carelon

Carelon Medical Benefits Management Rehabilitation Program (updated 9/10/2025)

Frequently Asked Questions

Contents

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Program overview and administration

What is the Rehabilitation Program? How does it benefit health plan members?

The Carelon Rehabilitation Program is here to support providers in helping their patients receive care that is appropriate, safe, and affordable. Through impactful communication and education about the program, we are poised to engage providers and their office support staff in the management of the complexities associated with physical, occupational, and speech therapy services. We have developed an approach that works with providers to promote standard of care through the consistent use of evidence-based criteria.

The health plan is implementing the program to help providers in their efforts to ensure their patients receive care that is appropriate, safe, and affordable – and delivers improved results for the provider's practice too. Asking the right questions leads to delivering the right answers at the right time to patients.

How will the program be administered?

The Rehabilitation Program will be administered by Carelon on behalf of the patient's health plan. Participating in the program is most easily managed using the Carelon provider portal available 24 hours a day, 7 days a week (except for maintenance periods).

What is the relationship between Carelon and the health plan?

The health plan has contracted with Carelon to work directly with providers to assist their efforts in patient care. Carelon helps providers manage outpatient physical, occupational, and speech therapy services.

Who is Carelon?

Carelon is a leading specialty benefits 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. Carelon's mission is to help ensure delivery of health care services are more clinically appropriate, safer, and more affordable. We promote 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. Carelon's Rehabilitation clinical guidelines were developed by a clinical team led by a physiatrist and therapists.

How does Carelon work with health plans?

Carelon collaborates with health plans to help improve health care quality and manage costs for some of today's complex tests and treatments, working with physicians and therapists like you 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. Carelon's powerful specialty benefits platform powers evidence-based clinical solutions that span the specialized clinical categories where a health plan has chosen to focus. Carelon's 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

How does the Rehabilitation program work?

Providers contact Carelon to request a review of physical, occupational, and speech therapy services. Carelon reviews these services in outpatient settings against evidence-based clinical guidelines to ensure care is medically necessary according to medical evidence and that service codes that do not warrant skilled care are not approved within the episode of care.

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

Carelon's program takes individual clinical details into account 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.

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

Are the clinical criteria available for review?
Yes, the Clinical Guidelines are easily accessible online. View Rehabilitation Clinical Guidelines.

Tools for patient success
Engaging patients in their health is a priority for therapy practices. The Rehabilitation Program supports provider efforts to reinforce important information about the therapy services recommended. The program is designed to drive adherence to care plans, motivate preventive action, and improve appropriate use of care by patients.

About the Carelon clinical review process

How do providers participate in the Rehabilitation Program through Carelon?
The most efficient way to submit a therapy service request is to use the provider portal.

The provider portal allows users to open a new order, update an existing order, and retrieve an order summary. As an online application, provider portal is available 24/7, except for maintenance periods. The first step is to register the provider on the provider portal, if not already registered. Go to *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.

*Some markets only allow access to the Carelon provider portal through single-sign-on through the health plan website.

Is registration required to access the provider portal?
Each staff member of the facility who enters therapy requests may register as a user.

Here's how to do it:

- Step one: Go to www.providerportal.com and select "Register Now" to launch the registration wizard.
- Step two: Enter user details and select user role as "Servicing Provider."
- Step three: Create username and password.
- Step four: Enter a provider identifier.
- Step five: Check for an email from Carelon. Click on the link to confirm email address.

The provider portal support team will then contact the user to finalize the registration process.

What does a provider need to register?

- Provider email address
- Providers identifier
- Provider phone and fax number

The provider portal allows providers to:

- Submit a new order request.
- Update an existing request.

- Retrieve the order summary.

Which procedures require review?

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

- Physical therapy services
- Occupational therapy services
- Speech therapy services

Providers should utilize modifiers when submitting claims (E&M and treatment lines) to the health plan to designate the therapy type:

- GP-Physical Therapy
- GO-Occupational Therapy
- GN-Speech Therapy

CPT Codes

See the billing codes for the procedures reviewed by Carelon

CPT codes are divided into two categories within the Carelon Rehabilitation Program.

1) 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 the date of service is authorized, the provider may render any additional main treatment CPT codes for that authorized date of service.

2) 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 line of business and health plan.

What markets (Carelon call center numbers below) and provider types are included in the Rehabilitation program?

The Carelon Rehab Program allows any qualified provider, based on state practice act or state regulation who can render therapy services, the ability to obtain authorization. See the Carelon Guidelines for further definition of "qualified provider". Carelon has the appropriate staff necessary to satisfy any same state licensure requirement.

- For Anthem Medicare requests, per CMS, Chiropractors are not in-scope as ordering and servicing providers for Medicare.

- For Anthem BCBS Commercial requests in Virginia, Chiropractors are not in-scope to receive prior authorization for therapy service codes within the Carelon Rehabilitation Program.

- For BCBS of NC Healthy Blue Medicaid requests, Chiropractors and Athletic Trainers are not in-scope to receive prior authorization for therapy service codes within the Carelon Rehabilitation Program.

- For BCBS of IL Blue Cross Community Health Plans requests, Chiropractors are not in-scope to receive prior authorization for therapy service codes within the Carelon Rehabilitation Program.

The need to come to Carelon for prior authorization depends upon the member's plan state of issuance.
If the member is eligible for the Carelon Rehabilitation Program based on the state of issuance of their plan, a therapy prior authorization request should be submitted. If the member cannot be found, check that the member

details have been entered correctly. If the member still cannot be found, they do not require prior authorization from Carelon based on the membership file details received from the health plan. The provider may contact the health plan to verify member eligibility or contact Carelon for assistance.

See below for markets in scope for the Carelon Rehabilitation Program.

Note: As of 10/1/2023 Anthem BCBS ME commercial members do not require prior authorization through Carelon until after the initial 12 treatment visits have been rendered in new therapy episodes of care, per therapy discipline. Treatment performed at the initial evaluation date of service will not count toward the 12 treatment visits that do not require prior authorization. Subsequent therapy treatment visits require prior authorization through Carelon.

Note: As of 8/1/2024 Anthem HealthKeepers Plus VA Medicaid members do not require prior authorization through until after the initial 8 treatment visits have been rendered in new therapy episodes of care, per therapy discipline, when treated by an in-network provider. If seen by an out-of-network provider, prior authorization is required for all treatment visits within the member's episode of care, per discipline. Treatment performed at the initial evaluation date of service will count toward the 8 treatment visits that do not require prior authorization. Subsequent therapy treatment visits require prior authorization.

Note: As of 7/1/2025, new legislation in Indiana will impact when a prior authorization is needed for physical therapy services for Anthem Blue Cross and Blue Shield of Indiana commercial fully insured members. Effective July 1, 2025, prior authorization will not be required for physical therapy services for Anthem Blue Cross and Blue Shield of Indiana commercial fully insured members. Physical therapy requests for Anthem Blue Cross and Blue Shield of Indiana commercial fully insured members to which the legislation applies will be messaged, "Authorization is not required for physical therapy for this member. Effective October 1, 2025, Anthem BCBS of IN commercial fully insured members do not require prior authorization for the first 12 physical therapy treatment visits, per physical therapy episode of care. Prior authorization for Anthem BCBS of IN commercial fully insured members is required from the 13th physical therapy treatment visit onward.

If you have questions, please contact the provider services number on the back of the member's ID card."

- Please note, Anthem Blue Cross and Blue Shield of Indiana commercial fully insured members will continue to require prior authorization of all occupational and speech therapy services, starting with the first treatment visit following the initial evaluation date of service.

- In addition, Anthem Blue Cross and Blue Shield of Indiana ASO/self-funded commercial members will continue to require prior authorization of all physical, occupational, and speech therapy services, starting with the first treatment visit following the initial evaluation date of service.

Healthy Blue (MO) Medicaid	855.574.6479
Anthem BCBS (WI) Medicaid	833.419.2142
Anthem BCBS (IN) Medicaid	844.767.8158
Empire BCBS Health Plus (NY) Medicaid	855.574.6481
BCBS Western (NY) Medicaid	855.574.6483
Anthem BC (CA) Med Adv	833.404.1684
Anthem BCBS (CO) Med Adv	833.342.1256
Anthem BCBS (CT) Med Adv	833.305.1811
Anthem BCBS (GA) Med Adv	833.404.1681
Anthem BCBS (IN) Med Adv	833.342.1252
Anthem BCBS (KY) Med Adv	833.404.1677

Anthem BCBS (ME) Med Adv	833.775.1954
Anthem BCBS (MO) Med Adv	833.775.1956
Anthem BCBS (NH) Med Adv	833.342.1261
Anthem BCBS (NY) Medicare and Fully Integrated Dual Eligible (NY)	866.745.1784
Anthem BCBS (OH) Med Adv	833.419.2143
Wellpoint (TN) Medicare	833.305.1801
Wellpoint (TX) Medicare	833.305.1809
Anthem BCBS (VA) Medicare Adv	888.240.5058
Wellpoint (WA) Medicare	833.342.1258
Anthem BCBS (WI) Medicare Adv	833.775.1959
Anthem BCBS (CT) Commercial	866.714.1107
Anthem BCBS (ME) Commercial	866.714.1107
Anthem BCBS (NH) Commercial	866.714.1107
Anthem CR (IN) Commercial	833.775.1952
Anthem CR (KY) Commercial	833.419.1357
Anthem CR (MO) Commercial	833.305.1807
Anthem CR (OH) Commercial	833.404.1678
Anthem CR (WI) Commercial	833.342.1253
Anthem BCBS (GA) Commercial	866.714.1103
Empire (NY) Commercial	877.430.2288
Anthem Commercial F/I (CO, NV)	877.291.0366
Anthem BCBS (VA) Commercial	866-789-0158
BCBS of NC Healthy Blue Medicaid	866-745-1788
Anthem HealthKeepers Plus VA Medicaid	855-574-6480
BCBS North Carolina Commercial	866-455-8414
Wellpoint FL Commercial	833-529-8775
Wellpoint MD Commercial	833-529-8820
Wellpoint TX Commercial	833-529-8773
BCBS of IL BCCHP Medicaid	866-455-8415

Does the program include inpatient services?

No, the program does not include inpatient services or day-rehab services. Please note, claims filed with any other POS than what is authorized may be subject to denial.

Rehabilitation Solution in scope outpatient places of service settings include:

- Outpatient Office – POS 11
- Outpatient Independent Clinic – POS 49
- Telehealth provided other than in the patient's home – POS 02
- Telehealth provided in the patient's home - POS 10 (for BCBS North Carolina Commercial requests only)
- Outpatient Hospital – POS 22

- Home – POS 12 (for BCBS North Carolina Commercial requests only)

What information does a provider need to submit a therapy request to Carelon?
The information needed to submit a therapy request to Carelon can be found on the Carelon microsite in the order request checklists resource.

How do providers and their support staff use the provider portal to submit treatment requests?
Once registered, log in to the provider portal to begin the order entry process. Providers will be guided through a series of questions regarding the patient, the requested service, and the patient's clinical condition.

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

What happens if providers do not call Carelon or enter information through the provider portal?
Providers are encouraged to request prior authorization before the start of services. Retrospective authorization requests may be initiated prior to or within two business days after treatment date, in most markets. Failure to contact Carelon for rehabilitation prior authorization may result in claim denial.

If the provider has rendered therapy services without a prior authorization on file and it is greater than the two business days allowed for retrospective authorization, those dates of service will need to be handled post-claim submission. Letters sent post-claim will direct the provider in the next step for prior authorization (i.e., post- claim clinical appropriateness review or appeal through the health plan), when available.

If the provider is being directed to Carelon for a post-claim prior authorization request the facility can complete this process on the Carelon portal or by calling the call center. The portal will recognize a date of service greater than two-business days and ask, "Has the health plan directed you to Carelon to submit a post-claim case after the claim was processed?". The provider would answer, "yes". The provider will then be prompted to enter a claim number from the health plan denial letter. The provider will then proceed with the prior authorization request. If clinical documentation is requested, please ensure the clinical documentation uploaded includes the post-claim dates of service for the request.

About determinations

What plays a role in request determination?
Carelon will first review whether the selected member is exempt from prior authorization due to age band or condition. Next, Carelon will validate provider network status based on the members' plan. Where applicable, Carelon will also review the site of care to ensure it is appropriate for the member's clinical scenario (see site of care question below). Carelon will then review for medical necessity based on the member's individual clinical details entered for the request. Finally, a courtesy benefit accumulator ping will review benefit limits for the member, where applicable.

How will providers receive a determination?
If the necessary information is provided through the provider portal, determinations are immediate in most cases. Refer to the order request checklists to view the information needed to enter a therapy request.

If the member is returning to the facility for treatment within the next 48 hours or the request is urgent and a determination has not been received, the facility can call Carelon and ask if the request can be reviewed live. If the provider cannot hold the line while the request is reviewed, they can request a same day call back with the request's determination.

How will providers know if the request met clinical criteria and was approved?

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

How does Carelon review the appropriateness of site-of-care?

New therapy episodes of care beginning on or after 8/1/2021 for Anthem Commercial (fully insured and ASO) members with Anthem coverage through CT, CO, GA, IN, KY, MO, NH, NV and OH will have treatment therapy requests reviewed for site of care. Services in an outpatient hospital setting (place of service designation 19 or 22) will be reviewed with this guideline.

*Note: As of 1/1/24 site of care review will take place utilizing the Carelon Guideline for Site of Care: Outpatient Rehabilitative and Habilitative Services. There will be no change to the Anthem Commercial markets where site of care review will apply.

How long is a prior authorization valid?

Unless otherwise required by state law, physical therapy, occupational therapy, and speech-language therapy valid timeframes will be based on the number of visits allocated for the service. Carelon communicates the valid timeframe in the approval notification for each case, which can range from 30 days to 274 days.

For BCBS IL-BCCHP therapy requests, the valid timeframe will be based on an attestation of chronicity. Per the Center for Disease Control, chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Acute plans of care will have a valid timeframe of the service date plus six months. Chronic plans of care will have a valid timeframe of the service date plus twelve months.

Can an authorization number for a medical necessity determination expire?

Carelon communicates the expiration date in the approval notification provided for each case. If a date of service changes and is outside of the valid timeframe of the authorization; then a new request should be submitted through Carelon. If the servicing provider is unable to render the authorized therapy treatment visits within the valid timeframe for the request, a new prior authorization request through Carelon should be submitted. The valid time frame of the existing request cannot be extended.

There is one exception for Anthem BCBSCO commercial therapy prior authorizations requests. Effective 1/1/21, BCBSCO commercial member therapy requests with a CO state of issuance may be extended to 180 days from the start date of service, if there are un-rendered visits remaining on the authorization. This process can be initiated by calling the Carelon call center.

Why does the portal state that the initial evaluation request cannot be completed?

This messaging means that the provider has previously submitted an initial evaluation request for the member. The provider's next request submission should be an initial request for treatment, post initial evaluation. The provider should document that an initial evaluation has taken place and document the date of the initial evaluation to proceed in submitting a treatment request.

Note: Not all markets have an "evaluation" request stage.

How often should providers update the episode of care initial evaluation date in the Carelon portal for members receiving long-term therapy services?

Within the Carelon 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 the members' therapy treatment requests on the Carelon portal.

What if the therapy request indicates, "Further review is required"?

While most requests within the Carelon Rehabilitation Program are approved at request submission, there are a few scenarios when a request can require additional review. The most common is a third/recurring request when clinical documentation upload is required. In this scenario, providers will receive messaging on portal indicating a need for clinical documentation. Providers should upload the specified documents.

Additional scenarios that may require additional review.

- Indication of a provider that requires a sanction check.
- Indication of a purpose of therapy that does not require the skills of a therapist or for which there is no allowable benefit.
- Indication of an adjunctive service code or codes that do not require the skills of a therapist on the request (See CPT code question for a link to the CPT codes Carelon reviews). Adjunctive codes require further review against additional guideline criteria before any determination or authorization can be rendered on the therapy request.
- Indicating a primary treatment which is not evidenced based.
- A member benefit limit has been reached, where benefit limits apply.
- Indicating no functional objective progression on the outcome tool or plan of care goals.
- No mitigating factor indicated along with a lack of functional objective progression.
- Clinical documentation is incomplete.

If the request does not approve upon submission or review is needed, the request is forwarded to an appropriate therapist (i.e., physical, occupational or speech) who uses additional clinical experience and knowledge to evaluate the request against clinical guidelines. The clinical reviewer has the authority to issue order numbers in the event it is determined that the request meets 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, you may contact Carelon to discuss the request or to provide additional information.

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

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

If the member is returning to the facility for treatment within the next 48 hours or the request is urgent and a determination has not been received, the facility can call Carelon and ask if the request can be reviewed live. If the provider cannot hold the line while the request is reviewed, they can request a same day call back with the request's determination.

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 portal where they can view the determination.

What are the most common reasons for a subsequent treatment request to receive a lower visit allocation?

When a subsequent treatment request received a lower than typical visit allocation, there are a few possible reasons for this outcome.

Note: BCBS of IL BCCHP therapy requests are approved in units when medical necessity is met. Please replace "visits"

with “units” for the below information for BCBS of IL BCCHP therapy requests.

- Did the provider omit an in-scope functional outcome tool (from the microsite list) on the initial treatment request and/or omit a baseline score?
- Did the provider reference the scoring scale on the provider microsite to ensure that the functional outcome tool score indicated matches the Carelon scoring scale?
- Did the provider indicate an in-scope functional outcome tool (from the microsite list) on the request and indicate an updated score from the member’s most recent visit?
- Did the provider indicate a mitigating factor if minimal to no progression is indicated on the functional outcome tool score between the initial or subsequent treatment request?
- Did the provider indicate a change to the plan of care if minimal to no progression is indicated on the functional outcome tool score between the initial or subsequent treatment request?
- Did the provider indicate short-term goal achievement (full or partial) on the request?
- Has a benefit limit been reached, where benefit limits apply?
- Has the member achieved the plan of care functional goals when fewer visits may be appropriate for discharge planning and home exercise program instruction?

The provider has the option to call Carelon at any time for a peer-to-peer discussion if they feel the details of their request need to be clarified.

What are the provider’s options if a request does not meet clinical criteria?

Providers can contact Carelon to discuss therapy requests at any time. 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 notice of an adverse determination, depending on the market, they may have post-determination options for further review.

- **Peer to Peer:** Providers can request a peer-to-peer conversation with a Carelon clinician at any stage in the request process. A peer-to-peer can be initiated through the Carelon call center. The provider has the option to schedule the peer-to-peer at a convenient time, if necessary.
- **Reconsideration:** Some markets allow reconsideration of the denied decision, within the market-established timeframe. Reconsiderations give the provider the opportunity to clarify existing clinical information on a therapy request. A reconsideration is initiated by calling the Carelon call center.
- **Provider Document Review (PDR):** Some markets allow provider document review of the denied decision, within the market-established timeframe. Provider document review gives the provider the opportunity to upload new clinical documentation on a therapy request that requires clinical documentation upload. Provider document review is initiated by uploading new clinical documentation on the portal.
- **Provider Courtesy Review (PCR):** In the BCBS North Carolina Commercial market, Carelon will allow for provider courtesy review (PCR) to be initiated on **prospective** therapy cases within 180 days of the adverse determination date. The PCR process allows the provider to discuss additional clinical details that were not previously considered or to upload new clinical documentation that may impact the request’s adverse determination. PCR process can be initiated by the servicing provider most commonly on the portal by uploading additional clinical documentation, by phone, or fax. The turnaround time for PCR is 7 calendar days.
- **Appeal:** Providers can file an appeal for the denied decision to the health plan, information on how to file an appeal can be found in the denial letter.

Our facility has noticed that some of the adjunctive codes are always denied as not medically necessary, is there a reason for this?

There are CPT service codes that may be deemed not medically necessary in most scenarios within the Carelon Rehabilitation Program after doing thorough evidence review. Based on evidence, these codes (refer to the Carelon Guidelines for treatments in the adjunctive guideline section) have either been deemed not medically necessary (or necessary in limited clinical scenarios) due to not being a skilled service and/or having net benefit over conventional therapies. If a provider feels that a member's unique circumstances make the guideline determinations not applicable for any reason, that can be presented and considered on a peer to peer.

If a provider has specific evidence supporting a determination contrary to our guidelines, they can submit information to medicalbenefitsmanagement.guidelines@carelon.com to be reviewed by the Carelon guideline team.

What members do not require prior authorization due to age or diagnosis?

- For Anthem commercial members ages birth up until the member's third birthday in **Wisconsin, Indiana, Ohio, Missouri, Kentucky**, **Maine, Connecticut, New Hampshire and Virginia**, physical , occupational, and speech therapy services do not require prior authorization.
- For Anthem commercial members ages birth up until the member's sixth birthday in **Colorado**, physical, occupational and speech therapy services do not require prior authorization.
- For Healthy Blue Medicaid members in **Missouri there are a few nuances for both age and condition:**
    - For some product codes, members **under** 21 years of age have a covered benefit for "rehabilitative" therapy services.
    - For some product codes, members **over 21** years of age have a covered benefit of "rehabilitative" therapy services when pregnant.
    - For some product codes, there is only a covered benefit of "**habilitative**" therapy services.
    - For all these product groups providers will see appropriate messaging on the Carelon portal based on the member's product code for therapy services which are a covered benefit and allowable for prior authorization.
- For Wellpoint commercial members ages birth up until the member's third birthday in **Florida, Maryland, and Texas**, physical ,occupational and speech therapy services do not require prior authorization.
- For Anthem commercial fully insured members with coverage through Georgia, Indiana, Kentucky, Missouri, Ohio, Wisconsin, Connecticut, New Hampshire, New York, Maine, Colorado, Nevada, and Virginia, a prior authorization is not required for PT, OT, or ST outpatient therapy services, when there is a confirmed diagnosis of Autism Spectrum Disorder/Pervasive Development Delays. Providers may file a claim without a prior authorization number if billing with one of the following primary ICD-10 codes: F84.0, F84.2, F84.3, F84.5, F84.8, or F84.9.
- BCBS North Carolina commercial members with a primary diagnosis of Autism Spectrum Disorder/Pervasive Development Delay, therapy services do not require authorization when focused on the primary diagnosis (primary ICD-10 codes: F84.0, F84.2, F84.3, F84.5, F84.8, or F84.9).
- For Wellpoint commercial fully insured members with coverage through FL, MD, and TX a prior authorization is not required for PT, OT, or ST outpatient therapy services, when there is a confirmed diagnosis of Autism Spectrum Disorder/Pervasive Development Delays. Providers may file a claim without a prior authorization number if billing with one of the following primary ICD-10 codes: F84.0, F84.2, F84.3, F84.5, F84.8, or F84.9.

  In the above applicable markets, if a member with a diagnosis of Autism Spectrum Disorder/Pervasive Developmental Delay is receiving therapy services for a primary diagnosis other than Autism Spectrum Disorder/Pervasive Developmental Delay, a prior authorization of therapy services through Carelon would be required.

Does the initial evaluation require authorization and is treatment included with the initial evaluation visit?

Commercial fully insured members **do not require** prior authorization for the therapy evaluation codes or treatment codes rendered with the initial evaluation.

Medicaid and Medicare members **do not require** prior authorization for the therapy evaluation codes performed alone but **do require** a prior authorization for any treatment codes rendered with the initial evaluation.

Note: As of 10/1/2023 Anthem BCBS ME commercial members do not require prior authorization through Carelon until after the initial 12 treatment visits have been rendered, for new episodes of care, per therapy discipline. Treatment performed at the initial evaluation date of service will not count toward the 12 treatment visits that do not require prior authorization. Subsequent therapy treatment visits require prior authorization through Carelon.

Note: As of 8/1/2024 Anthem HealthKeepers Plus VA Medicaid members do not require prior authorization until after the initial 8 treatment visits have been rendered in new therapy episodes of care, per therapy discipline, when treated by an in-network provider. If seen by an out-of-network provider, prior authorization is required for all treatment visits within the member's episode of care, per discipline. Treatment performed at the initial evaluation date of service will count toward the 8 treatment visits that do not require prior authorization. Subsequent therapy treatment visits require prior authorization.

Beginning August 1, 2021, Anthem Commercial requests for members with Anthem coverage through CT, CO, GA, IN, KY, MO, NH, NV and OH for outpatient therapy services provided in the hospital outpatient department will be considered medically necessary only in certain clinical scenarios. Therefore, providers treating/billing in POS Outpatient Hospital will be subject to site of care review on **treatment requests**. While a prior authorization for the initial evaluation is not required for Anthem Commercial members, providers may submit an evaluation request, prior to starting the episode of care. The initial evaluation will be authorized along with any main treatment codes performed that day and the provider will receive messaging on the Carelon portal regarding the site of care review for subsequent treatment requests.

Note: As of 1/1/24 site of care review will take place utilizing the Carelon Guideline for Site of Care: Outpatient Rehabilitative and Habilitative Services. There will be no change to the Anthem Commercial markets where site of care review will apply.

Note: As of 7/1/2025, new legislation in Indiana will impact when a prior authorization is needed for physical therapy services for Anthem Blue Cross and Blue Shield of Indiana commercial fully insured members. Effective July 1, 2025, prior authorization will not be required for physical therapy services for Anthem Blue Cross and Blue Shield of Indiana commercial fully insured members. Physical therapy requests for Anthem Blue Cross and Blue Shield of Indiana commercial fully insured members to which the legislation applies will be messaged, "Authorization is not required for physical therapy for this member. Effective October 1, 2025, Anthem BCBS of IN commercial fully insured members do not require prior authorization for the first 12 physical therapy treatment visits, per physical therapy episode of care. Prior authorization for Anthem BCBS of IN commercial fully insured members is required from the 13th physical therapy treatment visit onward.

If you have questions, please contact the provider services number on the back of the member's ID card."

- Please note, Anthem Blue Cross and Blue Shield of Indiana commercial fully insured members will continue to require prior authorization of all occupational and speech therapy services, starting with the first treatment visit following the initial evaluation date of service.

- In addition, Anthem Blue Cross and Blue Shield of Indiana ASO/self-funded commercial members will continue to require prior authorization of all physical, occupational, and speech therapy services, starting with the first treatment visit following the initial evaluation date of service.

When answering the question about an evaluation being conducted for this treatment episode, would it apply if another therapist in the servicing facility completed the evaluation?

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

How does a provider initiate an episode of care in the Carelon portal?

Providers have two options for initiating an episode of care:

1) Providers can come to the portal prior to the initial evaluation and submit and evaluation request. Answering the portal question, "has an initial evaluation been performed" as "no" would allow for a 1-visit authorization for the initial evaluation and any main treatment codes rendered with the initial evaluation. If additional skilled care is required, the provider would then return to the portal to submit an initial treatment authorization request.

   Note: Not all markets have an "evaluation" request stage.

2) Providers can perform the initial evaluation and main treatment codes and then come to the portal within two business days of the first date of service that requires authorization.

   If site of care criteria (where applicable) is not met, the health plan member services team will help the member find a convenient, approvable in-network site of service, where they can continue therapy.

   a) Note: If site of care criteria is not met, only the initial evaluation date of service can be submitted on the claim.
   b) Note: Submission of individual adjunctive CPT codes will be subject to additional medical necessity review.

What if the functional tool/milestone assessment the provider utilizes is not listed on the Carelon portal?

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.

Can providers enter more than one functional tool for a complex patient case or a patient with two body parts being treated in one episode of care?

There is an opportunity to document up to two functional tools on a request noting that the 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.

What if the patient has multiple diagnoses relevant to their treatment episode?

Carelon educates that if the member will be seen for both diagnoses on the same date of service, with the same initial evaluation date, 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. Please enter the most primary treatment diagnosis that is the reason the patient requires skilled therapy services.

Additional diagnoses can be captured in several ways.

The Carelon portal allows providers to document up to two functional outcome tools/milestone assessments for multiple diagnoses or body parts being treated. In addition, multiple diagnoses can be documented in the *conditions impacting treatment or comorbidities* section of the request. Lastly additional diagnoses should be documented within the clinical documentation upload for the request, with functional goals for each diagnosis within the plan of care.

If the initial evaluation date of service is different and the member is seen on different dates of service for two diagnoses by the same therapy discipline, two prior authorization requests may be submitted. In this scenario, when entering the requests on the Carelon portal/call center, the initial evaluation dates for the two body parts must differ. Each episode of care would be required to have a plan of care containing functional goals.

Can a patient receive treatment for more than one therapy discipline (PT, OT, and ST) at the same time?

Yes, providers should request and receive separate authorizations for each therapy discipline, if the request meets 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.

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

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, functional, 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.

What if the provider wants more than the number of visits determined to be clinically appropriate for the request?

Note: BCBS of IL BCCHP therapy requests are approved in units when medical necessity is met. Please replace "visits" with "units" for the below information for BCBS of IL BCCHP therapy requests.

The number of visits determined to be clinically appropriate for the request is based on the patient's individual clinical details documented by the provider. The Rehabilitation program model allows providers to render the approved visits and see how the patient responds to therapy. Once the initial treatment visits have been delivered, providers can re-enter the portal, report the patient's improvement and get additional treatment visits approved if clinically appropriate.

In some markets, providers can choose not to accept the visit allocation determined to be clinically appropriate for the request.

If the provider **accepts the visits determined to be clinically appropriate** this option provides immediate authorization. The provider agrees to submit the order for the clinically appropriate number of visits noted within the request. If additional skilled therapy is needed, the provider may submit another request as they are nearing the end of the approved visits.

If the provider **does not accept the visits** determined to be clinically appropriate, they must call for a Peer to Peer with a Carelon Clinical Reviewer utilizing the dedicated market number within the turnaround time of request, to discuss the clinical presentation of the member and the medical necessity of additional services. If Carelon is unable to approve the additional services requested, we will issue partial approval and a denial letter to allow the provider to appeal the decision with the health plan.

(Note: If the provider does not contact Carelon within the turnaround time for the of request, the provider agrees to submit the order without a peer-to-peer discussion, and they will receive an authorization for the clinically

appropriate number of visits noted within the request. If additional skilled therapy is needed, the provider may submit another request as they are nearing the end of the approved visits.)

Information for providers related to telehealth services

Is prior authorization required for physical, occupational and speech therapy services?

Yes, prior authorization is required for physical, occupational and speech therapy services. Treatment codes and re-evaluation codes will require utilization management (UM) prior authorization review through Carelon.

Certain CPT codes would be appropriate to consider for telehealth (audio and video) for physical, occupational, and speech therapies.

- Physical therapy (PT) evaluation codes 97161, 97162, 97163 and 97164
- Occupational (OT) therapy 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 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.

Telehealth requests are documented with place of service 02 on the prior authorization request and modifier 95 or GT on the claim.

Medicare Advantage Program (including Texas MMP members)

What do providers need to take into consideration when submitting a Medicare Advantage Carelon Rehabilitation request?

- Per CMS, Chiropractors are not in scope as ordering and servicing providers for Rehabilitation services included in this program.
- The initial evaluation code does not require authorization, but any treatment service codes will require authorization if performed at the initial evaluation. Providers have two options:
    I. Providers can come to the portal, prior to the initial evaluation and answer the question, “has an initial evaluation been performed, “no” and receive an immediate 1 visit allocation. The provider would then return to portal prior to the first subsequent treatment visit to submit a prior authorization request.
    II. Providers can perform the initial evaluation and treatment and then come to the portal within two business days of the initial evaluation to submit a request for authorization. In this example, the initial evaluation date and the start date of treatment would both be the same (the initial evaluation date).
- The following Physical Therapy and Occupational Therapy CPT codes are required to be entered individually on a request, if applicable to the treatment plan, as coverage determinations may vary:
    - 97129 - One-on-one therapeutic interventions focused on thought processing and strategies to manage activities
    - 97130 - each additional 15 minutes (list separately in addition to code for primary procedure)
    - 20560 - Needle insertion(s) without injection(s), 1 or 2 muscle(s)
    - 20561 - Needle insertion(s) without injection(s), 3 or more muscle(s)

- 97024 - Application of heat wave therapy to 1 or more areas
- 97026 - Application of low energy heat (infrared) to 1 or more areas
- 97032 - Application of electrical stimulation to 1 or more areas, each 15 minutes
- 97033 - Application of medication through skin using electrical current, each 15 minutes
- 97035 - Application of ultrasound to 1 or more areas, each 15 minutes
- G0283 - Electrical Stimulation, to one or more areas, for other than wound care
- The basis of the Rehabilitation program clinical appropriateness review includes the appropriate National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Benefit Policy Manual Chapter 15, Section 220 and 230.

Where can I access additional information?

For more information: The Rehabilitation Solution provider website offers providers tools and information at https://providers.carelonmedicalbenefitsmanagement.com/rehabilitation/