PHYSICAL MEDICINE PROVIDER PATHWAYS PROGRAM

ADMINISTRATIVE GUIDE

Guidelines for Professional and Facility Providers

Program effective with service dates beginning January 5, 2015

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INTRODUCTION

Purpose

Highmark developed the Physical Medicine Management Program to ensure that our members receive medically appropriate treatment in the proper setting. The program is designed to track and monitor utilization of physical medicine services to assure members receive high quality care that is aligned with evidence-based guidelines.

The goal of the Physical Medicine Management Program is to help reduce these variations in care and also protect members from overutilization, which can lead to poor quality of care. Highmark's priority remains focused on ensuring that members are receiving appropriate, quality care while minimizing additional health care costs for our members and group customers.

Using utilization management and claims data, Highmark has identified high-performing practitioners and/or facilities as qualifying providers for the Provider Pathways Program. The Physical Medicine Provider Pathways Program will allow qualifying providers to experience a greater level of self-management when obtaining care registrations and authorizations for Highmark members who need physical medicine services.

All Pennsylvania contracted providers who perform physical therapy, occupational therapy, or spinal manipulation services are eligible to participate in the Physical Medicine Provider Pathways Program.

Provider Pathways Program overview

Effective with dates of service on or after January 5, 2015, qualifying providers will experience the following changes with respect to physical medicine services:

- An increase in the number of auto-approved visits (from 8-12) when completing the Care Registration process through NaviNet®.
- Up to an additional eight (8) visits are auto-approved when completing subsequent care authorization requests in a timely manner.
- For any additional visits requested beyond the initial auto-approved twenty (20) visits, the provider will follow the regular Physical Medicine Management Program care authorization and medically necessity review process, pending benefit availability.

PROGRAM GUIDELINES

Qualifying criteria

The Provider Pathways Program has a defined set of metrics that will govern the overall Provider Pathways process. Baseline performance is based on one year of data analyzed. The yearly data ranges from June of the previous year to May of the current year.

The following Key Performance Indicators from claims and utilization management data analysis provide the basis for the Provider Pathways Qualifying Criteria:

- 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.

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

Metrics enhancements effective June 1, 2021

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%
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- Average visits per patient equal to or less than the following:
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- 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.

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PROGRAM GUIDELINES, Continued

IMPORTANT! Benefit visit limits apply	If a member's benefit plan has limits on the number of visits for physical therapy, occupational therapy, and spinal manipulation services, the visit limits will still apply.
Reimbursement	Reimbursement for all physical medicine services is not impacted by this program and will remain unchanged.
Provider identification and notification	Qualifying providers can submit Care Registration and Care Authorization requests for all practicing locations associated with their Blue Shield identification number and obtain the additional visits for Care Registration and auto-authorization for Care Authorization requests.
IMPORTANT! Providers moving to new practice	The Provider Pathways analysis does not calculate "individual provider" data that is included in a large group practice (i.e., same Blue Shield ID number). Every provider that is part of the large group practice submits authorization and claims under the same Blue Shield ID number; therefore, the performance data and status of a provider leaving one practice and opening a new practice cannot be transferred to the new Blue Shield ID number. Providers who qualify for the Provider Pathways Program and move to a newly established practice or non-qualifying practice will not be able to maintain their qualifying status.
Care registration and authorization submitted via NaviNet®	Qualified providers should continue to submit Care Registration and Care Authorization requests via NaviNet® to take advantage of the Provider Pathways qualification status. Providers will continue to submit the required clinical information associated with the request. Requests can be submitted beginning December 19 of the current year for dates of service January 1 of the following year.

PERFORMANCE MONITORING

Provider Pathways performance monitoring

Highmark will review and measure provider performance on an annual basis subsequent to the completion of each measurement year. Since the program began in June 2014, the measurement will begin in June of each year through May of the subsequent year. Providers are required to comply with the Physical Medicine Provider Pathways criteria for the measurement year.

Annual review of all Physical Medicine Management Program providers will be conducted using 12 months of claims and utilization management data with three month claims run-out. Performance evaluation will be conducted by using utilization management and claims data for the provider's Blue Shield identification number and not by individual provider.

Based on the retrospective annual review, Highmark will determine whether the provider is in compliance with the qualifying criteria and qualifies to continue in the Pathways Program for the subsequent year.

If the review determines that the provider was non-compliant with the protocols, the practice will follow the standard Care Registration/Authorization process in place for the Physical Medicine Management Program.

If a provider is determined to be non-compliant with the protocols in one year, it does not impact payment of claims for the year during which the provider is determined to be compliant with the protocols.

All qualifying providers will receive an annual pathways scorecard in November of every year. The scorecard will provide detailed information regarding their performance and Provider Pathways eligibility for the subsequent year.

NEWLY QUALIFIED OR REMAINING QUALIFIED

Qualifying for the Pathways Program

In order to qualify/remain eligible for Provider Pathways Program, providers must continue to adhere to the program's requirements as described in the **Qualifying Criteria** and **Performance Monitoring** sections of this guide.

If a provider's actual performance results meet or exceed the clinical target parameters:

- A current non-qualifying provider will be eligible for the Provider Pathways Program; or
- A current qualifying provider will continue as a qualifying provider under the Provider Pathways Program.

If a provider's actual performance results do not meet the qualifying criteria:

- A current non-qualifying provider will continue with the current prior authorization process; or
- A current qualifying provider will transition to the current prior authorization process.

Unless otherwise stated, provider qualification status will be effective on January 1 of every year.

NON-COMPLIANT DETERMINATIONS

Non-compliant determination

Providers that qualify for the Provider Pathways Program for the current year but are determined to be non-compliant with the protocols for the Provider Pathways Program in the following year will be entitled to a Compliance Review Process by Highmark.

Providers may provide information to Highmark to establish a rationale for not following the protocols. To request a review, submit a **Provider Pathways Reconsideration Request Form**, which is available on the Highmark Provider Resource Center. Select **CARE MANAGEMENT PROGRAMS** from the main menu on the left, and then **Physical Medicine Management Program**. Please be sure to select the appropriate form – Physical/Occupational Medicine or Chiropractics.

RECONSIDERATIONS AND APPEALS

Reconsiderations and appeals

The Provider Pathways Program will offer a reconsideration option for any qualifying provider who is required to transition to the current prior authorization process because of a failure to meet the qualifying criteria.

Note: A Qualifying or a Non-Qualifying provider may exercise any rights of reconsideration or appeal under its network participation agreement.