PHYSICAL MEDICINE PROVIDER PATHWAYS PROGRAM

FREQUENTLY ASKED QUESTIONS

March 31, 2021

Q1: Why was the Physical Medicine Provider Pathways Program created?

A1: Provider Pathways was designed to give Highmark's Clinical Services a formal process and framework for identifying and rewarding high-performing providers. The goal of the Pathways Program is to allow Highmark to confidently guide members to high-quality providers by comparing provider's metrics

Q2: When did the Physical Medicine Provider Pathways Program begin?

A2: The launch date for Pennsylvania and West Virginia was January 1, 2015. The first date authorizations were auto-approved was January 5, 2015.

Q3: What changes will take place for the Pathways Program starting June 1, 2021?

A3: Beginning June 1, 2021, the following enhancements to the Provider Pathways Program metrics will be implemented. These changes will impact Qualifying status for **January 1, 2023** and thereafter:

- Total Care Requests (Registrations and Authorizations) will exclude unused Care Registrations (CRAs)
- Therapeutic Procedures and Modalities will take into account additional procedure codes typically billed by the physical medicine providers:
    - **Modalities (Supervised & Constant Attendance):** Count of Billed Modalities or Units / Total PM Codes or Units for Modalities and Therapeutic Procedures
    - **Therapeutic Procedures:** Count of Billed Therapeutic Procedures or Units / Total PM Codes or Units for Modalities and Therapeutic Procedures
    - **Members with Physical Medicine Services (Chiro):**Total Therapeutic Procedures and Modality Codes or Units/ Accessing Members
    - **Average Physical Medicine (PM) Procedures or Units/Visits:** Total PM Procedures or Units / Total Visits

All physical medicine providers must meet or exceed all the defined metrics listed below to be included in the program and achieve Qualifying status.

- Total volume of Care Registration and Care Authorization requests should be equal to or greater than 20 between dates of service June 1 and May 31
- Care Authorization Approval Rate equal to or greater than 94%
- Visit Approval Rate equal to or greater than 94%
- NaviNet® Utilization equal to or greater than 90%
- Average visits per patient equal to or less than the following:
    - Manipulation services: 8 visits average
    - Physical/occupational therapy:
        - Category I diagnosis: 8 visits average
        - Category II diagnosis: 14 visits average
- Average number of procedures or modality units per visit equal to or less than 4 per visit
- Provider is not in an investigation or under a settlement agreement with Highmark's Financial Investigations and Provider Review department

NOTE: Only one of either the Care Authorization Approval or Visit Approval rates need to be met.

For additional questions, please contact your regional Highmark Provider Services Center.

Q4: What are the key performance metrics used to determine "Qualifying Status"?

A4: A defined set of metrics will govern the overall Physical Medicine Provider Pathways process. All physical medicine providers must meet or exceed all metrics to be included in the program. A provider must meet the following metrics to achieve Qualifying Status:

- Total volume of Care Registration and Care Authorization requests should be equal to or greater than 20 between dates of service June 1 and May 31
- Care Authorization Approval Rate equal to or greater than 94%
- Visit Approval Rate equal to or greater than 94%
- NaviNet® Utilization equal to or greater than 90%
- Average visits per patient equal to or less than the following:
  - Manipulation services: 8 visits average
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    - Category I diagnosis: 8 visits average
    - Category II diagnosis: 14 visits average
- Average number of procedures or modality units per visit equal to or less than 4 per visit
- Provider is not in an investigation or under a settlement agreement with Highmark's Financial Investigations and Provider Review department

NOTE: Only one of either the Care Authorization Approval or Visit Approval rates need to be met.

Q5: Are there any differences in the metrics for facilities vs. professionals?

A5: The criteria will be applied at the practice level and will be applied equally across all types of providers.

Q6: What are the benefits that qualifying providers will receive?

A6 : Qualifying providers will experience a greater level of self-management when it comes to obtaining authorizations. Providers can receive up to 20 auto-approved visits for a member without undergoing medical necessity review.

Q7: Who will not qualify for the Provider Pathways Program?

A7: A provider cannot qualify for the Physical Medicine Provider Pathways Program if he/she does not meet the qualifying criteria and/or is under financial or clinical investigation or under a settlement agreement with Highmark's Financial Investigations and Provider Review department during the measurement period used to determine annual program eligibility.

Q8: What are the advantages of being in the higher classification?

A8: Following the Provider Pathways assessment, providers will be divided into two classification levels based on their results. Those placed in the higher classification level of qualifying providers will be rewarded (i.e., increased self-management). Those providers who fall in the lower classification will follow today's current process.

NOTE: Reimbursement for both provider groups will be equal.

Q9: How did Highmark calculate the numbers for the metrics used?

A9: Highmark based the metrics on historical authorizations and claims data. The calculation for each metric is displayed in the Provider Profile Scorecards. For example, the claim metric "Average Visits Per Member" is calculated as follows: Total Visits/Accessing Members.

Q10: What is the calculation method used for each category and how did Highmark arrive at that percentage?

A10: The metrics "Average Visits Per Member" for physical therapy and occupational therapy are divided into two separate metrics by condition complexity:

- **Category I:** Conditions comprised of less complex diagnoses/conditions, such as mild/moderate strains and sprains.
- **Category II:** Conditions comprised of more complex diagnoses/conditions that typically require extensive rehabilitation, such as congenital development disorders and progressive diseases.

The qualification threshold for the Physical Medicine Provider Pathways Program on these two metrics was determined through analysis of claims data to determine the distribution of average visits across both categories of condition over a 12-month time frame. The established visit qualification thresholds are:

- **Category I:** ≤ 8 visits
- **Category II:** ≤ 14 visits

The established visits do not necessarily reflect a maximum number of visits for a given member and given diagnosis in a select condition category. The average visits represent calculations over a

snapshot in time comprising 12 months wherein members receiving treatment from a given provider are at various stages in the care management process (i.e., beginning of care only, entire course of care, or end of care only).

NOTE: This is not applicable to Doctors of Chiropractic.

Q11: When will the performance-monitoring scorecards be delivered?

A11: All qualifying providers will receive an annual Physical Medicine Provider Pathways scorecard in November of every year.

Q12: Should I call WholeHealth Networks, Inc. if I have an inquiry?

A12: Please direct all questions regarding the Physical Medicine Provider Pathways Program to your regional Highmark Provider Service Center.

Q13: How can providers improve their Physical Medicine Provider Pathways Overall Authorization Approval Rate?

A13: To help improve your experience with the Physical Medicine Management Program and improve your Pathways Overall Authorization Approval Rate, WholeHealth Networks, Inc. provides these helpful tips for submitting requests and documenting your patient's care:

Submitting Authorization Requests

1. Submit requests on a timely basis -- within ten (10) days of the Care Authorization's requested start date.
2. Ensure that your request aligns with the plan of care. Avoid requesting more visits than the treating provider states is medically necessary in the plan of care.
3. If it is the first time submitting medical records for an episode of care, be sure to include the initial evaluation. For example, if you receive eight visits approved via the care registration, and then four visits auto-approved via the Rapid Response System (RRS), when you submit records for a clinical review of visits 13+, please include the initial evaluation as progress will be measured from the baseline documentation.
4. Please make sure to submit all relevant medical records related to the episode of care. In addition to an initial evaluation, providers should submit all progress notes and any daily notes that are not covered by a progress note. For Medicare Advantage patients, submit complete progress notes at least every 10 visits.
5. The Highmark Physical Medicine Management Program is a calendar-year program. When requesting authorizations near the end of the year, request only those visits needed through December 31.
6. If you are performing a PT or OT initial evaluation without rendering any treatment, no authorization is required; however, if you are providing treatment with the initial evaluation, an authorization is required.
7. If a patient is currently receiving treatment and a new condition emerges that requires additional treatment, you may treat the new condition utilizing the visits that have been approved for the previous condition.

   When all or most of those visits have been used and the patient requires additional care (for the initial condition, the new condition, or both), submit a new care authorization request clearly indicating the additional diagnosis. The medical records should clearly reflect the addition of the new diagnosis.

Documentation and Patient Care

1. Ensure that your medical records reflect the recommendations, as applicable, found in the following:
    a. The American Physical Therapy Association's (APTA) **Defensible Documentation for Patient/Client Management**;
    b. The American Occupational Therapy Association's (AOTA) **Guidelines for Documentation of Occupational Therapy**;
    c. Rationale for the Use of a Chiropractic-Specific SOAP Acronym in Clinical Documentation. Frank RG, Wakefield TS. Chiropractic Techniques 1996; 8(4): pps. 171-7;
    d. Maximizing the Effectiveness of Clinical Documentation. Mootz RD. Topics in Clinical Chiropractic 1994; 1(1) 60-65. Adaptation accessible at: **https://chiro.org/documentation/ABSTRACTS/Maximizing_the_Effectiveness.shtml**; and/or
    e. Code of Federal Regulations (CFR): Plan of treatment requirements for outpatient rehabilitation services, available through the U.S. Government Publishing Office (GPO) website:
        i. **http://www.ecfr.gov/cgi-bin/text-idx?SID=157f60a613406bcf1e6e35fb4c1fdc29&node=42:2.0.1.2.10.2.35.46&rgn=div8**
        ii. **https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol2/pdf/CFR-2018-title42-vol2-part410-subpartB.pdf**
2. Use functional outcome tools and use the same tool throughout the episode of care. Ensure that outcome tools are scored and interpreted correctly.
3. Patient goals should be specific, measurable, and updated on a regular basis.
4. If you do not have a current progress note showing the current goal status, the medical records should include daily notes that have objective data related to the goals. It is important to use measurable data to demonstrate the patient's progress from care (e.g., objective measures, standardized testing measures, functional status, range-of-motion findings, and Patient-Specific Functional Scale [PSFS] scores).
5. When using electronic medical records, ensure that the information is not simply reiterated from visit to visit if not applicable. For example, "walking with a cane for the first time" reiterated across eight visits gives an incorrect picture of true status for seven of the eight visits.
6. As a patient progresses, guidelines state that it is appropriate to reduce treatment frequency. Reduce visit frequency when the patient can continue to make progress with less visits and more independent rehab with a home exercise program, community exercise programs, and self-care.
7. For Medicare Advantage patients, outpatient therapy treatment with a frequency of more than 2-3 times per week is not typically medical necessary. Treatment frequency of greater than three times per week requires documentation to support this intensity.

Q14: How or when will I know if I am on track for qualifying for the program for the next calendar year?

A14: Providers will be notified of their status for the next year in November.

Q15: Can you provide an example of how the Total Authorization Approval Rate and the Requested Visits Approval Rate are calculated?

A15: Example: Calculation of the rates below are based on the following:

- Ten authorization requests are submitted, with 10 visits requested for each submission;
- Nine of the 10 requests are fully approved; and
- Six of the 10 visits are approved for one request.

Total Authorization Approval Rate = Authorization Request Approvals/Authorization Requests
= 9/10
= 90%

Requested Visits Approval Rate = Visits Approved/Visits Requested
= 96/100
= 96%