Town Hall Meeting
BCN and Landmark
May 19, 2011

TODAY'S TOPICS

- Landmark Connect℠
- The PPS dashboard
- Treatment plans
- Turnaround time
- Retrospective reviews and appeals
- Quarterly letters from Landmark
- Categorization of providers
- Contact information
- Questions and answers

Landmark Connect℠

Accessing Landmark Connect

- Go to Landmark's secure website at **www.LandmarkHealthcare.com**
- Select "Landmark Connect" from the Practitioner menu.
- Log on if currently registered or complete the new user registration.
- Your BCN provider reps will also be able to assist you with site navigation.

Landmark Connect Tabs

The tabs on the menu bar are:

- My Network
- Patient Status
- e-Forms
- UM Requirements
- Clinical Resources
  - Clinical Practice Guidelines
  - Tools
- Administrative Resources
- Contact Info

My Network / Patient Status

My Network tab

- Landmark Connect’s landing page
- Select the portal you want to enter.

Patient Status tab

- Member search
- Treatment plans
- Look up review determinations
- Look up patient letters

E-Forms

e-Forms tab

- Submit New Request
- Saved Forms
- Online Treatment Plan History
- Utilization Management requirements for your facility

- Note: Add any additional information you feel supports the medical necessity of the care you are requesting before submitting the e-Form.

UM Requirements

UM Requirements tab

- Select your facility.
- Each specialty is listed along with the requirements for authorization.

Clinical Resources

Clinical Resources tab

- Performance Summary (security code required)
- PPS Reference Guides
- Clinical Practice Guidelines tab
  - PT/OT
  - Speech Therapy

Tools

Tools tab

- ICD-9 lookup
- Outcome Assessment Toolbox
- Quality Medical Record Documentation suggestions

Admin Resources / UM Guides

Administrative Resources tab

- Provider articles:
  - Tips for BCN Therapy Providers
  - U-M Premier Care Therapy Diagnosis Codes
- Utilization Management Program Guides:
  - Physical Therapy Treatment Authorization Guide
  - Occupational Therapy Treatment Authorization Guide
  - Speech Therapy Treatment Authorization Guide
  - Patient Specific Functional Scale Submission Guide

Forms / Training

Forms:

- Physical Therapy Treatment Plan
- Occupational Therapy Treatment Plan
- Speech Therapy Treatment Plan
- Patient Specific Functional Scale (Outcomes Assessment)
- Date Extension Request

Provider Training:

- Landmark Connect Provider Portal User Guide
- Provider Training Slideshow

Contact Info

Contact Info tab:

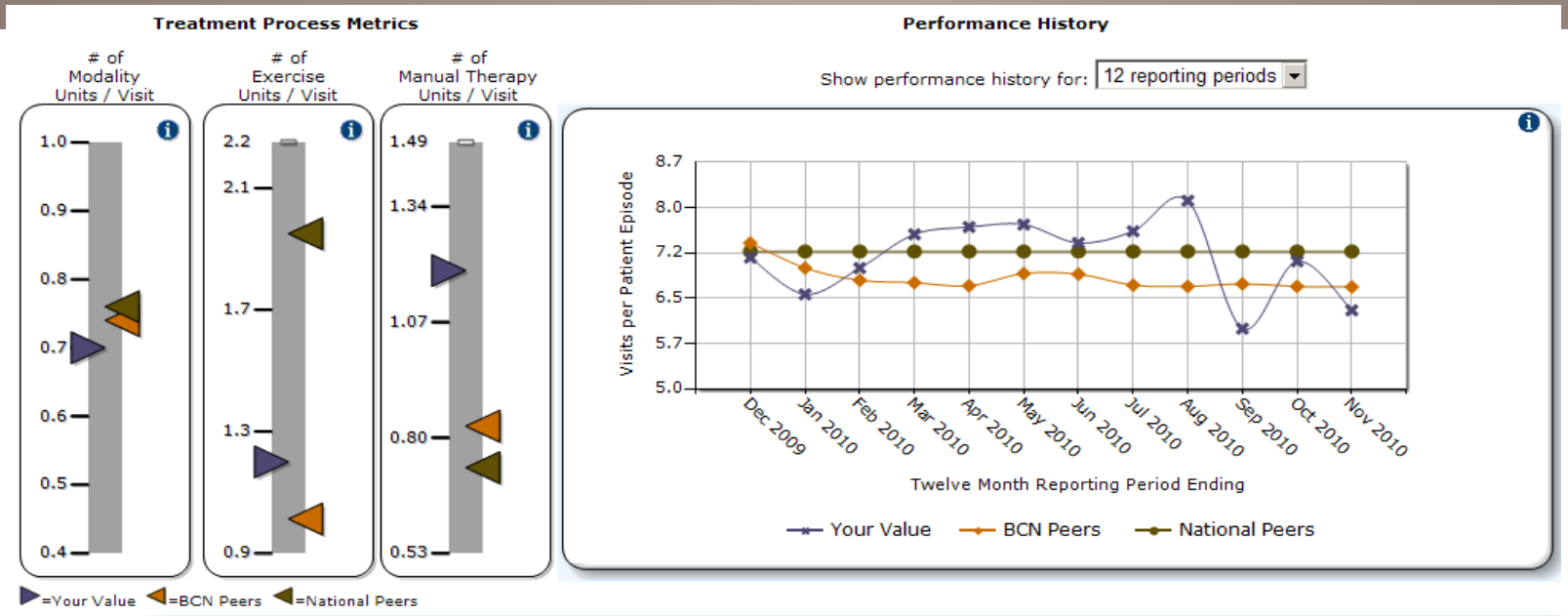
- Providers can reach us with any of the following methods:
  - By phone: 1-877-531-9139
  - By fax: 1-888-565-4225
  - By US mail: Landmark Healthcare, Inc. 1750 Howe Avenue, Suite 300 Sacramento, CA 95825
- Office hours are: Monday – Friday 8:30 a.m. to 8:00 p.m. EST
- Landmark Healthcare holiday schedule

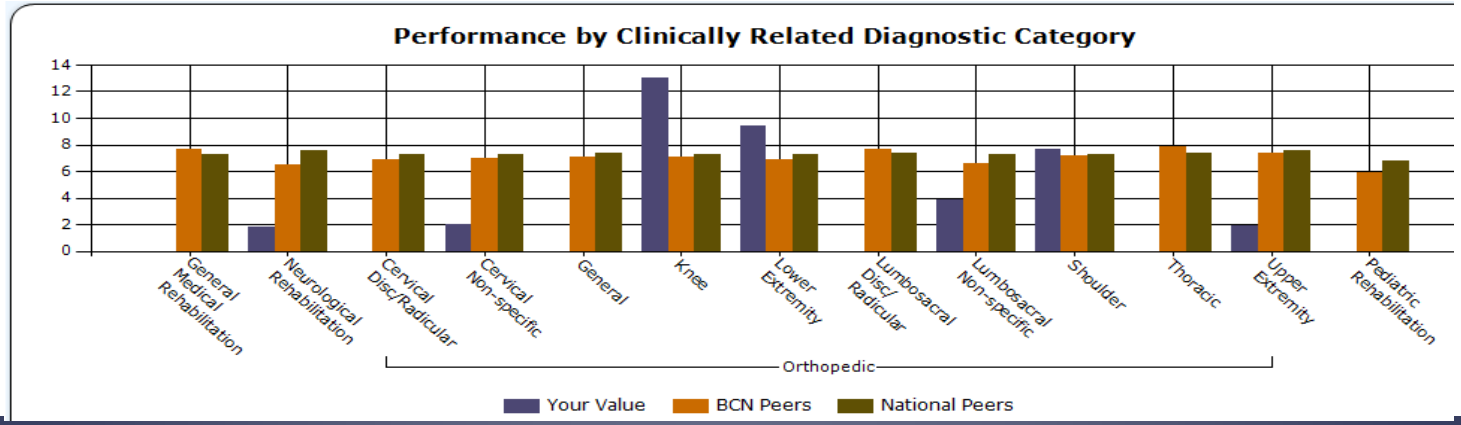
Practitioner Performance Summary (PPS)

Practitioner Performance Summary (PPS)

- Individual performance trends
- Comparative peer measures
- Clinically relevant dashboard metrics
  - Performance history
  - Clinical categories
  - Service units
- Accessible online and via hard copy

Performance Summary Dashboard





Summary Drill Down

Member Summary for 12/1/2009 to 11/30/2010

1

Member	Episodes	Visits	Risk Adjusted Visits	Total Units of Service	Modality Units	Exercise Units	Manual Therapy Units
[redacted]	1	3	3.2	9	3	3	3
[redacted]	1	3	2.7	10	3	3	3
[redacted]	1	1	0.7	3	1	1	1
[redacted]	1	16	13.2	48	16	16	16
[redacted]	1	9	9.9	18	0	9	9
[redacted]	1	7	6.0	32	4	14	14
[redacted]	1	33	25.6	97	15	42	38
[redacted]	1	18	13.0	75	21	26	26
[redacted]	1	1	1.0	9	3	3	3
[redacted]	1	1	1.2	2	0	1	1
[redacted]	1	2	2.1	4	0	2	2
[redacted]	2	19	15.4	38	0	19	18
[redacted]	1	2	1.5	6	0	3	3
[redacted]	1	3	3.1	7	4	0	3

Detail Drill Down

Visit Detail for 119946 from 1/1/2006 to 12/31/2006

Member	Date of Service	Diagnosis	Diagnostic Group	Procedure	Procedure Category
MM9946	1/23/2006 ▲	7242	Orthopedic - Lumbosacral Non-specific	97001	Evaluation
	1/25/2006	7242	Orthopedic - Lumbosacral Non-specific	97112	Exercise
	1/25/2006	7242	Orthopedic - Lumbosacral Non-specific	97014	Modality
	1/25/2006	7242	Orthopedic - Lumbosacral Non-specific	97110	Exercise
	1/26/2006	7242	Orthopedic - Lumbosacral Non-specific	97110	Exercise
	1/26/2006	7242	Orthopedic - Lumbosacral Non-specific	97014	Modality
	1/26/2006	7242	Orthopedic - Lumbosacral Non-specific	97112	Exercise
	1/30/2006	7242	Orthopedic - Lumbosacral Non-specific	97110	Exercise

Treatment Plans

Treatment Plans

- Attaching information
  - e-Form
  - Faxed form
- Must be legible
- Clinical information must be current.
- Reviews are typically based on a 30-day duration.
- A date is usually provided in the letter that states when the next request may be submitted.

Required Fields

- Patient name
- Patient date of birth and patient's age (include both)
- Patient's BCN ID number
- Name of health plan/insurance carrier (BCN)
- Provider name (the name of the treating therapist) and tax ID #
- Provider address, city, state and zip
- Provider telephone number and FAX number

Required Fields *(continued)*

- Dates, including:
  - Date of submission
  - Date of first treatment/visit
  - Date objective findings were obtained
  - Date of onset of the patient's condition
- Diagnosis codes – List the specific ICD-9 codes and the diagnoses descriptions. (Do not use a nonspecific code in the primary diagnosis field unless it is the only appropriate diagnosis.)

Required Fields *(continued)*

- Proposed length of treatment under the plan including “From” and “To” dates
  - The “From” date is the date the requested visits start for that treatment plan.
  - The “To” date is the date those visits are expected to be completed, i.e., the date of the last visit for that treatment plan submission.
- The number of visits requested for a 30-day period.
- If applicable, surgical information must be completed on the Treatment Plan form.

Physical Therapy Treatment Plan

Landmark Healthcare, Inc., 1750 Howe Ave., Suite 300, Sacramento, CA 95825
FAX (888) 565-4225

Date of Submission ___/___/___
Please check type of care:
☐ Initial care ☐ Continuing care

INSURED

Patient Last Name	Patient First Name	M.I.	Gender ☐ M ☐ F	Age	Date of Birth (MM/DD/YYYY) _____/_____/_____
Insured I.D. or SSN	Insured Last Name	M.I.	First Name		Patient Phone (area code first)
Patient Address	City			State	Zip Code

PAYOR

Employer Name	Insurance Company	Group Plan # or Union Local (Submit Copy of Patient's Insurance I.D. Card)	
Injury or illness is related to: ☐ Work ☐ Auto ☐ Other	Referring Physician/Practitioner	Doctor License #	Date of Referral _____/_____/_____

PT/OT

Therapist Last Name	Therapist First Name	M.I.	Group Name	Provider/Group ID#
Provider/Group Address	City	State / Zip Code		Phone # ( ) Fax # ( )

CURRENT MEDICAL HISTORY

Subjective Complaints:

Lost days from work to date _____ Days of work restriction to date _____

Mechanism of Onset for Primary Diagnosis

Date of Onset ___/___/_____ *Date of Initial Evaluation* ___/___/_____
☐ Acute Trauma ☐ Worsening of prior illness/injury
☐ Repetitive Motion ☐ Gradual Onset
☐ Chronic ☐ Other
Description:

Objective Findings *Date Obtained* ___/___/_____

Inspection/Palpation:

Spinal Range of Motion

Cervical ROM

_____°	Flexion	_____°	Lumbar ROM
_____°	Extension	_____°	
_____°	R.Lat.Flex	_____°	
_____°	L. Lat. Flex	_____°	
_____°	R. Rotation	_____°	
_____°	L. Rotation	_____°	

Extremity Range of Motion *(Circle Painful Tests)*
Extremity: (specify)_____

	Active (Degrees)	Passive (Degrees)	Manual Muscle Test Strength (0-5)
Flex.	R_____/_____L	R_____/_____L	R_____/_____L
Ext.	R_____/_____L	R_____/_____L	R_____/_____L
Abduction	R_____/_____L	R_____/_____L	R_____/_____L
Adduction	R_____/_____L	R_____/_____L	R_____/_____L
Int rotat.	R_____/_____L	R_____/_____L	R_____/_____L
Ext rotat.	R_____/_____L	R_____/_____L	R_____/_____L
Supination	R_____/_____L	R_____/_____L	R_____/_____L

Summary of Clinical Findings (Orthopedic, Neurologic, Additional Info.)

PATIENT'S CU

Summary of Clinical Findings (Orthopedic, Neurologic, Additional Info.)

Date of first tx at this office for this condition ____/____/_____ Anticipated Release Date ____/____/_____

Ext rotat.	R____/____L	R____/____L	R____/____L
Supination	R____/____L	R____/____L	R____/____L
Pronation	R____/____L	R____/____L	R____/____L
L Deviation	R____/____L	R____/____L	R____/____L
R Deviation	R____/____L	R____/____L	R____/____L
Opposition	R____/____L	R____/____L	R____/____L
Plantar flex	R____/____L	R____/____L	R____/____L
Dorsi flex	R____/____L	R____/____L	R____/____L
Eversion	R____/____L	R____/____L	R____/____L
Inversion	R____/____L	R____/____L	R____/____L

DIAGNOSES

ICD-9 Code:	Description:	Pain Scale (0-10)
1. Primary _____	_____	_____/10
2. Secondary _____	_____	_____/10
3. Additional _____	_____	_____/10
4. Additional _____	_____	_____/10

TREATMENT PLAN

Treatment Goals (Functional Improvement and Outcomes Expected)

Treatment Plan (MM/DD/YYYY)
From ____/____/_____
To ____/____/_____

Anticipated No. of Visits _____

Patient Home Care
☐ Stretching ☐ Exercise ☐ Hot/cold

Complicating Factors *(Check any that apply and /or list)*
☐ Surgery: Date_____/_____/_____
Type _____
Precautions_____
_____
☐ Poor tissue healing such as: pernicious anemia, diabetes, thyroid disease, pregnancy
Other: _____

Activities of Daily Living

Functional Limitations (check all that apply)

☐ Locomotion/movement
- ☐ Bed mobility
- ☐ Transfers (such as moving from bed to chair, from bed to commode)
- ☐ Walking _____(Duration/Distance)
- ☐ Stair climbing

☐ Self-care (such as bathing, dressing, eating, toileting)

☐ Home management (such as household chores, shopping, driving/transportation, care of dependents)

☐ Community and work activities
- ☐ Work/School
- ☐ Recreation or play activity

☐ Lifting/Carrying
- ☐ Overhead _____ lbs.
- ☐ From waist _____ lbs.
- ☐ From floor _____ lbs.

☐ Other _____

I declare that the above information is true and correct to the best of my knowledge. Further, it is my professional judgment that physical therapy is not contraindicated for this patient. If I am required under state law to obtain a prescription prior to rendering this treatment, I have obtained such a prescription in compliance with state law.

Signature_____Date_____

KAM012108

REVISED PATIENT SPECIFIC FUNCTIONAL SCALE (PSFS) **FAX (888) 565-4225**

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) / /
Provider Last Name	Provider First Name	Provider Phone (Area code first)	

Clinician Instructions: Complete after the history and before the exam

Initial Assessment

Ask the patient to list and score at least 3 activities that they are unable to perform or have the most difficulty performing, because of their chief complaint.

Follow-up or Discharge Assessment

Ask the patient to score the same activities that they were previously unable to perform, or were having the most difficulty performing, because of their chief complaint.

Patient Specific Activity Scoring scheme (Score one number for each activity for each date):

0=Able to perform at the same level As before injury or problem.	0	1	2	3	4	5	6	7	8	9	10	10=Unable to perform activity

ACTIVITY	DIAGNOSIS (ICD- 9 CODE)	DATE:	DATE:	DATE:	DATE:	DATE:
1.		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
2.		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)

6.		Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
Average Score						

I understand that the information I have provided above is current and complete to the best of my knowledge.

Clinician Signature:_____ Date: _____

Turnaround Time

- Documents arrive and are entered into the system.
- E-Forms have highest priority.
- If all information is present, the review is completed by a clinical case manager.
- Review by a physician
- Letter is posted to the website and faxed, or mailed to the provider and member.
- Most decisions are returned in less than 2-3 business days.

Retrospective Reviews

Retrospective authorization requests = all requested visits for a member have already occurred.

- Include a copy of all applicable documents (i.e., Treatment Plan, evals and reassessments, daily progress notes, outcomes assessments, flow sheets) for the services you provided.
- A request-for-information (RFI) letter will be sent if you do not send complete information.
- Attach a copy of the RFI letter with the requested information.
- Your RFI letter will state the time frame required to submit the requested information.
- Insufficient or missing clinical information may result in the number of visits you requested being reduced or denied.

Appeals Request

- If you disagree with a decision and choose to appeal, your request must be received within 45 calendar days of the date of the letter or you may forfeit your appeal rights. Requests are to be in writing and must include clarifying clinical documentation to support the request.
- You may request an expedited appeal if you believe the time frame for a written appeal would acutely jeopardize the member's life. You will receive a reply to your appeal within 72 hours.
- Blue Care Network participating providers, submit an appeal or expedited appeal by mail or fax to:

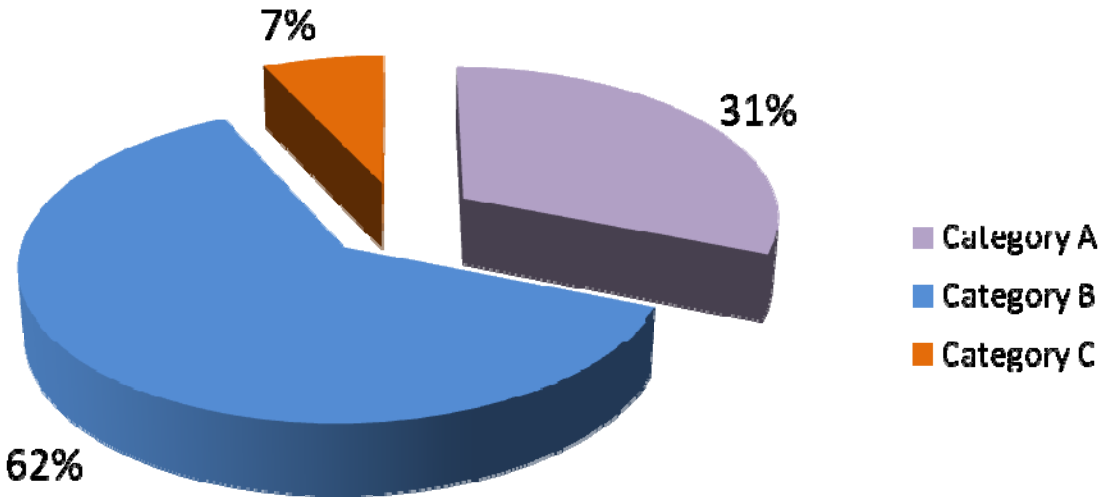
  Landmark Healthcare Inc.
  Attn: QM Dept. – Provider Appeals
  1750 Howe Ave., Suite 300
  Sacramento, CA 95825
  Fax: 1-888-565-4225
  Phone toll-free: 1-877-531-9139
  8:30 a.m. to 5:00 p.m. Monday through Friday

Categorization

Categorization

- Based on claims submitted to BCN
- Compared to your peers
- Risk adjusted to level the playing field
- Thresholds determined:
  - Up to 50th percentile = A
  - > 50th - 75th percentile = B
  - > than 75th percentile = C

BCN Provider UM Distribution – February 2011



Utilization Management Categories

A	• High volume, Efficient Providers (up to 50th Percentile) • Treatment Plan Not Required •Outcome Assessment Submissions Not Required • Retrospective Monitoring • Performance Summaries
B	• New, Low Volume & Average Performing Providers (>50th to 75th Percentile) • Annual 6 Visit Waiver Program •Treatment Plan Required Beyond Waiver Threshold • Voluntary Outcome Assessment Submission • Performance Summaries and Education
C	• High volume, Inefficient Providers (>75th Percentile & Above) • Treatment Plan Required Beyond 1st Visit • Mandatory Outcome Assessment Submission • Medical Record Audits • Peer-to-peer Telephonic Counseling • Performance Summaries and Education

OT Treatment Authorization Process

- Annual six-visit waiver program
- Treatment plan required beyond waiver threshold
- Voluntary outcome assessment submission
- Performance summaries and education

ST Treatment Authorization Process

- Treatment plan is necessary following first evaluation.
- Standardized tests and measurements are required.
- Submission via fax or mail

Recategorization Process

- Performance trend review twice a year
- Identify sustained changes in practice patterns
- Providers may move into a higher or lower UM category.
- Affected providers will be notified in advance.
- PPS allows self-monitoring
  - Online tool is updated monthly.
  - Hard copy is sent quarterly.

Physical Therapy
Practitioner Performance Summary

LANDMARK™ HEALTHCARE

Name: **ABC Clinic** Provider ID: **XXXXX**

Peer Group: **Outpatient Physical Therapy** Reporting Period: **10/01/06 - 09/30/07**

Practitioner Performance Summary

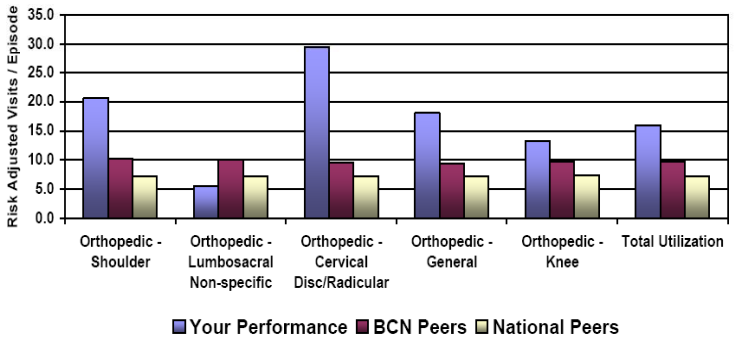
The Practitioner Performance Summary (PPS) provides you with a suite of reports that compare your risk adjusted treatment efficiency metrics to Blue Care Network and National Peer Performance Standards. As shown below, these reports allow you to understand differences between your practice patterns and those of such local and national standards and to track changes in your performance over time.**

The data compiled in the PPS has been aggregated according the Blue Care Network Provider ID F00000010091. <peer comparison text string>

The PPS will be mailed quarterly and is available anytime at LandmarkHealthcare.com.

Clinically Related Diagnostic Categories

Mean Risk Adjusted Visits per Episode for Top 5 Clinical Categories



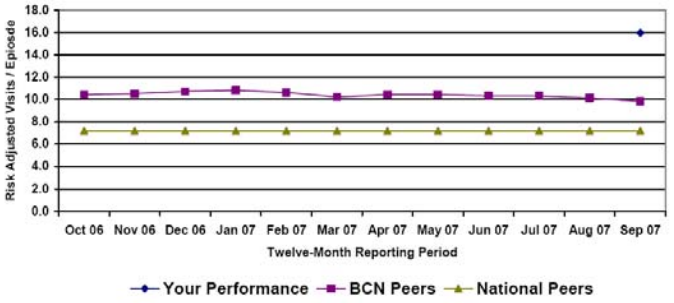
Clinically Related Diagnostic Categories

Top Clinical Categories Ranked by Number of Episodes

Clinical Category	Your Performance		BCN Peers	
	No. Episodes	Cost/Episode	No. Episodes	Cost/Episode
Orthopedic – Shoulder	6	$1,148	1,532	$616
Orthopedic – Lumbosacral Non-specific	4	$245	1,979	$470
Orthopedic – Cervical Disc/Radicular	1	$1,350	248	$531
Orthopedic – General	1	$1,118	732	$491
Orthopedic – Knee	1	$720	1,336	$590
All Other Categories	4	$858	3,623	$517
Total Utilization	17	$852	9,450	$532

Performance Trend

Mean Risk Adjusted Visits per Episode by Rolling 12-Month Reporting Period



**Please refer to the PPS FAQ document which accompanies this report for metric definitions and chart descriptions. Landmark's online Practitioner Performance Summary, the PPS FAQs and Physical Therapy Clinical Practice Guidelines are also available through Landmark's secure web-portal Landmark Connect™ at www.LandmarkHealthcare.com

Should you have any questions regarding this evaluation, please contact the Clinical Management Department at (800) 638-4557 between 8:30 a.m. and 5:00 p.m.

Communicating with Landmark

- Office hours:
  - Monday - Friday
  - 8:30 a.m. to 8:00 p.m. EST
- Toll-free number: 1-877-531-9139
- Fax number 1-888-565-4225
- Address:

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

Q & A