



UM Category A Guide

Introduction: Physical Therapy Utilization Management Program

The Physical Therapy Utilization Management (UM) program has two primary objectives. First is to bring transparency and accountability to the practice patterns of network practitioners by comparing utilization patterns to regional and national norms. Second is to reward practitioners that demonstrate superior practice patterns with clinical autonomy. Active management is limited to practitioners whose utilization patterns deviate significantly from their regional peer group. To achieve these objectives the physical therapy network has been stratified into three tiers identified as Categories A, B and C.

The information below represents a summary of UM requirements associated with each UM Category:

UM Category A

- A Treatment Plan is not required.
- Patient self-reported Outcomes Assessment surveys are voluntary.

UM Category B

- The Waiver Program allows you to treat patients up to six (6) visits per calendar year without the submission of a Treatment Plan.
- A Treatment Plan is required for treatment that exceeds the Waiver Program.
- Patient self-reported Outcomes Assessment surveys are voluntary.

UM Category C

- A Treatment Plan is required after the first visit.
- A patient self-reported Outcomes Assessment survey is required with each Treatment Plan.

UM Category A Requirements

The referring physician must obtain an initial authorization for physical therapy services with Blue Care Network. Upon receiving the initial authorization, you may render medically necessary services up to the patient's benefit maximum as long as significant functional improvements continue through the course of treatment.

While you are not required to submit Treatment Plans to request authorization, you have a responsibility to meet the standard UM practices that apply to all participating practitioners. Please consult the Complete Medical Records topic for details.

Please note that Category A practitioners are still subject to retrospective review of all care that is rendered to health plan participants. If practitioners do not meet standard UM

Physical Therapy UM Category A Guide

practices on retrospective review, Category A practitioners may be assigned to less favorable UM Category.

Complete Medical Records

Patient documentation serves as a permanent record that supports the treatment provided to your patients and allows for the reimbursement of that treatment. Good record keeping becomes especially important when establishing the medical necessity of the services you provide. Complete medical records include the following important elements:

- Must be legible with standard abbreviations, or a key to the unique abbreviations used.
- Patient name and/or identification number must be present on each page of the file.
- Demographic information, such as date of birth, sex, height, and weight must be present at least once.
- Complete medical history.
- Detailed description of subjective complaints.
- Detailed description of your objective examination findings.
- Description of any diagnostic testing, and the resultant findings.
- Working diagnosis or set of diagnoses.
- Treatment plan, including goals of treatment, frequency/number of visits, types of services planned, and expected time frame for improvement and discharge from care.
- If necessary, your referral of the patient to another practitioner and the clinical rationale for this decision.

Outcomes Assessments (Optional)

Patient-driven outcomes assessment measures are vital components of quality clinical management. These patient self-reporting tools provide a valid, reliable, and quantifiable measurement of a patient's clinical improvement over time, the effectiveness of treatment, and necessity of continued care.

Submitting the PSFS Outcomes Assessment

The Patient Specific Functional Scale (PSFS) outcomes assessment is *optional* for your UM Category. If you opt to send it, the initial PSFS should be completed prior to the start of care. Record the patient's limited functional activities (minimum of three) and scores exactly as stated by the patient. This first assessment will serve to document the patient's baseline symptoms and/or functional limitations. Sign and date the form and send the completed initial PSFS to Landmark.

Send an updated PSFS every 30 days while the patient is under care. Submit up-to-date scores to the same functional activities listed on the initial PSFS. For more information on the use of the PSFS, please refer to the PSFS Submission Guide on Landmark Connect.

Clinical Practice Guidelines

The Clinical Practice Guidelines provide clinical decision support tools necessary for clinical peer reviewers to render medical necessity review determinations. The Clinical Practice Guidelines have been developed systematically, and are based on current peer-reviewed scientific evidence, consensus peer evaluation, and generally recognized professional standards. Development involves input and direction from applicably licensed practitioners with current knowledge and experience in the clinical principles and standards of care under review. This includes clinical peer reviewers, clinical/medical directors, practitioner advisory committee members, and/or outside content experts.

The Clinical Practice Guidelines used for making authorization and review determinations are reviewed annually by a peer-review committee of participating practitioners. The review criteria are subject to further review by multi-disciplinary Utilization Management and Quality Improvement Steering Committees.

All services provided by practitioners must be delivered in accordance with the professionally recognized standards of care and practice, as reflected in the Clinical Practice Guidelines. Clinical criteria are used to establish medical necessity and to determine services covered and reimbursable under a member's benefit plan. We recognize that some practitioners provide services that are within their scope of practice, but do not meet the care parameters defined in the clinical criteria, or a member's benefit plan. We acknowledge that our Clinical Practice Guidelines are a subset of the professional practices provided within the practitioner community.



Physical Therapy Provider FAQs

Which BCN groups does Landmark manage?

Landmark's utilization management services apply to:

- Commercial plans
- BCNA
- Premier Care
- Grad Care

Follow existing procedures for other BCN groups.

What is a "Patient Episode?"

A Patient Episode of care refers to treatment rendered to a member, for a given condition, within a reporting period. Members that receive treatment for distinctly different conditions (i.e., shoulder and lumbar) within a reporting period are considered to have experienced two Patient Episodes of care. Patient Episodes are used to measure a practitioner's patient volume. The Mean Risk-Adjusted Visits per Episode of care is the primary metric used to assign UM Categories.

What is the "Peer Average?"

The Peer Average is calculated based on data gathered from Blue Care Network's entire practitioner panel. The Peer Average allows providers to compare their practice patterns to the network peer standard.

How many other UM Categories are there and how do they differ?

There are three UM Categories (A, B, and C). Each category has different Treatment Plan submission requirements. UM Category A does not have any Treatment Plan submission requirements. UM Category B providers have access to a six visit waiver. These practitioners may treat patients up to six times in a calendar year before they must submit Landmark's Treatment Plan form to request authorization for continued care. Providers in UM Category C have more stringent authorization requirements. UM Category C providers are required to submit Landmark's Treatment Plan form to request authorization for covered services beyond the initial evaluation and first treatment.

How do clinical peer reviewers decide on the number of visits they authorize?

Clinical peer reviewers use the clinical information submitted for review and proprietary Clinical Practice Guidelines to decide the number of visits authorized for each request. Clinical peer reviewers take into account the complexity and severity of a member's condition when rendering a clinical review. As such, severe, complicated cases requesting high numbers of visits require more detailed clinical information to establish medical necessity than mild, uncomplicated conditions requesting few visits. Please see the

Physical Therapy Provider FAQs

Authorization Guide for a detailed description of the authorization process.

Will these procedural changes affect my patients' coverage?

No. Changes in your authorization procedures do not affect patient coverage.

When am I required to submit a Treatment Plan authorization request form?

Services are subject to the Treatment Plan requirements for your UM Category assignment.

For patients you are actively treating during this transition, request authorization beginning with the first visit after any approval granted by BCN expires. For any new patients who present on or after the Landmark UM program effective date:

- Category B providers, submit the Treatment Plan to request authorization beginning with the seventh (7th) visit.
- Category C providers, submit the Treatment Plan to request authorization after the first treatment.

If a patient has existing authorizations in the BCN system, do I have to send a new request for services that BCN already authorized beyond the Landmark UM program effective date?

No. BCN is honoring treatment plans that have already been processed and approved by BCN. For example: You requested authorization on 7/15/08 for 20 visits from 7/17/08 through 9/17/2008, and BCN approved 20 visits from 7/17/08 through 9/17/08.. Continue to utilize the existing approved treatment plan from BCN until that authorization is exhausted.

Follow Landmark's authorization requirements for any unauthorized services falling on or after the Landmark UM program effective date.

Where can I obtain Treatment Plan forms?

Treatment Plan forms are available on Landmark's secure provider portal at www.LandmarkHealthcare.com. You may also submit electronic Treatment Plan "eForms" through Landmark's secure provider portal.

Can I call in an authorization?

Requests for authorization must be either completed on-line via Landmark's secure provider portal or faxed utilizing Landmark's Treatment Plan form to (888) 565-4225.

In cases of an emergency, requests are considered urgent if the standard review process could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or in the opinion of a practitioner with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. Contact Landmark for such services at (877) 531-9139.

How do I submit authorization requests to Landmark for therapy services?

Submit the Treatment Plan form to Landmark:

- Web Login to the secure provider portal at
 www.LandmarkHealthcare.com
 Click the eForms tab for electronic Treatment Plans
- Fax (888) 565-4225

Who do I direct questions to about my authorization request?

Check the status on-line through Landmark’s secure portal or call Landmark for inquiries about your authorization request at (877) 531-9139. Your approved or denied authorization can also be found in BCN’s on-line system through WebDenis.

Who do I call to verify Member Benefits?

Member benefits for therapy can be verified by following the normal BCN process for eligibility of benefits. The BCN options available include:

- Web-DENIS (Dial-in Eligibility Network Information System)
- CAREN (automated telephone system)
- BCN’s Provider Inquiry

Where do I submit claims?

There is no change in the claims process. Continue to submit claims directly to BCN.

Can I include DME supplies on an authorization request to Landmark?

You may document that a patient requires specialized DME equipment; however, DME supplies will not be authorized by Landmark. **Follow the normal BCN process for all DME.**

How do I appeal services not approved as medically necessary?

The review determination letters provided by Landmark include appeal information. Follow the information provided to you in this letter.



Contact Us

Landmark Connect

www.LandmarkHealthcare.com

E-mail

info@LMhealthcare.com

Phone

(877) 531-9139

Fax

(888) 565-4225

Mail

Landmark Healthcare, Inc.
1750 Howe Avenue, Suite 300
Sacramento, CA 95825

Office Hours

8:30 am to 8:00 pm (Eastern)

Register for your account today!

Landmark’s secure provider portal, **Landmark Connect**, is the quick, easy way to access important clinical tools, including:

- Clinical and Administrative Guidelines and Forms
- Interactive Clinical Tools
- Practitioner Performance Summary (PPS) – Landmark’s comprehensive practitioner profiling report.

System Requirements

Simply verify that your system meets the requirements below, then follow the step by step registration instructions.

- A broadband connection or at least a 56k modem speed dial-up connection
- Internet Explorer 4.0 or higher with 128-bit encryption, or
- A browser that is set up to enable cookies. Cookies help us recognize you as a user and are required for log on and use of the site.

General Account Registration

It’s easy to establish your Landmark Connect account:

1. Go to **www.LandmarkHealthcare.com**, click on the **Practitioners** menu and select “**Landmark Connect (Secure Area)**.”
2. Click the “**Register**” link under **New User Registration**.
3. Read and accept **Landmark’s Terms & Conditions of Use**.
4. Complete the registration form as shown in **Figure 1**. Please note, the License **and** Tax ID(s) entered must be those assigned to the named Practitioner.

You will receive an E-mail confirmation from Landmark to the E-mail address you provided during registration. Click on the link in this E-mail message to activate your account. Then,

5. Log on to Landmark Connect using the E-mail address (User ID) and password you selected during registration.

Account Registration for OPT’s, Facilities, and Hospitals

Follow Steps 1 through 3 above to download the **Landmark Connect** user application.

Need Help?

Call us at (877) 531-9139

Landmark’s Web Support team is available to assist you Monday – Friday from 8:30 AM to 5:00 PM EST.

Figure 1

The screenshot shows a registration form with the following fields:

E-mail (User ID)	<input type="text"/>
Confirm E-mail (User ID)	<input type="text"/>
Your first name	<input type="text"/>
Your last name	<input type="text"/>
Practitioner First Name	<input type="text"/>
Practitioner Last Name	<input type="text"/>
License Number	<input type="text"/>
State	Choose State <input type="button" value="v"/>
Number of Tax ID's	1 <input type="button" value="v"/>
Tax ID Number 1	<input type="text"/>
Password	<input type="text"/>
Confirm Password	<input type="text"/>
Question For Password Reset	****Please select a question**** <input type="button" value="v"/>
Answer	<input type="text"/>