Rehabilitation

PROVIDER OFFICE STAFF END USER TRAINING

Overview

AIM* works with leading insurers to improve healthcare quality and manage costs for today's most complex and prevalent tests and treatments, helping to promote care that is appropriate, safe and affordable. In today's session, you'll be introduced to our new **Rehabilitation** Program to be managed by AIM Specialty Health® (AIM), a separate company, for Commercial fully insured and Medicaid members.

The following resources are available now:

- ***ProviderPortal***$_{SM}$ (direct link www.providerportal.com or single sign on) will be available for order request submission twenty-four hours a day, seven days a week, processing requests in real-time using clinical criteria.
- AIM **Call Center** Monday through Friday 7:30 am – 7 pm (Central Time) at:

Medicaid - Healthy Blue Missouri (MO)	855.574.6479	Effective 1/1/2021 request starting on 12/21/2020
Medicaid - Healthy Blue Nebraska (NE)	855.574.6478	Effective 1/1/2021 request starting on 12/21/2020
Medicaid (IN, NY, WNY, WI)	800.714.0040	*live*
Medicare (CA, CO, CT, GA, IN, KY, ME, MO, NH, NM, NY, OH, TN, TX, TX MMP, VA, WA, WI)*	800.714.0040	*live* * FL, NJ preauthorization is managed by different vendor
Anthem Commercial (CT, ME,NH)	866-714-1107	*live*
Anthem Commercial (IN,KY,MO,OH,WI)	800-554-0580	*live*
Anthem BCBSGA	866-714-1103	*live*
Empire NY Commercial F/I	877-430-2288	*live*
Anthem Commercial F/I (CO,NV)	877-291-0366	*live*
Anthem Commercial F/I (CA)	877-291-0360	TBD 2021

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Preauthorization not required from AIM

Based on the following states, **lines of business** and **age bands**, a pre-authorization is not required from AIM:

Age	Line of Business	States
Birth – 3rd Birthday	Commercial Fully Insured	Wisconsin, Indiana, Ohio, Missouri, Kentucky, Maine, Connecticut, New Hampshire
Birth – 6th Birthday	Commercial Fully Insured	Colorado

Based on the following **state**, **lines of business**, **age band** and **condition**, are out of scope for AIM:

Age	Line of Business	State	Clinical Condition
21 and over	Medicaid	Missouri	Non covered benefit unless pregnant

Based on the following **states**, **line of business** and **clinical condition**, a pre-authorization is not required from AIM, but benefit limits, if applicable, may still be applied

Line of Business	State	Clinical Condition
Commercial Fully Insured	IN, KY, OH, MO, WI, NY, CT, NH, ME, GA, CO, NV	Autism Spectrum Disorder/Pervasive Development Delays (for the following primary diagnosis ICD-10 codes: F84.0, F84.2, F84.3, F84.5, F84.8, or F84.9)

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COVID-19 Update

Effective March 17, 2020, the Telehealth place of service is applicable where the AIM Rehabilitative program is live. The Rehab Telehealth FAQ was published in the April provider newsletters titled *"Information from Anthem for Care Providers about COVID-19".* See Provider News for updates for Care Providers about Coronavirus (COVID-19).

Certain CPT codes would be appropriate to be considered for telehealth (audio and video) physical, occupational, and speech therapies. Anthem will waive member cost shares for telehealth visits from in-network providers from March 17, 2020 through September 30, 2020 for commercial members and from March 17 2020 through December 31,2020 for Medicare and Medicaid plans, for the following physical, occupational and speech therapies for visits coded with Place of Service (POS) "02" and modifier 95 or GT:

- Physical therapy (PT) evaluation codes: 97161, 97162, 97163 and 97164
- Occupational therapy (OT) evaluation codes: 97165, 97166, 97167 and 97168
- PT/OT treatment codes: 97110, 97112, 97530 and 97535
- Speech therapy (ST) evaluation codes: 92521, 92522, 92523 and 92524
- Speech therapy treatment codes: 92507, 92526, 92606 and 92609

PT/OT CPT codes that require equipment and/or direct physical hands-on interaction and therefore are not appropriate via telehealth include: 97010-97028, 97032-97039, 97113-97124, 97139-97150, 97533 and 97537-97546.

Limitation related to state mandates and licensure/state practice act would still apply. Benefit limitations, where applicable, would still apply.

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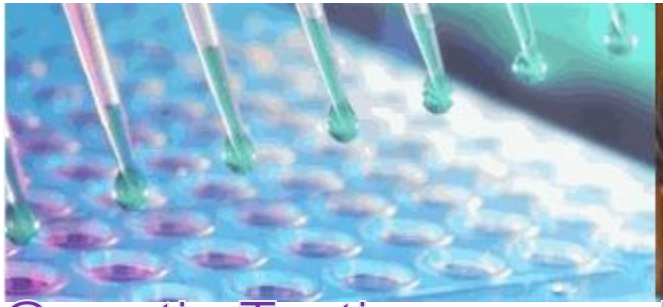
AIM clinical review programs

Radiology

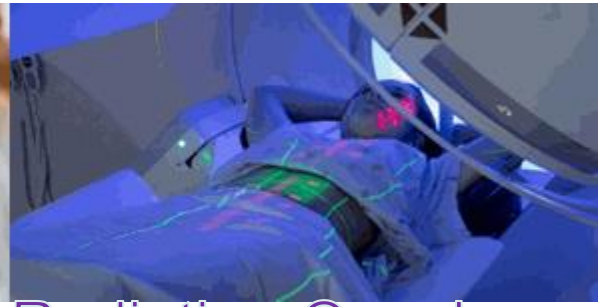
Cardiology

Sleep



Genetic Testing

Medical Oncology



Radiation Oncology

Rehabilitation

Joint and spine

Interventional pain

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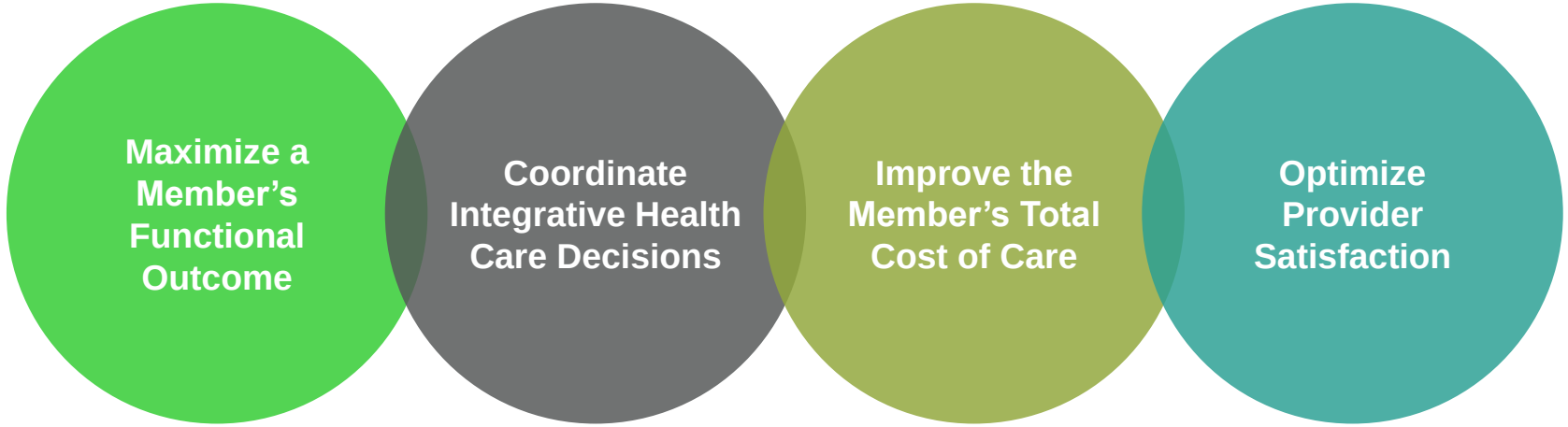
Rehabilitation Program

The AIM Rehabilitative Program uses evidence-based clinical practice guidelines focus on:



Clinical Appropriateness Review Process encompasses the appropriate duration of rehabilitative services at the appropriate place of service, with the goal of maximizing the member's functional improvement, while at the same time enhancing and simplifying the provider's experience in the delivery of care.

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Program scope

Disciplines included in the program

Physical Therapy

AIM guidelines
(Medicare: NCD,LCD, CMS Manual)

- Supervised Modalities
- Constant Attendance Modalities
- Therapeutic Procedures
- Adaptive Equipment Training
- Wound care and lymphedema Treatment
- Other Physical therapy services

Occupational Therapy

AIM guidelines
(Medicare: NCD,LCD, CMS Manual)

- Supervised Modalities
- Constant Attendance Modalities
- Therapeutic Procedures
- Adaptive Equipment Training
- Wound care and lymphedema Treatment
- Other Occupational therapy services

Speech Therapy

AIM guidelines
(Medicare: NCD,LCD, CMS Manual)

- Speech Fluency
- Speech sound production
- Language comprehension and expression
- Oral and pharyngeal swallowing function
- Auditory processing

Please note:

- *Procedure codes my vary by lines of business or may be managed by the local health plan.*
- *Chiropractors billing for Therapy codes require a pre-auth.*

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Clinical appropriateness review

Criteria Determining Visit Allotment

Initial Request:

- Primary Treatment Diagnosis
- Confirmation of autism, developmental delay, or traumatic brain injury
- Evaluation date consistent throughout the episode of care
- Functional outcomes tool and score
- Comorbidities/recent surgery

For Subsequent Requests:

- Member's response to treatment or any mitigating factors if poor response
- Member's attainment of goals
- Member's improvement in functional outcomes tool score
- Review of clinical documentation for all recurring requests

Included settings:

- Office
- Outpatient hospital
- Independent clinic
- Telehealth

Check to see if the facility is in network for the member before starting therapy

Please note: Additional documentation may be required when requesting additional visits (e.g. progress notes, initial evaluation/re-evaluation, etc.)

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Rehabilitation clinical experts power our program

An experienced team of therapist and physicians lead and support our Rehabilitation program

Their expertise across numerous clinical specialties provides clinical acumen immediately

Our clinical reviewers specialties include physical, occupational, and speech language therapy

Our clinical reviewers also specialize in physiatry, internal medicine, orthopedics and pediatrics

KERRIE REED

Medical Director, Rehabilitation

Clinical leader responsible for the clinical strategy.

GINA GIEGLING

GM / Vice President, Rehabilitation and MSK

Business leader responsible for the business strategy and design.

DISHA PATEL

Clinical Architect Director, Rehabilitation and MSK

Clinical Architect responsible for the clinical design.

YVONNE SULLIVAN

Provider Engagement Manager, Rehabilitation

Engagement Manager responsible for outreach and education.

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Episode of care

An episode of care is the managed care provided for a specific injury, surgery, condition or illness during a set time period.

AIM will provide an authorization with a visit allocation for those requests where the member meets medical necessity.

If after delivering the authorized number of visits, the member still needs additional skilled therapy, the provider can return to the AIM provider portal and create another request for visits.

For a given episode of care, it is possible that more than one case will get created, but it is dependent on the member's progress with their treatment plan.

For an optimal request response:

- Requests should be made only after an active authorization has either expired or there are no more authorized visits remaining for the member
- Initiating a request before visits have been rendered may not reflect the accurate medical necessity criteria
- An authorization will not be able to be obtained greater than 30 days prior to your service date

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Episode of Care Flow

Patient Evaluation

- Therapist performs the initial evaluation.
- The evaluation date should remain consistent throughout the episode of care for the member

Initial Evaluation with Treatment

(same date of service)

Commercial /Fully Insured:

- No pre-auth required for treatment rendered during the initial evaluation visit.

Medicaid /Medicare:
Pre-auth is required is required for treatment codes rendered during the initial evaluation (2 options)

- Come to portal prior to evaluation and request a 1 visit pre-authorization.
- Come to the portal within 2 business days after the initial evaluation with treatment to submit a request.

Initial Request

Provider creates an AIM portal request, reports patient's functional tool score, diagnosis, and answers clinical questions. If clinical necessity is met, an auth with visits is provided.

Render Therapy

Therapist Determines Status

Determine if the patient attained their goals discharge, didn't respond to therapy or made improvements but still needs more skilled therapy

Ready for Discharge

Additional Skilled Therapy is Needed

Report Progress in New Request

Therapist reports patient's updated functional tool score, progress towards goals, and if relevant, mitigating factors.

Uploading documentation may be necessary in certain scenarios.

Patient Attains Goals or Skilled Services are No Longer Needed

Patient is ready for discharge.

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Review responsibility

AIM will perform…

- Prospective reviews
- ≤2 Day service grace period
- Reconsiderations up to 3 business days with additional information
- Valid timeframe for requests are based on the number of visits that are allocated (or state mandate)
- Peer to Peer / Therapist to Therapist discussion

Healthy Blue will perform…

- Inpatient and home health requests
- Unspecified codes not managed by AIM
- >2 Day retro review
- Appeals (and reconsideration for Medicare)
- Pre-Authorization requirements prior to AIM's effective date
- Responding to member questions

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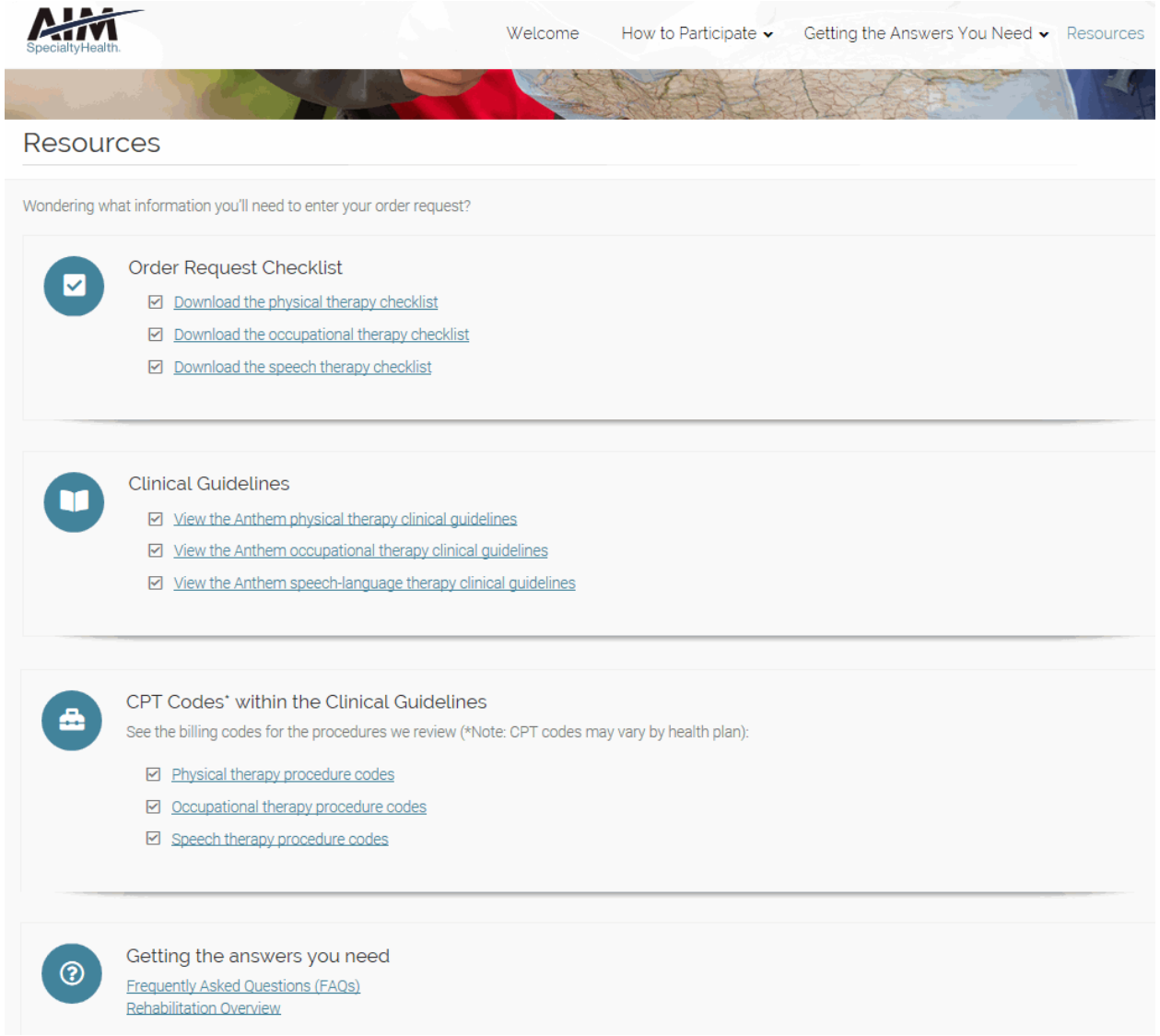
Rehabilitation microsite – resources



https://aimproviders.com/rehabilitation/resources/

Resources Section

- Checklists containing the information needed for requests, including a list of the functional tools and score values
- Link to Clinical Guidelines
- CPT Codes included in the program
- Portal Login Issues – (800) 252-2021
- Rehab Questions for providers only - rehabprogram@aimspecialtyhealth.com

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ProviderPortal Demo

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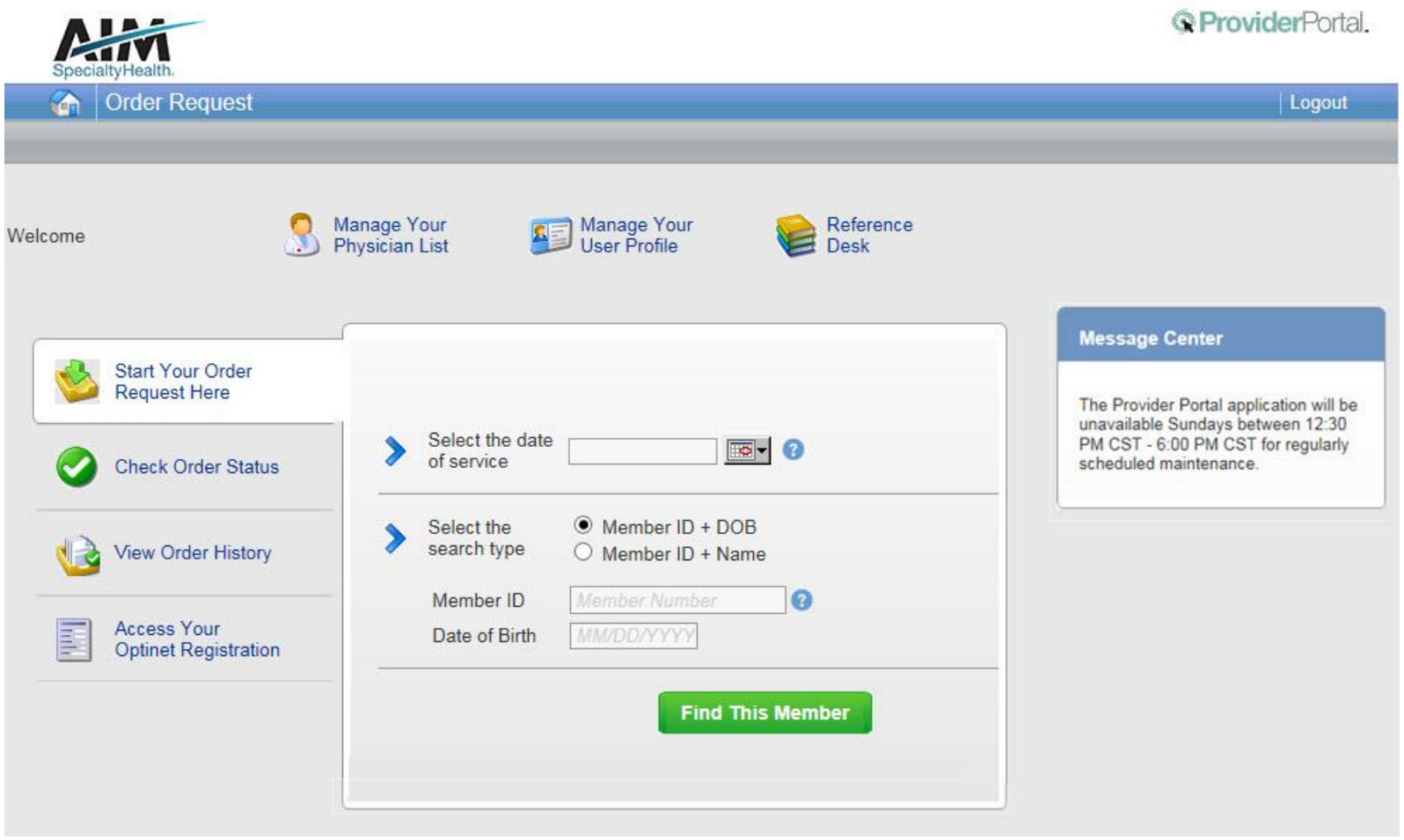
Portal home page



Create a pre-authorization request:

1. Please enter the treatment start date in the "**Date of Service**"
2. Provide the following member information:
   - Member ID and date of birth
   - or
   - Member ID and name
3. Next, chose "**Find this Member**" to search for your member.

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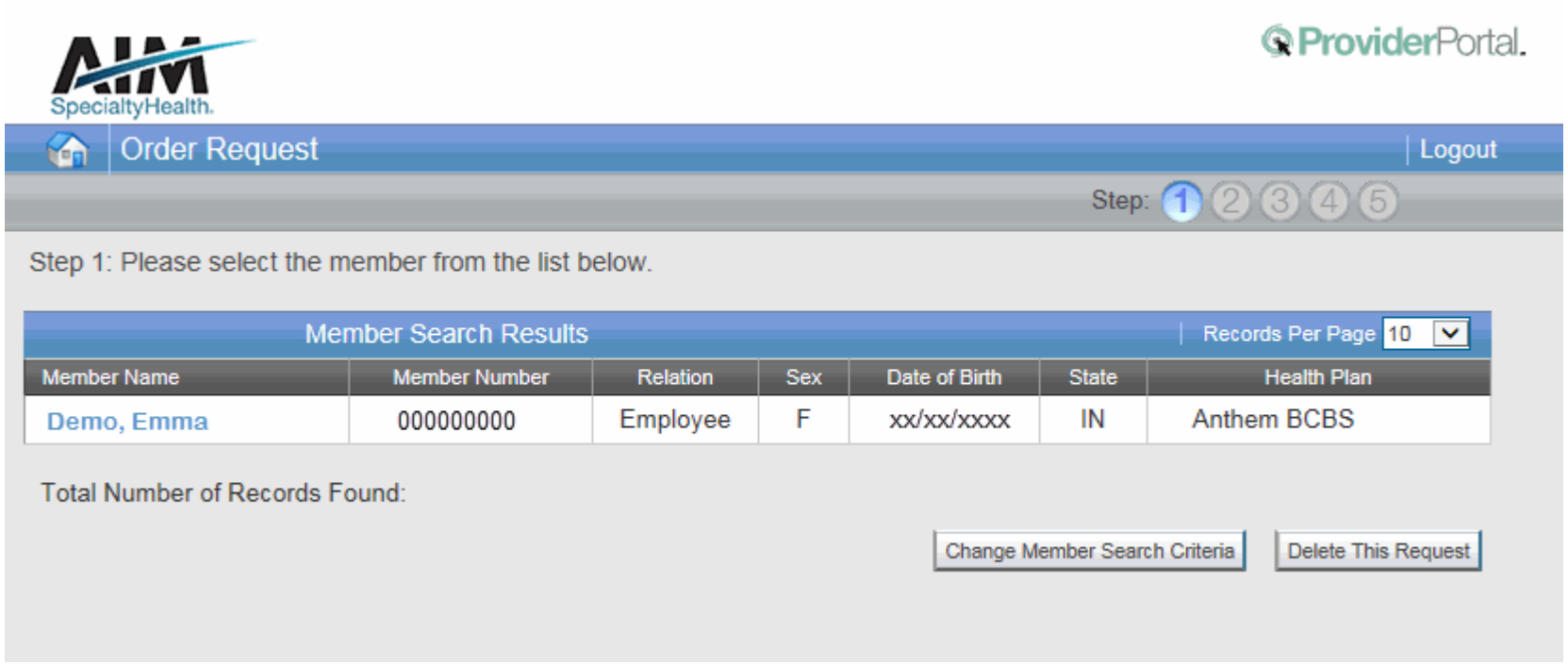
Step 1 – select member



Select your member from the search results by clicking on the **member name**.

If your member does not appear in the results, you can change your criteria and search again using the "**Change member search criteria**" button.

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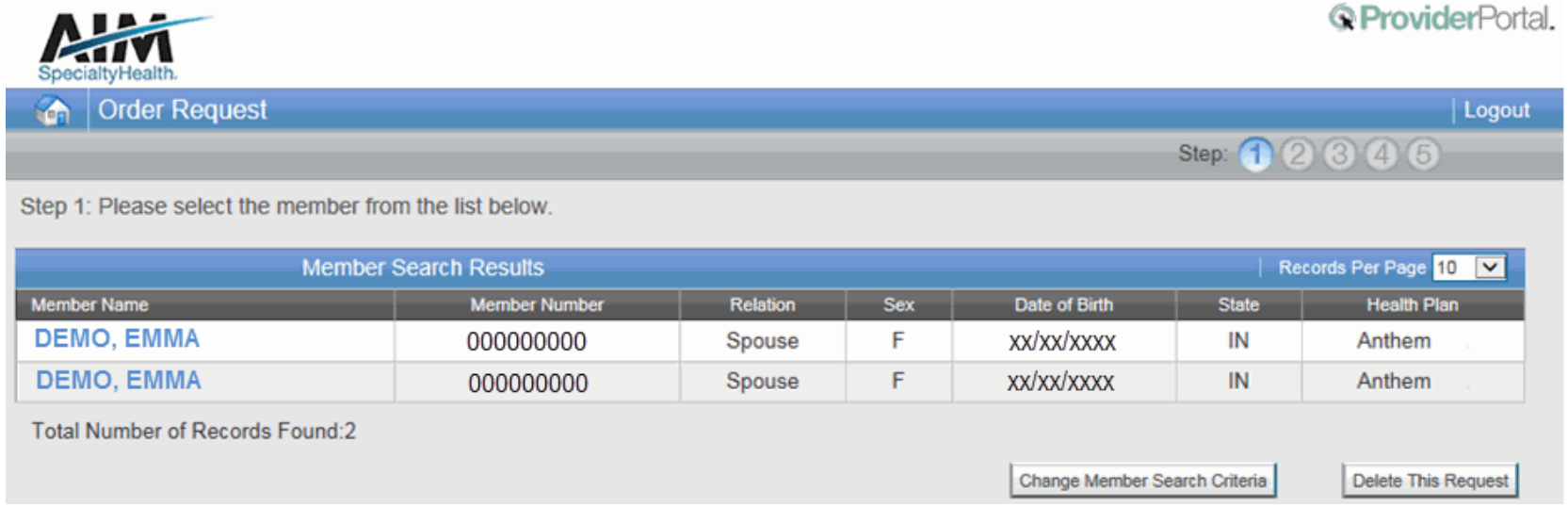
More than one result?



If the search results in more than one record, try selecting the last record in the list.

If that record doesn't require a preauthorization, go back and select the other record.

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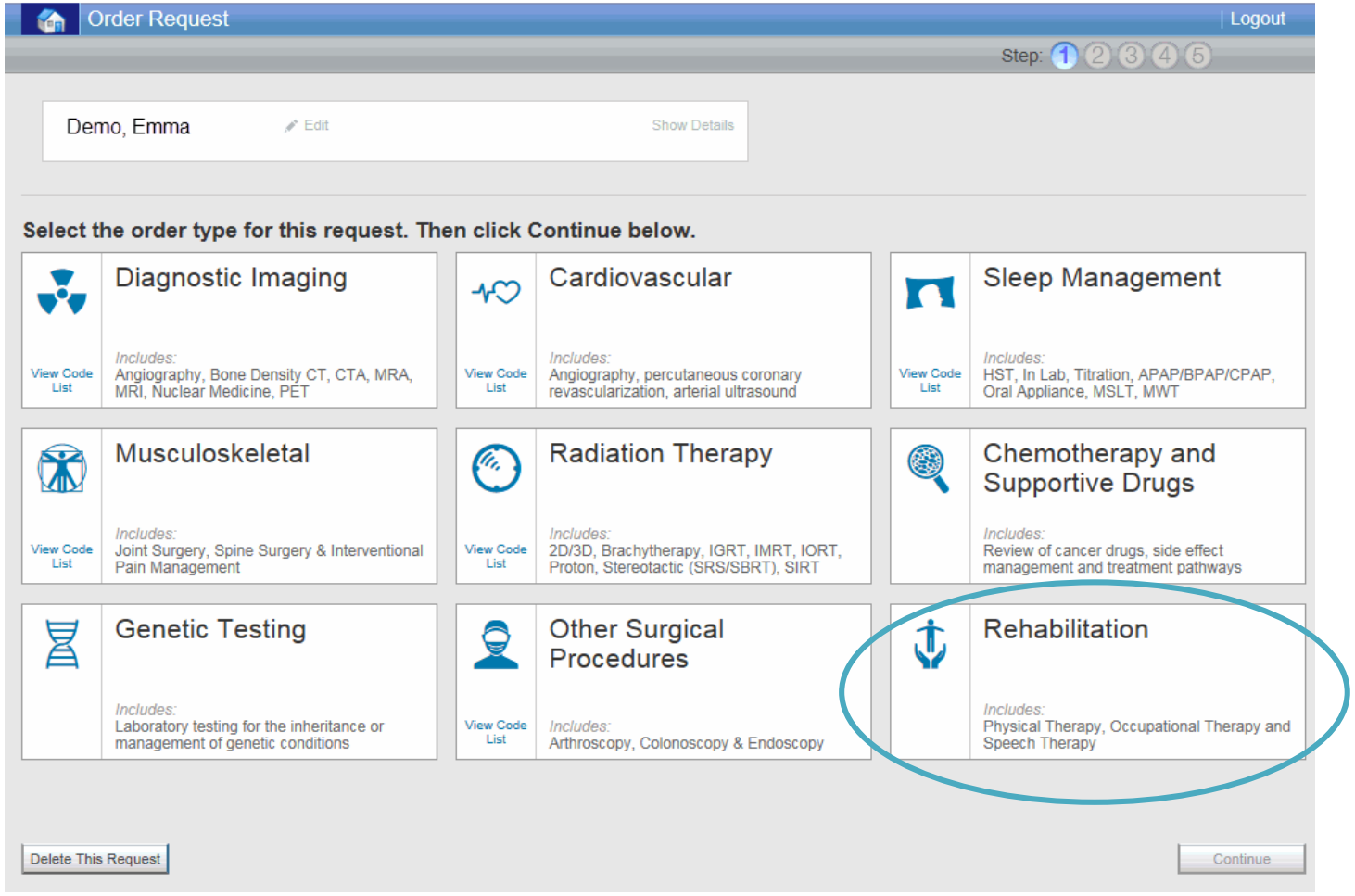
Select Rehabilitation



On the order type screen, select "**Rehabilitation**" and then select the "**Continue**" button.

Note: only programs that are currently managed by AIM for the selected member will display on the order type selection screen.

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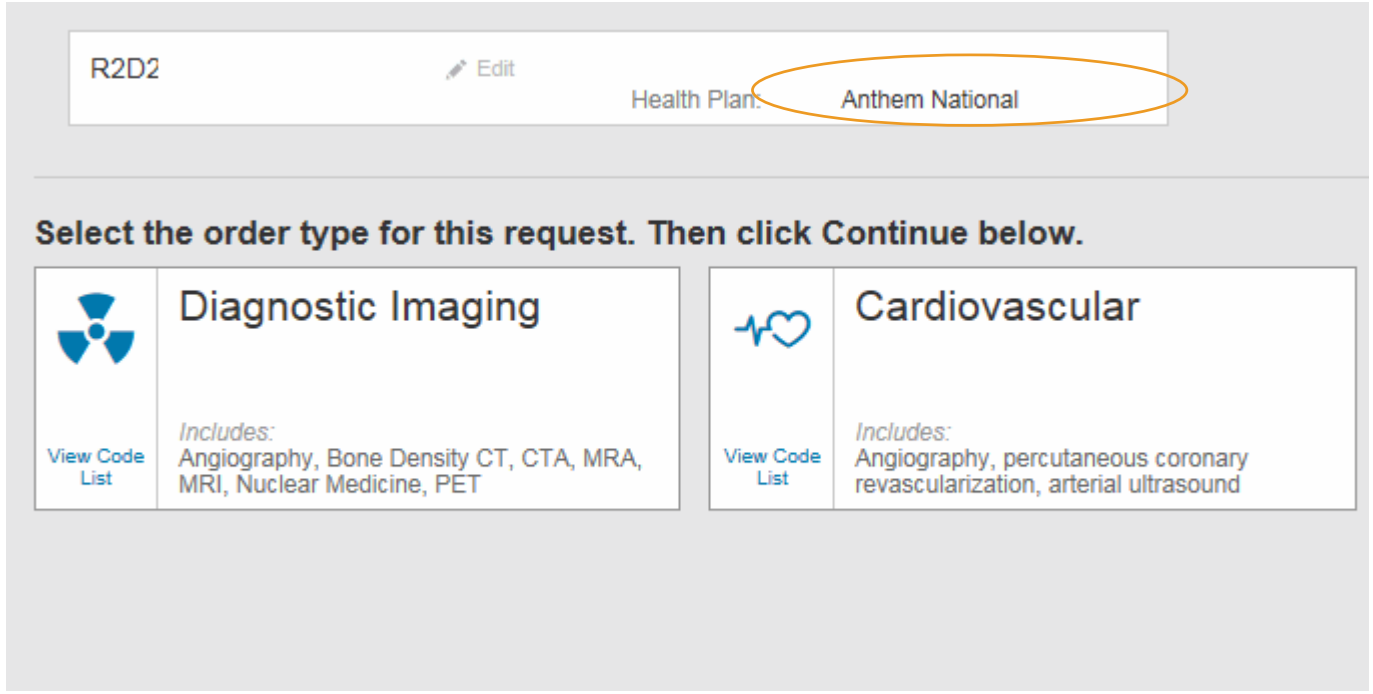
If there is no rehabilitation tile



If the rehabilitative tile is not displayed, that is an indication the member is not managed by AIM for rehab services.

Check the Health Plan name, for example, if it indicates Anthem National, their members are currently not participating.

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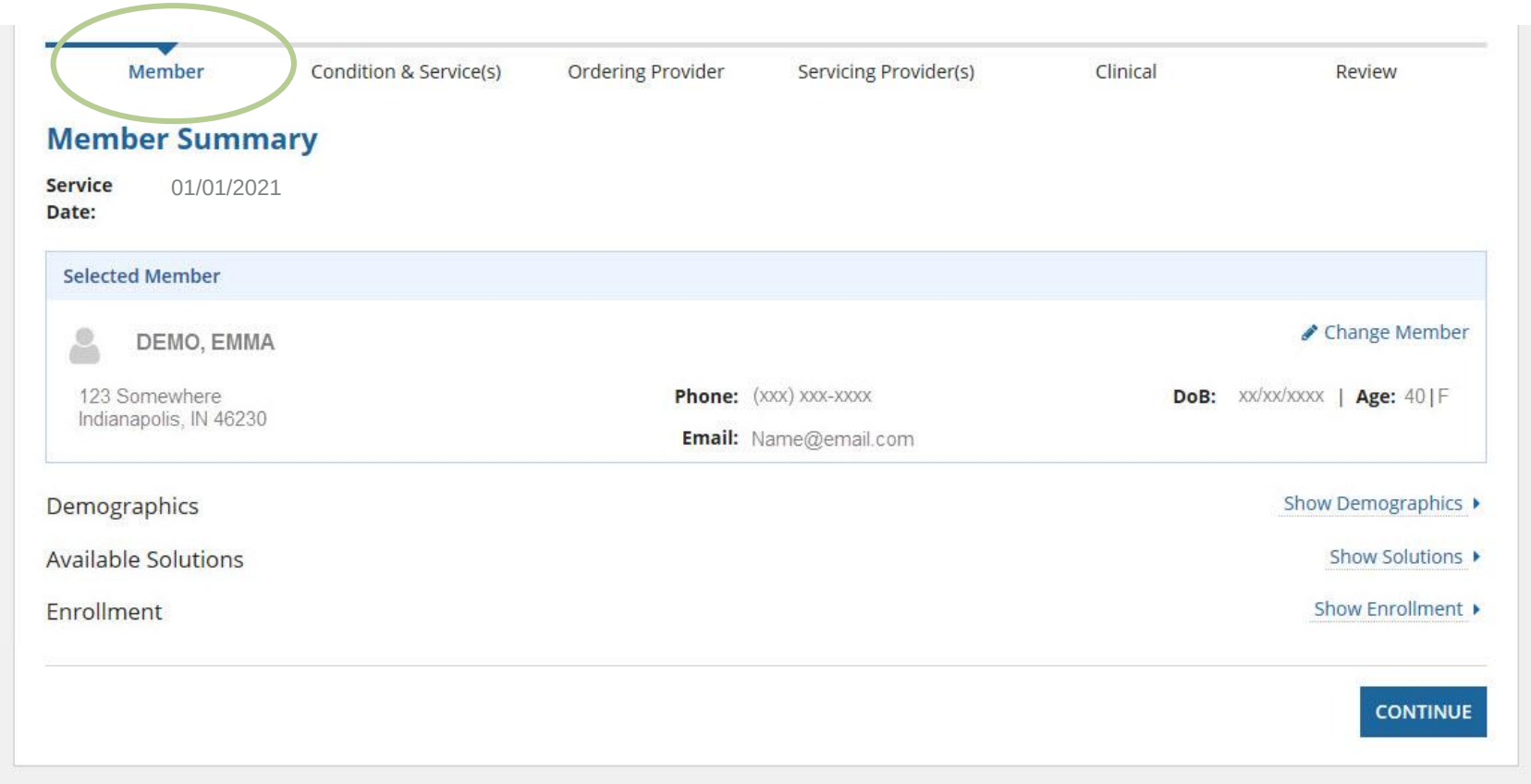
Step 1 – review member information



Select “Continue” to move forward with your request.

If the member is not the correct member, select “Change Member”.

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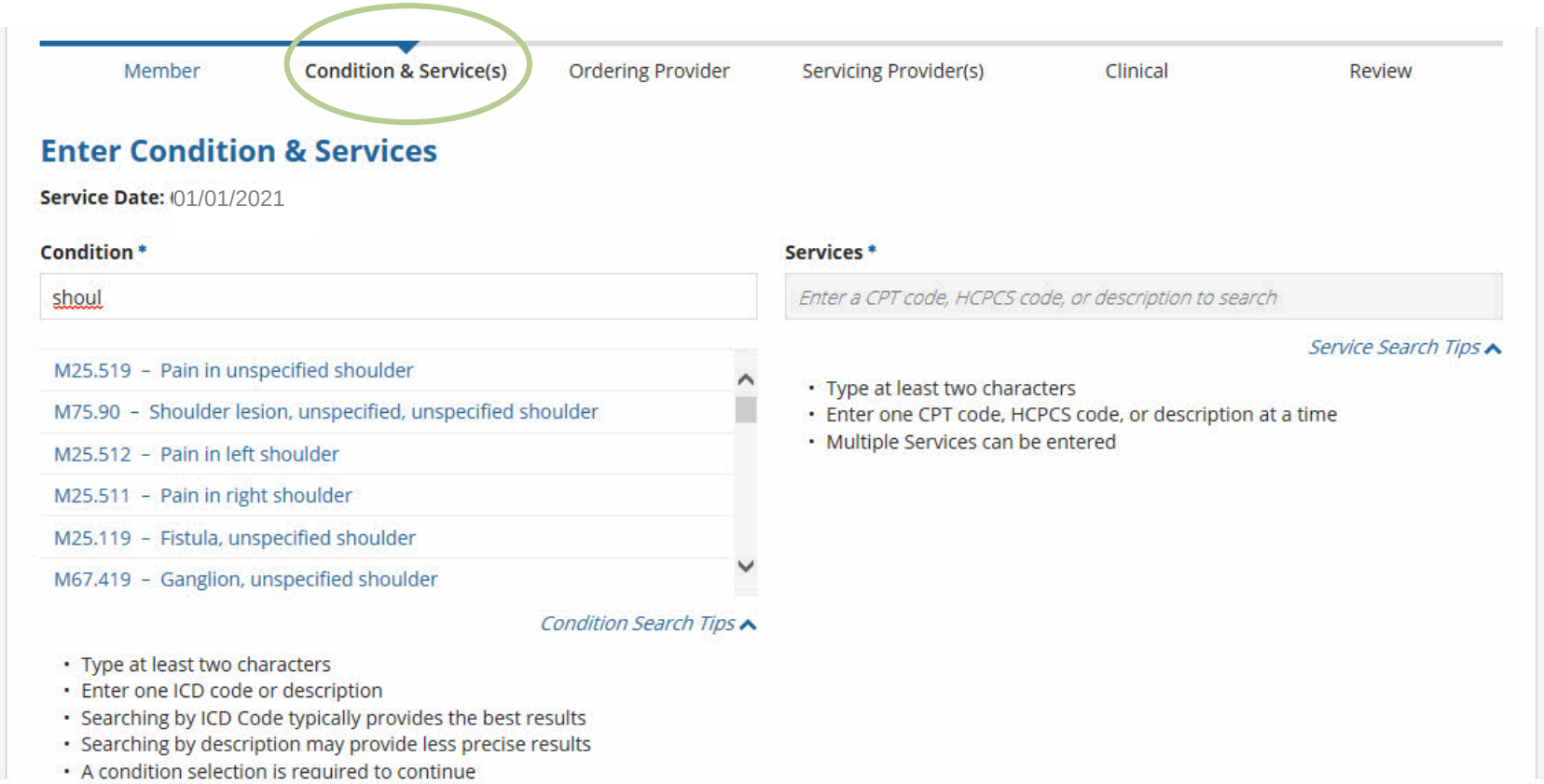
Step 2 – select primary diagnosis



Search for the primary diagnosis by the description or ICD code.

The diagnosis could be the ICD-10 code provided by the ordering / referring physician or if you are in a direct access state, the ICD-10 code that the therapist is allocating for this member.

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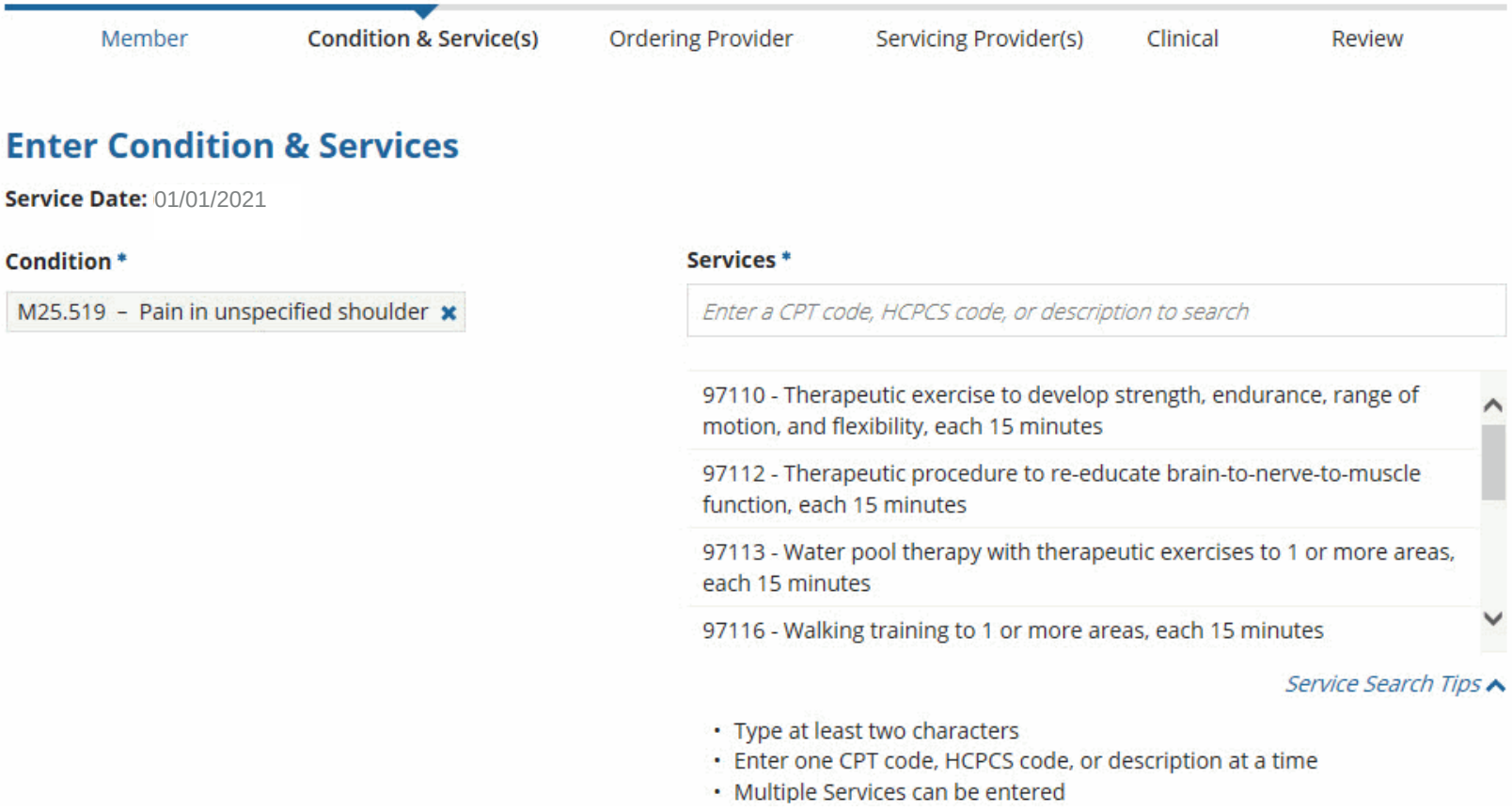
Step 2 – select service(s)



Search for services by the description or the CPT code.

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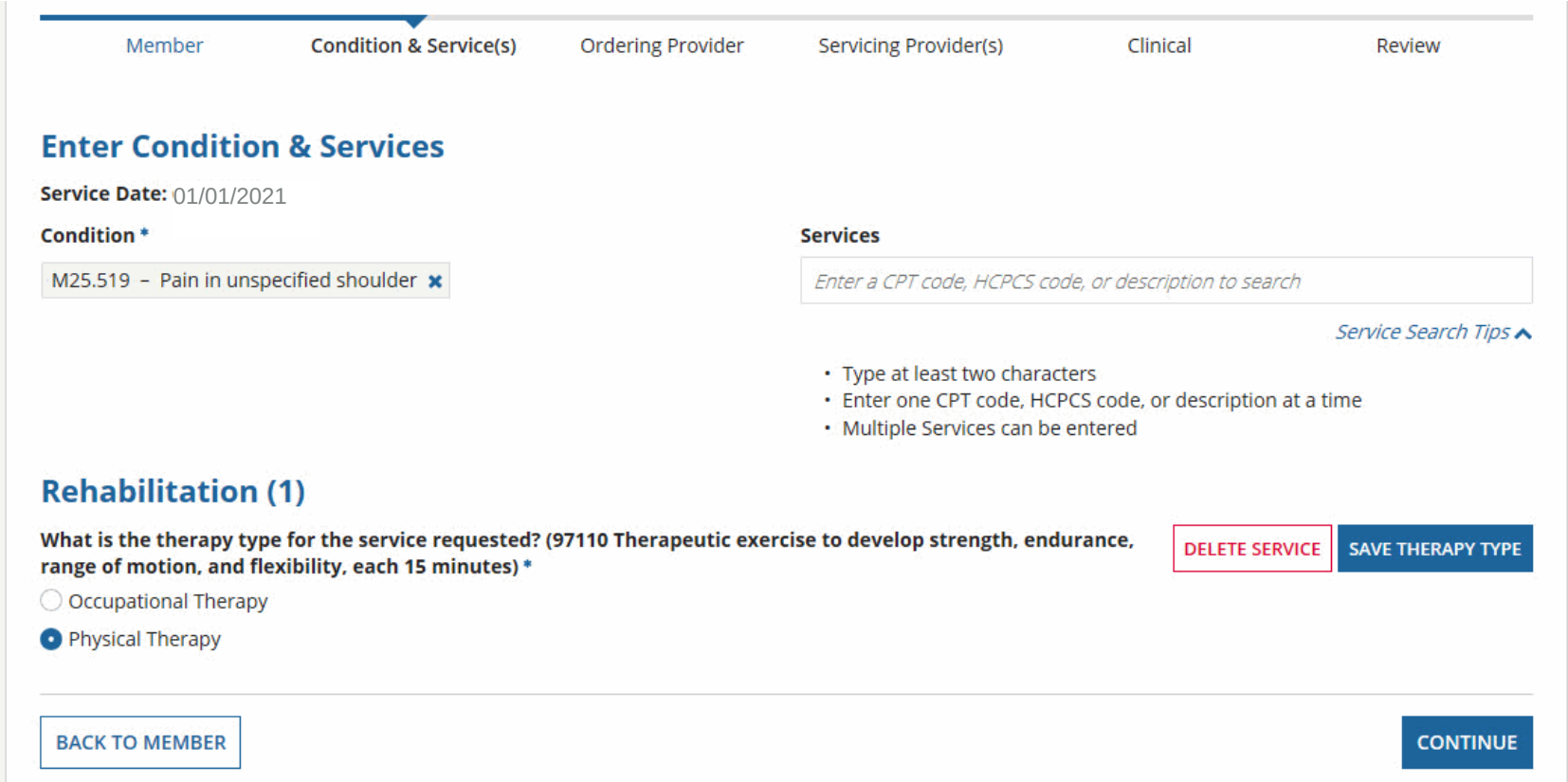
Step 2 – identify the therapy type



When the selected CPT code exists in more than one discipline, the system will prompt you to select which therapy you are requesting.

Once all of the CPT codes have been selected, select the "**Continue**" button.

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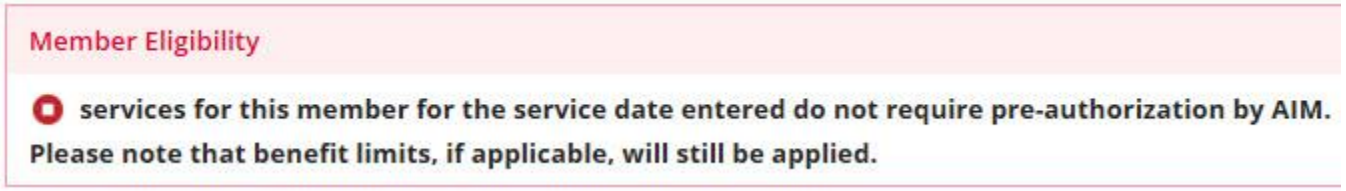
No pre-auth from AIM is required messages

Member is showing as ineligible and is currently not being managed by AIM at this time.



Member is not being managed by AIM for the selected therapy services at this time.

No pre-authorization is required due to member's age.

There are different circumstances where a pre-authorization is not required from AIM at the time of the request.

The system displays one of these message to indicate a pre-authorization is not required from AIM at this time.

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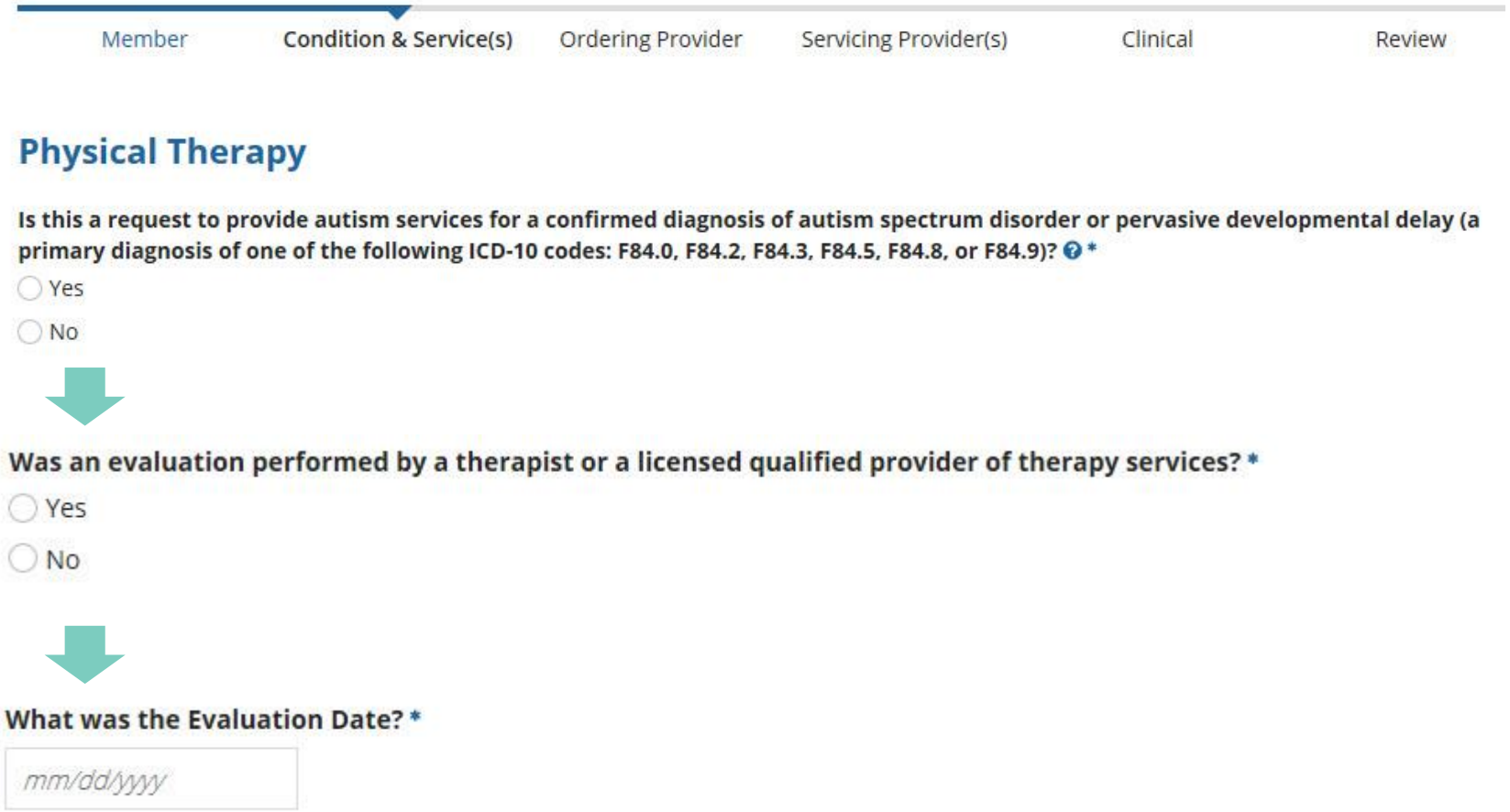
Step 2b – enter episode of care metrics



Enter the episode of care metrics.

1. Indicate if this request is to provide services for a confirmed dx of autism or pervasive developmental delay as specified by the listed ICD codes. (For some members, a "Yes" answer will result in no pre-auth from AIM).

2. Next, indicate if an initial evaluation has been performed. (A "No" answer will provide you with 1 visit to allow you to perform the initial evaluation).

3. If an initial evaluation was performed, enter the initial evaluation date. Please keep this initial evaluation date consistent throughout the episode of care

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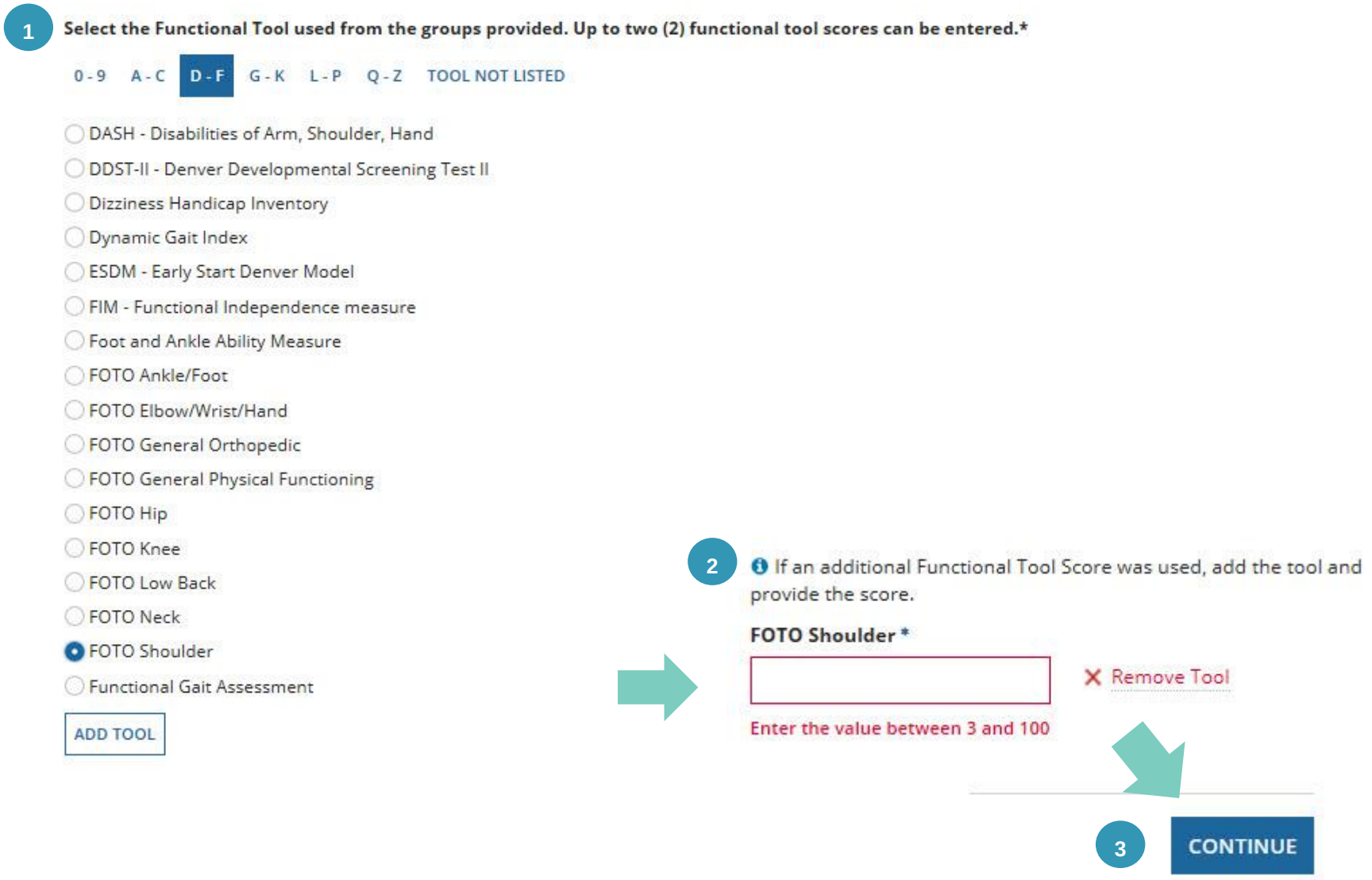
Step 2 – episode of care entry continued



Select the functional outcome tool from the list, which is in alphabetical order. Up to two tools can be selected. If you do not find your tool, please select “Tool not listed” and enter the name of your tool.

1. Once you find your tool, select “Add tool”
2. Then enter the tool score (note there may be some tools that do not require a score).
3. Select “Continue” once done the tool(s) have been selected.

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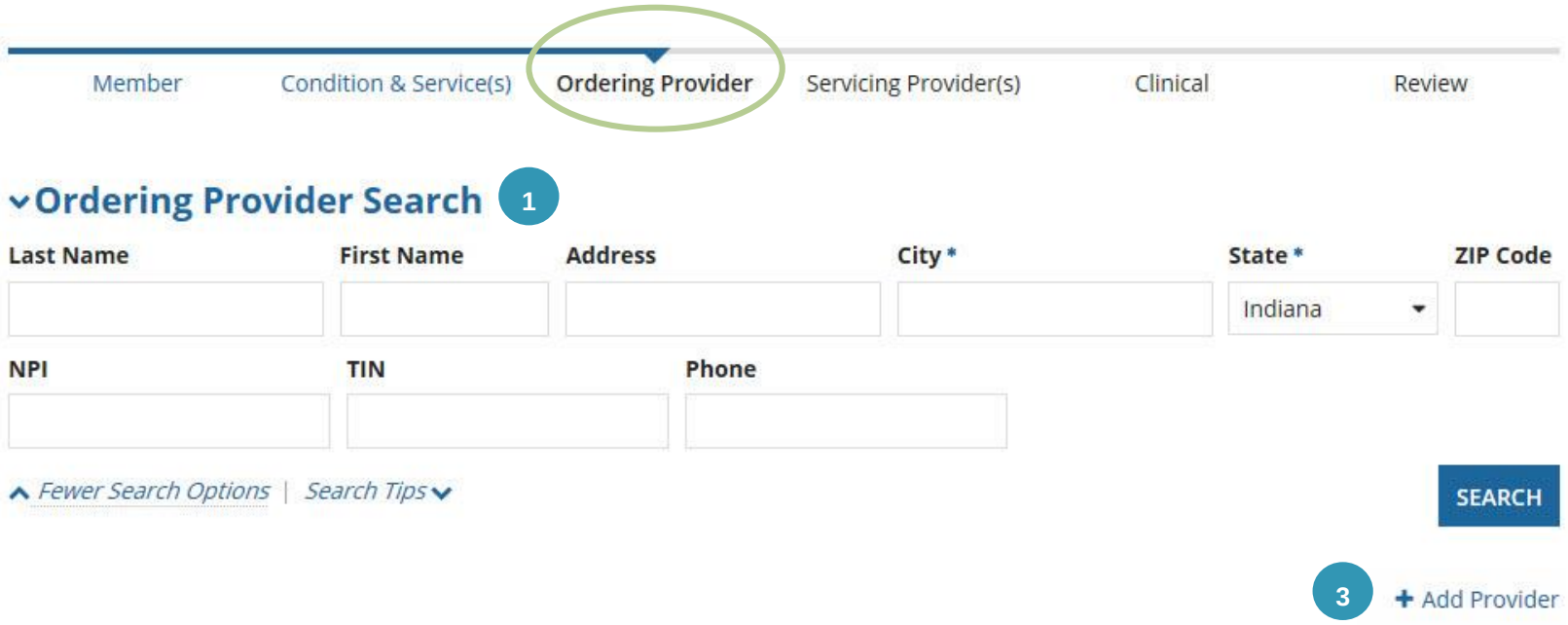
Step 3 – search and select referring provider



1. Search for the referring provider. For commercial plans, for some states there is a direct access option.

   When searching for a provider, the less information entered the better. City and State or Zip code and State are required

   Using the fictitious provider "Joe Smith, TIN 123456789, 3333 Nowhere avenue, Munster, IN, 46321" to illustrate some of the search options below:

   - TIN (or NPI), state and city (example: TIN 123456789, Munster, IN)
   - State, city and part of address (example: IN, Munster, 3333)
   - Part of provider name, city and state (example: Jo, Munster, IN)

2. Select provider if found in results.

3. If provider is not found, select "Add provider" link

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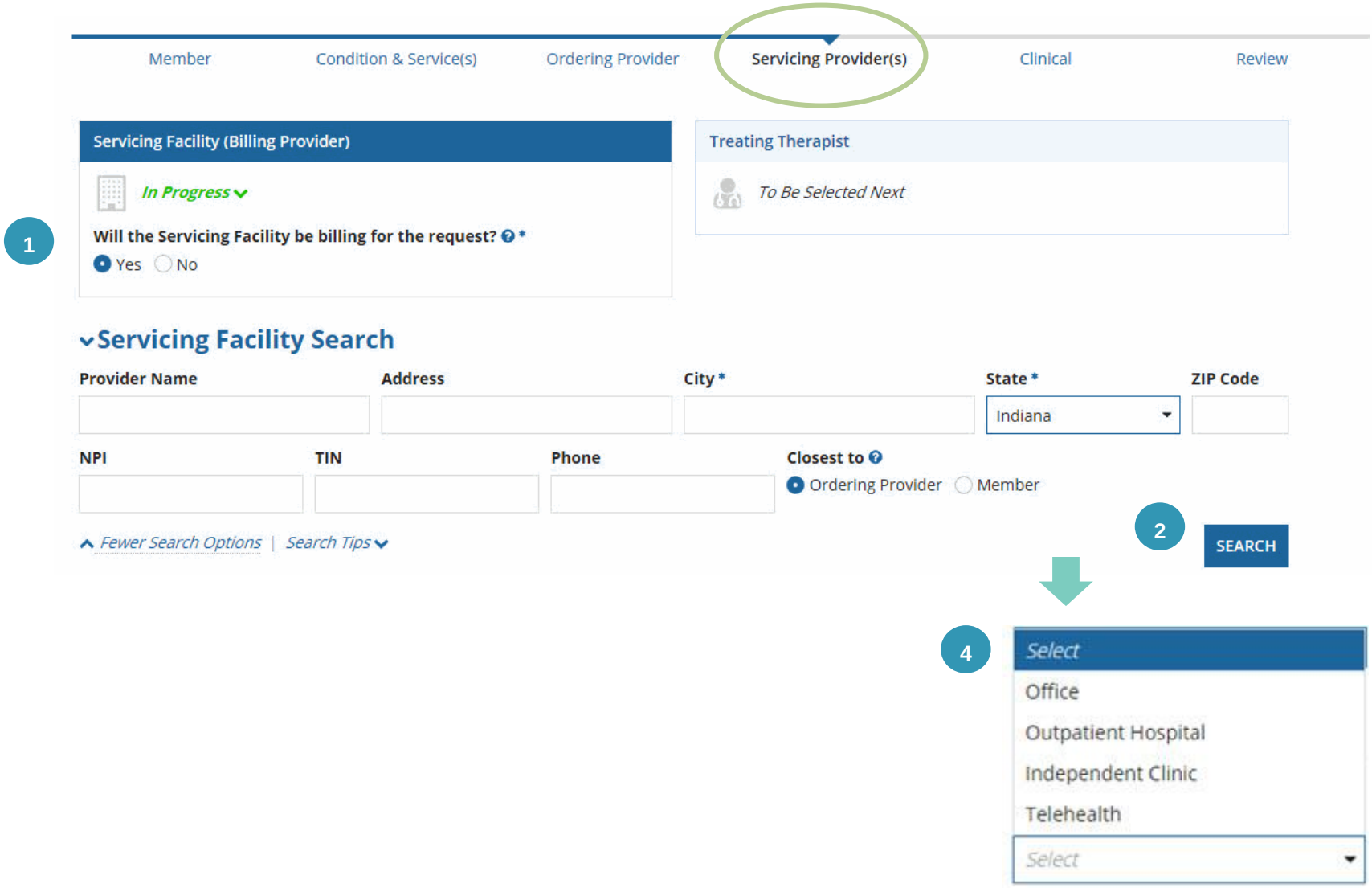
Step 4 – select facility and place of service



1. Identify who is billing (facility or therapist)
2. Search for the facility.

   When searching for a provider, the less information entered the better. City and State or Zip code and State are required

   Using the fictitious provider "ABC Therapy, TIN 123456789, 3333 Nowhere avenue, Munster, IN, 46321" to illustrate some of the search options below:

   - TIN (or NPI), state and city (example: TIN 123456789, Munster, IN)
   - State, city and part of address (example: IN, Munster, 3333)
   - Part of provider name, city and state (example: Therapy, Munster, IN)

3. Select provider if found in results.

   If provider is not found, select "Add provider" link

4. After selecting the facility, select the place of service

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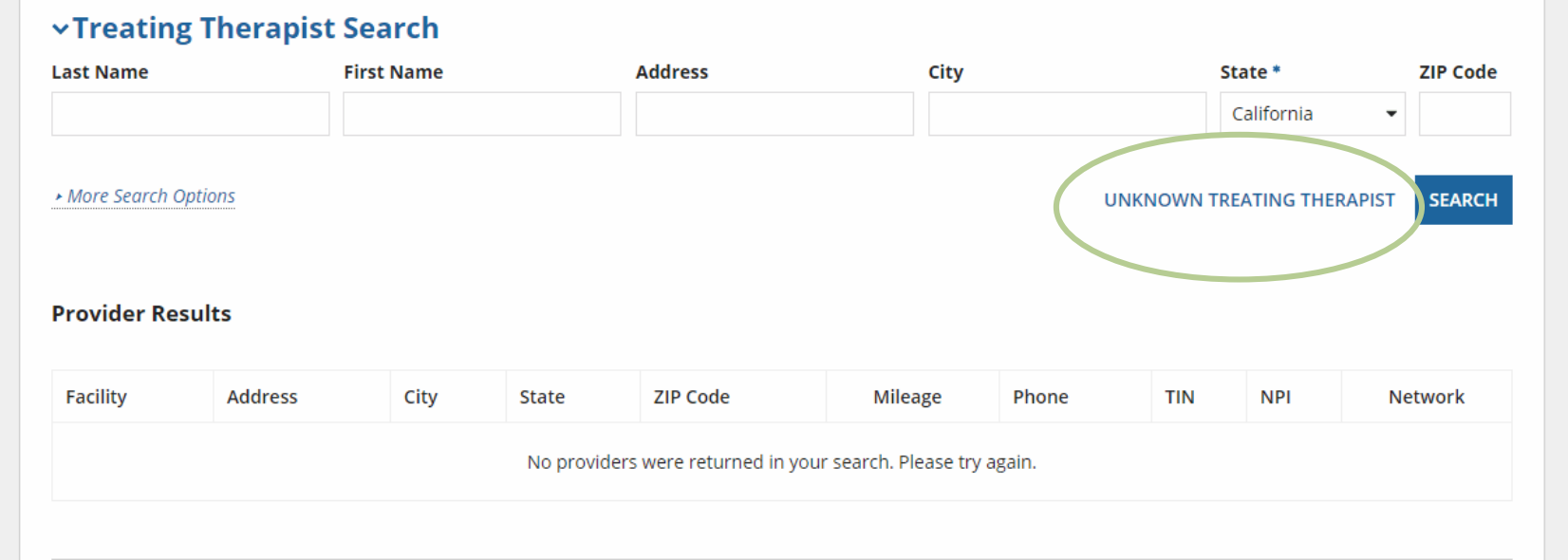
Step 4 – select therapist (optional)



Selecting the treating therapist is optional unless they will be the billing entity.

Otherwise, you can select “Unknown Therapist”

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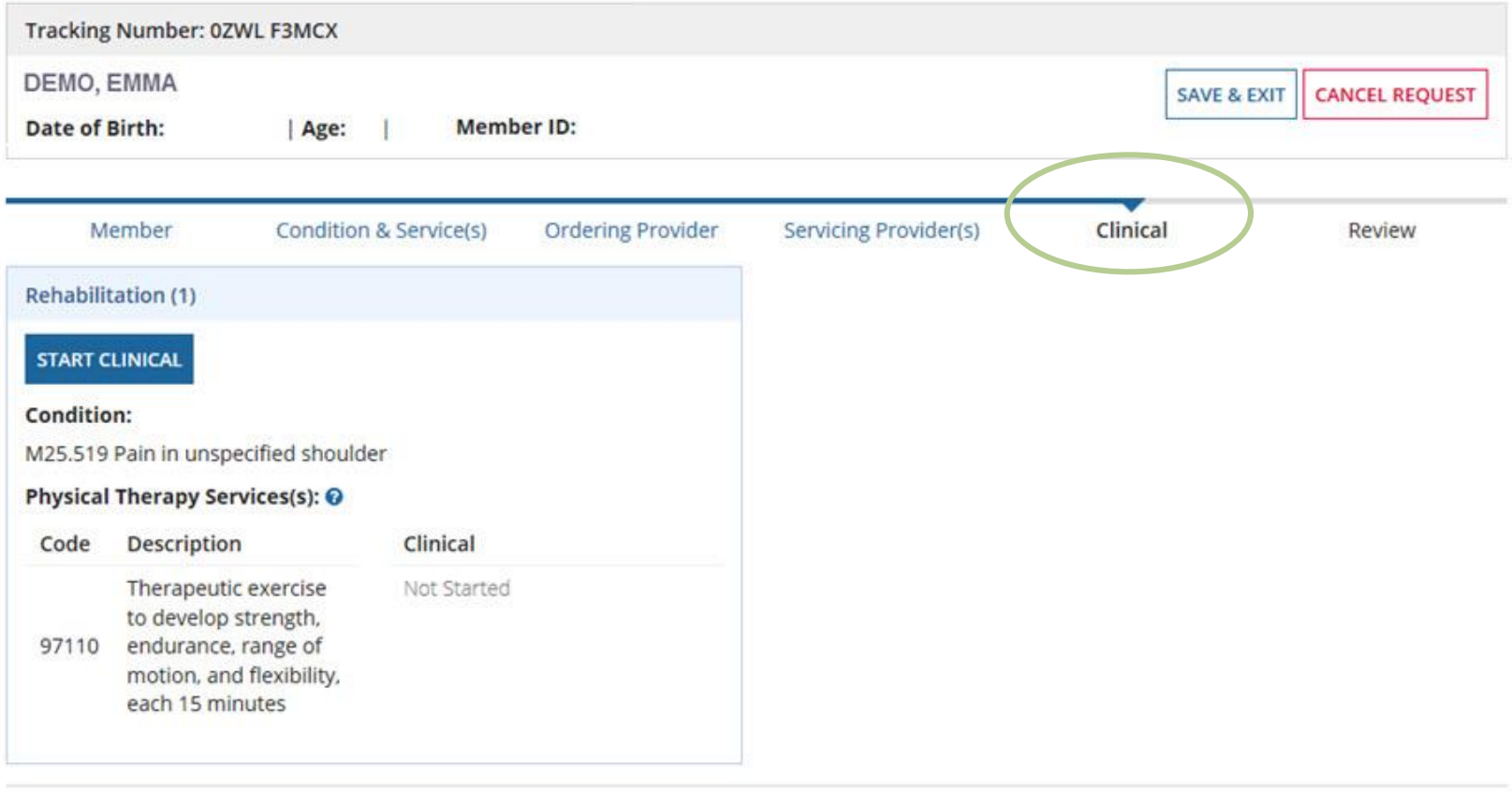
Step 5 – start the clinical entry



Based on the member clinical scenario and whether it is an initial or subsequent request, you will need to answer some clinical questions.

Select “Start clinical” button

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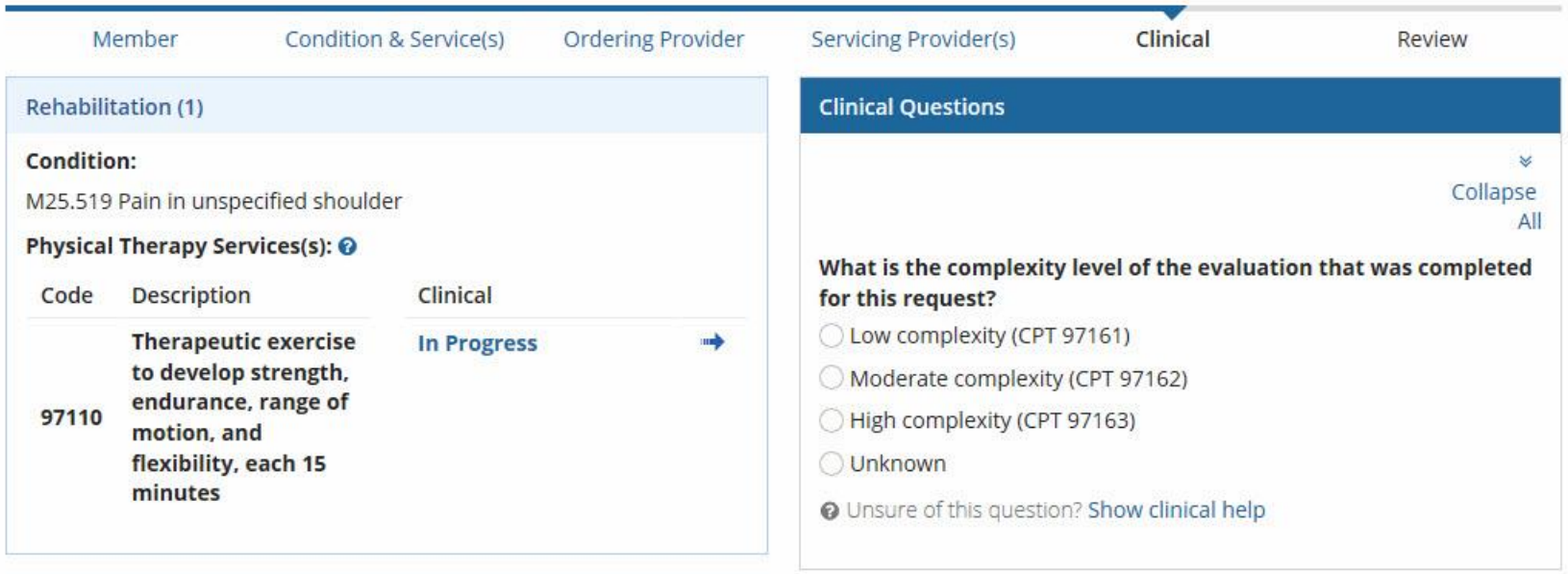
Step 5 – clinical entry

Based on the answer you provide, the next question will be displayed.



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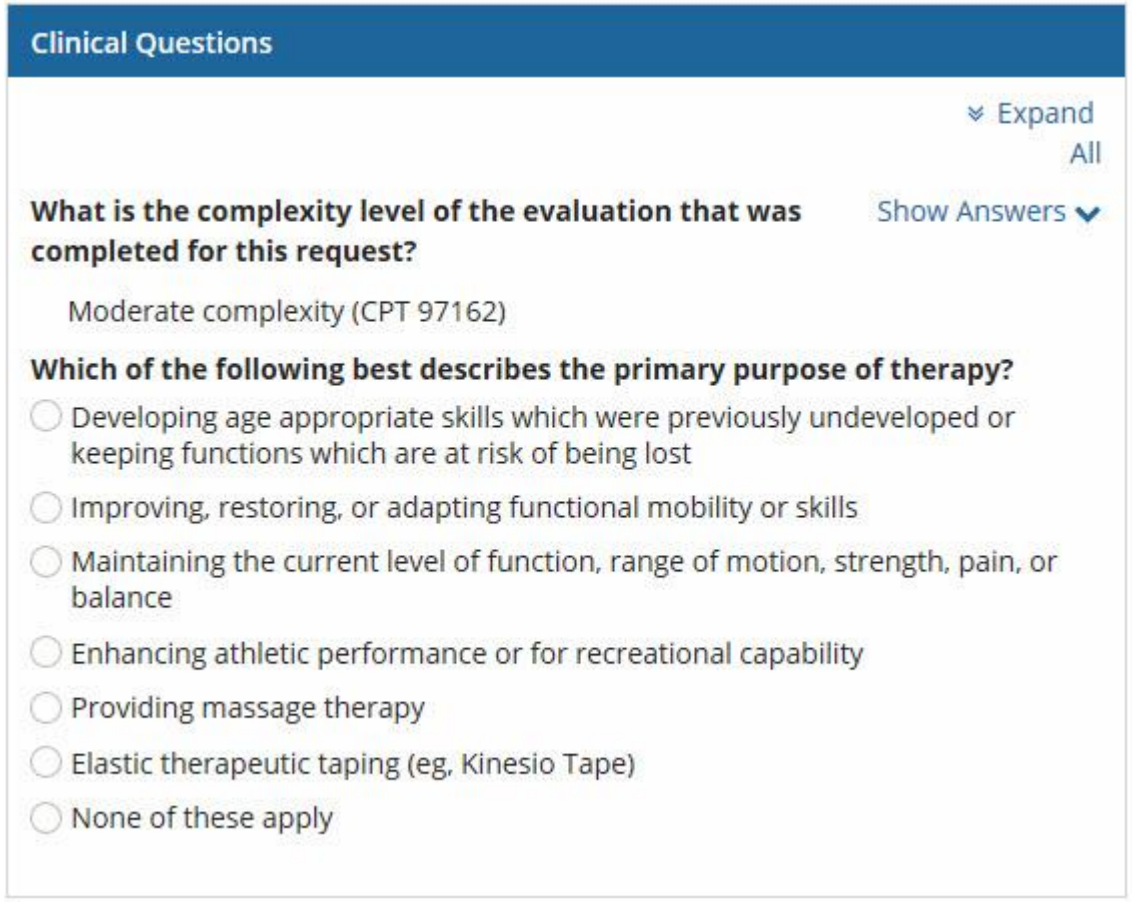
Step 5 – clinical entry



Based on your answer, the next question will display.

You can change the previous answer by selecting “show answers”.

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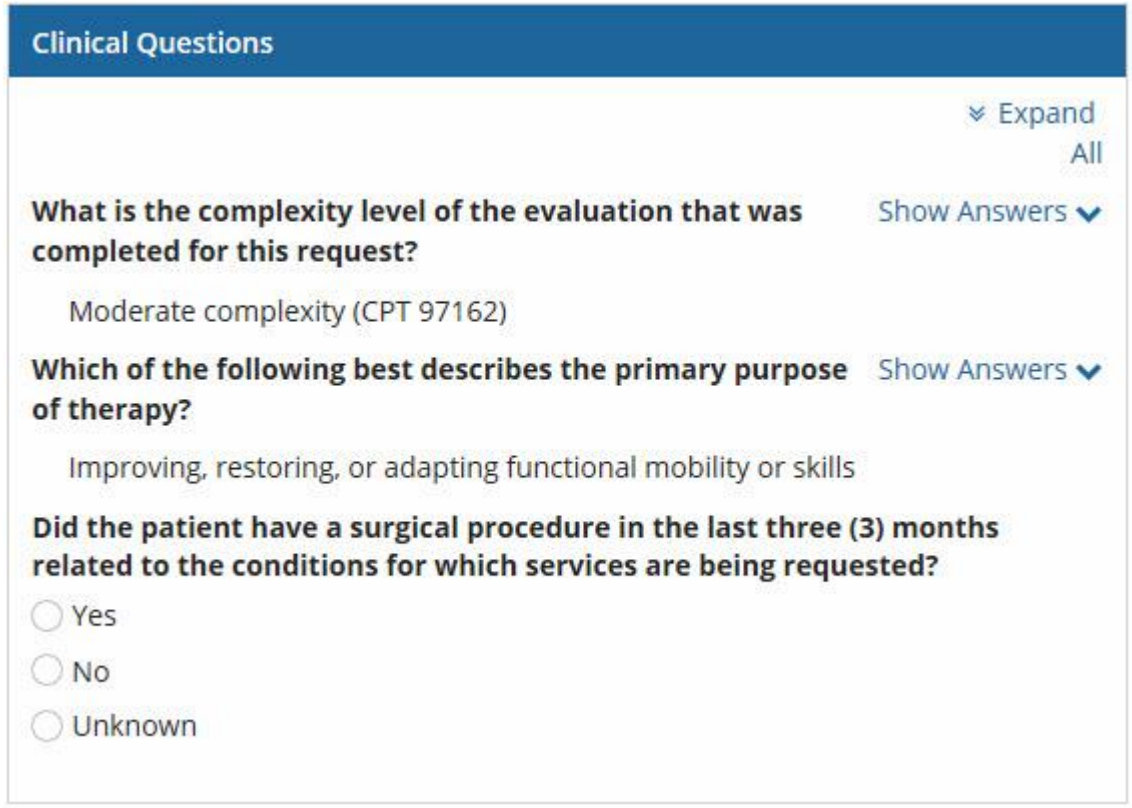
Step 5 – clinical entry



Based on your answer, the next question will display.

You can change the previous answer by selecting “show answers”.

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Step 5 – clinical entry

Did the patient have a surgical procedure in the last three (3) months related to the conditions for which services are being requested? Show Answers

No

Select all conditions expected to impact treatment:

- [ ] Morbid obesity
- [ ] Respiratory disorders
- [ ] Cognitive impairment
- [ ] Diabetes mellitus
- [ ] Musculoskeletal disorders
- [ ] Neurological condition
- [ ] Ongoing dialysis or cancer treatment
- [ ] Current pregnancy or recently postpartum
- [ ] Psychological disorders
- [ ] Uncorrected hearing or vision impairment
- [ ] Social determinants of health
- [ ] None of these apply
- [ ] Unknown

Continue

Unsure of this question? Show clinical help

Based on your answer, the next question will display.

If you need additional information on what is included on some of choices, select “show clinical help” for more details.

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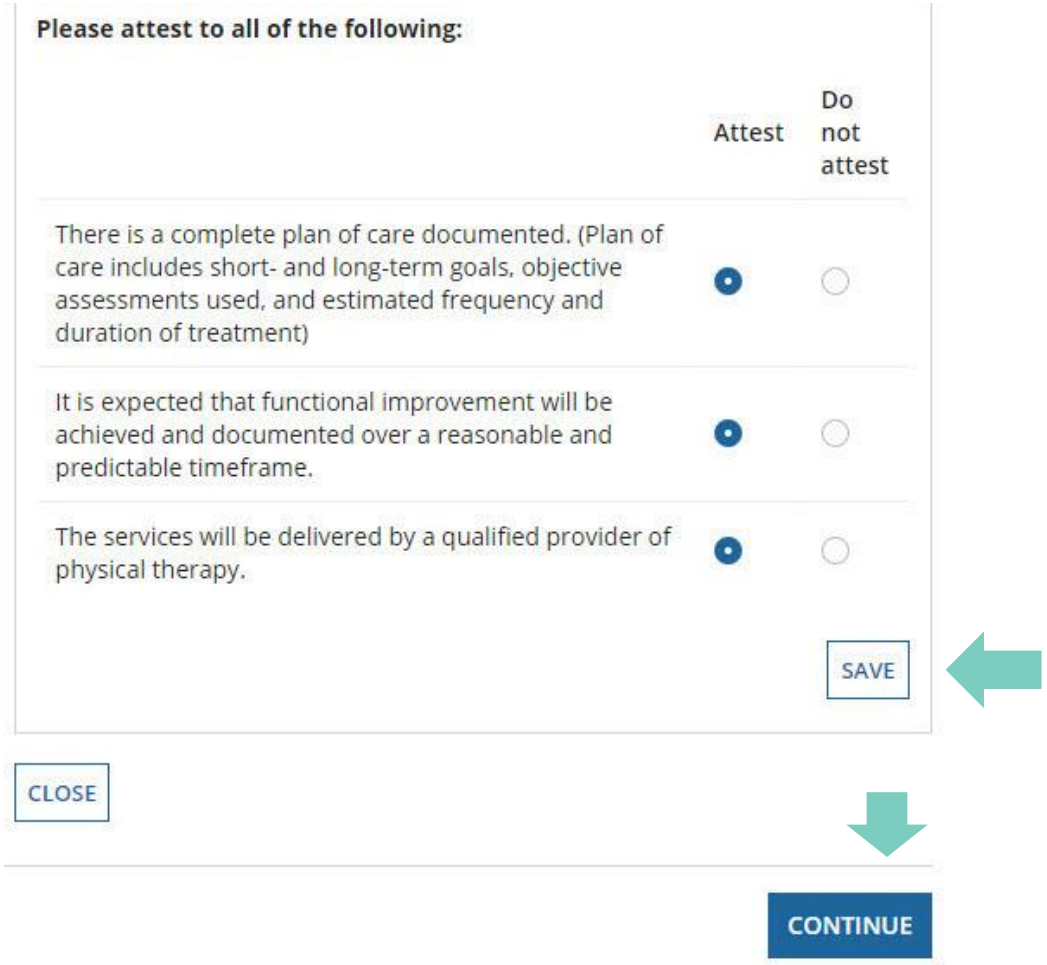
Step 5 – clinical entry



You will be asked to attest to three requirements as specified in the guidelines.

Next, you will need to “save” your answers and select “Continue”.

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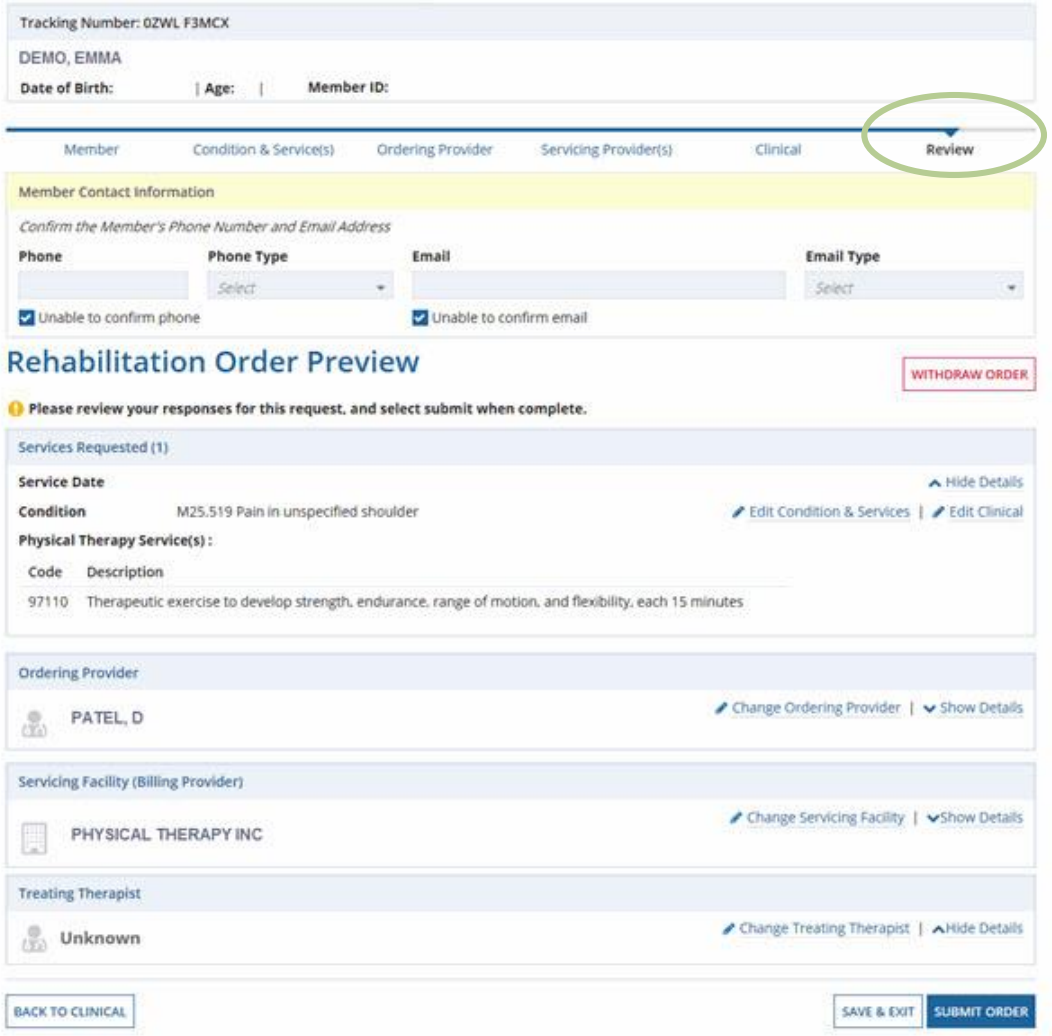
Step 6 – review collected information



The Order Request Preview allows you to review the information prior to submission and make any necessary modifications

Press the “Submit This Request” button once you have verified all of the information.

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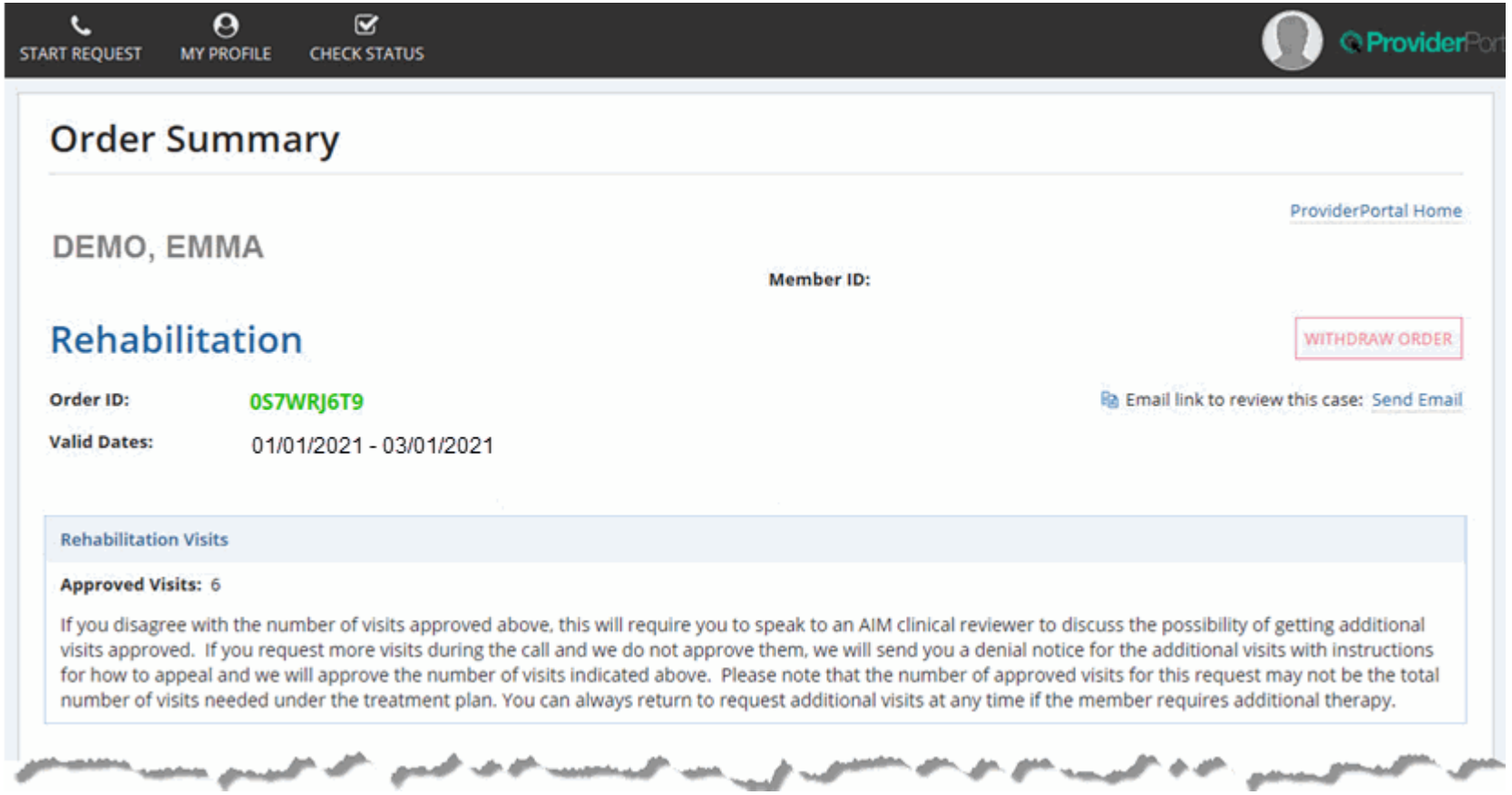
Order request results (after submission)



Requests that meet clinical criteria will be receive an immediate response with an Order number, approved visits and authorization valid timeframe.

Please note that the number of approved visits for this request may not be the total number of visits needed under the treatment plan. You can always return to request additional visits if the member requires additional therapy

If the request does not meet criteria, your request will be sent for clinical review. You can contact AIM to discuss your request at any time.

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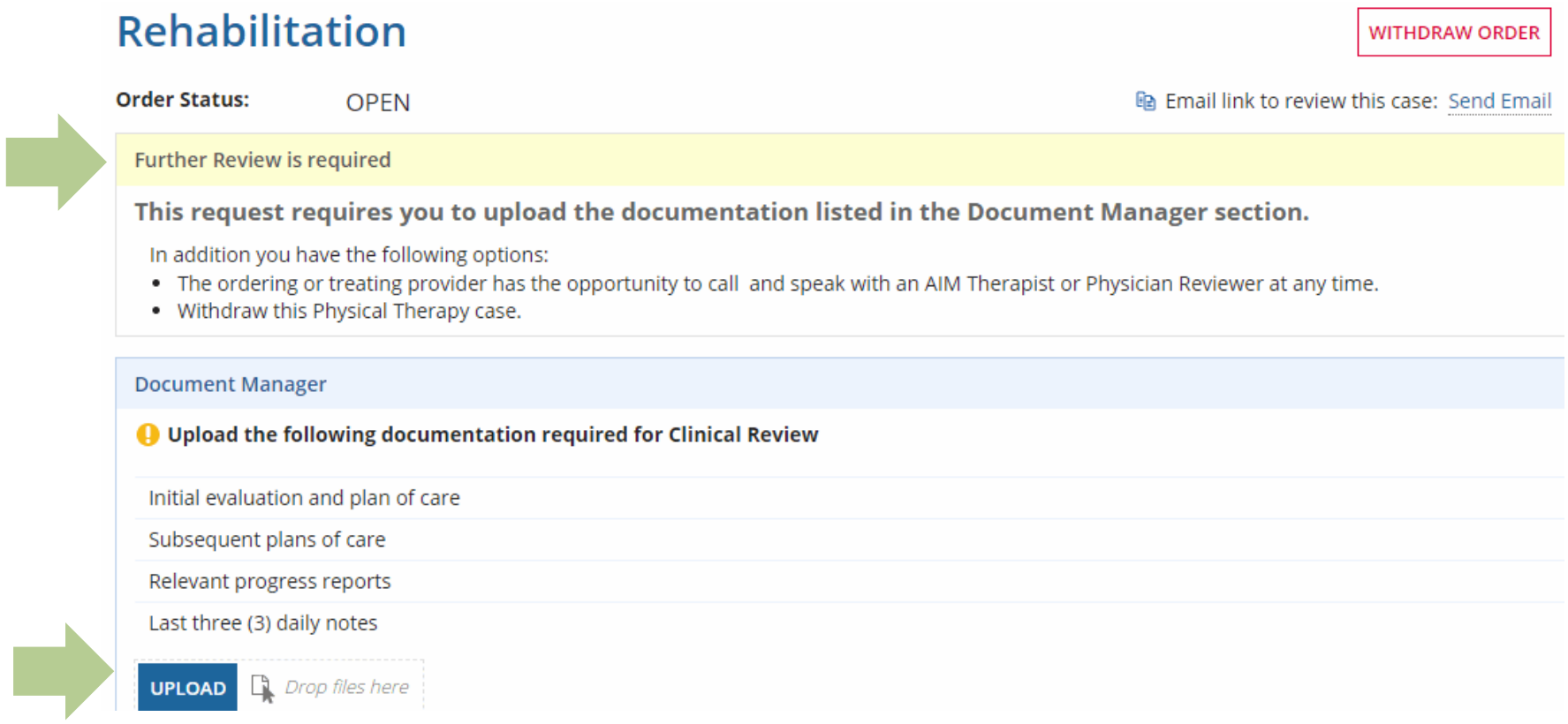
When uploads are required



When documentation is required, the system will indicate that an upload of documents is needed.

The list of requested documents can be found in the document manager.

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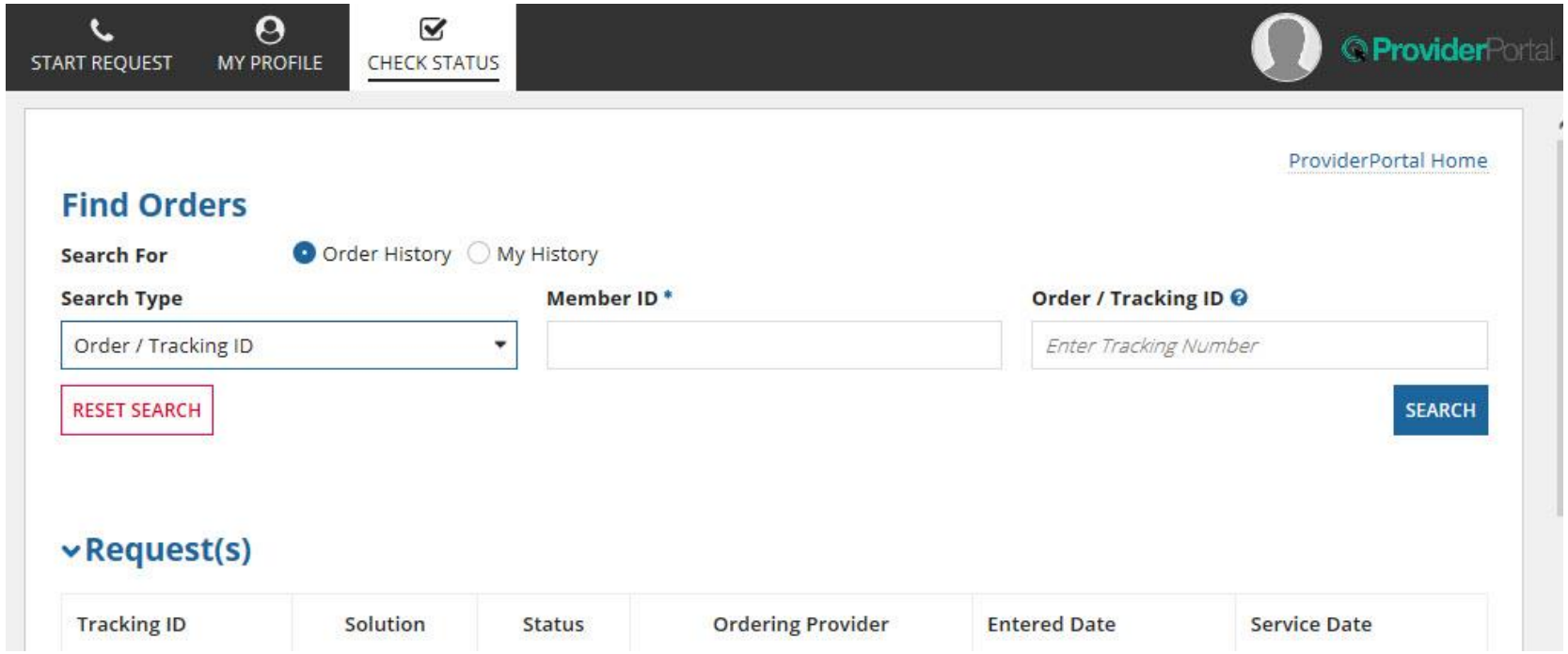
Finding a case using the tracking number



After submitting a request, you will be able to find out the status and review the information, by selecting “Check Status”.

Also while creating a request if you need to stop and finish later, select the “Save and Exit” button at time during the request creation. You can utilize the “Check Status” button to find and continue with your request.

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QUESTIONS

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Thank you for attending!

Rehabilitation Management Program provider website:
https://aimspecialtyhealth.com/solutions/health-plans/clinical-solutions/rehabilitation/

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Healthy Blue.

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