CARE IQ

Therapy Provider Manual

Effective date 11/2022

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Introduction

The CareIQ Therapy Program is based on the provision of only medically necessary therapy treatments with the focus on work-specific rehabilitation.

Provider Expectations

- Provider shall be a licensed Physical Therapist, Occupational Therapist, Physical Therapist Assistant, or Certified Occupational Therapist Assistant and practice in accordance with state laws and practice acts. The provider shall use best efforts to assign the patient to the same Physical or Occupational Therapist for each appointment. **CareIQ Therapy Program does not allow the use of Massage Therapists or Chiropractors in treatment**.

- Any non-licensed personnel may only participate with patient care as an aide in accordance to each provider's state practice act, including Athletic Trainers.

- Provider shall obtain a prescription from the physician for all visits completed. The therapy provider is responsible for all communication and submission of all documentation to the physician.

- All Documentation (Initial Evaluation, Progress Note, and Discharge Summary) must be sent to CareIQ Therapy Program within 24 hours of completed service.

- All patients are to be scheduled for their Initial Evaluation within 48 hours of referral. For the initial appointment, reimbursement includes both the evaluation and the treatment on the first day of therapy. **The provider is responsible for notifying CareIQ Therapy Program within 24 hours of appointments for which the patient cancels or does not show.**

- Provide future scheduled appointments upon request.

- Treatment sessions must include skilled physical therapy or occupational therapy; therapeutic modalities alone will not be accepted or reimbursed.

- If documentation received from the facility is lacking required documentation, CareIQ may require the provider to use CareIQ forms rather than their own forms. (Example: Progress Report)

- All progress reports completed by a Physical Therapy Assistant (PTA) or Certified Occupational Therapy Assistant (COTA) must also be signed by a licensed Physical or Occupational Therapist.

- CareIQ must be notified when the treating therapist plans to continue treatment beyond the current PIan of Care.

- It is CareIQ policy that after any 30 day lapse in therapy services, a discharge summary of the patient's last known status will be requested. If additional MD orders have been received, the facility must submit those to CareIQ for review before additional certification will be sent to the facility as a possible continuation of care.

- Therapy should be discontinued once discharge criteria have been met.

- The Dates of Service Form (page 11) should be submitted with the 6 visit Progress Note, or sooner if you are notifying CareIQ of a cancellation or no show.

- CareIQ Therapy Program will manage all documentation and communication between the adjuster, case manager, and/or employer. If an adjuster, case manager or employer contacts you, please supply a copy of the requested documentation and call 866-866-1101, to report the additional contact.

Contact Information

CareIQ Therapy Program

Toll Free Phone: 866-866-1101 Option 1: *To schedule new patient, start a new referral*
Option 3: T*o follow up with a current file.*
Option 5: For Spanish
Fax Number: 844-422-7347

CareIQ Therapy Program Billing

Toll Free Phone: 866-866-1101 Option 2: *For Billing Questions/Concerns/Claim Status*

Claims Address for CareIQ:

CareIQ Therapy Program
550 Congressional Boulevard
Suite 300
Carmel, IN 46032

CareIQ Therapy Program Provider Relations- To address any concerns with CareIQ Therapy Program

Email: CareIQ_Provider_Relations@corvel.com
Toll Free Phone: 866-866-1101
Fax: 866-913-1542

Documentation Requirements

All therapy documents and requests for additional visits should be sent to:

Fax: 844-422-7347
Email: PTdocuments@corvel.com

*****All documentation should be sent to CareIQ within 24 hours of the completed service*****

Failure to provide the required documentation in a timely manner may result in a delay in care.

Required Documentation for CareIQ Therapy Program

- **Initial Evaluation**:
  - **Subjective**
    - Pain Level (0-10) with duration (constant, frequent, intermittent or occasional)
    - Brief subjective job title, description and work status
  - **Objective**
    - Range of Motion
    - Strength
    - Functional status (ADLs and work tasks)
  - **Assessment**
    - Co-morbidities that may contribute to delay in return to work objectives
    - Functional return to work goals (based on Work Requirements Questionnaire)
  - **Treatment Plan**
    - Frequency and duration with anticipated time of discharge
- **Work Requirements Questionnaire:** This form should be completed at the Initial Evaluation. The top portion is to be completed by the patient, and the bottom portion is to be completed by the treating therapist. This questionnaire provides immediate information with the patient's subjective report of his/her job duties and thus assists in the therapy plan of care. Once the patient has provided the information, the treating therapist should make 2-3 long-term, functional goals using the information provided by the patient. (See page 8)
- **6 Visit Progress Reports:**
  - Progress Reports **MUST** be completed every 6 visits (i.e. visits 6, 12, 18, etc).
  - Reports must include updated objective measurements and functional status.
  - Reports require all information as listed on CareIQ Therapy Program sample progress report. You may use the CareIQ Therapy Program progress report *or* your own facility form as long as it contains the same information as the sample form. (See page 9)
- **Discharge Reports**:
  - Please include goal status (addressing all therapy goals), return to work status (full, limited, off work) and a reason for discharge. (See page 10)
  - Reasons for discharge include the following:
    - Patient terminated therapy
    - Patient non-compliance (3 consecutive no-shows/cancellations)
    - Physician terminated therapy
    - Patient achieved all therapy goals, treatment no longer necessary
    - Patient reached a plateau in treatment
    - Patient has met majority of treatment goals and no longer requires skilled intervention to obtain functional restoration
    - Therapy contraindicated or condition worsened
    - Patient referred to specialist or is having surgery

Certification Process (Requesting Additional Approval)

CareIQ Therapy Program certifies visits by using *Levels of Care* which are broken down into increments of six (6) visits. To request certification of the next *Level of Care*, please submit the following documentation:

- 6 visit Progress Report
- Prescription to cover additional visits requested (if not already submitted)
- Updated Dates of Service including cancelled or no show appointments. (See page 11)

- Upon approval, the therapy facility will receive notification in the form of a certification letter which will state the *Level of Care* that has been approved.
- If facility has not heard from CareIQ Therapy Program within 48 hours of faxing the Progress Report, please contact CareIQ at **866-866-1101** to check the status of the certification.

Clinical Review

Upon receipt of appropriate documentation, the file will be clinically reviewed to assess progress and the plan of care. CareIQ Therapy Program utilizes clinical reviews performed by licensed therapists. If the clinical review identifies clinical concerns, a therapist will be contacting the therapy office to discuss the case with the treating therapist. In the same manner, a licensed Physical Therapist is available to assist with any clinical concerns that the treating therapist may have with a case.

Durable Medical Equipment

All DME requests over $50.00 require Prior Authorization. Please send prescription to 844-422-7347.

If the DME is under $50.00, it can be given directly to the patient. To be reimbursed for the DME/medical supplies, please see billing instructions on page 7.

Functional Capacity Evaluations

A sample FCE with HIPPA identifying information redacted, must be submitted and pre-approved before your facility can be contracted to perform FCE's for CareIQ Therapy Program.

Work Conditioning / Work Hardening

An Initial Evaluation needs to contain functional and work related baseline measurements, not just skilled PT measurements.

The goals need to be functional and work related.

The patient needs to be performing general strengthening and conditioning activities as well as specific work related activities in the facility for 2-4 hours per day, 3-5x/week, unless otherwise prescribed by the treating MD.

A Progress Report is required every 6 visits for all frequencies of treatment during Work Conditioning/Work Hardening.

Billing Process

The following is a brief summary of CareIQ Therapy Program billing process:

- Bills are to be sent to CareIQ Therapy Program regularly by the provider, to the billing address below.
- Bills should be submitted to CareIQ Therapy Program within **30 days** of the rendered service.
- **Bills not received within 60 days of rendered services may be rejected at CareIQ's discretion.**
- Payment is typically received within **30** days from the time the bill is received by CareIQ Therapy Program.

Below is a list of suggestions to avoid claim denials or a delay in payment:

- Provider must notify CareIQ immediately of any changes in name, ownership, address, phone numbers, tax ID number (include W-9 form) or billing office address. Failure to do so may result in delays or incorrect reimbursement. Providers must also notify CareIQ of any suspension, revocation, condition, limitation, qualifications or other restrictions on providers' licenses, certifications and permits by any government under which the provider is authorized to provide health care services. **Changes/Updates can be emailed to CareIQ Provider Relations (CareIQ_Provider_Relations@corvel.com) or Faxed to 866-913-1542.**
- Submit bills on a standard medical claim form *(such as CMS-1500, UB-04, UB-92)* using customary CPT codes. List the therapist name and therapist license number in appropriate boxes. In addition, the service facility location must also be filled out in its entirety to identify the site where services were delivered. (On a standard CMS-1500 form, these are located in Boxes 31-33.)
- Bills must be submitted along with daily notes for each single visit. These notes must be marked with a handwritten *or* digital signature. If preferring a digital signature on daily notes, the name must clearly and unmistakably authenticate that the typed name is a "digital" or "electronic" signature.
    - Suggestions include: "Digitally signed by", "Electronic Signature".
    - **Work conditioning /hardening must include time in and time out on clinical documentation for each date of service. Your contracted Work Conditioning/Hardening Codes are:**
        - **97545: Initial 2 hours (includes Initial Evaluation)**
        - **97546: Each additional hour**
- Supplies and equipment are to be billed on separate forms from therapy services and are reimbursed independently from therapy care.
    - **Misc. Supply Code: 99070** can be used to submit claim for medical supplies.
    - Any supply billed over $50.00 requires prior authorization from CareIQ Therapy Program.
    - Custom made or off the shelf Orthotics must be pre-certified then billed for professional fitting and supplies separately.
    - Original Invoice, or copies of original invoice, must accompany all supply codes where possible.
    - If an invoice is unavailable or not present at the time of billing, reimbursement will be according to CareIQ Therapy Program's reimbursement policies.
    - Supplies should be documented in daily notes, so that when a supply is billed there is supporting documentation of application.
- Bill authorized Initial Evaluations (IE) with appropriate and valid CPT codes. If the service being billed is an IE, the "note" must contain actual documentation from the IE.
- Bill each injury on separate HCFA forms with the ICD9 diagnosis codes corresponding with the daily notes.

Note: Please do not bill the employer or adjuster directly.

Billing Address:
CareIQ Therapy Program
550 Congressional Boulevard
Suite 300
Carmel, IN 46032

CARE IQ

Care IQ Therapy Program
550 Congressional Boulevard, Suite 300
Carmel, IN 46032

Work Requirements Questionnaire

Provider Name: _____
Patient's Name: _____ Claim #: _____
Body Part: _____ Date of Injury: _____
Service: _____ Today's Date: _____

To be completed by patient and therapist on first visit (or as soon as possible, if received after 1st visit).

Completed by Patient: (Subjective Report)

Please circle the number that best represents your current pain level:
No Pain 0……1…...2…...3…...4…...5…...6…...7…...8…...9…...10 Emergency Room Pain

What is your Job Title? _____

Previous Work Status: ☐ Full Time ☐ Part time
Current Work Status: ☐ Full Duty ☐ Off Duty Last Day Worked (If off duty): _____
☐ Modified Duty; Restrictions: _____

In one hour of FULL duty, how long do you typically do the following activities:

Sit:	☐ 0-15 min	☐ 15-30 min	☐ 30-40 minutes	☐ 45 minutes-1 hour
Kneel:	☐ 0-15 min	☐ 15-30 min	☐ 30-40 minutes	☐ 45 minutes-1 hour
Walk/Stand:	☐ 0-15 min	☐ 15-30 min	☐ 30-40 minutes	☐ 45 minutes-1 hour
Run:	☐ 0-15 min	☐ 15-30 min	☐ 30-40 minutes	☐ 45 minutes-1 hour

How much weight do you push/pull? _____ How many times per hour? _____
How much weight do you lift? Floor to waist _____ How many times per hour? _____
Waist to Shoulder _____ How many times per hour? _____
Shoulder to Overhead _____ How many times per hour? _____

How many times do you do the following in one hour of full duty?
Squat: _____ Times Climb stairs or ladders _____ Times Reach _____ Times

Do you have concerns about physically performing your job? ☐ Yes ☐ No
Are you anticipating returning to your same job position? ☐ Yes ☐ No

Completed By Therapist: Please use this form to assist the patient in progressing toward full duty, if appropriate, by setting goals to address the above demands as given in the patient's report of his/her job duties. Indicate functional goals only.

To be met in _____ weeks

1. _____
2. _____
3. _____

My therapist has reviewed my job duties and discussed my functional and/or work related goals with me.

_____ _____
Patient Signature Date

_____ _____
Therapist Signature Date

Care^{IQ} Therapy Program
550 Congressional Boulevard, Suite 300
Carmel, IN 46032

Progress Report

Provider Name: _____
Patient's Name: _____ Claim #: _____
Body Part: _____ Date of Injury: _____
Service: _____

Date: _____ **Date of Next MD Visit:** _____

Visit Number: _____ **Cancellations/No Shows:** _____

Subjective: _____

Pain Rating: Previous Rating: _____/10 Current Rating: _____/10

Work Status: ❑ Full Duty ❑ Light/Modified Duty ❑ Off Work

Functional Outcome Questionnaire Used:
❑ The Lower Extremity Functional Scale ❑ Modified Oswestry Low Back Pain Disability Index (ODI)
❑ Neck Pain Disability Index Questionnaire ❑ QuickDASH ❑ ChildsH - FABQ
❑ Other: _____

Previous Score: _____ Current Score: _____

Objective: _____

Range of Motion		
Movement	Previous Measurement (Date:)	Current Measurement (Date:)

Strength		
Movement	Previous Measurement (Date:)	Current Measurement (Date:)

Functional Deficits:

	Maximum Ability	Meets Treatment Goal?				Maximum Ability	Meets Treatment Goal?		
Sit (time):	_____	❑N/A	❑ No	❑ Yes	Lift (lbs):	_____	❑N/A	❑ No	❑ Yes
Stand/Walk (time):	_____	❑N/A	❑ No	❑ Yes	Push/Pull (lbs):	_____	❑N/A	❑ No	❑ Yes
Run (time):	_____	❑N/A	❑ No	❑ Yes	Reach (reps or time):	_____	❑N/A	❑ No	❑ Yes
Stairs (#):	_____	❑N/A	❑ No	❑ Yes	Squat (reps):	_____	❑N/A	❑ No	❑ Yes

Assessment: _____

Potential To Meet Remaining Goals: _____

Plan: ❑ Discharge from Skilled Therapy ❑ Recommend Work Conditioning ❑ Hold therapy; awaiting MD orders
❑ Continue therapy with anticipated DC in _____ visits ❑ Hold therapy; refer to MD for Medical Intervention

Therapist Signature **Date**

Printed Name

Physician Signature **Date**

Printed Name

Care^{IQ} Therapy Program
550 Congressional Boulevard, Suite 300
Carmel, IN 46032

Discharge Summary

Provider Name: _____
Patient's Name: _____ Claim #: _____
Body Part: _____ Date of Injury: _____
Service: _____ Today's Date: _____

# of Visits Completed: _____ # of Cancellations: _____

# of No-Shows: _____ Last Date of Service: _____

Subjective:

Work status at D/C: Full Duty: ☐ Modified Duty: ☐ Off Work: ☐ Unknown: ☐

Final Pain Index Score: ____ /10

Other: _____

Objective:

ROM: _____

Strength: _____

Other: _____

Assessment:

_____

_____

Reason for Discharge:

Met Therapy Goals ☐ MD Released/Terminated ☐ Transition To Work Conditioning/Hardening: ☐

Patient Has Reached Plateau ☐ Patient Non-Compliance ☐ Change In Plan Of Care: ☐

Patient Returned To Work ☐ Patient Scheduled For Surgery ☐ Other: _____

_____ _____
Therapist Signature Date

_____ _____
Physician Signature Date

Care[IQ] Therapy Program
550 Congressional Boulevard, Suite 300
Carmel, IN 46032

Dates of Service Form

Provider Name: _____

Patient's Name: _____ Claim #: _____

Body Part: _____ Date of Injury: _____

Service: _____ Today's Date: _____

Instructions: Complete this form throughout the patient's therapy service. Submit this updated form with a current progress note every 6 visits to the Care[IQ] Therapy Program when additional visits are being requested.

Submit Documentation To:
Fax: 844-422-7347
Email: PTDocuments@corvel.com

Level I:		**Advanced Care .**		**Cancellations and No Shows:**
IE)	Initial Evaluation - sent within 48 hours of appt.	19)		↓ Your facility is responsible for notifying CareIQ Therapy Program within 24 hours of all missed appointments.
2)		20)		
3)		21)		
4)		22)		
5)		23)		
6)	Progress Note - completed and sent within 24 hours	24)	Progress Note- completed and sent within 24 hours	
Level II:		**Advanced Care III:**		**Cancelled Appts:**
7)		25)		1)
8)		26)		2)
9)		27)		3)
10)		28)		4)
11)		29)		5)
12)	Progress Note - completed and sent within 24 hours	30)	Progress Note- completed and sent within 24 hours	6)
Advanced Care I:		**Advanced Care IV:**		**No Show Appts:**
13)		31)		1)
14)		32)		2)
15)		33)		3)
16)		34)		4)
17)		35)		5)
18)	Progress Note - completed and sent within 24 hours	36)	Progress Note- completed and sent within 24 hours	6)

If care exceeds Advanced Care IV and an additional Dates of Service Form is required, please contact Care[IQ] Therapy Program to request.

Care[IQ] Therapy Program
550 Congressional Boulevard, Suite 300
Carmel, IN 46032

Patient Therapy Satisfaction Questionnaire

Dear Valued Patient,

Care[IQ] Therapy Program is dedicated to providing quality care and services to all patients. We ask your assistance in achieving this goal by completing the following questionnaire. Your comments are for Care[IQ] quality assurance purposes only.

Is this the facility where you received your care? If incorrect, please provide corrected information.

Name of Facility:
Address:
City, State, Zip:

Please rank the following (circle one):

(1) indicates dissatisfied with care, (5) indicates excellent care

	Dissatisfied				Excellent
Facility cleanliness……	1	2	3	4	5
General impression of facility……	1	2	3	4	5
Courtesy of staff……..	1	2	3	4	5
Consistently treated by the same therapist……..	1	2	3	4	5
Did therapy incorporate your work activities…….	1	2	3	4	5
Appointment availability……..	1	2	3	4	5
Overall satisfaction……...	1	2	3	4	5

Additional Comments:

Optional Information:

Therapist Name: _____

Your Signature: _____

Submit questionnaire by picking the delivery method, which is most convenient for you:

E-mail	Mail	Fax
PTDocuments@corvel.com	Care[IQ] c/o Provider Relations 550 Congressional Boulevard, Ste 300 Carmel, IN 46032	844-422-7347

Patient's Name: _____

Provider and Documentation Requirements

Provider Requirements

- **Please submit documentation to: Fax: 844-422-7347 or E-mail: ptdocuments@corvel.com**
- The provider shall be a Licensed Physical Therapist, Occupational Therapist, Physical Therapist's Assistant, or Certified Occupational Therapist's Assistant and will follow appropriate individual State Laws and Practice Acts.
- Care[IQ] must be contacted each time the patient fails to show or cancels an appointment within 24 hours of the failed appointment.
- Provider shall obtain a prescription from the referring physician for all visits completed, per Care[IQ] Therapy Program requirements.

Documentation Requirements

- Upon completion of the **Initial Evaluation,** please send the following **within 24 hours**:
  - Initial Evaluation Report
  - **Work Requirements Questionnaire:** This form should be completed at the Initial Evaluation. The top portion is to be completed by the patient, and the bottom portion is to be completed by the treating therapist. This form was developed as a tool to allow the patient to provide a subjective report of his or her duties. Once the patient has provided the information, the treating therapist should make 2-3 long term goals using the information provided by the patient.
  - **Initial Prescription:** if not already submitted
- **Requests for Additional Visits:** send the **within 24 hours** after the 6th visit is complete:
  - MUST be submitted every 6 visits (i.e. visits 6, 12, 18, etc.). Reports require all information as listed on Care[IQ] Therapy Program's sample progress report. (Updated objective measurements, progress towards goals, plan of care/recommendations by the therapist)
  - Updated list of dates of service attended, cancelled, and/or no show, preferably using the Dates of Service Form included
  - Prescription to cover additional visits, if not already submitted
- **Discharge Report**: Discharge report must include reason for discharge and work status at time of discharge
- Failure to provide the required documentation in a timely manner may result in a delay in care.

Billing Process

- Submit bills on a HCFA using standard CPT codes.
- Bills must be submitted with daily notes for each visit within 30 days of the rendered service. These notes must be marked with a handwritten or digital signature. If choosing a digital signature, the notes must visibly state "digital" or "electronic" signature.
- Supplies and equipment over $50.00 requires prior authorization.
- Payment is typically mailed within **30 days** from the time the bill is received by Care[IQ] Therapy Program.
- **Note**: Please never bill the employer or adjuster directly. Penalties may be applied for incorrect billing.

Submit Bills to:
Care[IQ] Therapy Program
550 Congressional Boulevard, Suite 300
Carmel, IN 46032