Utilization Management Program Guide
Physical Medicine Program
Physical Medicine and Therapy
Effective November 1, 2013
Physical Medicine and Therapy Program Overview
The Health Plan partners with CareCore National to assist with the management and administration of benefits for spinal surgeries and physical medicine/therapy services including:

- Acupuncture treatments
- Manipulation treatments
- Speech therapy treatments
- Massage therapy treatments
- Physical therapy treatments
- Occupational therapy treatments.

Beginning November 1, 2013, pre-authorization for these services will begin as a voluntary quality program. During the time period of November 1, 2013 through January 31, 2014, claims for these services will not deny for lack of medical necessity. The purpose of this grace period is to educate the provider community, focusing on providers registering with CCN, obtaining pre-authorization for the following services and learning to navigate the new process requirements in anticipation of the formal process, beginning February 1, 2014, where services that do not have an approved authorization will not be paid.

This guide provides an orientation to the Physical Medicine and Therapy Utilization Management Program.

Practitioner Performance Summary and Tiering
Physical Therapy and Chiropractic Networks
For physical therapy and chiropractic care, CareCore National performs a network assessment using quality standards and the Health Plan’s claims data. This assessment, the Practitioner Performance Summary (PPS), allows you to understand your performance at the date of the PPS and how your performance has changed over time.

CareCore National provides an online PPS to physical therapy and chiropractic practitioners with more than 10 episodes of care in three of the six most recent reporting periods.

Using the PPS, CareCore National places practitioners into utilization management (UM) tiers based upon their practice profile. Your pre-authorization requirements depend on your placement into one of the following UM tiers:

**Tier A**

The most efficient practitioners are autonomous and do not require pre-authorization of visits. Only submission of the initial Notification is required. Refer to Autonomous UM Program for more information.
Tier B
Practitioners in Tier B have average utilization and follow the Basic UM Program. Submission of the initial Notification is required. The Basic UM program waives the requirement to submit a Treatment Request for either four (Acupuncture/Massage) or six (Manipulation/Therapy) medically necessary visits for a new patient's first covered condition of the calendar year. The "waiver" visits are approved for a 60-day period. Refer to Basic UM Program for more information.

Tier C
The practitioners in Tier C are the least efficient practitioners and follow the Comprehensive UM Program. Tier C practitioners are required to submit a Treatment Request to obtain pre-authorization for all treatment after the initial visit. Refer to Comprehensive UM Program for more information.

Notification and Pre-Authorization Requirements

All Physical Medicine and Therapy Services

Notification
A Notification is the required information submitted to CareCore National informing the Health Plan that a member is starting care. This Notification consists mostly of patient demographic information. The Notification allows for claims payment, the number of visits payable varying based on each practitioner's assigned UM Program. In all cases, a Notification must be submitted for physical medicine/therapy services. Depending on your assigned UM Program, you may also need to submit clinical information to obtain pre-authorization for treatment.

The preferred method to submit the Notification is online at www.carecorenational.com. Online submissions are available 24/7. Notifications can also be submitted by phone 7 a.m. through 7 p.m. local time Monday through Friday.

The submission of a Notification can be performed by the practitioner or his/her office staff and must be submitted within seven days of the initial evaluation or the claim will be denied for service dates on or after February 1, 2014.

Treatment Request
The Treatment Request is a tool required for submission of patient and practitioner information for medical necessity review. You may submit the condition-specific Treatment Request either online or by phone.

Submission online is recommended since it is the fastest and most efficient method of obtaining pre-authorization:

- You may receive automatic pre-authorization when you submit the Treatment Request.
- There is no limit to the number of Treatment Requests you can submit online.
- You can submit information online 24/7.

Depending upon the pre-authorization requirements of your UM Program, you may be prompted to initiate your first Treatment Request at the time you submit your initial Notification.

**Autonomous UM Program**

Practitioners in the Autonomous UM Program include:

- Tier A chiropractors
- Tier A physical therapists.

You are required to submit a Notification after the initial evaluation. Upon receipt of a timely Notification submission, CareCore National will authorize visits for claims payment over an approved time period. You are not required to submit a Treatment Request for medical necessity review.

**Basic UM Program**

Practitioners in the Basic UM Program include:

- Acupuncturists
- Speech therapists
- Massage therapists
- Occupational therapists
- Tier B chiropractors, including low-volume and newly contracted practitioners
- Tier B physical therapists, including low-volume and newly contracted practitioners.

Practitioners in the Basic UM Program are required to submit a Notification after the initial evaluation. The Basic UM program waives the Treatment Request requirement for either four (Acupuncture/Massage) or six (Chiro/Therapy) medically necessary visits for a new patient's first covered condition of the calendar year. The "waiver" visits are approved for a 60-day period. medically necessary visits for the patient's first covered condition of the calendar year.

Note: Physical, occupational and speech therapy and manipulation treatments have a six-visit "waiver"; acupuncture and massage therapy have a four-visit "waiver".

If the patient requires more than the granted "waiver" visits for the episode, you are required to submit a Treatment Request for pre-authorization of visits prior to the patient's 5th (Acu, Mt) or 7th (Pt, Ot, St or DC) visit. Updated clinical information is necessary to make a Medical Necessity Determination.
Note that if the patient already had services in the same calendar year (with any physical medicine/therapy practitioner), treatment for a new episode does not qualify for a six-visit "waiver". You will be prompted to initiate a Treatment Request for medical necessity review at the time you submit your Notification.

**Comprehensive UM Program**
Practitioners in the Comprehensive UM Program include:

- Tier C chiropractors
- Tier C physical therapists.

You are required to submit a Treatment Request to obtain pre-authorization for all treatment after the initial visit. You will be prompted to initiate a Treatment Request for medical necessity review at the time you submit your Notification.

**Submitting the Treatment Request**

**Initial Care**

**Basic UM Program**
You are required to submit a Treatment Request for medical necessity review after the patient's "waiver" visits of the calendar year or after the initial evaluation if the patient had physical medicine/therapy services earlier in same calendar year. Please note the following information regarding your initial Treatment Request:

- Enter the first date you need authorization for the calendar year as your requested Start Date. Or, enter the initial evaluation date for the current episode if the patient's care did not qualify for the "waiver".
- Do not submit the Treatment Request more than seven days before or seven days after your requested Start Date.
- If your Treatment Request is approved, you will be notified of the approved number of visits and the Approved Time Period.

**Comprehensive UM Program**
You will be prompted to submit a Treatment Request for medical necessity review when you submit your Notification after the initial evaluation.

- Enter the patient's initial evaluation date as your requested Start Date.
- Do not submit the Treatment Request more than seven days before or seven days after your requested Start Date.
- If your Treatment Request is approved, you will be notified of the approved number of visits and the Approved Time Period.
The Approved Time Period is the time period (duration) available to use approved visits. Visits must be spread throughout the authorized period to avoid a gap in care at the end of the Approved Time Period. Medical necessity authorizations are typically approved for a 30-day period, allowing the servicing practitioner to assess the patient’s response to treatment. If additional care is required, updated clinical information must be submitted via a Continuing Care Treatment Request.

Continuing Care Treatment Request

If you believe a patient will require visits after the End Date of an Approved Time Period, submit an updated Continuing Care Treatment Request. In order to establish the need for ongoing care, each request must include updated clinical information that documents significant lasting benefit from previous treatment.

- Your requested Start Date will be the first visit requiring authorization after the End Date of the patient’s existing Approved Time Period.
- Do not submit the Continuing Care Treatment Request more than seven days before or seven days after your requested Start Date.
- Report updated clinical findings. Medical necessity cannot be established based on outdated clinical findings.

Date Extensions on Existing Authorizations

A date extension is an extension to the End Date of an Approved Time Period. CareCore National does not provide date extensions. Any remaining visits will expire when the authorization expires. Services that are required in a new time period will require an authorization that spans the dates of service.

Review Determinations

Authorizations are based on medical necessity and evidence-based criteria. If medical necessity can be established based on these criteria, then visits will be pre-authorized at the time of your Treatment Request submission. When you submit online, this pre-authorization may be instantaneous. Requests requiring clinical evaluation will be reviewed by appropriate specialty clinicians. For example, chiropractors review Treatment Requests for chiropractic services. All adverse determinations for therapy services are physician reviewed.

A review determination letter will indicate the number of approved visits, the number of approved service units, 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 peer-to-peer discussion
- 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 Request. The Start Date of your subsequent Treatment Request should be after the End Date of the existing Approved Time Period, but cannot be more than seven days after the date you submit the request.

Practitioners can view and track all submitted authorizations online at www.carecorenational.com (a one-time registration is required).

Access to Clinical Reviewers
When there is a request for a peer-to-peer conversation, we will make an effort to immediately transfer the call to an available clinical reviewer. When one is not available, we will offer a scheduled call-back at a time that is convenient for your practice. These timeframes will comply with applicable regulation and law.