Carelon Medical Benefits Management (Carelon) Rehabilitation Program

Frequently Asked Questions

Program Overview and Administration

1. Who is Carelon?

Carelon Medical Benefits Management (Carelon)* is a utilization management company with more than 25 years of experience and a growing presence in the management of radiology, cardiology, genetic testing, oncology, musculoskeletal, sleep management, and additional specialty areas. Our mission is to help ensure delivery of health care services are more clinically appropriate, safer, and more affordable. Carelon promotes the most appropriate use of specialty care services through the application of widely accepted clinical guidelines delivered via an innovative platform of technologies and services. This rehabilitation program for Blue Cross® and Blue Shield® of North Carolina (Blue Cross NC) plan will be administered by Carelon.

2. How does Carelon work with health plans?

Carelon collaborates with health plans like Healthy Blue to help improve health care quality and manage costs for some of today's complex tests and treatments, working with physicians and therapists to promote patient care that's appropriate, safe, and affordable. In partnership with health plans, Carelon is fully committed to achieving their goals – and providers – to improve health outcomes and reduce costs. Our powerful specialty benefits platform powers evidence-based clinical solutions that span the specialized clinical categories where a health plan has chosen to focus. Our robust medical necessity review process is fully compliant with regulatory and accrediting organizations, while offering a superior experience for the health plan's providers.

About the Rehabilitation Program

1. What is the Rehabilitation Program?

The Rehabilitation Program is a utilization management program for Healthy Blue members that requires providers to request prior authorization for rehabilitation services. The requests are evaluated against evidence-based, Carelon Clinical Guidelines.

Healthy Blue providers should contact Carelon starting April 17, 2023, to obtain a prior authorization for any therapy services rendered for Healthy Blue members on or after May 1, 2023. Participation is required when requesting rehabilitation services for Healthy Blue® members, May 1, 2023. Providers are strongly encouraged to obtain prior authorization before initiating, scheduling, and performing services.

2. Which Healthy Blue members require prior authorization through Carelon?

Please check member benefits and eligibility to determine whether prior authorization is required. Healthy Blue members will require clinicians ordering rehabilitative services to request prior authorization for applicable Medicaid services.

3. Which Healthy Blue services require review?

When selecting a service that does not require prior authorization from Carelon, the provider will be notified via a message on provider portal or by a representative in the Carelon Contact Center that Carelon prior authorization is not required. Providers should contact Blue Cross NC to verify prior authorization requirements. Reference each care category for more details on the applicable services that require prior authorization.

Contact Carelon to obtain pre-service review for the following non-emergency clinical services:

- Physical therapy
- Occupational therapy
- Speech therapy

4. How does the Rehabilitation Program work?

Note: Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services for Healthy Blue providers on behalf of Blue Cross® and Blue Shield® of North Carolina.

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Providers should contact Carelon to request a review of physical, occupational, and speech therapy services for Healthy Blue members. Carelon reviews for these services in outpatient settings against evidence-based clinical guidelines to ensure care is medically necessary according to medical evidence.

When the care requested does not meet clinical criteria, our established staff of therapists and physicians provide peer-to-peer consultation.

Our program takes individual clinical details into account in order to titrate the number of authorized visits as opposed to program models that approve a standard number of visits upfront. Carelon measures progress based on condition management and patient outcomes. Additional visits are approved as clinically appropriate. Our Rehabilitation clinical guidelines were developed by a clinical team led by a physiatrist and therapists.

Unlike models that offer a one-size-fits-all approach, our program reviews based on multiple clinical factors.

5. When will this program begin for Healthy Blue members?

Beginning April 17, 2023, Carelon's call center and provider portal, are available for submission of order requests for therapy services occurring on or after May 1, 2023.

6. What happens if I do not call Carelon or enter information through the Carelon provider portal?

Providers are encouraged to request prior authorization before the start of services. Retrospective authorization requests may be initiated up to 2 business days after the date or service. Failure to contact Carelon for rehabilitation services prior authorization may result in claim denial.

About the Carelon Clinical Review Process

1. How do providers participate in the Rehabilitation Program through Carelon for Healthy Blue members?

Providers are strongly encouraged to obtain prior authorization before initiating, scheduling, and performing services for Healthy Blue members. The most efficient way to submit a therapy service request is to use the Carelon provider portal.

The provider portal allows providers to open a new order, update an existing order, and retrieve their order summary. As an online application, the provider portal is available 24/7. The first step is to register in provider portal if the provider is not already registered. Go to www.providerportal.com to register.

If the provider has previously registered for other services managed by Carelon (diagnostic imaging, radiation therapy), there is no need to register again.

2. Which therapy CPT service codes require review?

To access the current CPT code list and which codes will require prior authorization, please refer to the Prior Authorization Lookup Tool on the Healthy Blue website located at https://provider.healthybluenc.com/north-carolina-provider/prior-authorization-lookup.

The therapy CPT Service codes requiring review for Healthy Blue members can be found in a provider friendly format for education purposes, on the Carelon Rehabilitation microsite by therapy discipline as the effective date approaches.

The Carelon Rehabilitation Program CPT service codes are divided into two categories.

a) Main treatment CPT codes – These service codes follow a grouper concept within the Carelon Rehabilitation Program. If the provider enters only one main treatment CPT code into the request and that date of service is authorized, the provider may render any additional main treatment CPT codes for that authorized date of service.

b) Adjunctive CPT codes – These service codes do not follow a grouper concept within the Carelon Rehabilitation Program. These CPT codes require further review against additional guideline criteria before any determination or authorization can be rendered on the therapy request as a whole and therefore must be entered individually for the request.

Note: Procedures reviewed may vary by health plan.

3. Are the Carelon clinical criteria available for review?

Yes, the Carelon Clinical Guidelines are accessible online at https://guidelines.carelonmedicalbenefitsmanagement.com/.

The Carelon Rehabilitation clinical guidelines were developed by a clinical team led by a physiatrist and therapists. Healthy Blue providers should check benefits and eligibility to determine the member's benefits and prior authorization requirements.

4. Does the program include inpatient services?

No, the Rehabilitation program does not include inpatient services or day-rehab services. Only services requested on an outpatient basis are applicable to this program.

5. What should providers do if they scheduled services for after, May 1, 2023, before this prior authorization program going live?

Healthy Blue providers should contact Carelon and obtain a prior authorization for any services on or after May 1, 2023.

If a provider has a current prior authorization with Blue Cross NC for dates of service that expands beyond May 1, 2023, providers will not need to obtain a new prior authorization with Carelon until the authorized units of time has expired on the Healthy Blue prior authorization.

6. How far in advance can a provider request prior authorization for services?

Providers can submit a prospective request for services up to 30 calendar days prior to the date of service but not prior to the program start date.

7. How does the program benefit providers and patients?

When providers prescribe test or treatment for a Healthy Blue patient and submits it to Carelon for review, it is compared against evidence based Carelon Clinical Guidelines in real time, so the provider knows medical necessity criteria is met.

Engaging patients in their health is a priority for providers. Our Rehabilitation Program supports the provider's efforts to reinforce important information about the therapy services recommended. This program is designed to reduce anxiety, drive adherence to care plans, motivate preventive action, and improve appropriate use of care by the provider's patients.

8. How does the provider's office staff, or therapist request prior authorization with Carelon?

The therapist and/or the facilities support staff can enter a therapy prior authorization on the provider portal. All users are required to register for a portal account at www.providerportal.com. Clinicians ultimately are responsible for ensuring accurate input of clinical information on the prior authorization request.

There are three ways providers can contact Carelon to request review and obtain an order number for Healthy Blue members:

Availity

- Through Availity, which can be accessed via Healthy Blue website at https://provider.healthybluenc.com/

Online

- Get fast, convenient online service via the Carelon provider portal (registration required). The provider portal is available 24 hrs./day, 7 days/week. Go to www.providerportal.com to begin.

By phone

- Call Carelon toll-free at: (866)745-1788
- Hours: Monday – Friday 8:00 am - 5:00 pm EST (except holidays)
- Carelon Call Center is closed on the following holidays: Martin Luther King Jr. Day, Memorial Day, Independence Day, and Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Day, and New Year's Day.

If the provider needs any help using the Carelon provider portal, call provider portal support at 1-800-252-2021.

9. Will providers be required to provide medical records or other clinical documents?

Initial and second treatment requests within the Rehabilitation Program can approve at request submission, without documentation upload. The third/recurring treatment request and each request moving forward in a member's episode of care will require clinical documentation upload. Providers will be prompted on the provider portal for the documentation upload on these requests.

Providers **should not send medical records proactively**, unless specifically requested, and then send only what is requested (e.g., specific test result vs. full medical record). For most services, answers to clinical questions allow us to capture the relevant information to make a determination on the request. This delivers efficiency and eliminates the time and effort of submitting medical records that may not be needed.

10. Does Carelon only allow one diagnosis to be entered per request?

Carelon accepts prior authorization requests for a specific diagnosis. Only the primary diagnosis is needed. Users can enter additional clinical information after selecting a primary diagnosis. Multiple services or CPT codes can be requested per diagnosis.

11. What if the patient has multiple diagnoses relevant to their treatment episode of care?

Carelon educates that if the Healthy Blue member will be seen for both diagnoses on the same date of service, by the same therapy discipline, one prior authorization request can be submitted for both diagnoses. The expectation is that both diagnoses will have functional goals captured in the plan of care. If the member will be seen on different dates of service for the two diagnoses, two prior authorization requests with differing initial evaluation dates may be submitted.

Please enter the most relevant treatment diagnosis that is the reason the patient requires skilled therapy services. Additional diagnoses can be captured in several ways: in the conditions impacting treatment or comorbidities section of the request, with the addition of a second functional outcome tool as well as within the clinical documentation upload.

If care is being rendered for more than one diagnosis, both should be captured in the plan of care documentation. If care is completed for one diagnosis and the provider is continuing care for another diagnosis, they should document the need for continued skilled care and document the remaining functional goals for the additional diagnosis.

12. What information do Healthy Blue providers need to submit to Carelon?

For most services, answers to clinical questions allow us to capture the relevant information to make a determination on the request. If you need assistance completing the clinical questions, please consult your clinical staff. They should be able to assist in where to find information in the patient's medical chart. Please also visit Carelon's provider microsites for order request checklists to help gather all the clinical information necessary to submit a prior authorization request.

The order request checklists can be viewed at https://providers.carelonmedicalbenefitsmanagement.com/rehabilitation/.

13. When answering the question about an evaluation being conducted for this treatment episode, would it apply if another Healthy Blue therapist in my office completed the evaluation?

Yes, it would apply to anyone in the billing facility that completed the evaluation and had developed a plan of care that a qualified provider would follow.

14. Do the initial evaluation CPT codes require prior authorization and does treatment rendered at the initial evaluation date of service require prior authorization?

Healthy Blue members **do not require** prior authorization for therapy initial evaluation CPT codes when performed alone on the initial evaluation date of service. A prior authorization **is required** for these members if treatment CPT codes will be rendered at the initial evaluation date of service. These members also **require** prior authorization for subsequent treatment requests.

If the provider submits a prior authorization request before the initial evaluation has been completed, they will receive a prior authorization for one visit allowing the facility to complete the initial evaluation and any treatment rendered at the initial evaluation date of service. If the therapist determines that the member requires skilled care after the initial evaluation, the provider should return to Carelon and enter an initial treatment request.

15. How often should providers update the episode of care initial evaluation date in the provider portal for Healthy Blue members receiving long-term therapy services?

Within the Rehabilitation Program, requests are staged based on the initial evaluation date of service as well as the previous request's medical necessity determination. For these reasons, providers are asked to keep the initial evaluation date consistent throughout the member's episode of care when submitting prior authorization requests for additional treatment.

There is one scenario in which the initial evaluation date may change, and that is typically for chronic, long term or pediatric episodes of care that extend past a calendar year of treatment. In these scenarios, there is a reasonable expectation that the initial evaluation and plan of care would be updated annually. The updated initial evaluation date should also be documented annually within in the member's therapy treatment requests on the provider portal.

16. What if the functional tool that the provider utilizes is not listed in the selection box?

Providers are encouraged to document an in-scope functional outcome tool on the initial treatment request and document a

baseline score utilizing the scoring scale from the microsite. On subsequent treatment requests, providers should enter the updated functional outcome tool score from the member's most recent visit.

There is an option to enter "tool not listed" and a text box allowing providers to document the name of the functional tool/milestone assessment that was utilized. A manually entered functional outcome tool will not be scored. Note: The Rehabilitation Program's clinical decision trees are based on the most common functional tools/milestone assessments utilized in the therapy industry. Providers can contact the Rehabilitation Program if there is a functional outcome and/or milestone assessment tool they would like us to review for addition to the program. Functional outcome tools are reviewed biannually.

17. What if the provider utilizes more than one functional outcome tool for a complex patient case?

There is an opportunity to enter up to two functional outcome tools on a request noting that the Healthy Blue patient is being treated for more than one body part. Please refer to the microsite for a list of the functional outcome tools in-scope for the program and their scoring scales.

18. Can a patient receive treatment for more than one discipline (PT, OT, ST) at the same time in the program?

Yes, providers can request and receive separate authorizations for each therapy discipline if the request meets criteria for medical necessity and they do not constitute duplicative treatment (e.g., distinct goals). Each authorization would have a separate order number and a distinct valid timeframe.

Each discipline would decrement to the Healthy Blue patient's annual benefit level for that service. For example, the PT authorization would be considered against the patient's annual PT benefit limit. If a patient has a combined service limit, the authorization would be matched against the consolidated benefit limit on a first come, first served basis.

19. Why do I have to attest to the fact that services will be delivered by a licensed provider of therapy?

The Rehabilitation Program allows any qualified Healthy Blue provider, based on state practice act or state regulation that can render therapy services, the ability to obtain authorization. See the Carelon Guidelines for further definition of "qualified provider".

Carelon clinical guidelines require that services meet medical necessity criteria when they are delivered under the supervision of a licensed clinician to perform those services. They are part of a complete plan of care that includes measurable and objective goals that can reasonably be attained in a predictable period of time and require the skills of a licensed provider of therapy services.

20. Can providers request an urgent authorization?

While most outpatient therapy services do not meet the criteria for urgent care, providers should contact Carelon at (866)745-1788.

21. What place of service settings are in scope for the Carelon Rehabilitation Program?

Providers should select an out place of service designation on portal that coincides with the place of service designation they will send on their claim for a Healthy Blue member. If the outpatient place of service designation that your facility bills with is not shown, your facility will be referred to the health plan for prior authorization.

The outpatient place of service settings a provider can choose from for a Carelon Rehabilitation request include.

- Outpatient Office - place of service designation 11
- Outpatient Independent Clinic - place of service designation 49
- Telehealth - place of service designation 02
- Outpatient Hospital - place of service designation 22/19

Other place of service such as 03 (school), 99 (other), and 12 (home) will be the responsibility of the Health Plan to review.

22. Is a prior authorization required when the Medicaid plan is the secondary insurance?

Blue Cross NC does not complete medical necessity reviews if the member has active insurance on file, unless one of the following situations is in place:

1) Service is a non-covered benefit with the primary insurer
2) Primary insurer has denied the request for medical necessity
3) Primary benefit has been exhausted

Providers do need to submit an Explanation of Benefit (EOB) from the primary insurance.

About Determinations

1. How will the request be reviewed by Carelon?

The provider submits the order requests through the provider portal or through the Carelon contact center. Web users and callers will be guided through a series of questions regarding the patient, the requested service, and the patient's clinical condition. Refer to the order request checklists to view the information needed to enter a request.

If the necessary information provided meets the Carelon clinical criteria, an order number, the number of approved visits and authorization timeframe will be issued.

If all criteria are not met or additional information or review is needed, the case is forwarded to an appropriate therapist (i.e., physical, occupational or speech) who uses clinical experience and knowledge to evaluate the request against clinical guidelines. The therapist or RN reviewer has the authority to issue order numbers in the event it is determined that the request meets our clinical criteria.

If an order number could not be issued by the clinical reviewer, a Carelon physician will review the request. The physician reviewer can approve the case based on a review of information collected or through their discussion with the provider. At any time, the provider may contact Carelon to discuss the request or to provide additional information.

If the Carelon physician reviewer cannot approve the case based on the information previously collected or on the information supplied by the provider during a peer-to-peer discussion, the physician reviewer will issue a denial for the request.

2. Once the provider submitted a request, how long will it take to receive a response from Carelon?

Requests that meet medical necessity criteria:

Requests that meet criteria receive a **response immediately** in the provider portal or on the phone with the Carelon contact center.

Requests that do not meet medical necessity criteria:

When an order request cannot be approved immediately, providers have the option of discussing the case with one of Carelon's clinical experts. No adverse determination is made until the case has been reviewed by a physician reviewer at Carelon.

For requests that did not require clinical uploads, the case will pend for peer-to-peer conversation. It is important that the provider calls Carelon as soon as possible to discuss the request with a Carelon physician. Until we receive a phone call back from the provider, the case will continue to pend.

For requests that prompt for clinical uploads, clinical information should be sent prior, and time allowed for the Carelon clinicians to review the information before a peer-to-peer conversation is requested.

At that time, if the clinical information requested is not provided, or peer-to-peer did not take place, the case will be denied. The denial letter will be sent to the member (via US mail) and to the provider. Denial rationale is included in every denial letter. If you have any questions regarding a denial, please call Carelon Contact Center.

3. How can a provider obtain prior authorization results?

When registering for a portal login, users can specify the email address where notifications should be sent. Once a determination is made on the therapy request, the provider will receive an email containing a link to the determination.

4. How long does my Healthy Blue patient's approval last?

Unless otherwise required by state law, physical therapy, occupational therapy, and speech-language therapy valid timeframe will be based on the number of visits allocated for the service. Carelon communicates the valid timeframe in the approval notification for each case.

5. Can a prior authorization number for a medical necessity determination expire?

Yes, Carelon communicates the expiration date in the approval notification provided for each case. If the request valid timeframe has expired and the member still requires skilled care, the provider can return to the portal to submit an additional request.

6. What should a provider do if they have not received the request determination, but the patient is scheduled to return for treatment soon?

If a provider has not received a determination on their request and the patient is returning to the facility, the provider may contact the Carelon call center and ask that the request be reviewed live. If the provider is unable to hold while the request is reviewed, the provider facility can request a call back once the review is completed.

7. What are the provider's options if a review request does not meet clinical criteria?

Providers can contact Carelon to request a peer-to-peer discussion at any time before or after the determination. When there is a request for a peer-to-peer consultation, Carelon will make an effort to transfer the call immediately to an available Carelon clinical reviewer. When a clinical reviewer is not available, Carelon will offer a scheduled call back time that is convenient for the provider.

If the provider receives a notice of a denial on a prior authorization request, the provider may have the following options for further review:

- **Reconsideration:** Providers can call Carelon for a reconsideration on eligible cases with an adverse determination within the allowable timeframe. The reconsideration process allows the provider to clarify existing clinical information on a therapy prior authorization request that did not require clinical documentation upload. If a reconsideration is not available for the request, the provider may be able to submit a new prior authorization request with new clinical information.

- **Provider Document Review (PDR):** Requests with an adverse determination that required a clinical documentation upload may be eligible for the provider document review process within an allowable timeframe of the adverse determination. Providers can initiate the re-review process for requests that required documentation upload by uploading new clinical documentation that may impact the request outcome.

8. What if I want more visits than the current authorization includes?

The number of visits authorized is based on the patient's individual clinical circumstances. The Rehabilitation Program model allows the provider to render the clinically appropriate number of visits and see how the patient responds to therapy. Once those visits have been delivered, the provider has the opportunity to re-enter the portal and report the patient's improvement and get additional visits approved, if clinically appropriate.

For Blue Cross NC, providers can choose not to accept the visit allocation determined to be clinically appropriate for the request. In these scenarios, the provider should call Carelon to discuss the visit allocation with an Carelon clinician via peer to peer. If necessary, a partial denial can be issued for the remaining requested visits to allow the provider the opportunity to appeal through the health plan.

More Information

1. Where can providers access additional information?

Our dedicated Rehabilitation Solution provider website offers providers all the tools and information they need. To access, go to https://providers.carelonmedicalbenefitsmanagement.com/rehabilitation/.

For assistance using the Carelon provider portal contact us at 800-252-2021.

2. Where can providers get a copy of the training presentation?

Providers can find a PDF of the webinar slides on the Healthy Blue provider website at https://provider.healthybluenc.com/.

About the Provider Portal

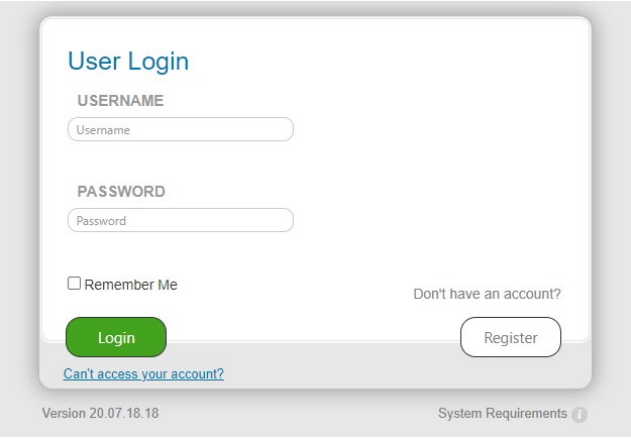
1. How do I access the Carelon provider portal?

Access Carelon provider portal at www.providerportal.com

If you need assistance, please contact the provider portal Support Team at 800-252-2021 8am-7pm EST.

2. How do I register for the provider portal?

To begin the registration process, select the Register button located on the provider portal home page at www.providerportal.com. Complete the required fields under Details, Login Information and Health Plan Details tabs. Once registered, the user will receive an email requesting that they validate their email to continue the registration process.



If you are already registered and need to add additional health plan(s) to your profile, please contact Carelon provider portal support team at 800-252-2021 (available weekdays between 8am-7pm EST).

3. How often do I need to change my password to access provider portal?

You will be prompted to change your password every 90 days.

4. How can I look up prior authorization for a member?

To view the details of a prior authorization, you will need to log into the provider portal and select Check Order Status. Select Healthy Blue NC, the member's Health Plan , Order Type and Search Type. After selecting Find Order, the Order Request Summary will display.

5. Can I look up prior authorizations for a member for all care categories/Carelon solutions at once?

Prior authorizations for a Healthy Blue member cannot be looked up for all care categories/Carelon solutions at once. During the search process, the user will be prompted to select one care category/order type.

6. What if the provider is not available in the Carelon provider portal?

Users should search in the portal using the provider's TIN or NPI, city, state, and zip code in the search fields. If the provider is not available for selection, the user can manually add the provider or contact Carelon.

7. Why is the physician showing as Out-of-Network?

If you believe your provider is in-network for the member, please check with your Healthy Blue Provider Relationship Account Consultant to confirm the provider's Healthy Blue participation status. Participation inquiries can be sent to NC_Provider@healthybluenc.com. Provider files are sent weekly to Carelon.

8. Can both ordering and servicing providers view required authorizations for patients?

Yes, users registered under either the ordering or servicing provider roles can view authorizations on the Carelon provider portal.

9. What if the provider cannot find the procedure on the Carelon provider portal?

Only services managed by Carelon as part of the Rehabilitation Program can be submitted for review. If providers are unable to find the service code in the system, they may call Carelon Customer Service at 800-252-2021 or contact Healthy Blue Provider Services at 844-594-5072.

10. What if a member is not available for selection in the provider portal?

If the provider comes to Carelon to submit a request for prior authorization and the Healthy Blue member cannot be found, the provider will be notified via messaging to check the member details and re-attempt the search. The member currently does not require authorization from Carelon based on membership file details received from Healthy Blue. The provider may contact Blue Cross NC to verify eligibility or contact Carelon for assistance. If necessary, a 3-way call can be performed with Blue Cross NC to

manually add the member and assist with the prior authorization request. Specific member information will need to be supplied to Carelon from the health, in order to manually add the member.

11. How do I view order requests submitted by other users in my practice?

Provider portal users can view preauthorization requests entered by their colleagues if they use common provider identifier (TIN or NPI) for their requests. This eliminates the potential of entering duplicate requests by individuals in the same group. User profiles are linked by the provider identifier for a specific health plan, so each user should follow the steps below to add additional health plans and corresponding provider identifiers.

- Log in to www.providerportal.com
- Click on Provider Management
- Click on Add Provider Identifier button in the upper right-hand corner
- Then enter a provider identifier such as a TIN or NPI for the health plan
- Repeat for other health plans, as necessary