HMSA Physical and Occupational Therapy Utilization Management Authorization Guide

Published 03.10.10
Physical and Occupational Therapy Utilization Management Authorization Guide

Specifically for Phase II from April 1, 2010 through December 31, 2010 Waiver Program

Program Overview

Hawaii Medical Service Association (HMSA) has partnered with Landmark Healthcare Services, Inc. to assist in the management of outpatient physical and occupational therapy services. The utilization management program has two primary objectives. The first is to bring transparency and accountability to the practice patterns of therapy providers by providing timely and easy access to utilization data. This data will be displayed in a profiling tool called the Practitioner Performance Summary (PPS). Landmark’s PPS tool contains a suite of clinical reports derived from HMSA claims data that will allow you to compare your utilization metrics to those of regional and national peers and to track changes in your performance over time.

The program’s second objective is to promote efficiency in the delivery of therapy services and to ensure that therapy providers deliver care within acceptable utilization parameters.

To realize these objectives the program has been divided into three phases as follows:

**Phase I** - November 2009 through March 31, 2010 (Performance Reporting): The practice patterns of physical therapists will be profiled using Landmark’s Practitioner Performance Summary profiling tool. There will be no active utilization management during this phase.

**Phase II** - April 1, 2010 through December 31, 2010 (Performance Reporting and Utilization Management): The patient’s benefit will determine when authorization is required. For patients who are not covered by Fed 87, authorization will be required after the 8th visit per benefit period. For Fed 87 patients, authorization will be required after the 10th visit per episode of illness/injury. When authorization is required, a treatment plan must be submitted to a Landmark peer reviewer and authorization for services will be based on medical necessity and the need for ongoing care. Performance reporting using the PPS tool will continue during this Phase and throughout the program.

**Commencing April 1, 2010 occupational therapy services will be managed under the processes established for Phase II above; there will be no variable intensity review, performance reporting or changes in the utilization management requirements in Phase III for OTs.**

**Phase III** - January 1, 2011 forward (Performance Reporting and Variable Intensity Review): The physical therapy network will be divided into three tiers based on each provider’s utilization experience during the period from November 2009 through the summer of 2010. Prior authorization requirements will depend on your placement in one of the following tiers:

- Clinical Autonomy: No prior authorization required.
- Basic UM: Prior authorization required after exhaustion of the member’s waiver visits.
- Comprehensive UM: Prior authorization required after the initial evaluation.
During Phase III, each participating provider’s performance will be analyzed bi-annually for re-evaluation of tier status using the PPS. The criteria for each tier, expressed in terms of risk adjusted visits per episode of care and services (units) per visit, will be published at [www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com).

Increases in utilization, whether in respect to visits per episode of care or services per visit, may move you into a tier with more administrative requirements and vice versa. It is your responsibility to monitor your practice patterns in order to understand where you stand with respect to tier criteria and placement. To assist in this effort Landmark will mail a quarterly PPS in January, April, July, and October to physical therapy providers with more than 10 episodes of care. Each “hard copy” PPS that you receive in the mail will display key utilization metrics regarding visits and services that will allow you to understand your performance at the date of the PPS and how it has changed over time. The summary report 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 level at which data is aggregated for PPS profiling purposes and tiering is determined by your HMSA 6-digit root ID number. For most practitioners who bill using their unique HMSA root ID, the PPS will measure individual utilization. Independent PTs, and MDs or DOs who bill for their own services will be able to track personal practice patterns. Physical therapists who practice in a group setting and bill using the ID of the group will not get a personal PPS report. The report will be a summary of all therapists who practice and bill within that setting. In general, hospitals bill for all therapists employed by the hospital. If the hospital uses only one root ID number for all locations, the PPS report will be a summary of all locations. If the facility has different root ID numbers for distinct locations, then the PPS report will be specific to each location.

In addition to the hardcopy version of the PPS that will be mailed quarterly, an on-line version is available through the LandmarkHealthcare.com website. The on-line PPS provides a number of features not available in the hardcopy format. The on-line tool provides timelier information, since it is updated on a monthly, rather than a quarterly basis. In addition, it 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 on-line, 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.

**Waiver Program**

As noted above the Waiver Program begins April 1, 2010. All physical and occupational therapy providers will participate in this phase of the utilization management program. It’s called a “waiver program” because prior authorization is waived for a patient’s first series of therapy visits during a given benefit period.

- **The “standard waiver”:** For most HMSA members, the waiver is set at eight (8) visits. This means you may treat a patient up to eight (8) visits in a benefit period without the submission of a treatment plan. Unused visits are available if the member returns for additional therapy during the benefit period. For example, if the member sees you for five (5) visits for a neck condition and returns later that benefit year for treatment of his knee, you may use those three (3) remaining visits of the eight-visit waiver before submitting the Landmark treatment plan for authorization. For PPO/HMO members there is an eight (8) visit waiver for OT and an eight (8) visit waiver for PT. QUEST members have a combined eight (8) visit waiver for OT and PT.

- **Fed 87:** Fed 87 members have a ten (10) visit waiver (PT and OT combined) per condition. A condition is defined as a distinctly different diagnosis, usually falling within a different clinical diagnostic category. These clinical diagnostic categories are described in your PPS, the web version of which can be found under Landmark Connect at our website [www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com). If the member uses all ten (10) visits for treatment of the...
back and returns later for treatment of the wrist, the member receives another ten (10) visit waiver before a treatment plan is required for preauthorization.

The waiver is specific to the HMSA member; visits during a benefit period are accumulated across all the PT and OT providers that a member sees during a benefit period for purposes of calculating the waiver. For example, if a member has a standard eight (8) visit waiver and sees another therapist during the benefit period for five visits prior to seeing you, he or she only has three visits remaining under the waiver. Treatment by you after your third visit with that member requires the submission of a treatment plan and prior authorization.

Please note the following information about the Waiver Program:

- In order to prevent denied claims, it is your responsibility to determine if the waiver visits have already been used for the benefit period. You should ask the member if s/he has received therapy during the current benefit period. You may also contact HMSA to see if claims have been paid for that member. Keep in mind that claims data is generally at least three months delayed. If in doubt, submit a treatment plan and request the visits you believe are required.
- If your patient needs additional visits beyond those allowed under the waiver, submit a treatment plan prior to the last visit available under the waiver. If the applicable waiver is eight (8) visits submit the treatment plan prior to the patient’s sixth or seventh visit to avoid a break in care. The date following the eighth visit should be the "From" date on the first treatment plan you submit for that patient.
- If the patient returns for additional therapy in the same benefit period, any remaining waiver visits may be used prior to submitting a treatment plan. Remember, in the case of the standard eight (8) visit waiver, there is only one waiver per member per benefit period. Once those eight (8) visits are used, the treatment plan must be submitted if additional visits are needed.
- For PPO/HMO members there is a separate eight (8) visit waiver for PT and for OT.
- For QUEST members there is one eight (8) visit waiver for PT and OT combined.
- For Fed 87 members there is one ten (10) visit waiver per condition for PT and OT combined.
- Although the program waives the requirement to submit a treatment plan for the first eight (8) visits, you are expected to keep the patient’s chart current and to follow all medical records requirements (see the "Complete Medical Records" section below). Patient records may be audited for compliance with HMSA policies.

**Submitting Your Initial Treatment Plan**

You are required to submit Landmark’s Treatment Plan form to request authorization. You may submit an electronic Treatment Plan though Landmark Connect's eForm tool or you may download Landmark’s Treatment Plan from Landmark Connect at [www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com). Submit your treatment plan at least three business days prior to the first visit that requires authorization in order to prevent any disruption in care. Report your clinical findings of the patient’s current condition in the appropriate sections of the treatment plan.

Landmark accepts treatment plans on-line or by fax. If your treatment plan is received before 4:30 p.m. HST, it is considered received on the same day as you transmitted it to us. If your form is received after 4:30 p.m. HST, it is considered received on the next business day.

**Required Fields of the Treatment Plan**

Clear and complete treatment plans will speed the processing of your authorization requests. Please be sure the following information is complete on your treatment plan before you submit it. If this information is not included, the treatment plan will be returned to you. Required information:
Phase II Treatment Authorization Guide

- Patient name
- Patient date of birth and patient’s age (include both)
- Patient’s HMSA’s ID number
- Name of health plan/insurance carrier (HMSA)
- Provider name (the name of the treating therapist), the 10-digit HMSA provider number and contact information (Provider/Group ID field)
- Provider address, city state and zip
- Provider Phone Number and Provider Fax Number
- 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 ICD9 codes and the diagnoses descriptions)
- 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.
  - Your treatment plans should cover a one month period.
- The number of additional visits requested (beyond the visits that have already occurred or been authorized)

Clinical findings and other supporting information may be inserted in the comments field of the electronic Treatment Plan or faxed with the hardcopy treatment plan. The documentation must be legible and if possible, typed. Some providers create typed monthly progress summaries for the referring physician. These may be included with the treatment plan. Please include the comment “see attached” if you substitute an attachment for the clinical findings required on the treatment plan.

**Key Elements for Clinical Review of Treatment Plans**

Clinical review decisions are based on key data provided with the treatment plan. It should be noted that uncomplicated cases requiring fewer visits do not require as detailed clinical information as complicated cases requiring more visits.

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

- Objective findings (such as range of motion, strength, and sensation)
- Functional limitations
- Clinical diagnosis(es)
- Date and mechanism of onset
- Subjective complaints
- Pain intensity levels
- Symptom frequency levels
Co-morbidity issues and other medical complications
Recent surgeries
Proposed plan of treatment and goals
Age of the patient

Landmark’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. These Clinical Practice Guidelines are available to you through our secure provider portal at www.LandmarkHealthcare.com. Treatment plans that present a clear clinical picture (e.g., subjective complaints are validated by the objective findings), and that are accompanied by a consistent diagnosis better support the necessity for the requested visits.

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. If additional care is required beyond the authorized visits, you must submit an updated treatment plan to receive further authorization. It is important to remember that the HMSA therapy benefit is a short term benefit for the treatment of acute conditions that are usually expected to resolve in less than 90 days.

Subsequent (Continuing Care) Treatment Requests

When additional care is required after the exhaustion of the initial set of authorized visits or time period established for those visits, a new treatment plan containing updated clinical information is required. You are required to use the Landmark treatment plan form. Please note that in order to establish the need for ongoing care; the updated clinical information must document significant lasting benefit from previous treatment.

If you believe that a patient will require therapy beyond the initially authorized visits, we suggest that you submit an updated treatment plan at least three full business days prior to the last authorized visit. The "From" date on the treatment plan should coincide with the date you would like the second set of authorized visits to begin. The "Anticipated No. of Visits" should reflect the number of additional visits you are requesting on the updated treatment plan form.

Please note: Treatment plan dates can not overlap. The start date of the subsequent treatment plan must reflect the date following the end date of the previous authorization.

Follow the same process throughout the course of care. Submit a new treatment plan with updated clinical information at least three business days before the currently authorized visits are exhausted.

Date Extensions of Existing Authorizations

To extend the expiration date of an existing authorization, submit a request for a date extension. An extension may be necessary due to unforeseen delays, such as your patient’s inability to attend all scheduled visits. Only one date extension will be allowed per episode of care.

To Submit a Date Extension Request

- Submit a Date Extension Request form on-line by logging on to Landmark Connect at www.LandmarkHealthcare.com.
- Or you may download the form from Landmark Connect and fax your Date Extension Request form to Landmark at (888) 565-4225.
Retrospective Treatment Request

If you fail to request authorization for visits that do not fall under the waiver, payment will be denied. You may, however, request authorization retrospectively. Retrospective authorization requests are requests for visits that have already occurred. Please note the following policies applicable to retrospective authorization requests.

- You are required to include a copy of all evaluations, progress summaries, and daily treatment notes for the services you provided. Outcome assessment information will assist in the authorization determination.
- Landmark will provide a review determination within the timeframe required by applicable regulations.
- Landmark will not process retrospective authorization requests as expedited or urgent requests.

Requests for Additional 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" 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, a determination will be made based on the 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 information, attach a copy of the "Request for Information" letter you received and fax it and the information requested to Landmark Healthcare at (888) 565-4225. 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 HMSA ID number
- Practitioner name and 10-digit HMSA provider ID number

Note

If you resubmit a corrected 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. The requested information must be faxed to Landmark Healthcare at (888) 565-4225.

Notification of Review Determinations

We will provide you with written notifications of clinical review determinations via a faxed letter. A copy of the letter will also be available on-line through Landmark Connect at www.LandmarkHealthcare.com. We will notify members by a separate mailed letter.

When we approve your request for authorization in its entirety, we will send you a notification letter identifying the number of approved visits and the treatment period. The letter will also include information on how to submit a new treatment plan should additional care be necessary.
When the number of visits and/or services requested on a treatment plan is modified or denied, written notification will include the following:

- Number of visits approved and the treatment period during which such visits may be used.
- 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.

If the number of visits you requested is modified, and you agree with the clinical rationale, provide treatment up to the number of visits authorized. If you determine that the patient will require additional care beyond the treatment period authorized, submit a new treatment plan about three business days before the last authorized visit. Refer to the Subsequent (Continuing) Treatment Requests section above for more information. If you disagree with a decision, you may contact a Clinical Case Manager to discuss this case by calling our Customer Service number at (888) 638-7876.

Access to Clinical Peer Reviewers

Landmark uses licensed physical therapists and medical physicians to render review determinations. All of our clinical professionals have many years of practice experience. You may request a peer-to-peer discussion about treatment plan denial or modification determinations. A clinical peer reviewer will be available to speak with you within one business day of your request. To request such a peer-to-peer discussion, please contact Landmark Customer Service at (888) 638-7876. A representative will help connect you with a clinical peer reviewer.

Status of Authorization Request

We process authorization requests and notify practitioners within the time frames mandated by applicable state and federal regulatory requirements. You may check the status of your requests anytime through Landmark Connect. After you log on, click on the Patient Status tab to inquire about the status of your authorization requests.

You may also call our Customer Service Department at (888) 638-7876.

Duplicate Treatment Plans

Please do not resubmit your treatment plan unless you have verified that we did not receive your original submission. Submission of duplicate treatment plans will delay processing.

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.
Phase II Treatment Authorization Guide

- Complete medical history.
- Detailed description of subjective complaints.
- 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, frequency/number of visits, types of services planned, and expected time frame for improvement and discharge from care.
- If applicable, your referral of the patient to another practitioner and the clinical rationale for this decision.

Clinical Practice Guidelines

Landmark’s proprietary Clinical Practice Guidelines provide decision support for its peer reviewers as they make medical necessity determinations. The Clinical Practice Guidelines were developed and are regularly updated through a systematic approach that gathers material from peer-reviewed scientific publications and generally recognized care protocols. Importantly, guideline development also involves input and direction from active practitioners who contribute their knowledge and experience to the clinical principles and standards of care under review. These contributors include clinical/medical directors, practitioner advisory committees and outside content experts.

The Clinical Practice Guidelines are reviewed annually by a committee of participating practitioners. The guidelines are subject to further review by Landmark’s multi-disciplinary Utilization Management and Quality Improvement Steering Committees.

All services provided by practitioners must be delivered in accordance with professionally recognized standards of care, as reflected in the Clinical Practice Guidelines. The guidelines are used to establish medical necessity and to determine services covered and reimbursable under a member’s benefit plan.

The Clinical Practice Guidelines are a subset of the professional practices provided within the practitioner community; some practitioners provide services that are within their scope of practice, but do not meet the care parameters defined in the guidelines or a member’s benefit plan. Conversely the inclusion of a specific form or type of treatment in the Clinical Practice Guidelines is not determinative of health plan coverage. Examples of these include iontophoresis, infrared, ultraviolet modalities and laser therapy. Covered services are determined by the member’s benefit plan. Landmark’s Clinical Practice Guidelines are available at www.LandmarkHealthcare.com.

Appropriate Utilization

Landmark’s clinical department oversees and monitors patient care, ensuring that each patient receives effective, quality care resulting in a positive outcome. Accordingly, the clinical department affirms that:

- Clinical peer reviewers render authorization 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 committee members to encourage modification or denial of requested care.

Review decisions and determinations are not arbitrary. All information submitted in or with a treatment plan is reviewed. Decisions are based on the reviewer’s clinical experience as further informed by our Clinical Practice Guidelines, scientific evidence, and research literature.
Contact Us

**Landmark Connect**
www.LandmarkHealthcare.com

**Email**
info@LMhealthcare.com

**Phone**
(888) 638-7876

**Fax**
(888) 565-4225

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

**Landmark Office Hours**
8:00 a.m. to 4:30 p.m. HST