

PROVIDER ORIENTATION

SOONERCARE SCHOOL-BASED SERVICES
THERAPY MANAGEMENT PROGRAM



PRESENTATION OBJECTIVES

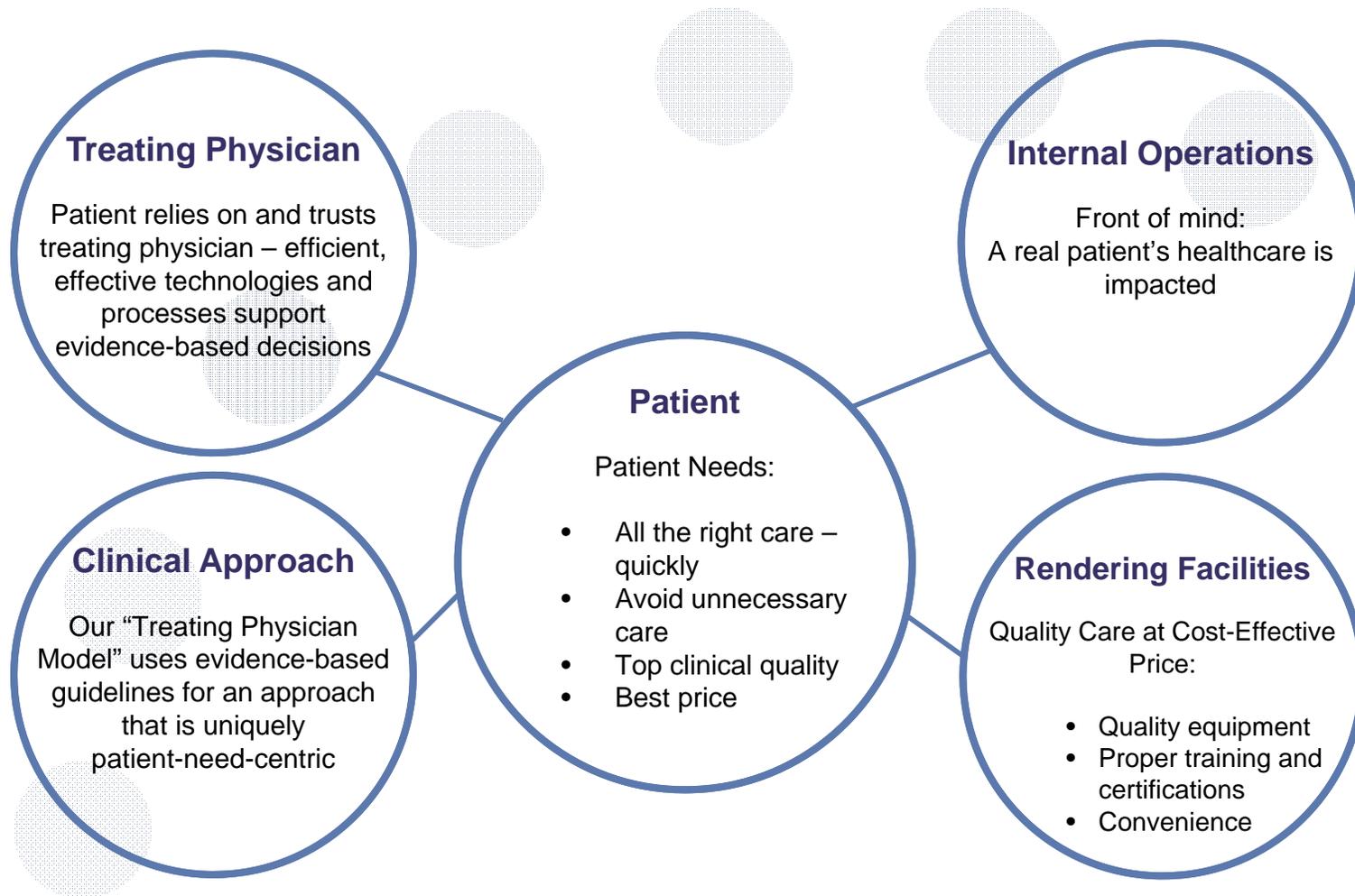
- ❖ Introduction to eviCore healthcare
- ❖ Scope of the therapy management prior authorization requirements
- ❖ Submission of musculoskeletal prior authorization requests to eviCore healthcare
- ❖ Responsibilities of the ordering provider and the rendering provider
- ❖ Resources available for more information



Who is eviCore healthcare?

- ❖ eviCore healthcare has taken the clinical knowledge, proprietary technology, and forward thinking we perfected in radiology management and applied it to other areas of healthcare where we see opportunity for significant improvement, both in quality of care and in cost savings to health plans.
 - ❖ eviCore healthcare continues to evolve to meet the challenges of the healthcare industry through intelligent cost management, to develop and introduce new services that extend beyond utilization management, to capture maximum savings, to reduce overall treatment costs, and to ensure diagnostic accuracy.
- **Advanced Imaging**
 - **Cardiac Imaging**
 - **Cardiac Rhythm Devices (CRD)**
 - **Lumbar Spine Surgery**
 - **Musculoskeletal Management**
 - **Post-Acute Care**
 - **Radiation Therapy**
 - **Sleep Management**
 - **Ultrasound**

Our Guiding Principle: Patient Centric View



OUR CLINICAL APPROACH



Clinical Platform: Multi-Specialty Expertise

Family Medicine	Oncology/Hematology
Internal Medicine	Radiology
Pediatrics	Therapy
Sports Medicine	<ul style="list-style-type: none">• Physical• Occupational• Speech
OB/GYN	
Cardiology	Musculoskeletal
Nuclear Medicine	<ul style="list-style-type: none">• Orthopedic Surgery• Spine Surgery• Interventional Pain
Anesthesiology	
Radiation Oncology	
Sleep Medicine	

Multi-Specialty Expertise

- 190+ Board Certified Medical Directors
- Diverse representation of medical specialties
- 700 nurses with diverse specialties and experience
- Dedicated provider teams by specialty for Therapy

Evidence-Based Guidelines

- **Policies developed by panels of multi-disciplinary provider specialists who form:**
 - **Medical Operations Committee (MOC)**
 - **Academic Advisory Committee (AAC)**
 - **Medical Quality Improvement Committee (MQIC)**
- **Review current scientific literature**

- American College of Cardiology
- American Heart Association
- American Society of Nuclear Cardiology
- Heart Rhythm Society
- American College of Radiology
- American Academy of Neurology
- American College of Chest Physicians
- American College of Rheumatology
- American Academy of Sleep Medicine
- American Urological Association
- National Comprehensive Cancer Network
- American College of Therapeutic Radiology and Oncology
- American Society for Radiation Oncology
- American Society of Clinical Oncology
- American Society of Colon and Rectal Surgeons
- American Academy of Orthopedic Surgeons
- North American Spine Society
- American Association of Neurological Surgeons

SERVICE MODEL



The New World of eviCore healthcare Service Delivery

Client Service Delivery Team:

The client service delivery organization is responsible for overall service delivery not only to our health plan clients, but to ordering and rendering providers nationwide.



Client service representatives serve as designated “intake” phone and email specialists cross-trained to handle all routine provider and health plan issues. They insure that all incoming issues are logged in our Cherwell system and tracked through to completion.



Client service specialists serve as the primary contact for account executives, health plans, and high profile provider clients for complex issues. The specialists also handle escalated issues generated through the Client Service Representative Team.



The regional manager is a local, on-the-ground resource who serves as the voice of eviCore healthcare to the provider community.

Why Our Service Delivery Model Works

1. One centralized intake point allows for timely identification, tracking, trending and reporting of all issues. It also enables eviCore healthcare to quickly identify and respond to systemic issues impacting multiple providers.
2. Routine issues are handled by a team of representatives who are cross trained to respond to a variety of issues. There is no reliance on a single individual to respond to your needs.
3. Complex issues are escalated to resources dedicated to specific providers, who are the subject matter experts, and can quickly coordinate with matrix partners to address issues at a root cause level.

At eviCore healthcare our focus is ensuring we are delivering a service experience based on a quality encounter with our team members and a singular focus on issue resolution in a timely and accurate manner.

School-based Therapy Management Prior Authorization Program



Program Overview

eviCore healthcare will begin accepting requests on **June 15, 2015 for dates of service July 1, 2015 and beyond.**

Prior authorization applies to therapy services that are:

- Outpatient
- School-based

Specialized therapy services that require prior authorization:

- Occupational Therapy
- Physical Therapy
- Speech Therapy

It is the responsibility of the ordering provider to request prior authorization approval for services. **It is required for the treating provider to furnish the referral or order for the requested services.**

Applicable Membership

Authorization is required for Oklahoma Health Care Authority members enrolled in the following programs:

- SoonerCare children under 21

Members who do not require prior authorization are:

- SoonerCare adults 21 and over

Prior Authorization Requests

There are three ways to request prior authorization:



Web Portal

www.triadhealthcareinc.com/providers



Fax

(888) 328-3662

Fax forms available:

www.triadhealthcareinc.com/soonericare



Phone

(888) 693-3281

8:00 a.m. to 6:00 p.m. (CST)

Monday through Friday

You may also request fax forms by contacting eviCore healthcare at (888) 693-3281. Only eviCore healthcare fax forms will be accepted.

Needed Information

MEMBER:

- Member ID
- Member Name
- Date of Birth (DOB)

Rendering Provider/School Information

- School Name
- OCHA Provider Identification Number
- National Provider Identifier (NPI)
- Phone and Fax Numbers

REQUEST:

- CPT Code(s)
- TM modifier for school-based services
- The Diagnosis Code(s) (ICD-9) for the working of differential diagnosis

Referring Provider: MD referring the patient for therapy services

- Provider Name
- National Provider Identifier (NPI)
- Phone Number

Separate prior authorization requests must be submitted for school-based therapy and outpatient therapy services. School-based therapy requests must include a 'TM' modifier with the CPT code.

Prior Authorization Fax Form



MED SOLUTIONS
INTELLIGENT COST MANAGEMENT



Oklahoma
HealthCare
Authority

Therapy Management Authorization Fax Form

MEDICAL RECORDS ARE REQUIRED WITH THIS FORM
Please fax this form and medical records to MedSolutions at 888-328-3662

MEMBER INFORMATION - Who is receiving services?

Member Name: _____ Date of Birth: _____
 Member ID Number: _____ Male Female

RENDERING PROVIDER INFORMATION - Who is billing for or rendering services?

Rendering Provider Name: _____ Office Contact: _____
 OHCA Provider ID: _____ NPI: _____
 Provider Street Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____

REFERRING PROVIDER - MD referral required and copy of referral must be included with submitted medical records.

Referring Provider Name: _____ NPI: _____
 Phone: _____ Fax: _____ OHCA ID: _____
 Street Address: _____ Zip: _____

REQUESTED SERVICES

Service Type (check one only*): Physical Therapy Occupational Therapy Speech
*Separate authorization is required for each Type of Service.

For Speech, indicate primary language spoken by patient in home setting, if other than English: _____
 Can speech therapist evaluate and treat in patient's primary spoken language? YES NO

Anticipated Date of Service: _____ Anticipated Number of Visits: _____
 Duration of Care: 30 Days 60 Days 90 Days Duration of Session (minutes): _____

Diagnoses:
 Code _____ Code _____ Code _____ Code _____ Code _____

CPT Codes: Requested CPT Codes and total number of units per CPT Code for the duration of care.

	Code	Units	Modifiers		Code	Units	Modifiers
A	_____	_____	_____	E	_____	_____	_____
B	_____	_____	_____	F	_____	_____	_____
C	_____	_____	_____	G	_____	_____	_____
D	_____	_____	_____	H	_____	_____	_____

Submission of this form, without complete medical records, as noted below, will limit our ability to administer prior authorizations and may result in a denial. Please include the following:

- Signed Provider Referral and Referring Providers Note to Document Need for Services
- Exam Narrative / Office Notes
- Diagnostic Test Results
- Include Detailed Documentation of Visits with Parental Engagement
- Parental Consent Form

PRV-CP-FM-022-003 (04/14/2015)

Required Documentation

- **Exam narrative/office notes**
 - Referring physician note must specify the need for therapy
- **Referral**
 - Signed, dated and therapy specific dated within a year of the request
- **Evaluation Notes**
 - Objective measures of functioning
 - Subjective measures of functioning
 - Short/Long term goals
 - Length of time to reach goals
 - Expectations for progress
- **Diagnostic Test Results**
 - Standardized scores
 - Percentage of age equivalency
 - Severity rating of an objective measure of function

Required Documentation (CONT).

- Parental Consent Form
 - Dated within the year and submitted once per year
- Parental Participation: documentation of the % and method used is required
 - Required for 50% of treatment sessions
 - Phone calls
 - Email
 - Direct participation in therapy
 - Homework notebook/log
- Change of provider form (if applicable)

Incomplete medical records will limit our ability to administer prior authorizations and may result in a denial.

Change of Provider Form



Change of Provider

Prior Authorization Form

Member Name: _____
Member RID #: _____
Service Being Rendered: _____

I (print name of member/parent/legal guardian) _____
hereby wish to change the above listed services being provided by
(print name of previous provider) _____
to (print name of New provider) _____
effective _____ (date the change is to take place).

Signature of Member or Parent/Legal Guardian if a minor

Date Signed by Member/Parent/Legal Guardian

Relationship to Member

****If member is in a Nursing Facility, Please complete the below information****

The Nursing Facility _____ has validated that this member has notified
the previous provider, if applicable, of their desire to change providers.

Signed By _____ Nursing Facility Attendant

Printed Name: _____ Nursing Facility Position (LPN, Administrator, etc.)

****Please Note: Form must be completed in its entirety or will be considered incomplete and will not be accepted. Also, the effective date of change will depend on current billing cycle.****

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Parental Consent Form

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STATE OF OKLAHOMA
Oklahoma Health Care Authority

Parental Consent Form

Member Name: _____
Member RID #: _____
Member Diagnosis: _____

I _____ (print name of parent/legal guardian) hereby authorize _____ (print name of provider) to evaluate, as well as provide any subsequent treatment based on the evaluation results for Physical Therapy, Occupational Therapy and/or Speech Therapy (circle all services that apply) for child named above.

Signature of Parent/Legal Guardian

Date Signed by Parent/Legal Guardian

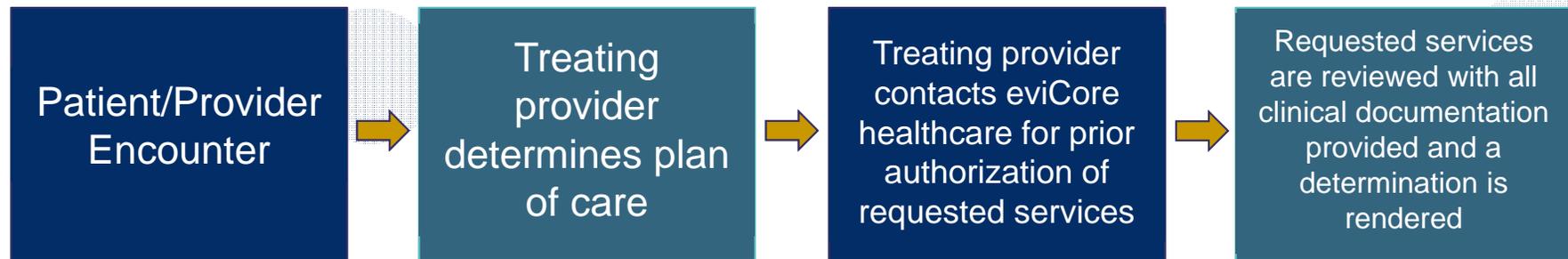
Relationship to Member

Signature of Therapist or Representative of Therapy Group

Date Signed by Provider

****Please Note Form must be completed in its entirety or will be considered incomplete and will not be accepted****

Prior Authorization Process Workflow



Prior Authorization

- **In compliance with NCQA and other regulations, all requests are processed within 14 calendar days after the original request. It is our business practice to complete requests within 2 business days from the receipt of complete clinical information.**
- **Approval determinations are communicated in the following manner:**
 - Faxed to the requesting provider if request was submitted by fax
 - Email notification if submitted on portal
 - Mailed to the member
- **Denial determinations are communicated in the following manner:**
 - Faxed to requesting provider if request was submitted by fax
 - Email notification if submitted on portal
 - Mailed to the member
 - Includes the rationale for denial, how to request a peer to peer discussion

Sample Authorization



730 Cool Springs Boulevard, Suite 800, Franklin, TN 37067
 Fax: 888-693-3210/ Phone: 888-693-3281

Pre-Authorization Fax

Case ID: 123456 Case Type: Web Submission
 Auth ID: A456789101 Effective: 06/01/2015
 Status: Approved Expires: 07/01/2015
 Modifier: Physical Therapy

Patient Information

Name: Super Man DOB: 01/02/03
 HP Member ID: 550055005 Health Plan: Soonercare
 Address: 1 Street Avenue Phone:
 OKC, OK 73101

Performing Provider Information

Referral to: Donald Duck Therapy Health Plan ID: 100200300A
 Address: 1 Duck Lane Phone:
 OKC, OK 73101 Fax: 5558655309

Referring Physician Information

Procedure Requested by: Bat Man Health Plan ID: 200300200A
 Address: 1 Gotham Lane Phone:
 OKC, OK 73101 Fax: 55778899
 Specialty: Referring Provider Specialty

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Clinical Information

Requested ICD-9/10 Codes: 781.2
 Requested Duration of Care: 60
 Authorized Duration of Care: 60

CPT Code	Code Description	Requested Units	Approved Units
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength	24	24

Fax sent to Donald Duck Therapy on 05/25/2015

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Post Decision Discussions

- **Reconsiderations:**

- Not allowed with this program

- **Peer to Peer Discussion:**

- If a provider receives a denial of a request for prior authorization, he or she may speak with a peer reviewer in the same or similar specialty. The peer will:
 - Clarify and explain clinical rationale, clinical logic and the medical evidence used in the determinations
 - Discuss unique requirements of each patient or clinical scenario
 - A peer to peer discussion may be scheduled by calling: (888) 693-3281

Special Circumstances

RETROSPECTIVE REVIEW:

- Initial 90 days of program will allow retrospective reviews
- Terminate on October 1, 2015

RETROSPECTIVE REVIEWS **EXCEPTION:**

- TEFRA Members
 - Providers have 30 days from the parents award letter to submit for services previously rendered
 - Award letter must be included to avoid a delay in review for medical necessity

WEB PORTAL SERVICES



Secure Web Portal

www.triadhealthcareinc.com/providers

- **Select provider portal from drop down menu**
- **You must register prior to the submission of a prior authorization**
- **Medical records can be uploaded if you have the ability to do so**

Secure Web Portal

The screenshot shows a web browser window displaying the Triad Healthcare Provider Portal. The browser's address bar shows the URL: <https://secure.com>. The page features the Triad Healthcare logo in the top left and a navigation menu with 'Home' and 'Contact Us' buttons in the top right. A central content area contains a 'Welcome to Triad's Online Provider Solutions' header, a descriptive paragraph, a bulleted list of features, and a registration prompt. A sidebar on the left includes a login form with 'User Name' and 'Password' fields, a 'Log In' button, and links for 'New Users: Register here!', 'Forgot Password?', and 'Forgot User Name?'. Below the login form is a 'Need Help' section with contact information for the Provider HelpDesk. The footer contains a copyright notice and links to 'Terms and Conditions', 'Privacy Policy', 'Browser Requirements', and 'Security'. The browser's status bar at the bottom shows 'Done' and 'Internet'.

https://secure.com - TriadHealthcare Inc Secure WebSite - Microsoft Internet Explorer provided by Triad Heal

TRIAD HEALTHCARE Provider Portal

Home Contact Us

Log In
User Name:
Password:
Log In

[New Users: Register here!](#)
[Forgot Password?](#)
[Forgot User Name?](#)

Need Help
For technical support or assistance:
Email: [Provider HelpDesk](#)
Phone: 800-409-9081

Welcome to Triad's Online Provider Solutions

Triad's secure web portal provides a simple, comprehensive tool for all transactions between Triad and participating providers who prefer electronic transactions. The portal will support:

- **Member Status Search** to verify that your patient is currently included in a Triad program
- **Care Planning** transactions, including forms, medical records and determination letters
- **Claims** and payment status verification
- **On-Line P2P** to send a question or schedule a call with a clinical peer
- **Medical Policy Survey** to review and comment on proposed medical policy changes
- **Assignable Privileges** for office staff to administer all of the above functionality

The portal's function is Health Plan specific, therefore please select the Health Plan(s) you are participating with to determine available functionality.

User set up is simple and will only take a few minutes. [Click here to register](#). For assistance please contact us at 800-409-9081

Copyright © 2012 Triad Healthcare, Inc. All rights reserved. [Terms and Conditions](#) [Privacy Policy](#) [Browser Requirements](#) [Security](#)

Done Internet

Web Portal Registration

Provider Registration: Step 1 of 2 (All fields are required)

Registration Type: Individual Group

First Name:

Last Name:

TaxID:

License Number:

License State Code: Alabama

Provider Registration: Step 2 of 2 (All fields are required)

Phone Number:

Date of Birth:

Password:

Confirm Password:

Email:

Security Question:

Security Answer:

Manage Users

User Authorization

Use this area to authorize administrative users to access the Provider Portal on your behalf.

Email Address:

Manage Users

Change Your Password

Current Password:

New Password:

Confirm New Password:

Change Your Email Address

Change Your Security Question/Answer

Registration:

First Name:

Last Name:

Email: MPereira@triadhealthcareinc.com

Phone Number: () - -

Date of Birth: / /

Password:

Confirm Password:

Security Question:

Security Answer:

Member Search

Member Status Search

Use this search feature to determine if a member is included in a Triad program.

Health Plan Card Code search

Health Plan Card Code:

Name Search
(All fields are required)

Last Name:

First Name:

Date Of Birth: (mm/dd/yyyy)

First Name	Last Name	Card Code	Birth Date	Date Range	Participation Status
SCROOGE	MCDUCK	55555510	05/28/1977	09/01/2014 - 09/30/2014	In Deal
SCROOGE	MCDUCK	55555510	05/28/1977	10/01/2014 - 10/31/2014	In Deal
SCROOGE	MCDUCK	55555510	05/28/1977	11/01/2014 - 11/30/2014	In Deal
SCROOGE	MCDUCK	55555510	05/28/1977	12/01/2014 - 12/31/2014	In Deal
SCROOGE	MCDUCK	55555510	05/28/1977	01/01/2015 - 01/31/2015	In Deal
SCROOGE	MCDUCK	55555510	05/28/1977	02/01/2015 - 02/28/2015	In Deal
SCROOGE	MCDUCK	55555510	05/28/1977	03/01/2015 - 03/31/2015	In Deal

Program Resources

- **SoonerCare Implementation Site** – Copies of all Program documents.
<http://www.triadhealthcare.com/soonerCare>
- **Medical Policies:** <http://www.triadhealthcareinc.com/providers/policies.aspx>
- **Web-Based Services:** www.triadhealthcareinc.com/providers
- **Call Center:** (888) 693-3281, 8:00 am-6:00 pm CST
- **Fax Number:** (888) 328-3662
- **Client Services** – for questions that are not about a specific case
contact: clientservices@medsolutions.com or (800) 575-4517
- **For Provider Enrollment questions**, please contact SoonerCare at (800) 522-0114

QUESTIONS?

