Clinical Physical and Occupational Therapy QRG

Clinical Criteria – available at www.eviCore.com

Implementation Website – www.evicore.com/healthplan
In addition to the main website, implementation websites tailored to a specific health plan are available. The websites include the CPT code list (list of codes that require prior authorization for a specific health plan), Frequently Asked Questions (FAQ), Quick Reference Guides (QRG), links to clinical worksheets, and links to eviCore's evidence-based guidelines.

Clinical Consultation – Visit www.evicore.com and select "Request a Clinical Consult" in the *Provider Shortcuts Menu* in the top right-hand corner of your browser. If you require a call-back at a specific time, please indicate that time and time zone in the message field when making your request. eviCore will contact you if your request cannot be accommodated.

Date extension
A date extension can be granted for a therapy case in which a provider was authorized visits, but was unable to perform those visits within the amount of time given. You can request a date extension via our Web Portal or telephonically. A one-time date extension will be granted for up to 30 days. The extension must be requested before the authorization expires.

How do I submit documents for review for prior authorization or a medical necessity review?
The preferred method of submission is via the Web Portal. However, you can also call eviCore or fax in your request; the fax number is (855) 744-1319. While eviCore discourages submission by fax, if you must fax your request, include a completed eviCore clinical worksheet. If the worksheet is completed, there is no need to include additional clinical notes.

What information is needed to request authorization of Physical and Occupational Therapy services?
eviCore requires clinical information to determine if services are medically necessary. Submitted cases lacking complete clinical information often take longer to process and may result in a reduction of services or a denial. To reduce the time needed to create a case on the web or phone, have the following information available:

- Member information, including Name, Date of Birth, Address, Phone #, Health Plan ID
- Provider information, including Name, NPI #, TIN, Phone #, Fax #, Address, Specialty Type
- Current Clinical information
    - Adult – use eviCore's clinical worksheets to identify the clinical information needed
    - Pediatrics - use eviCore's clinical worksheets to identify the clinical information needed, including:
- Standardized test scores within 1 year
    - Current clinical (typically collected within the prior 20 days)
    - Progress toward goals
- Patient reported functional outcome measures (ODI, NDI, LEFS, HOOS JR, KOOS JR, or DASH/QuickDASH)
- Requested start date – this is the date you would like the authorization to begin.

How soon can I request additional visits? In order to prevent interruption in care, **submit requests for additional visits as early as 7 days prior to the requested start date.**

What will eviCore approve?
Depending on the health plan, eviCore will approve visits, units, or visits and units for use within an approved period.

Visits/units should be spread over the approved period to prevent a gap in care. If eviCore reduces or denies a request (also known as an adverse determination), the letter will include clinical rationale to explain why. The rationale is written in language a member can understand in order to comply with regulatory standards. If there has been an adverse determination, the letter will include directions for reconsiderations, clinical consultation (Peer to Peer), or the appeal process. Please review your letter for information on next steps.

Will eviCore approve services performed by two providers (same specialty) within the same period of time?
It depends on the conditions being addressed and/or the providers' plans of care. eviCore's authorizations for a specific specialty, for example PT, cover all conditions treated within the approved authorization period. If a second provider submits a request for authorization to treat the member, the provider will be required to either (1) provide a discharge date from the original therapist to demonstrate that the member is no longer receiving care from the original therapist, or (2) document that the care they will be providing is specialized and cannot be provided by the original therapist. For example, the first therapist is providing care for a lower back condition and the second therapist is providing care for a vestibular problem.

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Will eviCore approve services performed by two providers (different specialties) within the same period of time?
That depends on the conditions being addressed and/or the providers' plans of care. eviCore will approve care by two different specialties during the same period when (1) providers are treating different conditions (for example, Chiropractic for lumbar condition and Occupational Therapy for a hand condition), or (2) when treating the same conditions but the plan of care and goals are different (for example, PT and OT services following a brain injury). eviCore will not approve care by two specialties for the same condition when the plan of care is similar/overlaps and the care provided is duplicative.

What documentation should be submitted for a Retrospective Authorization Request?
If the health plan allows retrospective requests, eviCore must review clinical information to determine if the services provided were medically necessary. Requests for retrospective review should be faxed to eviCore. Please include the following with any retrospective request:

- Dates of service you are requesting authorization for; include visits and units
- The initial evaluation and progress reports/reevaluation
- Clinical records (including daily treatment notes, attendance logs) for each date of service you are requesting authorization for.

How can I determine if services are *medically necessary*? To be considered medically necessary, the following conditions must each be met:

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy, by or under the supervision of a therapist.
    - Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.
- For non- Medicare cases, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time.
- For Medicare cases, coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care.
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

What services are not considered medically necessary? The following services are generally not considered medically necessary. (Refer to specific health plan policy for specific-coverage policies.)

- Service(s) that can be self-administered or safely and effectively furnished by an unskilled person without the direct or general supervision of a therapist.
- Training in nonessential self-help, recreational tasks, or sport-specific performance.
- Services related to activities for the general good and welfare of the member, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation.
- Passive modalities that extend beyond the acute phase of recovery.
- Non-skilled routine, repetitive and reinforced procedures that do not require one-to-one intervention, such as stationary bike riding, progressive resistive exercise after instruction, and passive range of motion.
- Services not provided under a therapy plan of care.
- Services provided by staff who are not qualified or appropriately supervised. (The unavailability of a competent person to provide a non-skilled service does not mean it becomes a skilled service when the therapist furnishes it.)