HMSA Physical and Occupational Therapy
Utilization Management Guide

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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. To achieve this objective, Landmark provides the Practitioner Performance Summary (PPS). Landmark’s PPS tool contains a suite of clinical reports derived from HMSA claims data that 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. Through the PPS, each participating provider’s performance history is analyzed bi-annually for placement in one of three variable intensity review (VIR) tiers. Each tier requires a practitioner to adhere to specific administrative requirements.

Variable Intensity Review

VIR focuses on outlier providers – those who are less efficient than their peers. Efficiency is measured by the two drivers of utilization – risk-adjusted visits per episode of care and service units per visit. Using these criteria, we divide the network into three tiers according to utilization efficiency and manage each tier differently. Precertification requirements depend on your placement in one of the following tiers:

- **Clinical Autonomy**: No precertification is required. (Refer to Section I)
- **Basic Utilization Management (UM)**: Precertification is required after the member’s eighth visit. (Refer to Section II)
- **Comprehensive Utilization Management (UM)**: Precertification is required after the initial evaluation. (Refer to Section III)
Practitioner Performance Summary and Tier Placement

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

To assist in this effort, Landmark mails a quarterly PPS in January, April, July, and October to physical therapy providers with more than 10 episodes of care in the most recent reporting period. Each hard copy PPS that you receive in the mail displays key utilization metrics regarding visits and services. The PPS allows 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 root ID number:

- Most practitioners bill using their unique HMSA ID; the PPS measures their individual utilization. Independent PTs, MDs or DOs who bill their own services are able to track personal practice patterns.
- Physical therapists that practice in a group setting and bill using the ID of the group do not get a personal PPS report. The report is 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 a single HMSA ID number for all locations, the PPS report is a summary of all locations. If the facility has different HMSA ID numbers for distinct locations, then the PPS report is specific to each location.

In addition to the hard copy version of the PPS that is mailed quarterly, an online version is available through the Landmark website, Landmark Connect, at www.LandmarkHealthcare.com.

The online PPS provides a number of features not available in the hardcopy format. The online tool provides more timely 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 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.
**Section I – Clinical Autonomy Tier**

Providers in the Clinical Autonomy tier are not required to submit Treatment Plans. You may submit claims for short-term therapy to HMSA without obtaining precertification.

Although you are not required to submit Treatment Plans to request precertification, you have a responsibility to maintain complete medical records to support patients’ care.

**Section II – Basic Utilization Management Tier**

Providers in the Basic Utilization Management tier include the following:

- Physical therapy providers performing at average efficiency
- Low volume physical therapy providers
- Occupational therapists

**Precertification Requirements**

- The Basic Utilization Management program requires providers to obtain precertification for visits that exceed eight therapy visits per benefit year.
- To maximize efficiency, precertification requests should be submitted electronically on Landmark’s website, Landmark Connect at [www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com). The online process is easy to use and ensures that the request includes complete information. In certain circumstances, an immediate response to the Treatment Plan is presented to you.
- Alternatively, you may fax the Physical/Occupational Therapy Treatment Plan form to (888) 565-4225. Faxed forms follow standard utilization management processes and turnaround times.
- Outcomes assessment reporting via the Revised Patient Specific Functional Scale (PSFS) is requested but optional under the Basic Utilization Management program.

Under the Basic Utilization Management program, HMSA waives the precertification requirement for eight (8) therapy (PT and OT) visits per benefit year. For most patients, the benefit year is a calendar year; for QUEST members, the benefit year starts each July 1. Since a patient may have been treated by another therapist, it is important that you verify whether each patient has already received treatment. Contact HMSA or check online in HHIN to see if visits have already been rendered. 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.

Note that there is a separate eight (8) visit accumulation for PT and for OT services.

Following are some treatment scenarios and your precertification requirements under the Basic Utilization Management program:
- A patient who has not had any therapy visits in the benefit year sees you for treatment. You may render up to eight (8) visits before you request precertification.
- A patient sees you for five (5) visits for a neck condition and returns later that benefit year for treatment of his knee. He has seen no other therapist during the benefit year. You may render up to three (3) additional visits before you request precertification.
- A patient sees another therapist for four (4) visits for a neck condition, and later that benefit year sees you for treatment of his knee. He has seen no other therapist during the benefit year. You may render up to four (4) visits before you request precertification.
- A patient sees another therapist for eight (8) visits for a neck condition, and later that benefit year sees you for treatment of his knee. You must request precertification for treatment after the initial evaluation.

**Section III – Comprehensive Utilization Management Tier**

Providers in the Comprehensive Utilization Management tier require the highest level of clinical oversight.

**Precertification Requirements**

- The Comprehensive Utilization Management program requires providers to obtain precertification for treatment after the initial evaluation visit.
- To maximize efficiency, precertification requests should be submitted electronically on Landmark’s website, Landmark Connect at [www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com). The online process is easy to use and ensures that the request includes complete information. In certain circumstances, an immediate response to the Treatment Plan is presented to you.
- Alternatively, you may fax the Physical/Occupational Therapy Treatment Plan form to (888) 565-4225. Faxed forms follow standard utilization management processes and turnaround times.
- Outcomes assessment reporting via the Revised Patient Specific Functional Scale (PSFS) is required.

**Obtaining Precertification**

Providers in the Basic and Comprehensive Utilization Management tiers are required to submit Treatment Plans according to the precertification requirements described in the Variable Intensity Review section.

**Electronic Submission (e-Forms)**

Landmark encourages use of “e-Forms” to improve the overall efficiency of the utilization management process. Use of e-Forms requires a user account with Landmark’s provider portal, Landmark Connect. To login or register, select “Landmark Connect (Secure Area)” from the Practitioners menu at [www.LandmarkHealthcare.com](http://www.LandmarkHealthcare.com).
The following e-Forms are available for use under both the Basic Utilization Management and the Comprehensive Utilization Management programs.

**Fast Form**

The Fast Form is a short, easy-to-use version of the e-Form that offers immediate, online precertification for a patient’s initial course of care. When you submit your Treatment Plan using the e-Form, you are automatically directed to the Fast Form if this is the first precertification request for that specific patient. The Fast Form is available after a break in care of more than 90 days. In all instances where you are using the e-Form you will be automatically directed to the Fast Form if this option is available.

After you complete a Fast Form, you will immediately be presented with a recommended number of therapy visits. The Fast Form calculates the recommended number of visits by applying a proprietary clinical algorithm to the clinical data you provided. As the requesting provider, you can decide whether the recommended course of treatment is acceptable. In most cases, the recommended Treatment Plan will meet your patient’s treatment needs for the initial course of care, but in other cases it may not.

**If you accept the recommended Treatment Plan** Landmark will issue an precertification. You will be provided with an online confirmation and a faxed approval letter. You may immediately start to treat the patient and submit claims according to the agreed upon visits and duration of care.

**If you do not accept the recommended Treatment Plan** you will be automatically directed to Landmark’s standard Treatment Plan e-Form. The information you provided on the Fast Form will be pre-populated in the standard e-Form. You must complete the remaining standard e-Form fields, and submit your request to Landmark. A clinical peer reviewer will make a review determination, which you will receive by fax or mail (if no fax number is provided) within the standard response timeframe.

Occasionally the request for an initial course of care requires more information than is gathered by the Fast Form. In those cases, you will be automatically re-directed to the standard Treatment Plan e-Form. You will complete the remaining fields, and then submit your request to Landmark.

**Standard Treatment Plan e-Form**

The electronic Treatment Plan form is easy to use and ensures that your precertification request includes complete information. The standard Treatment Plan is required in the following situations:

- The patient already has an precertification for visits within 90 days of your request.
- You do not accept a Fast Form Treatment Plan recommendation for an initial course of care.
- The patient’s initial course of care requires more information than is gathered by the Fast Form.
The information you provide on the Treatment Plan will be reviewed by a clinical peer for a review determination. To provide clinical findings and other supporting information not otherwise required by the Treatment Plan form, document this information in the e-Form “comments” field.

**Obtaining Precertification by Fax**

If you do not have Internet access, request precertification by fax using Landmark’s Physical/Occupational Treatment Plan and Revised Patient Specific Functional Scale (PSFS) forms.

Clear and complete Treatment Plans will speed the processing of your precertification 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.

- 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 telephone number and 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. *(Do not use non-specific codes in the primary diagnosis field unless it is the only appropriate diagnosis.)*
- 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 up to a 30-day period.
- The number of visits requested (not including any previously precertified visits or visits rendered).
- If applicable, surgical information must be completed on the Treatment Plan form.

You may fax clinical findings and other supporting information with the Treatment Plan. The documentation must be legible, and preferably typed.
Outcomes Assessment

Patient-reported outcome assessments are vital components of Landmark’s clinical management. The revised Patient Specific Functional Scale (PSFS) outcomes tool provides a valid, reliable and quantifiable measurement of the following:

- A patient’s clinical improvement over time
- The effectiveness of treatment
- The necessity of continued care

The submission of the PSFS is requested but optional under the Basic Utilization Management program, and required under the Comprehensive Utilization Management program.

Updating PSFS Scores

Submit an updated PSFS with each Treatment Plan. If you request precertification online, the PSFS is included in the Outcomes Assessment section of the Fast Form and the standard Treatment Plan e-Form. If you fax your precertification request, submit the PSFS form with your Treatment Plan.

Complete the baseline PSFS prior to the start of treatment. Enter the date of the baseline assessment in the appropriate date field. Ask the patient to state in his or her own words, at least three (3) activities that he or she is unable to perform, or is having the most difficulty performing because of the chief complaint. Enter these three activities in rows one, two and three of the “Activity” column.

Ask the patient to score each activity limitation on a numerical rating scale of 0-10. Enter the patient-reported score for each documented activity limitation in the appropriate field.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to perform the activity at the same level as before injury or problem</td>
</tr>
<tr>
<td>10</td>
<td>Unable to perform activity</td>
</tr>
</tbody>
</table>

Record the activities and scores exactly as stated by the patient. Submit the baseline outcome assessment with the first Treatment Plan. For subsequent precertification requests, enter the date of the follow-up/discharge assessment in the appropriate date field. The “Activity” column will contain activity limitations that the patient had previously identified related to the condition. During the follow-up/discharge assessment, ask the patient to score each of the activities previously listed on the PSFS, using the numerical rating scale 0-10.

Each activity MUST be scored in each PSFS assessment. If an activity is no longer limited and the patient can perform the activity at the same level as before the injury or problem, then the activity should be given a score of “0”. If the patient has a new functional limitation, you may add the activity to the form and it should be assessed for the remainder of the treatment episode.

The following instances will require the completion of a new or additional PSFS:
The patient’s previous condition is resolved and the patient presents for treatment of a new condition. Discontinue use of the previous PSFS and complete a new PSFS for the new condition.

The patient presents for treatment of a new condition and the previous condition continues to require ongoing care. Complete a new PSFS for the new condition.

Review Determinations

Written notifications of clinical review determinations are provided online on Landmark Connect. We will also fax or mail you a copy of each determination letter. Members are notified by a separate mailed letter.

When we approve your request for precertification 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 request 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 within the duration specified. If you determine that the patient will require additional care beyond the treatment authorized, submit a new request no more than five (5) days prior to the proposed start date of the new Treatment Plan. Read the Subsequent (Continuing Care) Precertification Requests section of this guide for more information.

If you disagree with a decision, you may contact a clinical peer reviewer to discuss the case by calling our Customer Service number at (888) 638-7876.

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
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, attach a copy of the "Request for Information" letter you received and fax it with 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

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

Clinical review decisions are based on key data provided with the Treatment Plan and the PSFS. Critical data impacting the review determination made by the clinical peer reviewers include the following:

- 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. 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, specific diagnosis better support the medical necessity for the requested visits.

Treatment is typically authorized in 30-day increments. Precertification in these timeframes allows the clinical peer reviewers to assess the patient’s response to treatment. Please note 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.
Clinical Review

Review decisions and determinations are based on the reviewer’s clinical experience as further informed by our Clinical Practice Guidelines, scientific evidence, and research literature. Accordingly, the clinical department affirms that:

- Clinical peer reviewers render precertification 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.

Clinical Practice Guidelines

Landmark’s proprietary Clinical Practice Guidelines provide decision support for its peer reviewers as they make medical necessity determinations and are a reference tool for providers as they develop their Treatment Plans. Landmark’s Clinical Practice Guidelines are available for review on Landmark Connect.

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.

Treatment Plan Status Inquiries

We process precertification requests and notify practitioners within the time frames mandated by applicable state and federal regulatory requirements and NCQA and URAC timeliness standards. 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 precertification requests.
Subsequent (Continuing Care) Precertification Requests

If you believe a patient will require therapy after a precertification expires, 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. Submit your updated Treatment Plan within five (5) days before the start date of your new request. A Treatment Plan submitted more than five (5) days in advance will not be accepted.

Please note: Treatment Plan dates can not overlap. The proposed start date of a subsequent Treatment Plan must be a date after the end date of the previous precertification. The number of visits you request should reflect the number of additional visits sought beyond those previously authorized.

Retrospective Treatment Request

If you fail to request precertification based on the precertification requirements of your assigned tier, payment will be denied. You may, however, request precertification retrospectively. Retrospective precertification requests are requests for visits that have already occurred. Please note the following policies applicable to retrospective precertification requests.

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

Date Extensions of Existing Precertifications

An extension may be necessary due to unforeseen delays, such as your patient's inability to attend all scheduled visits. To extend the expiration date of an existing precertification, submit a Date Extension Request. Only one date extension per course of care will be allowed.

- Submit a Date Extension Request form online by logging on to Landmark Connect.
- Or download the form from Landmark Connect and fax your Date Extension Request to Landmark at (888) 565-4225.

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. The requested information must be faxed to Landmark Healthcare at (888) 565-4225.
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 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.

Contact Us

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Landmark Office Hours
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