# Therapy Services

Prior Authorization Process

# Governing Regulations

- **907 KAR 8:040. Coverage of occupational therapy, physical therapy, and speech-language pathology services provided by various entities**.
- **907 KAR 8:045. Reimbursement of occupational therapy, physical therapy, and speech-language pathology provided by various entities.**

# Fee Schedules

The Fee Schedules for each therapy discipline (Physical, Occupational or Speech Therapy) can be found on the CHFS website.

http://www.chfs.ky.gov/dms/fee.htm

The fee schedule defines the unit value for each procedure code

- Episode = 1 visit/unit
- 15 minute = 1 unit
- 1 hour = 1 unit
- Additional 30 minutes = 1 unit

# Procedure Codes/Unit Values

When requesting prior authorization for  therapy services, pay special attention to the unit value assigned to the code. Request the number of units corresponding to the modality that will be performed. Request the total number of units to be provided during the prior authorized period.

Examples:

- Unit value = 15 minutes - code to be provided for 1 hour = request 4 units for each day of service to be provided
- Unit value = Episode - request 1 unit for each day of service to be provided regardless of the amount of time the service will be provided

# Initial Request for Therapy

- Kentucky Medicaid Therapy Prior Authorization Form
- Order signed by a KY Medicaid participating Physician, Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) or Psychiatrist (when applicable)
    - Specify type of therapy being requested
    - Specify whether evaluation or evaluate and treat
    - Frequency and duration not required, but if indicated the requested units must match the order

*Note this is for initial therapy requests only, individuals who have previously received therapy in the waiver program should follow the Ongoing Therapy Request

# Ongoing Request for Therapy

- Kentucky Medicaid Therapy Prior Authorization Form
- Order signed by a KY Medicaid participating Physician, Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) or Psychiatrist (when applicable)
    - Specify type of therapy being requested
    - Specify whether evaluation or evaluate and treat
    - Frequency and duration not required, but if indicated the requested units must match the order
- Therapy progress notes, including an updated/current evaluation
    - Monthly Summary notes are acceptable – Progress notes should support the ongoing need for therapy services

# Clinical Criteria

- Interqual – The gold standard in evidence-based clinical decision support
- Therapy will be reviewed using the Home Care Module
  - Format is question and answer based with each response determining the next question
  - End result is a recommended number of discipline- specific visits
  - Allows for maintenance therapy
- Organizational Kentucky Medicaid Specific Policy
  - Services can be approved up to 90 days
  - Services can be utilized to cover maintenance therapy to prevent regression

# Prior Authorization

## Waiver CM responsibility

- Referral to and assistance in connecting the individual with a KY Medicaid participating therapy provider
- Aid in the sharing of information between waiver service provider and new therapy provider

## Therapy Provider Responsibility

- Review previous therapy notes/services
- Obtain therapy order
- Request Prior Authorization

# Prior Authorization

- Initial 20 visits do not require Prior Authorization
  - Visit is determined by date of service regardless of the number of codes to be billed during the visit
- First 2 therapy requests (6 months) following transition from services provided in the waiver program – the same number of visits approved through the waiver will be approved through the state plan
  - Provider responsible for requesting the codes and number of units to be provided during the visits
- Beginning with the 3rd therapy request, the number of visits will be based on the Interqual determination
  - Medical Necessity and number of visits determined based on each individual's needs

| Kentucky Medicaid<br>Therapy Prior Authorization Form | | | | | |
|---|---|---|---|---|---|
| **Provider Information** | | | | | |
| Provider Name | | | Provider Number | | |
| Provider Address | | | Facility Contact Person | | |
| Provider Phone Number | | | Fax Number | Date | |
| **Member Information** | | | | | |
| Member Last Name | Member First Name | | Medicaid Number | DOB | Age |
| Member Address | | | City | Zip Code | |
| Diagnosis | ICD 10 Code | | Diagnosis | ICD 10 Code | |
| Diagnosis | ICD 10 Code | | Diagnosis | ICD 10 Code | |
| Diagnosis | ICD 10 Code | | Diagnosis | ICD 10 Code | |

Complete Provider and Member Demographic Section

- Facility Contact Person and Phone Number – This is the person who should be contacted with any questions about the request
- Member Information – Verify the Member name and Medicaid Number Match
- Diagnosis – Include all applicable diagnoses and the corresponding ICD 10 code

| Service Requested | CPT Code | # of Episodes/Units Requested | # of Visits Requested | Start Date | End Date |
|---|---|---|---|---|---|
| | | | | | |
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- Service Requested – List the service description
- CPT Code – List the covered CPT Code found on the fee schedule
- # of Episodes/Units Requested (total number of units based on defined values on fee schedule) – this is the number that will be reviewed for prior authorizations
- # Visits – Informational only - Indicate the total number of visits requested for the time period – field may be left blank
- Start and End Date – Indicate the requested start and End dates – Maximum amount of time 90 days, start date cannot be prior to the therapy order date

| Request Checklist | | |
|---|---|---|
| 1. Requested services are physician, physician assistant, advanced practice RN or psychiatrist directed | Yes | No |
| 2. A. Treatment is for the maximum reduction of the effects of a physical or intellectual disability; OR<br>B. Rehab potential with expectation for clinical/functional improvement | Choose One A/B | |
| 3. There is documented member adherence to home exercise program (HEP) | Yes | No |
| 4. There are documented short-term goals (STG) and long-term goals (LTG) | Yes | No |
| **Therapy Information** | | |
| **Is this a new PA?** Y/N | | |
| **Treatment Plan Overview** | Services to be rendered: ____times per week for____ weeks. | |

- Please address all 4 questions and indicate the number of times per week and the total number of weeks therapy will be provided during the requested dates.
- For example: Services to be rendered 3 times per week for 12 weeks

# Prior Authorization

- Fax requests to Carewise Health
  - 1-800-807-7840, 502-429-5233, 1-800-807-8843
- Carewise Health has 3 business days to process/render a determination for incoming initial request.
- Physician Referral
  - If the clinical reviewer is unable to determine medical necessity of the service being requested, the case will be referred to a physician.
  - Carewise Health physicians have 24 hours to review referral and render a determination.
  - Providers will be notified via telephone of outcome of referral.
  - Denials: If a service is denied the individual and servicing provider will receive a denial letter with the appeal rights.
- Please check KY Health Net for PA

# Lack of Information

- If additional information is needed by the reviewer at Carewise Health a Lack of Information letter will be generated.
- The requesting provider will have fourteen (14) days from the date of the letter to submit the information required to complete the review.
- If the requested information is not submitted within the 14 days, Carewise Health, will issue a Lack of Information denial.
- The provider may submit complete information at any time following the issuance of a denial letter.  Upon receipt of this request, a new review will be conducted.

# Reference Page

| Department | Phone Number | Email or Fax | Roles |
|---|---|---|---|
| **HP Provider Billing Inquiry** | 800-807-1232 | KY_provider_Inquiry@hpe.com | Claim Status, claim denials, RA's, billing questions, member eligibility |
| **EDI Help Desk** | 800-205-4696 | KY_edi_helpdesk@hpe.com | Electronic billing, electronic RA's, PIN#, and password reset |
| **Provider Enrollment** | 877-838-5085 | Program.Integrity@ky.gov | Questions or updates to provider file including NPI/taxonomy, updating address, EFT's and enrollment of providers |
| **HPE** | Varies | UM_Research@hpe.com | Billing problems, PA questions |
| **Carewise Health** | 800-292-2392 | | Prior Authorization, Lack of Information (LOI), Medical Necessity or LOI denials |