evaluation. Use a best guesstimate/clinical judgement in the initial course of treatment. This should be based on clinical practice guidelines. As treatment progresses, clinical notes should specifically address any significant change needed to the originally planned frequency and duration and discharge to home program. Progress and information regarding the home program should be continually addressed in clinical documentation.
20	Is the Outpatient Medicaid Authorization PT/OT/ST form required for online submissions via the provider portal?	Yes. The forms need to be completed, saved, and attached to the authorization request via the provider portal.
21	Are authorizations #'s be available on the Nebraska Total Care portal?	Yes.
22	Are providers able to see the total sessions/visits used on the website?	No, providers would only be able to see the number of visits in their own claims history, not visits to other providers.
23	Will providers get some sort of confirmation when they submit the authorization request by fax so that they have proof of timely filing?	Yes, you will get a fax letter. Also, your authorization can be seen on the Provider Portal.
24	Where are these forms located on the website?	Forms and the power point presentation can be found on Nebraska Total Care's website, on the provider tab under provider forms at www.NebraskaTotalCare.com/providers/resources/forms-resources.html

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25	Is authorization required when Nebraska Total Care is secondary to Medicare or Commercial policies?	No, however at any time if Nebraska Total Care becomes primary (i.e., exhausted benefits with primary payer, etc.) then an authorization would be required prior to services being rendered. This does not apply to members in Skilled or Rehab facilities as those are considered IP services and the therapy is the qualifier for the approval of the Skilled level of care. Prior authorization applies to all Outpatient settings (Home Health, Long Term Care, Office, hospital outpatient services) and it does include residents in custodial/long term care facilities as this is their place of residence and the therapies would be considered an outpatient service.
26	Does this apply to members in a skilled level of care and/or in a long term/custodial care setting?	This does not apply to members in Skilled or Rehab facilities as those are considered IP services and the therapy is the qualifier for the approval of the Skilled level of care. Prior authorization applies to all Outpatient settings (Home Health, Long Term Care, Office, hospital outpatient services) and it does include residents in custodial/long term care facilities as this is their place of residence and the therapies would be considered an outpatient service.
27	Is the length of an authorization able to be extended?	You would need to call or fax in a request for a date extension **prior to the end date of the authorization**. It is helpful to provide reason(s) for why visits were not delivered as planned. Granting a date extension may depend on the reason why those visits were not utilized during the initial date span. Medical necessity would still be a consideration for extending dates. If granted, this would be on a one-time basis for up to 30 days. If asking for a date extension, please clearly write, “DATE EXTENSION” on the request form.
28	Do peer to peer reviews need to be with a similarly credentialed clinician (i.e. PT to PT, OT to OT, ST to ST)?	While we strive to have peer to peer reviews done by a similarly credentialed clinician that is not always possible at that level of review. Peer to peer reviews are done by clinicians, who if not similarly credentialed, are experienced in multi-disciplinary reviews. At the authorization appeal level, per NCQA standards, reviews are conducted by similarly credentialed clinicians.
29	How do I find my PR rep?	Every provider has a Nebraska Total Care Provider Representative. You can look up your PR rep by visiting our webpage at www.NebraskaTotalCare.com/providers/provider-relations.html