UMPQUA HEALTH
ALLIANCE
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Prior Authorizations FAQ: Chiropractic Services

Umpqua Health Alliance (UHA) requires prior authorization (PA) of all chiropractic services. The UHA PA grid is located on our website and provides information on PA requirements. The section for Chiropractic and Acupuncture states the following:

> *"Requires initial prior authorization submitted by Primary Care Provider; subsequent visits for same condition are requested by Chiropractor/Acupuncturist. Of note, Chiropractic is a covered benefit ONLY for diagnoses of Scoliosis/Conditions of the Back & Spine (Prioritized List Lines 361, 401)."*

1. **What chiropractic services does UHA cover?**
   UHA provides coverage of services/supplies in compliance with the Oregon Health Plan (OHP). Services must be medically appropriate/necessary and consistent with the Prioritized List of Health Services (PLHS). Chiropractic services are subject to Guideline Note 56 of the PLHS which limits coverage of chiropractic manipulation to conditions of the back and spine.

2. **How much treatment will UHA cover?**
   OHP members are eligible for a maximum of 30 visits per year of any combination of evidence-based therapies when appropriate. This total includes the sum of all chiropractic, osteopathic, acupuncture and physical/occupational therapy visits that are deemed medically appropriate.

3. **What are the PA determinations based on?**
   InterQual is an evidence-based clinical decision support tool used to make clinically appropriate medical utilization decisions. UHA applies this tool to PA requests, including chiropractic services. The determination process includes evaluation of the duration of treatment. Documentation of the InterQual criteria (example included) is included in each PA processed in CIM which can be accessed by CIM users.

4. **What is the process for requesting a PA to begin treatment?**
   1) Primary care provider submits request with supporting documentation.
   2) UHA reviews the request with InterQual criteria.
   3) If approved, the initial request would allow for:
      a. One evaluation within the range of CPT 99201-99205 or 99211-99215.
      b. Treatment to start with the first visit, with the total number of visits based on the InterQual review. All treatment is within the range of CPT 97012, 97110, 97124, 97140, 98940, and 98941.

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5. What is the process for requesting a PA to continue treatment?

1) Chiropractic provider submits request indicating the number of visits with supporting documentation.
    a. Documentation must support measurable clinically significant progress toward the therapy plan of care goals and objectives using evidence based objective tools.
2) UHA reviews the request with InterQual criteria.
3) If approved, the initial request would allow for additional treatment visits based on the InterQual review. All treatment is within the range of CPT 97012, 97110, 97124, 97140, 98940, and 98941.

6. How are re-evaluations requested?

A PA may be submitted by the chiropractic provider for the appropriate re-evaluation code. This would follow the same process as FAQ#5. CPT 99201-99205 are evaluation and management codes for new patient and would not be appropriate for re-evaluation.

7. How many visits can be requested?

InterQual is able to determine the number of treatment visits appropriate based on the documentation reviewed. In most initial approvals, 4 visits are included. Additional visits would be subject to the review of additional documentation for continued treatment requests.

UHA understands that the treatment and individual codes/units cannot always be anticipated when requesting authorization, compared to what is actually provided on the date of service and billed on a claim. To streamline the process, UHA analyzed the utilization of chiropractic services and implemented system updates in CIM for PA's. This grouping of codes allows each visit to include CPT 97012, 97110, 97124, 97140, 98940, and 98941. Each unit <u>on a PA</u> is equal to 1 visit. Evaluation and management codes are also grouped so that 1 unit/visit authorized may be billed on a claim with any code within the range of 99201-99205 and 99211-99215.

When billing a claim, each visit may include multiple units of services. See example* below comparing units and CPT code groups on a PA and a claim:

Approved PA	
4 units = 4 visits	97012, 97110, 97124, 97140, 98940, and 98941
1 unit = 1 visit	97201-97205 and 97211-972015

Claim #1	
4 units	97140
1 unit	98941
1 unit	97201

Claim #2	
1 unit	97140
1 unit	98941
1 unit	97110

Claim #3	
1 unit	97140
1 unit	98941

Claim #4	
1 unit	97140
1 unit	98941
1 unit	97110

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8. **What if the patient has been established but has a new condition?**
   Each condition is a separate episode of treatment and requires a new PA starting with the PCP.

9. **What is the prioritized List?**
   The Prioritized List of Health Services (PLHS) ranks health services by priority. It contains 660 line items consisting of condition-treatment pairs, of which the services on lines 1-469 are covered for UHA members. The list uses ICD-10-CM diagnosis codes and CPT and HCPCS procedure codes to define the condition-treatment pairs that make up each line. The methodology used to prioritize health services places a high emphasis on preventive services and chronic disease management in the recognition that the utilization of these services can lead to a reduction in more expensive and often less effective treatments provided in the crisis stages of disease.
   https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

10. **Where is the UHA PA form and PA Grid?**
    https://www.umpquahealth.com/for-providers/#provider-ohp-services

11. **What is the coverage guidance from the Health Evidence Review Commission?**
    Low Back Pain Non-Pharmacologic, Non-Invasive Interventions:
    https://www.oregon.gov/oha/HPA/DSI-HERC/EvidenceBasedReports/Low-Back-Pain-Non-Pharmacologic-Non-Invasive-Interventions-11-13-14.pdf

*Examples are for educational purposes only. UHA does not provide coding advice or assume responsibility for claim submission or reimbursement. All services must be medically necessary and medically appropriate.