



Blue Care Network Physical & Occupational Therapy Utilization Management Guide

(Also applies to physical medicine services by chiropractors)
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Program Overview

Blue Care Network partners with eviCore healthcare (eviCore) to assist in the management of outpatient physical, occupational and speech therapy services. This also applies to physical medicine services provided by chiropractors.

The program's primary goal is to promote best practices and efficiency in the delivery of services through utilization management and provider education. The information in this guide serves as an orientation to the Utilization Management Program.

Physical Therapy Variable Intensity Review

For physical therapists only

eviCore develops and makes available to each physical therapist an individualized Practitioner Performance Summary (PPS). The objective of the PPS is to bring transparency and accountability to the practice patterns of physical therapy providers by providing timely and easy access to utilization data. eviCore's PPS tool contains a suite of clinical reports derived from Blue Care Network physical therapy claims data that allows you to compare your utilization metrics to those of regional peers and to track changes in your performance over time.

Using the PPS, each physical therapy provider's performance history is analyzed bi-annually for placement in one of three variable intensity review (VIR) categories. Physical therapy authorization requirements depend on your placement in one of the following VIR categories:

Category A

Treatment Plans are not required.

Category B

The Waiver Program allows you to treat patients up to 6 visits per calendar year without submission of Treatment Plans. Treatment Plans are required to request authorization for treatment that exceeds the Waiver Program.

Category C

Treatment Plans are required to request authorization for treatment after the first therapy visit.

Changes in your utilization may move you into or out of a VIR category that requires or relaxes administrative requirements. It is your responsibility to monitor your practice patterns so you know where you stand with respect to criteria and VIR category placement.

Your Practitioner Performance Summary

For physical therapists only

The PPS allows you to understand your performance at the date of the PPS and how it has changed over time. The PPS presents your utilization by diagnostically related categories; it also displays changes in your total visit utilization and reports the average per visit use of key therapeutic interventions.

The online tool provides is updated on a monthly basis and has drill-down features that allow you to go behind the aggregate performance metrics to view the detailed patient and claims information used to generate those metrics. Using the online PPS, you can see and understand the source data at its most granular level and use it to monitor and manage your patients and organization more effectively.

To access the online PPS:

1. Log in to the provider portal at www.LMHealthcare.com.
2. Click on the Clinical Resources tab.
3. Click Practitioner Performance Summary.
4. Select the provider (if you are affiliated with multiple practices).
5. Enter the PIN for the selected provider.

How to Read Your PPS

Your PPS provides an aggregate view of key treatment metrics that allows you to understand the differences between your practice patterns and those of your Blue Care Network peers. Below are the descriptions of the graphs and charts contained within the PPS.

Clinically Related Diagnostic Category

This graph illustrates your mean risk-adjusted visits billed per episode of care and provides Blue Care Network peer comparative values. This graph can be used to identify where your practice patterns differ from your peers in the network. Your online PPS includes data for thirteen Clinically Related Diagnostic Categories. Review of evidence-based literature and peer-to-peer discussions with eviCore clinical peer reviewers can help reduce unnecessary utilization identified within these graphs.

Performance Trend: Mean Risk-Adjusted Visits per Episode

The Performance Trend chart graphs your mean risk-adjusted visits billed per episode of care over rolling 12-month reporting periods. Each data point represents a 12-month reporting period ending at the month displayed. This graph also provides peer comparative values.

Treatment Process Metrics: Mean Service Units per Visit

The Treatment Process Metrics summarize your mean utilization of passive modalities (CPT codes *97010-*97039), therapeutic exercises (CPT codes *97110, *97112, *97113, * 97116, and *97530), and manual therapy units (CPT code *97140) billed per visit. These metrics reflect the latest 12 month reporting period. This chart also provides your peers' comparative values.

Episode of Care: *eviCore defines an “episode” as all physical therapy treatment rendered to a member for a specific body part, related body part, or diagnosis within a given 12-month period. Members who receive treatment for separate conditions within a reporting period have two episodes. The diagnosis in the primary diagnosis field on the claims form is used to determine the affected body part or diagnosis, and the episode of care.*

Risk Adjustment: *In an effort to create a balanced playing field among practitioners, eviCore utilizes an externally validated statistical model to account for factors that have been found to significantly alter utilization patterns and that are beyond the practitioner’s control. Factors that have been found to significantly affect utilization levels are age, gender, diagnostic complexity, and geographic location. The statistical model adjusts the raw utilization data to control these factors that may artificially inflate or deflate utilization levels. The use of this statistical adjustment allows practitioners with different member populations to be fairly compared with each other.*

Reporting Period: *Reporting periods are defined as 12-month periods in which physical therapy claims from practitioners are examined. These periods are designated by the month and year in which the period ends. For example, the January 2015 reporting period represents claims data from February 1, 2014 to January 31, 2015.*

Obtaining Authorization

Therapy Management: Physical and Occupational Therapy Including chiropractors providing physical medicine services

Initiating a Blue Care Network Referral

Submit a request through e-referral or call Blue Care Network Care Management at 1-(800) 392-5212 to initiate a Blue Care Network referral. Chiropractors must request one physical medicine treatment only; other therapy providers must request one therapy evaluation and one treatment.

Note: The therapy/physical medicine provider may enter an authorization request for an episode of care with approval from the physician's office. Refer to the BCN Provider Manual for details.

For additional services after the evaluation, therapy/physical medicine providers must obtain treatment plan authorization according to the guidelines that apply for the type of service to be provided.

Physical therapy services provided by physical therapists

Physical therapists are assigned one of the following categorizations based on their utilization of therapy and claims data reported for each provider and on an understanding of the best practices in the field. Physical therapists' utilization category assignments are reviewed every six months, based on the most recent paid claims data.

Category A

- › Providers in this VIR category include physical therapy providers performing at above-average efficiency. Please note the following information about the Category A UM program:
- › After a referral is approved, 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.
- › The "Start" date specified by the referring physician is used as the beginning date for the episode of care.
- › eviCore will load an authorization in the Blue Care Network system reflecting a total of 30 visits for the patient's benefit duration. In the event the member has an unlimited benefit period, the duration will reflect 120 days.
- › Should the member require additional treatment beyond the initial authorization of 30 visits, or if a new episode occurs, contact eviCore at (877) 531-9139. Notify our Customer Service Department that you are a UM Category A provider calling to request additional visits, or that a new episode has occurred. A request will be submitted to eviCore's Utilization Review Department for processing.

Category B

Providers in this VIR category include the following:

- › Physical therapists performing at average efficiency
- › Physical therapists seeing a low volume of BCN members
- › Newly-contracted and non-contracted therapists

Please note the following information about the Category B UM program:

- › After a referral is approved, you are eligible for the Waiver Program. This means you are eligible to treat a patient up to 6 therapy visits without the submission of a Treatment Plan for the patient's first covered condition in a calendar year.
- › The Waiver Program only allows up to 6 visits within the patient's benefit limit. For example: If coverage is limited to 30 or 60 calendar days, the Waiver Program is restricted to that benefit period.
- › If the patient requires more than 6 visits for the episode, you are required to submit a Treatment Plan to request authorization.
- › Should a patient be referred for additional therapy services related to another episode of care in the same year, a Treatment Plan is required for all subsequent visits. The Waiver Program is limited to the patient's first condition you treat within a calendar year.

Category C

Providers in this VIR category include physical therapy providers performing at below-average efficiency. Please note the following information about the Category C UM program:

After a referral is approved, you are required to submit a Treatment Plan after the initial evaluation and 1st visit.

Physical medicine services provided by chiropractors

For chiropractors, the requirement for treatment plan authorization of physical medicine services is waived through the sixth visit. This waiver is available for the member's first covered condition in a calendar year. Treatment plan authorization, including the submission of updated clinical information from the six waived visits, is required for all visits starting with the seventh visit.

The waiver and any subsequent authorization from eviCore are for physical medicine services (*97-series procedure codes). eviCore does not authorize chiropractic manipulation, which may also be performed during the authorized treatment period.

Occupational therapy services

For all providers, the requirement for treatment plan authorization is waived through the sixth post-evaluation therapy visit. The waiver is available for the member's first covered condition in a calendar year. Treatment plan authorization, including the submission of updated clinical information from the six waived visits, is required for all post-evaluation visits starting with the seventh visit.

Speech Therapists

Refer to the Speech Therapy Authorization Guide for speech therapy authorization requirements.

Physical and Occupational Therapy Treatment Plans

Including plans for physical medicine services by chiropractors

eviCore's clinical peer reviewers consider requests for care based on the information you submit on a Treatment Plan form. Various versions of eviCore's Treatment Plan are available for requesting physical or occupational therapy or for requesting physical medicine services, including:

- › Standard Therapy Treatment Plan

- › Hand Therapy Treatment Plan
- › Lymphedema Management Treatment Plan
- › Neurological Rehabilitation Treatment Plan (for pediatric and adult patients)
- › Vestibular Rehabilitation Treatment Plan
- › Supplemental Joint Form (to be submitted together with a Treatment Plan when additional joint measurements need to be recorded)

This collection of forms allows you to report pertinent information based on each patient's primary condition. You may submit Treatment Plans by either of the following methods.

Electronic Submission

Several online features make eviCore's "e-Form" the preferred method for requesting physical and occupational therapy and physical medicine services:

- › The selection of the proper Treatment Plan form is automated based on the primary diagnosis you enter at the beginning of the form.
- › Much of the demographic data is populated for you, saving you time.
- › Help tools are available to guide you through clinical edits for each field.
- › You are notified of errors and have the opportunity to correct them, helping to avoid delays caused by incomplete information.
- › The "Finish Later" option allows you to save incomplete e-Forms for up to two weeks.
- › Completed e-Forms are converted to printable PDF documents.
- › Electronic submissions are more legible and are processed as a priority.

Follow these steps to begin an electronic submission:

1. Login to the provider portal at www.LMHealthcare.com.
2. Select 'e-Forms' from the navigation bar.
3. Click the applicable link to begin a Physical Therapy or Occupational Therapy Treatment Plan.

The e-Form will guide you through selecting the requesting provider and the member to populate the demographic sections of the Treatment Plan. You will then be prompted to complete the clinical sections. The following sections are global, meaning that the fields are the same for all of the Treatment Plan forms:

- › The Treatment Request section specifies the type of request (initial care, continuing care, or retrospective care) and the start date of the requested care.
- › The Diagnosis section specifies the patient's primary and secondary diagnoses. The primary ICD code you enter determines whether you will be prompted to complete the Standard Therapy Treatment Plan or one of the special condition versions listed above.

The following e-Form sections are dynamic based on the primary ICD code you provide:

- › Patient History
- › Clinical Findings
- › Functional Assessment using the Revised Patient Specific Functional Scale

As you fill out each section, you will only be prompted to complete the pertinent information based on the version of the Treatment Plan you are completing.

Fax Submission

Follow these steps to submit a Treatment Plan via fax:

1. Determine the appropriate form for the patient's condition: the Standard Therapy Treatment Plan, or a special condition Treatment Plan.
2. If necessary, login to the provider portal at www.LMHealthcare.com to download the proper form. eviCore does not accept authorization requests on any document other than an eviCore Treatment Plan form.
3. Complete every boxed section of the Treatment Plan. If a section is not applicable to your patient, select "N/A." Forms with incomplete sections or references such as "See attached" in lieu of completing items on eviCore's form will be returned to your office for correction and resubmission.
4. Fax the completed Treatment Plan to eviCore at (888) 565-4225.

When to Submit the Treatment Plan

Initial Care Request

The timing of your first authorization request depends upon the type of provider you are and your VIR category:

Physical Therapists (Category B), Chiropractors, and Occupational Therapists

You are required to submit an eviCore Treatment Plan to request authorization after the patient's 6th visit of the calendar year and/or after the 1st visit if the patient presents with a new episode in the same calendar year. Please note the following information regarding an initial request:

- › Select "Initial Care" as the type of request on your e-Form or paper Treatment Plan.
- › As your Start Date, enter the date of your patient's 7th visit of the calendar year. Or, if you previously treated the patient for a different episode in the same calendar year, enter the 1st visit for the current episode.
- › Do not submit the Treatment Plan more than 7 days prior to your requested Start Date. eviCore will not accept a Treatment Plan submitted more than 7 days in advance.
- › Report updated clinical findings. If your "Date Current Objective Findings Obtained" is more than 7 days prior to your Start Date, you will likely receive a Request for Information letter back from eviCore, which will delay consideration of your request.
- › If your Initial Care request is approved, eviCore will notify you of the approved number of visits and the Approved Time Period.

Physical Therapists (Category C)

You are required to submit an eviCore Treatment Plan to request authorization after the patient's initial visit. Please note the following information regarding an initial request:

- › Select "Initial Care" as the type of request on your e-Form or paper Treatment Plan.
- › As the Start Date, enter the date of your patient's 1st therapy treatment.
- › Do not send the Treatment Plan more than 7 days prior to your requested Start Date. eviCore will not accept a Treatment Plan submitted more than 7 days in advance.
- › If your Initial Care request is approved, eviCore will notify you of the approved number of visits and the Approved Time Period.

Approved Time Period: *The Approved Time Period is indicated in the review determination letter and is the time period (duration) you have available to use approved visits. Visits must be spread throughout the authorized period to avoid a gap in care at the end of the Approved Time Period. Note that the benefit period is NOT the same as the Approved Time Period. The benefit period is the period of coverage included in the member's benefit for an episode. The Approved Time Period is based on medical necessity review. Medical necessity authorizations are typically approved for a 30-day period.*

Continuing Care Request

If you believe a patient will require therapy or physical medicine services after the End Date of an Approved Time Period, submit an updated Treatment Plan to request continuing care. In order to establish the need for ongoing care, each request must include updated clinical information that documents significant lasting benefit from previous treatment.

- › Select "Continuing Care" as the type of request on your e-Form or paper Treatment Plan.
- › As your Start Date, enter the date of your patient's first requested visit that occurs after the existing Approved Time Period ends.
- › Do not send the Treatment Plan more than 7 days prior to your requested Start Date. eviCore will not accept a Treatment Plan submitted more than 7 days in advance.
- › Report updated clinical findings. If your "Date Current Objective Findings Obtained" is more than 7 days prior to your Start Date, you will likely receive a Request for Information letter back from eviCore, which will delay consideration of your request.

Retrospective Care Request

If you do not obtain authorization based on your assigned category requirements, payment will be denied. You may, however, request authorization retrospectively. Retrospective requests are requests for treatment that has already occurred. Please note the following policies applicable to retrospective requests.

- › Select "Retrospective Care" as the type of request on your Treatment Plan.
- › You are required to fax a copy of all evaluations, progress summaries, daily treatment notes, and any flow sheets used for the services you provided.
- › eviCore will provide a review determination within the timeframe required by applicable regulations.
- › eviCore will not process retrospective requests as expedited or urgent requests.

Date Extensions on Existing Authorizations

A date extension may be necessary due to unforeseen delays, such as your patient's inability to attend all scheduled visits. Date extension requests are not required as long as they occur within the benefit period. If your patient has an unlimited benefit and needs more than the 120 days that were initially loaded in the system, please submit a date extension request. Download the Date Extension Request form and fax it in or contact eviCore at (877) 531-9139 to request the adjustment.

Resubmitted Treatment Plans

If you resubmit a modified Treatment Plan for any reason, be sure to write the word "CORRECTED" or "RESUBMITTED" across the top. And, if applicable, write the case Reference Number on the form.

Clinical Review

Review decisions and determinations are based on our Clinical Practice Guidelines, scientific evidence, literature reviews, and the reviewer's clinical experience. Accordingly, the clinical department affirms that:

- › Clinical peer reviewers render decisions based on the appropriateness of care and services.
- › Clinical peer reviewers are not compensated in any way for denying, limiting, or modifying care.
- › No incentive is provided to the clinical peer reviewers or consulting physician reviewers to encourage modification or denial of requested care.
- › eviCore prohibits making decisions regarding hiring, promoting or terminating practitioners or other individuals based on the likelihood or perceived likelihood that the individual will support or tend to support a denial of benefits.

Treatment is typically authorized in 30-day increments. Authorization in these timeframes allows the clinical peer reviewers to assess the patient's response to treatment.

Critical data impacting the review determination made by the clinical peer reviewers include the following:

- › Patient function
- › Objective findings
- › Special tests and measures
- › Clinical diagnoses
- › Date and mechanism of onset
- › Pain intensity levels
- › Symptom frequency levels
- › Co-morbidity issues and other medical complications
- › Recent surgeries
- › Age of the patient

Treatment Plans that present a clear clinical picture and that are accompanied by a consistent, specific diagnosis better support the medical necessity for the requested treatment. eviCore's clinical peer reviewers use the submitted clinical information in conjunction with our proprietary Clinical Practice Guidelines to determine the number of visits to authorize for each request. eviCore's proprietary Clinical Practice Guidelines provide decision support for peer reviewers as they make medical necessity determinations and are a reference tool for providers as they develop their treatment plans. eviCore's Clinical Practice Guidelines are available on the Resources page in the provider portal.

Review Determinations

eviCore processes Treatment Plan requests and issues review determinations within the timeframes mandated by applicable state and federal regulatory requirements and NCQA and URAC timeliness standards. You may check the status of your requests and download your review determination letters anytime through the provider portal:

1. Login to the provider portal at www.LMHealthcare.com.
2. Select 'Patient Status' from the navigation bar.
3. Use the Member Search page to display a list of authorization records for your patient.

4. Click the 'View Letters' button to view or print the review determination letters from eviCore.

eviCore will also fax or mail you a copy of each review determination letter. Members are notified by a separate mailed letter.

The review determination letter will indicate the number of approved visits and the Approved Time Period. When a treatment request is modified or denied, written notification will also include the following:

- › Clinical rationale for the decision.
- › Instructions for requesting a copy of the Clinical Practice Guideline(s) used in the decision.
- › Instructions for contacting a clinical peer reviewer to discuss the modification or denial.
- › Instructions for appealing a determination, including your right to submit additional information.
- › Time limits for submitting an appeal request.

Upon receiving a review determination, provide treatment up to the number of visits authorized within the Approved Time Period. If you determine that the patient will require additional care beyond the End Date of the Approved Time Period, submit a new Treatment Plan. The Start Date of your subsequent Treatment Plan should be after the End Date of the existing Approved Time Period, but cannot be more than 7 days beyond the date you submit the request.

Access to Clinical Peer Reviewers

eviCore uses licensed therapists, chiropractors, and medical physicians to render review determinations. Our clinical professionals, all with many years of practice experience, are available to discuss Treatment Plan determinations. To request such a peer-to-peer discussion, please contact eviCore's Customer Service Department. A clinical peer reviewer will be available to speak with you within one business day of your request.

Requests for Information

If we cannot make a decision regarding a request for treatment due to a lack of information, we will send you a "Request for Information" (RFI) letter. The letter will describe the information required, and the length of time you have to submit it. If we do not receive the requested information within the designated time period, eviCore will follow the RFI closure process applicable to the member's benefit plan. Your Treatment Plan request will either be closed without review or a determination will be made based on the limited clinical information originally submitted. If you disagree with this determination, you will be provided with instructions on how to appeal the decision.

When you submit the requested additional information, fax it to eviCore along with a copy of the RFI letter you received. If a copy of the letter is not attached, be sure that you note the following on your new documentation to avoid processing delays:

- › Case Reference Number
- › Patient name
- › Patient date of birth
- › Patient ID number
- › Provider name and ID number

Requests for Additional Care Within an Existing Approved Time Period

To request additional care within an Approved Time Period, you must submit a new Treatment Plan with updated clinical findings. Based on your requested Start Date, eviCore will either review the Treatment Plan for a new Approved Time Period, or consider more treatment within the existing Approved Time Period.

e-Form Requests

When you request a Start Date that is within an existing Approved Time Period, the e-Form will prompt you to choose one of the following options:

1. Either request additional treatment within the existing Approved Time Period. This results in the following:
 - You will be required to enter additional information that describes the patient's progress since the previously submitted Treatment Plan and explains why visits were not spread over the Approved Time Period.
 - If additional treatment is approved, it will be granted only within the same date range as the existing Approved Time Period.
 - A new Treatment Plan will be required for any treatment requested after the End Date of the existing Approved Time Period.
2. Or, change the Start Date of the request so that it is not within the existing Approved Treatment Period. If treatment is approved, it will be for a new Approved Time Period beginning after the End Date of the existing Approved Time Period.

Fax Requests

- In order for additional treatment to be considered within an existing Approved Time Period, you must submit a new Treatment Plan with updated clinical findings.
- eviCore will send a Request for Information (RFI) letter with a Request for Additional Treatment Within an Existing Authorization Period form if medical necessity cannot be established. Complete the form to describe the patient's progress since the previously submitted Treatment Plan and explain why visits were not spread over the Approved Time Period.
- Return the Request for Additional Treatment Within an Existing Authorization Period form to eviCore along with a copy of the RFI letter. Incomplete forms will be returned for completion.
- Based on your requested Start Date, eviCore will either review the Treatment Plan for a new Approved Time Period, or consider more treatment within the existing Approved Time Period.
- A new Treatment Plan will be required for any treatment requested after the End Date of the existing Approved Time Period.

Complete Medical Records

Timely and accurate records document the treatment provided to your patients and support 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:

- The writing is legible with standard abbreviations or contains a key to unique abbreviations.
- Patient name and/or identification number must be present on each page of the file.

- › Demographic information, such as date of birth and gender must be present at least once.
- › Complete medical history.
- › Detailed description of your objective examination findings.
- › Description of any diagnostic testing and the resultant findings.
- › Primary diagnosis or set of diagnoses.
- › Treatment Plan, including goals of treatment, objective findings, functional deficits, and the need for skilled care based on evidence-based research should be provided.
- › If applicable, your referral of the patient to another practitioner and the clinical rationale for this decision.

Contact Us

Provider Portal

www.LMHealthcare.com

Email

info@LMHealthcare.com

Phone

(877) 531-9139

Fax

(888) 565-4225

Address

eviCore healthcare
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Office Hours

8:30 am to 5:00 p.m. EST

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