Obtaining Precertification

This program will help chiropractors determine if HMSA will cover more than eight chiropractic visits in a calendar year. Chiropractors can submit a treatment plan and HMSA’s vendor, eviCore healthcare, will make a decision based on medical necessity, the need for ongoing care, and other criteria set by HMSA.

eviCore healthcare

eviCore healthcare is a national leader in integrated medical benefits management solutions for managed care and risk-bearing providers. It delivers custom, calibrated strategies and services to reduce and control costs, helping its clients to ensure higher quality, evidence-based care for patients. Among its services, eviCore provides chiropractic precertification and payment determination for HMSA through the chiropractic utilization management (UM) program.

Chiropractic Services Precertification Requirements

In the chiropractic UM program, HMSA waives the precertification requirement for the patient’s first eight visits each calendar year. The visit count for calendar year 2016 has a one-time reset to zero on April 1, 2016, for commercial PPO and HMO plans. For HMSA Akamai Advantage and Fed 87 plans, the visit count for calendar year 2016 reset to zero on September 1, 2016.

Since a patient may have been treated by another chiropractor during the year, verify if the patient already received treatment or has used all or part of the exempt eight visits. To find out, call HMSA at 948-6330 on Oahu or 1 (800) 790-4672 toll-free on the Neighbor Islands, Monday through Friday, 8 a.m. to 4 p.m. You can also check Hawaii Healthcare Information Network (HHIN) at hmsa.com/providers/. Click on hhin.

Please keep in mind that claims data may not be available until you or another provider bills for services performed. If in doubt, submit a treatment plan to precertify the visits you believe are required.

Precertification is required for chiropractic services in accordance with HMSA’s Chiropractic Services Policy for the following HMSA members:

- Commercial PPO.
- Commercial HMO.
- FEHB Program (Fed 87).

For HMSA Akamai Advantage members, precertification isn’t required for chiropractic services. However, pre-service payment determination is available to ensure compliance with the criteria in the Centers for Medicare & Medicare Services Local Coverage Determination (CMS LCD) for Chiropractic Services (L34242). If a pre-service payment determination isn’t obtained, services beyond the first eight visits per calendar year will be subject to a post-service review to ensure CMS LCD criteria are met. If you don’t obtain pre-service payment determinations for services beyond the first eight visits, please submit claims for these services to HMSA with medical notes attached. If you don’t include medical notes with your claims for these services they will be rejected.

Here are several situations that require precertification:

- A patient who hasn’t had any chiropractic visits in the calendar year sees you for treatment. You may perform up to eight medically necessary visits before you request precertification.
A patient sees you for five visits and returns later that year for a different condition. That patient hasn’t seen any other chiropractor during the year. You may perform up to three medically necessary visits before you request precertification.

A patient sees another chiropractor for four visits and sees you later that year for a different condition. You may perform up to four medically necessary visits before you request precertification.

A patient sees another chiropractor for eight visits and sees you later that year for a different condition. You must request precertification for treatment after the initial evaluation and you must submit the claim with notes. Otherwise, it will be returned to you for resubmission.

**Treatment Plans**

eviCore’s clinical peer reviewers consider requests for care based on the information you submit on a treatment plan.

**Electronic Submission**
eviCore’s e-Form is the most convenient, efficient way to request precertification for chiropractic services. The e-Form:

- Populates demographic data, saving you time.
- Notifies you of errors, such as incomplete information, so that you can correct them. This prevents delays.
- Allows you to save incomplete e-Forms up to two weeks with the Finish Later option.
- Converts completed printable PDF documents.
- Ensures that electronic submissions are legible and processed as a priority.

To begin an electronic submission:

1. Log on to the secure provider portal at LMHealthcare.com.
2. Access Landmark Connect from the Provider section.
3. Log on and select Enter the Portal.
4. Select e-Forms from the navigation bar.
5. Click the applicable link to begin the e-Form process.

The portal will guide you through selecting the requesting provider and the patient to populate the demographic sections of the treatment plan. You’ll then be prompted to complete the clinical sections.

**Fax Submission**
To fax a treatment plan:
1. Log on to eviCore’s provider portal at LMHealthcare.com and access the Resources Tab to download the Chiropractic Services Treatment Plan form. eviCore doesn’t accept treatment requests on documents other than an eviCore treatment plan.

2. Complete every boxed section of the treatment plan. If a section isn’t applicable to your patient, select N/A. Forms with incomplete sections or references such as "see attached" in place of completing items on eviCore’s form will be returned for resubmission.

3. Fax the completed treatment plan to eviCore at 1 (888) 565-4225 toll-free.

**When to Submit the Treatment Plan**

**Initial Care Request**
The HMSA Chiropractic Services Policy requires precertification after the patient's eighth visit of the calendar year for members with Commercial HMO, PPO, and FEHB Program (Fed 87) plans. For an initial request:

- Select Initial Care as the request on your e-Form or paper treatment plan.

- Enter the date of your patient's ninth visit of the calendar year as the Start Date for This Treatment Plan. Include visits to all chiropractors in addition to visits to you. Or, if the patient has already had more than eight visits in the calendar year, enter the date of the first treatment you provided to the patient as the start date.

- Don’t submit the treatment plan more than seven days before the requested start date. To ensure that clinical information is current, eviCore won’t accept a treatment plan submitted more than seven days in advance.

- Report updated clinical findings. If your Date Current Objective Findings Obtained is more than seven days before the start date, you’ll receive a Request for Information letter from eviCore, which will delay consideration of your request.

- If your initial care request is approved, eviCore will notify you of the allowed number of visits and the approved time period.

**What’s an approved time period?** When care is allowed, the approved time period is the period you have available for allowed visits. Visits must be made during the determination period 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.

**Continuing Care Request**
If you believe a patient will require more treatment after the end date of an approved time period, submit an updated treatment plan to request continuing care. To establish the need for ongoing care, each request must include updated clinical information that documents significant lasting benefit from previous treatment. The turnaround time for treatment plan review and authorization of visits averages less than two business days. Please don’t send your requests any earlier than seven days before the start date of the next authorization period. A window of two days is sufficient to maintain ongoing care.

- 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.

Don't send the treatment plan more than seven days before your requested start date. eviCore doesn't accept treatment plans submitted more than seven days in advance.

Report updated clinical findings. If your Date Current Objective Findings Obtained is more than seven days before your start date, you may receive a request for information letter from eviCore, which will delay consideration of your request.

Retrospective Care Request
If you don't obtain precertification when required, payment will be denied. You may, however, request certification retrospectively. Please note the following policies for retrospective requests:

- Select "Retrospective Care" as the type of request on your treatment plan.
- Include copies of evaluations, progress summaries, daily treatment notes, and flow sheets for the services that you provided.
- eviCore will provide a review determination within the required time frame.
- eviCore won't process retrospective requests as expedited or urgent requests.

Date Extensions on Existing Authorization Periods
You may need an extension 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:

1. Log on to the provider portal at LMHealthcare.com.
2. Access Landmark Connect from the Provider Section.
3. Log on and select Enter the Portal.
4. Select e-Forms from the navigation bar.
5. Click the Complete Date Extension Request link.

You can also download the form from the portal and fax your date extension request to eviCore at 1 (888) 565-4225 toll-free.

Resubmitted Treatment Plans
If you resubmit a modified treatment plan, write "Corrected" or "Resubmitted" at the top. 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. The clinical department affirms that:
- Clinical peer reviewers make decisions based on the appropriateness of care and services.
- Clinical peer reviewers are not compensated for denying, limiting, or modifying care.
- Clinical peer reviewers or consulting physician reviewers don’t have an incentive 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 perception that the individual will support or tend to support a denial of benefits.

Treatment is typically authorized in 30-day increments so that clinical peer reviewers can assess the patient’s response to treatment.

Critical data that impacts the reviewers’ determination include:

- Patient function.
- Objective findings.
- Special tests and measures.
- Clinical diagnoses.
- Date and mechanism of onset.
- Pain intensity levels.
- Symptom frequency levels.
- Comorbidity issues and other medical complications.
- Recent surgeries.
- Treatment goals.
- Patient age.

Treatment plans that present a clear clinical picture and include a consistent, specific diagnosis can better support the medical necessity for the requested treatment. eviCore’s clinical peer reviewers use the clinical information with our proprietary clinical practice guidelines to determine the number of visits to authorize for each request. eviCore’s proprietary clinical practice guidelines help reviewers make decisions on medical necessity determinations and are a reference tool for providers to develop their treatment plans. The guidelines are available on the Resources page in the provider portal.

**Review Determinations**

eviCore processes treatment plan requests and issues review determinations within the time that’s required by state and federal regulatory requirements, NCQA, and URAC. You can check the status of your requests and download your review determination letters anytime through the secure portal:

1. Log on to the secure provider portal at LMHealthcare.com.
2. Access Landmark Connect from the Provider section.
3. Log on and select Enter the Portal.
4. Select Patient Status from the navigation bar.
5. Use the Member Search page to display a list of authorization records for your patient.
6. Click View Letters to view or print the review determination letters from eviCore.

eviCore will also fax or mail you a copy of each review determination letter and mail a letter to notify your patients.

The notification letter will indicate the number of allowed visits and the approved time period. When a treatment request is modified or denied, written notification will also include:

- 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.

When you receive a review determination, provide treatment up to the number of visits allowed within the approved time period. If you determine that the patient will need 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 seven days beyond the date you submit the request.

**Access to Clinical Peer Reviewers**

eviCore uses licensed chiropractors for review determinations. Our experienced clinical professionals are available to discuss treatment plan determinations. To request a peer-to-peer discussion, call eviCore’s customer service at 1 (888) 638-7876 toll-free. A clinical peer reviewer will be available to speak with you within one business day of your request.

**Requests for Information**

If we can’t make a decision about a request for treatment due to lack of information, we’ll send you a request for information (RFI) letter. The letter will specify the information we need and the length of time you have to submit it. If we don’t receive the information within the designated time period, eviCore will follow the RFI closure process applicable to the patient’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’ll receive instructions on how to appeal the decision.

When you submit the additional information, fax it to eviCore at 1 (888) 565-4225 toll-free. Include a copy of the RFI letter you received. If a copy of the letter isn’t attached, include the following on your new document to prevent 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, 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 additional treatment within the existing approved time period.

Medicare doesn't allow reconsiderations and will reject requests for additional care within an approved treatment period for HMSA Akamai Advantage members. To appeal the denial, complete an appeal form (available at hmsa.com) and submit it to HMSA.

When you request a start date within an existing approved time period, the e-Form will ask you to choose one of these options:

1. Request additional treatment within the existing approved time period. This results in the following:
   - Enter additional information that describes the patient's progress since the previously submitted treatment plan and explains why visits weren't approved during the approved time period.
   - If additional treatment is approved, it will be allowed only during the 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's not within the existing approved treatment period. If treatment is allowed, it will be for a new approved time period beginning after the end date of the existing approved time period.

**Fax Requests**
- For additional treatment to be considered within an existing approved time period, submit a new treatment plan with updated clinical findings.
- eviCore will send an RFI 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 weren't in 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.
- If additional treatment is allowed, it will be granted only within the 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, accurate records document your patients’ treatment for reimbursement. Good recordkeeping helps establish the medical necessity of the services you provide. Complete medical records include these important elements:

- Legible writing with standard abbreviations or with a key to unique abbreviations.
- Patient name and/or identification number on each page of the file.
- Demographic information, such as date of birth and gender.
- Complete medical history.
- Detailed description of your objective examination findings.
- Description of any diagnostic tests and the results.
- Primary diagnosis or set of diagnoses.
- Treatment plan including goals of treatment, objective findings, functional limits, and the need for skilled care based on evidence-based research.
- Your referral of the patient to another practitioner and the clinical rationale for this decision, if applicable.

**Contact HMSA or eviCore healthcare**

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<td>P.O. Box 860</td>
<td>eviCore healthcare</td>
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<td>Honolulu, HI 96808</td>
<td>1610 Arden Way, Suite 280</td>
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