Preferred Occupational Therapy Manual

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

The Preferred Occupational Therapist (OT) Network consists of therapists who have agreed to provide our members quality services in an efficient and effective manner. The OT network was implemented January 1, 2001. Benefits are provided for medically necessary hand therapy services under Major Medical or other covered services. Specific group benefits and limitations continue to apply. Access **"Find A Doctor"** to locate a Preferred Occupational Therapist.

For general information, refer to the Provider Manual.

Covered Services

The Preferred OT Network specifically adds coverage for hand therapy and the treatment of lymphedema. Specific Current Procedural Terminology® (CPT) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes commonly used by OTs treating hands are covered by this program. Special care should be given in reporting and documenting these services. For occupational hand therapy to be medically necessary, it must be reasonable and necessary for the member's diagnosis or the treatment of the member's condition.

Medical necessity is indicated when:

- The diagnosis established by the physician supports utilization of the therapy.
- There is documentation of objective physical and functional limitations [strength/range of motion (ROM)/mobility/activities of daily living (ADL) levels, edema, pain, sensory deficits, fine/gross motor coordination and skin integrity].
- A plan of care includes treatment services that are expected to result in improvement of these limitations in a reasonable and generally predictable period of time. The amount, frequency and duration of the services must be reasonable.
- Services are one-to-one.
- Services are skilled. Services must be of a level of complexity and sophistication, or the condition of the member must be such that the services required can be safely done and effectively performed only by a qualified occupational therapist or under his/her supervision when covered by the member's contract.

Services such as the application of hot and cold packs, use of exercise equipment and repetitive exercises do not ordinarily require the skills and full attention of a qualified occupational therapist; therefore, these services are not separately billable. If such treatments are given as a prerequisite to a skilled occupational therapy procedure, they are considered part of that modality and are not separately billable.

Non-Covered Services

Member contracts that do not have coverage for additional OT services will have no coverage for services other than hand therapy. Preferred Occupational Therapists are responsible for notifying the patient of services that are not medically necessary for the treatment of his/her condition or are not covered. A Notification of Non-Covered Services statement can be used to explain to the member that he/she is responsible for these charges. The member should sign the statement prior to services being rendered. Please refer to the Provider Manual on our website for details and examples.

Examples of Non-Covered Services:

- Occupational therapy services other than hand therapy or lymphedema treatment, unless the contract has additional OT benefits
- Treatments that do not have a physician referral (the initial evaluation visit does not require physician referral)
- Services considered a routine part of nursing care (e.g., turning patients to prevent pressure areas, walking patients to maintain mobility, routine dressing changes)
- Services that do not require the professional skills of a qualified OT (e.g., hot packs/cold packs, except for instances of documented paresthesia, wounds)
- Repetitive services/treatments not requiring the skills of an OT (e.g., general supervision of exercises previously taught to the member or caregiver, exercise equipment, Stairmaster, treadmill, bicycle)
- Group therapy
- Services related to activities for the general good and well-being of patients such as general exercise to promote overall fitness and flexibility, and activities to provide diversion or general motivation
- Endurance enhancing activities
- Services provided when the patient's expected restoration potential is insignificant in relation to the extent and duration to the OT services required to achieve such potential
- Passive exercises not related to restoring specific loss of function
- Maintenance care (e.g., lack of progress in restoring function/plateau)

Remember: *Blue Cross and Blue Shield of Alabama does not provide benefits for professional services of an OT rendered to a member who is related to the OT by blood or marriage or who lives in the provider's household.*

Covered Providers

- Licensed Occupational Therapist
- OT students are covered providers when working under the direct on-site supervision of a Preferred OT. All treatment notes must be co-signed by the supervising/Preferred OT. Services should be billed using the supervising OT's National Provider Identifier (NPI).
- OTs with temporary licenses are covered providers when working under the direct on-site supervision of a Preferred OT. All treatment notes must be co-signed by the supervising/Preferred OT. Services should be billed using the supervising OT's NPI.

- Licensed certified occupational therapist assistants (COTA) are covered providers when working under the direction of a Preferred OT with the following provisions:
  - The OT must interpret the physician's referral.
  - The OT must perform the initial evaluation.
  - The OT must develop the treatment plan and program, including long and short-term goals.
  - The OT must re-evaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
  - The OT must implement (perform the first treatment) and supervise the treatment program.
  - The OT must co-sign treatment notes written by the OTA.
  - The OT must indicate he/she has directed the care of the patient and agrees with the documentation as written by the OTA for each treatment note.
  - The OT must render the hands-on treatment, and write and sign the treatment note every sixth visit.

- COTA students are covered providers when working under the direct on-site supervision of a Preferred OT or under the direct on-site supervision of a licensed occupational therapist assistant working under a Preferred OT. All treatment notes must be co-signed by the supervising/Preferred OT. Services should be billed under the supervising OT's NPI.

- COTAs with temporary licenses are covered providers when working under the direct on-site supervision of a Preferred OT or under the direct on-site supervision of a licensed OTA with the approval of the supervising OT. The OT must co-sign treatment notes written by the COTA and services should be filed using the supervising OT's NPI.

Note: Services should be billed using the supervising/Preferred OT's NPI.

Non-Covered Providers of Occupational Therapy Services

Athletic trainers, exercise physiologists, massage therapists, RNs, LPNs, certified strength trainers, secretaries and office personnel are not considered covered providers; therefore, services performed by these providers are not covered.

Filing for these kinds of services under the OT's NPI is not acceptable and is not reimbursable.

Precertification

Several benefit plans require precertification for the first date of service. For these groups, this contractual requirement must be adhered to. Some groups also require the initial evaluation order and goals for treatment prior to the first visit. Please refer to the Provider Manual on our website for details and examples.

In addition, precertification is **not** required by Blue Cross and Blue Shield of Alabama for:

- A Blue Cross contract that is secondary to a Blue Cross primary contract
- Medicare or any insurance that is primary to Blue Cross and Blue Shield of Alabama
- Out-of-State Blue Cross Plans (e.g., the member's Plan is Blue Cross & Blue Shield of Mississippi, but services are provided in Alabama)
- Federal Employee Program (FEP)

Specific contract requirements may be verified through *ProviderAccess*, your practice management software or by calling Provider Customer Service at 205-988-2213. Verification of benefits will assist in identifying members that do not require precertification or who may have have special benefits.

For all contracts that do not require precertification for the first date of service, or some other variation, precertification is required if the OT determines that the member's care will require more than 15 visits. Requests for precertification should be submitted after the 14th visit. If precertification is not obtained, all services associated with the 16th and subsequent visits will be non-covered and the patient will be held harmless (with the exception of a new evaluation for a new episode of care and the services performed on the date of such initial evaluation). Patients may be billed if they have signed a Notification of Non-Covered Services statement for each visit indicating that they have been properly informed that the services to be rendered are not covered by Blue Cross and that the patient will be responsible for paying the service(s). There are no retroactive certifications on these contracts.

When filing a request for a precertification, submit the completed precertification form (including all dates of services in boxes) along with the documentation of evaluation and last five progress notes. If additional information is needed, you will be notified. Please make sure the required fields on the precertification form are complete. A determination can only be made if all required information is provided. Review decisions will be made within 72 hours of receipt of the required information and will be returned via facsimile or email and confirmed with a letter mailed upon completion of the review decision. Precertification requests received after 2 p.m. will be considered as received the following business day.

Precertification requests should be faxed to:

Blue Cross and Blue Shield of Alabama
Fax Number: 205-402-9369
Attention: Occupational Therapy Precertification

For Personal Choice Network (PCN) and Primary Care Select Physician (PCSP) Network, OT is considered a related service. Related services do not require a direct referral from the Primary Care Select Physician (PCSP) to the OT. However, if occupational therapy is ordered by a physician other than the patient's PCSP, a valid referral from the PCP to the physician ordering the therapy must be received by Blue Cross. Remember, the Preferred Medical Doctor (PMD) contract requires PMDs to refer to preferred providers. By referring a member to a non-participating provider, the member will not receive in-network level benefits and will not be held harmless for any amounts not paid to the provider. Inpatient services provided at a Participating Hospital are considered at that in-network benefit level.

The number of visits per patient is defined as visits provided by the Preferred OT of the same group and/or tax identification per calendar year. For precertification purposes, Preferred OTs are only responsible for the therapy provided by their group and/or tax identification.

Note: A current physician referral must be maintained in the patient's medical record. Patients should be discharged when:

- Goals have been achieved,
- There is no expectation of significant progress,
- The patient is unable to participate in the treatment program for medical, psychological, or social reasons,
- The patient is non-compliant to the treatment plan, or
- The patient is restored to normal ADL functioning level.

Appeals of Determination Not to Precertify

One appeal, either expedited or standard, may be performed for medical necessity non-certification determinations.

Expedited Appeal

An expedited appeal is available when there is an imminent or ongoing service requiring additional review of a non-certification determination. Appeal by telephone, facsimile or email with additional information to be included in the review. Notification of appeal results are made by telephone to the provider within 24 hours of receipt of the request followed with written notification.

Standard Appeal

A standard appeal is a formal request to review healthcare services already provided and not certified as medically necessary for the benefit coverage. It may be initiated by telephone, facsimile or mail by the member, attending physician or other ordering provider, or the facility rendering the service. A peer reviewer not involved in the original non-certification decision will review the appeal. The necessary medical record will be required for review if not submitted previously to Blue Cross and Blue Shield of Alabama. The member, attending physician or other ordering provider, and claims administrator will be notified in writing of the appeal determination by no later than 30 days after receiving the required documentation to conduct the appeal review.

Appeal requests should be mailed or faxed to:

Blue Cross and Blue Shield of Alabama
Post Office Box 362025
Birmingham, Alabama 35236
Fax Number: 205-402-9369
Telephone Number for Expedited Appeals: 205-220-6356 or 205-220-7202

When requesting an appeal, additional information to support the medical necessity of the requested visits should be included. Appeals should not be requested until covered visits are used. Appeals can only be requested when no additional treatments have been confirmed. Appeals of partial confirmation or approvals are not an option. For instance, if eight additional visits are requested by an OT and four visits are approved by Blue Cross and Blue Shield of Alabama, the OT may not request additional visits if he/she determines additional treatment is necessary.

When a non-certification decision is made without a physician conversation, a peer-to-peer conversation may be requested within 10 days of the decision using the telephone number provided on the non-certification letter. If the original peer reviewer is not available, a peer alternate will be available to discuss the case. This request does not count as an appeal.

Preferred Occupational Therapist Audits

A major strength of Blue Cross and Blue Shield of Alabama in managing healthcare costs is our ability to audit Preferred Providers and affect changes in utilization practice habits. Our contractual arrangements give us the right to audit Preferred Occupational Therapists' medical records in order to objectively evaluate coding, billing and practice patterns, as well as the completeness of their medical records.

An audit can be triggered by external referrals from members, group administrators, anonymous tips, and even other occupational therapists that feel that a particular occupational therapist, group or facility is not in compliance with the program guidelines. An audit may be triggered from internal claims and precertification data also.

If an offsite audit reveals unusual practice patterns or billing procedures that result in overpayments, refunds are required from the occupational therapist and the amount is returned to the groups whose members were affected by the incorrect practices. Any occupational therapist having an unsatisfactory audit must immediately correct any problems. A follow-up audit will be performed to ensure that he/she is in compliance with the Preferred Occupational Therapist guidelines. A second unsatisfactory audit can result in the therapist being removed from the Preferred Occupational Therapy Program.

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