Evolent
Frequently Asked Questions (FAQs)
Absolute Total Care
Prior Authorization Program Physical Medicine Services

Question	Answer
General	
When does the Physical Medicine Services program require a prior authorization for Absolute Total Care?	Effective January 1, 2020, Physical Medicine Services - physical therapy (PT), occupational therapy (OT), and speech therapy (ST) - will require prior authorization for Absolute Total Care South Carolina Healthy Connections Medicaid members, Allwell from Absolute Total Care (Medicare) members, and Absolute Total Care Healthy Connections Prime (Medicare-Medicaid Plan) members. Prior authorization for Ambetter from Absolute Total Care (Health Insurance Marketplace) and BabyNet members should continue to be requested through Absolute Total Care.
What services now require prior authorization?	Prior authorization will be required for all treatment rendered by a physical therapist, occupational therapist, or speech therapist.
Will a prior authorization be required for the initial evaluation?	The CPT codes for PT, OT, and ST initial evaluations do not require an authorization for participating providers. However, all other billed CPT codes, even if performed on the same date as the initial evaluation date, will require authorization prior to billing.
Which Absolute Total Care members will be covered under this relationship and what networks will be used?	Evolent (formerly National Imaging Associates, Inc.) will manage Physical Medicine Services for Absolute Total Care Healthy Connections Medicaid members, Allwell from Absolute Total Care (Medicare) members, and Absolute Total Care Healthy Connections Prime (Medicare-Medicaid Plan) members who will be utilizing Physical Medicine Services (PT, OT, ST). Prior authorization for Ambetter from Absolute Total Care (Health Insurance Marketplace) and BabyNet members should continue to be requested through Absolute Total Care.

Is prior authorization necessary for Physical Medicine Services if Absolute Total Care is NOT the member's primary insurance?	Yes. This program applies to Absolute Total Care Healthy Connections Medicaid members, Allwell from Absolute Total Care (Medicare) members, and Absolute Total Care Healthy Connections Prime (Medicare-Medicaid Plan) members who have Absolute Total Care as their primary insurance or secondary insurance.
What services are included in this Physical Medicine Services program?	All outpatient PT, OT, and ST services are included in this program in the following setting locations: • Outpatient Office • Outpatient Hospital
Which services are excluded from the Physical Medicine Services program?	Therapy provided in a Hospital Emergency Room (ER), Inpatient and Observation Status, Acute Rehab Hospital Inpatient, Home Health, Assisted Living, and Inpatient and Outpatient Skilled Nursing Facility settings are excluded from this program. The treating provider should continue to follow Absolute Total Care's policies and procedures for services performed in the above settings.
Why is Absolute Total Care implementing a Physical Medicine Utilization Management program?	This physical medicine solution is designed to promote evidence based and cost-effective PT, OT, and ST services for Absolute Total Care members.
Why focus on physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services?	A consistent approach to applying evidence-based guidelines is necessary so Absolute Total Care members can receive high quality and cost-effective physical medicine services.
How are types of therapies defined?	Rehabilitative Therapy – A type of treatment or service that seeks to help a patient regain a skill or function that was lost as a result of being sick, hurt, or disabled. Habilitative Therapy – A type of treatment or service that seeks to help patients develop skills or functions that they didn't have and were incapable of developing on their own. This type of treatment tends to be common for pediatric patients who haven't developed certain skills at an age-appropriate level.

	The simplest way to distinguish the difference between the two is that habilitative therapy is treatment for skills/functions that the patient never had, while rehabilitative therapy is treatment for skills/functions that the patient had but lost. Neurological rehabilitative therapy – A supervised program of formal training to restore function to patients who have neurodegenerative diseases, spinal cord injuries, strokes, or traumatic brain injury.
What types of providers will potentially be impacted by this Physical Medicine Services program?	Any independent providers, hospital outpatient, and multispecialty groups rendering PT, OT, and/or ST services will need to ensure prior authorization has been granted.
Prior Authorization Process	
How will prior authorization decisions be made?	Evolent will make medical necessity decisions based on the clinical information supplied by practitioners/facilities providing physical medicine services. Decisions are made as quickly as possible from submission of all requested clinical documentation. All decisions are, at minimum, rendered within state-required timelines. Peer-to-peer telephone requests are available at any point during the prior authorization process. Evolent's clinical review team consists of licensed and practicing physical therapists, occupational therapists, speech therapists and board-certified physicians. Clinical determinations are rendered only by clinical peer reviewers with appropriate clinical experience and similar specialty expertise as the requesting provider. Clinical peer reviewers will be available for peer-to-peer requests as necessary consultation as needed. The Absolute Total Care appeals process will be available if a provider disagrees with a prior authorization determination.
Who is responsible for obtaining prior authorization of the procedure?	Responsibility for obtaining prior authorization is the responsibility of the physical medicine practitioner/facility rendering and billing the identified services. A physician order may be required for a member to engage with the physical medicine practitioner, but the provider rendering the service is ultimately responsible for

	obtaining the authorization based on the plan of care they establish. Approval and denial letters are sent to the member, and physical medicine practitioner. Absolute Total Care contracts generally do not allow balance billing of members. Please make every effort to ensure that prior authorization has been obtained prior to rendering a physical medicine service.
Will CPT codes used to evaluate a member require prior authorization?	Initial PT, OT, and ST evaluation codes do not require authorization. It may also be appropriate to render a service that does require authorization at the time of the evaluation. After the initial visit, providers will have up to 10 calendar days to request approval for the first visit. If requests are received timely, Evolent is able to backdate the start of the authorization to cover the evaluation date of service to include any other services rendered at that time.
What will providers and office staff need to do to get a physical medicine service authorized?	Providers will contact Evolent using the RadMD website (RadMD.com) or by calling 1-866-433-6041 to obtain authorization for physical medicine services effective January 1, 2020.
What kind of response time can providers expect for prior authorization of physical medicine requests?	Evolent does leverage a clinical algorithm to assist in making real time decisions at the time of the request based on the requestors' answers to a few simple clinically based questions. If we cannot offer immediate approval, generally the turnaround time for completion of these requests is within two to three business days upon receipt of sufficient clinical information. There are times when cases may take up to the maximum timeframe of 15 calendar days (i.e., if additional clinical information is needed), but that is not the norm.
If the servicing provider fails to obtain prior authorization for the procedure, will the member be held responsible?	This prior authorization program will not result in any additional financial responsibility for the member, assuming use of a participating provider, regardless of whether the provider obtains prior authorization for the procedure or not. The participating provider may be unable to obtain reimbursement if prior authorization is not obtained, and member responsibility will continue to be determined by plan benefits, not prior authorization. If a procedure is not prior authorized in accordance with the program and rendered at/by an Absolute Total Care participating provider, benefits will be denied, and the member will not be responsible for payment.

How do I obtain an authorization?	Authorizations may be obtained by the physical medicine practitioner via the online portal, RadMD or via phone at 1-866-433-6041. The requestor will be asked to provide general provider and patient information as well as some basic questions about the member's function and treatment plan. Based on the response to these questions, a set of services may be offered real-time. If we are not able to offer a real-time approval for services or the provider does not agree to accept the authorization, additional clinical information may be required to complete the review. Clinical records may be uploaded via RadMD or faxed to 1-800-784-6864 using the coversheet provided.
What information should you have available when obtaining an authorization?	• Member name/Date of birth • Member ID • Diagnosis(es) being treated (ICD10 Code) • Requesting/Rendering provider type (PT, OT, ST) • Date of the initial evaluation at their facility • Type of therapy: habilitative, rehabilitative, neuro rehabilitative • Surgery date and procedure performed (if applicable) • Date the symptoms started • Planned interventions (by billable grouping category) and frequency and duration for ongoing treatment • How many body parts are being treated, and is it right or left? • The result of the Functional Outcome Tool used for the body part evaluated. The algorithm is looking for the percentage the patient is functioning with their current condition. Example: If a test rated them as having a 40% disability, then they are 60% functional. • Summary of functional deficits being addressed in therapy
How will I confirm physical medicine benefits for a member?	Member benefits, benefit limitations, and number of visits remaining for the year should be confirmed through Absolute Total Care Provider Services. Each date of service is calculated as a visit.

If a provider has already obtained prior authorization and more visits are needed beyond what the initial authorization contained, does the provider have to obtain a new prior authorization?	Additional services on an existing authorization should NOT be submitted as a new request. If/when an authorization is nearly exhausted, additional visits may be requested as an addendum/addition to the initial authorization. To initiate a request for additional care, providers can use the fax cover sheet from the initial authorization to submit updated clinical records or may load these records to the existing authorization in RadMD. To obtain additional services, clinical records will be required. Providers may upload these records through RadMD or fax them to Evolent at 1-800-784-6864 using the coversheet provided at the time of the initial authorization. Additional fax coversheets may also be printed from RadMD or requested via phone at 1-866-433-6041. If the member needs to be seen for a new condition, or there has been a lapse in care (more than 30 days) and care is to be resumed for a condition for which there is an expired authorization, providers should submit a new initial request through RadMD or via telephone at 1-866-433-6041.
What if I need more time to use the services previously authorized?	A one-time, 30-day date extension on the validity period of an authorization is permitted and can be requested via phone at 1-866-433-6041, by submitting an electronic request through RadMD or fax to 1-800-784-6864 using the coversheet provided. Date extensions are subject to any benefit limits that may restrict the length of time for a given condition/episode of care. Extensions beyond the initial 30-day request or outside of any benefit constraints may require clinical records to be submitted.
If a patient is discharged from care and receives a new prescription or the validity period ends on the existing authorization, what process should be followed?	A new authorization will be required after the one-time, 30-day extension or if a patient is discharged from care.

If a patient is being treated and the patient now has a new diagnosis, will a separate authorization be required?	If a provider is in the middle of treatment and gets a new therapy prescription for a different body part, the treating provider will perform a new evaluation on that body part and develop goals for treatment. If the two areas are to be treated concurrently, the request would be submitted as an addendum to the existing authorization, using the same process that is used for subsequent requests. Evolent will review the request and can add additional visits and the appropriate ICD10 Code(s) to the existing authorization. If care is to discontinue on the previous area being treated and ongoing care will be solely focused on a new diagnosis. Providers should submit a new request for the new diagnosis and include the discharge summary for the previous area. A new authorization will be processed, and the previous will be ended.
Could the program potentially delay services and inconvenience the member?	The preferred method for obtaining prior authorization is via Evolent's website (RadMD.com) or can be initiated by calling 1-866-433-6041. In cases where additional clinical information is needed, a peer-to-peer consultation with the provider may be necessary and can be initiated by calling 1-866-433-6041. Responses to Evolent requests for additional clinical information or peer-to-peer are needed to ensure a timely review and determination. Requests initiated via fax require clinical validation and may take additional time to process. The fax number is 1-800-784-6864.
What happens in the case of an emergency?	The Evolent website (RadMD.com) cannot be used for medically urgent or expedited prior authorization requests during business hours. Those requests must be processed by calling 1-866-433-6041.
How are procedures that do not require prior authorization handled?	If no authorization is needed, the claims will process according to Absolute Total Care's claim processing guidelines.

Appeals and Re-Review/Re-Open Process	
If a provider disagrees with a physical medicine determination made by Evolent, is there an option to appeal the determination	The peer-to-peer process can be initiated once the adverse determination has been made for Medicaid. In the event of any sort of adverse determination, Evolent will reach out to the provider to offer a peer-to-peer discussion. After the determination has been finalized, providers may still request to discuss the case as an informal reconsideration (peer-to-peer/re-review) prior to requesting a formal appeal. Re-reviews on determinations must be made within one business day for Medicaid members via this peer-to-peer process. The phone number to initiate a peer-to-peer is 1-866-433-6041. These discussions provide an opportunity to discuss the case and collaborate on the appropriate services for the patient based on the clinical information provided. In the event a provider disagrees with Evolent's final determination, as a vendor for Absolute Total Care, Evolent will offer options for an informal reconsideration and/or an appeal. Formal appeal guidance is provided in the initial determination letter. Peer-to-peer consultations can be conducted anytime during normal business hours, or as required by federal or state regulations. - **Medicaid** **Medicare plans:** Effective 8/5/2024, peer-to-peer discussions must be performed before a final determination has been made on the request. **Medicare** re-opens are only allowed if the request complies with the CMS definition of a re-open. Providers will continue to have the option to submit an appeal utilizing the health plan's process.
Is the re-review process available for the Physical Medicine Services program once a denial is received?	A re-review (informal reconsideration) can be initiated through the peer-to-peer process. Once the denial determination has been made the provider will be offered a peer-to-peer discussion or can call 1-866-433-6041 to initiate the peer-to-peer process themselves. Re-review must be initiated within one business day for Medicaid members from the date of the denial and may be submitted verbally or in writing. Medicare cases may not be re-opened.

RadMD Access	
What option should I select to receive access to initiate authorizations?	"Physical Medicine Practitioner" which will allow you access to initiate authorizations.
How do I apply for RadMD access to initiate authorization requests?	The user would go to the Evolent website (RadMD.com) • Click on "NEW USER". • Choose "Physical Medicine Practitioner" from the drop-down box • Complete application with necessary information. • Click "Submit" Once an application is submitted, the user will receive an email from Evolent's RadMD support team within 72 hours after completing the application with their approved username and a temporary passcode. Please contact the RadMD Support Team at 1-800-327-0641 if you do not receive a response with 72 hours. Your RadMD login information should not be shared.
What is rendering provider access?	Rendering provider access allows users the ability to view all approved authorizations for their office or facility. If an office is interested in signing up for rendering access, you will need to designate an administrator. • The user would go to the Evolent website (RadMD.com) • Select "Facility/Office where procedures are performed" • Complete application • Click "Submit" Examples of a rendering facility that only need to view approved authorizations: • Hospital facility • Billing department • Offsite location • Another user in location who is not interested in initiating authorizations Once an application is submitted, the user will receive an email from the RadMD support team within 72 hours after completing the application with their approved username and a temporary passcode. Please contact the RadMD Support Team at 1-800-327-0641 if you do not receive a response with 72 hours. Your RadMD login information should not be shared.

Who can I contact if we need RadMD support?	For assistance or technical support, please contact RadMDSupport@Evolent.com or call 1-800-327-0641. RadMD is available 24 hours a day, seven days a week, except when maintenance is performed once every other week after business hours.
Contact Information	
Who can a provider contact at Evolent for more information?	If you have a question or need more information about this physical medicine prior authorization program, you may contact the Evolent Provider Service Line at 1-800-327-0641. You may also contact your dedicated Evolent Provider Relations Manager: Priscilla W. Singleton 1-314-387-5023 psingleton@Evolent.com
Who can a provider contact at Absolute Total Care if they have questions or concerns?	You may contact Absolute Total Care provider services at 1-866-433-6041. Providers can also access the Absolute Total Care website at: absolutetotalcare.com