Carelon Medical Benefits Management

Supplemental Guide to the Rehabilitation Program - January 2024

Carelon Medical Benefits Management (Carelon) recognizes the key role that you and other medical practices play in the delivery of care for patients. The Carelon Rehabilitation Solution provides a clinical appropriateness review process that encompasses the appropriate duration of rehabilitation services at the appropriate place of service, with the goal of maximizing the patient's functional improvement, while at the same time enhancing and simplifying the provider's experience in the delivery of care. In order to continue to support your therapy practice and patients, we would like to inform your practice about a new program workflow update that went into effect after the program's effective date.

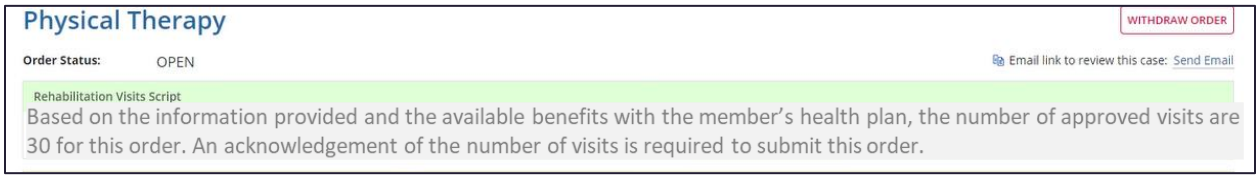
Prior Authorization Determinations

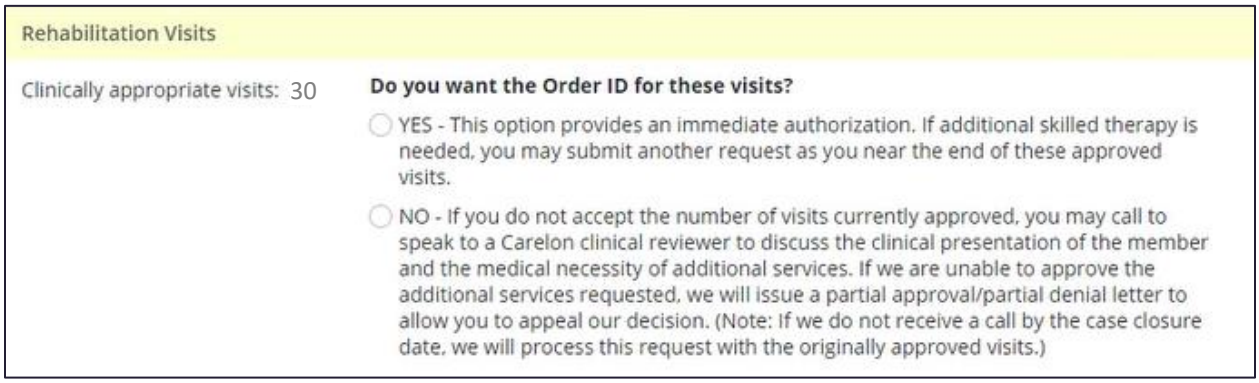
Prior Authorization Requests that meet medical necessity criteria:

After submitting a therapy prior authorization request, treatment requests that meet clinical criteria will receive a response with an order tracking number, and the number of visits determined to be clinically appropriate for the request. The provider is given the following options:

- ***Accept the visits*** *determined to be clinically appropriate for the request knowing if additional skilled care is required after rendering the initial visits, the provider can return to Carelon and submit additional treatment requests.*

- ***Not accept the visits*** *determined to be clinically appropriate for the request and call Carelon for a peer-to-peer discussion with a Carelon clinician. The peer-to-peer discussion allows the treating therapist the opportunity to clarify clinical information or provide additional clinical details relative to the prior authorization request. The providers additional requested visits will be reviewed per the Carelon Medical Benefits Management Clinical Guideline for Outpatient Rehabilitative and Habilitative Services as well as a second EPSDT (Early, Periodic, Screening, Diagnosis, and Treatment) review. If the additional requested visits are not considered medically necessary at the time of the request, a partial denial will be issued for the remaining requested visits. The partial denial will open appeal rights for the member and provider with the health plan.*





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Prior Authorization Requests that do not meet medical necessity criteria:

After submitting a therapy prior authorization request, treatment requests that do not meet criteria will be sent for clinical review with a Carelon clinician (PT, OT, ST). The Carelon clinician reviews the request and may approve if criteria are met. If criteria are still not met after the Carelon clinician review, the request will be sent for additional review with a Carelon physician. If criteria are still not met after the Carelon physician review, the request will be denied for medical necessity. As a reminder, the provider can contact Carelon to discuss the request's details via peer-to-peer at any time.

All therapy prior authorization requests for Healthy Blue® members will close within 7 business days for standard/non-urgent and 24 hours for urgent requests.

How can your facility contact Carelon for a peer-to-peer discussion of a prior authorization request?

- Call Carelon toll-free at 1-866-745-1788, Monday through Friday between 8:00 AM – 5:00 PM ET.

How can your facility submit additional clinical information for consideration during a peer-to-peer discussion of a prior authorization request?

- **Phone:** Additional clinical information may be reviewed in a peer-to-peer discussion by calling Carelon toll-free at 1-866-745-1788, Monday through Friday between 8:00 AM – 5:00 PM ET.
- **Portal:** Additional clinical information requested during a peer-to-peer discussion may be submitted via the portal on requests that required clinical documentation upload at case submission.
- **Fax:** Additional clinical information requested during a peer-to-peer discussion may be faxed to 1-833-420-9489. Please note that it may take 24-48 hours to upload and attach faxed clinical documentation to your request.

For more information:

- **Online:** The Rehabilitation Program website https://providers.carelonmedicalbenefitsmanagement.com/rehabilitation/ helps you learn more about the program and provides access to useful information and tools such as order entry checklists, clinical guidelines, and FAQs.

- **Email:** Contact your Healthy Blue Provider Relationship Account Consultant directly or email NC_Provider@healthybluenc.com.

Blue Cross® and Blue Shield® of North Carolina values your participation in our Healthy Blue network, as well as the services you provide. We look forward to working with you to help improve the health of our members.