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Program Overview
Hawaii Medical Service Association (HMSA) partners with Landmark Healthcare Services, Inc. (Landmark) 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 physical therapy providers by providing timely and easy access to utilization data. To achieve this objective, Landmark develops and makes available to each physical therapist an individual Practitioner Performance Summary (PPS). Landmark’s PPS tool contains a suite of clinical reports derived from HMSA 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.

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. Using the PPS, each physical therapy 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.

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 (RAVE) and service units per visit (SUV). Using these criteria, we divide the network into three tiers according to utilization efficiency and we manage each VIR tier differently.

Precertification requirements depend on your placement in one of the following VIR tiers:

- **Clinical Autonomy**: No precertification is required.
- **Basic Utilization Management (UM)**: Precertification is required after the member’s 8th visit.
- **Comprehensive Utilization Management (UM)**: Precertification is required after the initial visit.

Changes in your utilization may move you into or out of a VIR tier that requires or relaxes administrative requirements. It is your responsibility to monitor your practice patterns using the PPS tool so you know where you stand with respect to criteria and VIR tier placement.
Practitioner Performance Summary and Tiering

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 HMSA peers. Below are the descriptions of the graphs and charts contained within the PPS.

Mean Risk-Adjusted Visits per Episode for Top 5 Clinical Categories

This graph illustrates your mean risk-adjusted visits billed per episode of care for the top five clinical categories and total utilization. The top five clinically related diagnostic categories are ranked by your episode volume. These metrics reflect the latest 12-month reporting period. This chart also provides HMSA peer comparative values.

Risk Adjustment: In an effort to create a balanced playing field among practitioners, Landmark 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 November 2011 reporting period represents claims data from December 1, 2010 to November 30, 2011.

Top Clinical Categories Ranked by Number of Episodes

This table shows the number of episodes of care and cost per episode for the top five clinically related diagnostic categories, the combined values for all other clinically related diagnostic categories, as well as a summation of total utilization. These metrics reflect the latest 12-month reporting period. This chart also provides HMSA peer comparative values.

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

The Performance History chart graphs your mean risk-adjusted visits billed per episode of care over consecutive, rolling 12-month reporting periods. All diagnostic categories are included. Each data point represents a full 12-month reporting period ending at the month displayed on the horizontal axis. This chart also provides HMSA peer comparative values. There is an “Export to Excel” button just above the Performance History line graph. This may be used to export your patient list and related data found in the PPS to an Excel spreadsheet. This will allow you to study your patient data offline from the Landmark Connect webpage.

Performance by Clinically Related Diagnostic Category

This graph can be used to identify where your practice patterns differ from your peers in the network. Review of evidence-based literature and peer-to-peer discussions with Landmark clinical peer reviewers can help reduce unnecessary utilization identified within these graphs.
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.

Practitioner Performance Summary
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.

Landmark mails a PPS quarterly in January, April, July, and October to physical therapy providers with more than 10 episodes of care in three of the six most recent reporting periods. This mailing includes a PIN for you to access to your PPS online. 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.
- 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.
- It gives you the capability to export the data into Microsoft Excel.
- 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:

2. Click on the 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.

The level at which PPS data is aggregated for VIR tiering is determined by your HMSA root ID number:

- Independent PTs, MDs or DOs who bill their own services are able to track personal practice patterns.
- Physical therapists who practice in a group setting and bill using the ID of the group do not get a personal PPS. The PPS is a summary of all therapists who practice and bill within that setting.
- If a hospital uses a single HMSA ID number for all locations, the PPS is a summary of all locations. If the facility has different HMSA ID numbers for distinct locations, then the PPS is specific to each location. Typically, the PPS is a summary of all therapy providers employed by the hospital.
Obtaining Precertification

Precertification Requirements by VIR Tier

Clinical Autonomy
Providers in this VIR tier include physical therapy providers performing at above-average efficiency. As a provider in this VIR tier, you are not required to submit Treatment Plans. You may submit claims for short-term therapy without obtaining precertification. Although you are not required to submit Treatment Plans, you have a responsibility to maintain complete medical records to support patients’ care.

Basic Utilization Management
Providers in this VIR tier include the following:

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

Under the Basic Utilization Management program, HMSA waives the precertification requirement for the patient's first 8 therapy visits of each 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 during the benefit year, it is important that you verify whether the patient has already received treatment and so may have used all or part of the exempt 8 visits. 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 to precertify the visits you believe are required.

Note that there is a separate 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 8 visits before you request precertification.
- A patient sees you for 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 3 additional visits before you request precertification.
- A patient sees another therapist for 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 4 visits before you request precertification.
- A patient sees another therapist for 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.
Comprehensive Utilization Management

Providers in this VIR tier include physical therapy providers performing at below-average efficiency. As a provider in this VIR tier, you are required to obtain precertification after the initial visit, which may be an evaluation or an evaluation with treatment.

Physical and Occupational Therapy Treatment Plans

Landmark’s clinical peer reviewers consider requests for care based on the information you submit on a Treatment Plan form. Various versions of Landmark’s Treatment Plan are available for requesting physical or occupational therapy, 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 Landmark’s "e-Form" the preferred method for requesting physical and occupational therapy 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:

2. Select ‘e-Forms’ from the navigation bar.
3. Click the applicable link to begin a Physical Therapy or Occupational Therapy Treatment Plan.

Landmark Connect 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-9 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-9 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 Landmark Connect at www.LMHealthcare.com to download the proper form. Landmark does not accept authorization requests on any document other than a Landmark 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 Landmark's form will be returned to your office for correction and resubmission.
4. Fax the completed Treatment Plan to Landmark at (888) 565-4225.

Treatment Plan Help Tools
For help completing the e-Form or paper Treatment Plans, access the Treatment Plan Resources available on Landmark Connect.

When to Submit the Treatment Plan

Initial Care Request
The timing of your first precertification request depends upon your VIR tier:

The Basic Utilization Management program requires precertification after the patient's 8th therapy visit of the benefit 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.
• Enter the date of your patient's 9th therapy visit of the benefit year as the "Start Date for This Treatment Plan" (Start Date). Remember to count visits from all therapy providers in the benefit year, not just your visits with the patient. Or, if the patient has already had more than 8 therapy visits in the benefit year, enter the treatment date that occurs after the date of the initial evaluation.
• Do not submit the Treatment Plan more than 7 days prior to your requested Start Date. Landmark 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 Landmark, which will delay consideration of your request.
• If your Initial Care request is approved, Landmark will notify you of the approved number of visits and the Approved Time Period.

The Comprehensive Utilization Management program requires precertification 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.
• Enter the date of your patient's therapy treatment that occurs after the date of the initial evaluation as the "Start Date for This Treatment Plan" (Start Date).
• Do not send the Treatment Plan more than 7 days prior to your requested Start Date. Landmark will not accept a Treatment Plan submitted more than 7 days in advance.
• If your Initial Care request is approved, Landmark will notify you of the approved number of visits and the Approved Time Period.

Approved Time Period: When care is approved, the Approved Time Period is the time period (duration) you have available to use approved visits. Visits must be spread throughout the authorized duration to avoid a gap in care at the end of the Approved Time Period. Medical necessity authorizations are typically approved for a 30-day period.

See "Review Determinations" on page 9 for more information about the notification process.

Continuing Care Request
If you believe a patient will require therapy 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.
• Enter the date of your patient's first requested visit that occurs after the existing Approved Time Period ends as your Start Date.
• Do not send the Treatment Plan more than 7 days prior to your requested Start Date. Landmark 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 Landmark, which will delay consideration of your request.

Retrospective Care Request
If you do not obtain precertification based on your VIR requirements, payment will be denied. You may, however, request certification 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 e-Form or paper Treatment Plan.
• 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.
• Landmark will provide a review determination within the timeframe required by applicable regulations.
• Landmark will not process retrospective requests as expedited or urgent requests.

Date Extensions on Existing Authorization Periods
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 Approved Time Period, 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:

2. Select 'e-Forms' from the navigation bar.
3. Click the 'Complete Date Extension Request' link.

Or, download the form from Landmark Connect and fax your Date Extension Request to Landmark.

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.
• Landmark 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
- Treatment goals
- 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. 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. Landmark’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. Landmark’s Clinical Practice Guidelines are available on the Resources page in Landmark Connect.

**Review Determinations**

Landmark 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 Landmark Connect:

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 Landmark.

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

The notification 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**

Landmark uses licensed therapists 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 Landmark’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, Landmark 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 Landmark 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 Treatment Period, you must submit a new Treatment Plan with updated clinical findings. Based on your requested Start Date, Landmark 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.
Landmark 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 Landmark along with a copy of the RFI letter. Incomplete forms will be returned for completion.

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.

See "Requests for Information" on page 10 for more information about the RFI process.

**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.
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