PHYSICAL MEDICINE MANAGEMENT PROGRAM

FREQUENTLY ASKED QUESTIONS

Revised: November 1, 2019

BACKGROUND

1. **What is the Physical Medicine Management Program (PMMP)?**
   To help ensure that physical medicine (physical therapy and occupational therapy) services provided to our members are consistent with nationally recognized clinical guidelines, Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) contracts with WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC. to administer a registration process for physical medicine services. WHN also provides medical necessity review and authorization, where applicable, for these services.

2. **Why was the PMMP created?**
   Highmark Delaware developed the PMMP 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 ensure our members receive high-quality care aligned with evidence-based guidelines.

3. **What services are included in the PMMP?**
   Physical therapy and occupational therapy services are included in the PMMP program. PMMP does not include services such as speech therapy, respiratory therapy, cardiac rehabilitation, pulmonary rehabilitation, and chiropractic spinal manipulation.

4. **When is PMMP effective for Highmark Delaware?**
   Implemented on March 1, 2014, the program has been applicable to all providers licensed to perform physical medicine services, *except* doctors of chiropractic. Effective beginning January 1, 2020, the program requirements also apply to doctors of chiropractic.

5. **Which provider types are most likely to be affected by the PMMP?**
   Applies to all providers providing these services.

6. **Can employer groups choose to opt-in to PMMP?**
   PMMP applies to all fully insured employer groups. Certain employer groups (e.g., self-funded) may choose to opt in to PMMP. If a client/employer group does not opt in, the medical policy(ies) and benefit(s) will still apply.

7. **How can we tell if a patient is in an employer group that has PMMP?**
   In the Group Information section of the Eligibility and Benefits Details screen in NaviNet®, the PMMP indicator will read “YES.”

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8. **How does this program affect members enrolled through other Blue Cross Blue Shield plans?**
   PMMP does not apply to BlueCard® members.

9. **Are participating providers in contiguous counties part of PMMP?**
   As long as the provider has signed a Highmark Delaware contract, they are subject to PMMP.

10. **Does PMMP apply to inpatients or patients in the emergency department or observation?**
    No, PMMP does not apply to any of these settings.

CARE REGISTRATION

11. **What is a care registration request?**
    A care registration request documents the initial visits in the calendar year to determine when the visit limit is reached and when authorization is needed for further treatment.

12. **How many visits are automatically approved for care registration?**
    Eight (8) visits are auto-approved under the care registration.

13. **How are visits counted?**
    Visit counts vary by group and benefit design.

14. **What criteria were used to choose eight as the visit limit for care registration?**
    Analysis of WHN's large database of historical claims, as well as Highmark Delaware claims data, revealed that two-thirds of patients receiving physical medicine services used less than eight visits per year, on average. The threshold of eight visits was established to allow the provider more flexibility in treating the member.

15. **Regarding care registrations, do physical therapy and occupational therapy each get eight visits?**
    Care registration is available for either eight physical therapy **or** eight occupational therapy visits.

16. **If a member has a certain number of visits covered under his or her benefit plan (e.g., 30 physical therapy visits per benefit period), why are only eight visits approved initially?**
    Based on an analysis of physical therapy and occupational therapy utilization and claims data, Highmark Delaware determined an initial eight visits was appropriate before reviewing treatment for medical necessity.

    Under PMMP, the provider must obtain a care registration for the initial eight visits. Any additional visits subsequent to the care registration and up to the benefit limit will require an authorization based upon medical necessity. The number of visits a member has under his or her benefit plan is the maximum amount covered.

17. **How does a provider submit a care registration request?**
    Providers are able to use the Authorization Submission function in NaviNet to submit a care registration request. Once the information is complete, the request will be sent to WHN's Care Registry. Once the member is registered, an "auto-approval" is entered that allows eligible claims for the initial eight (8) visits in a calendar year to process according to the member's benefit plan.

18. **Will the provider receive a fax confirmation for care registrations?**
No. Providers will not receive faxes for care registrations. If needed, providers can print and retain a copy of the NaviNet screen with the information for the eight auto-approved visits.

19. **What if NaviNet is not available or the provider is not enrolled in NaviNet?**
Providers can call WHN at **1-866-656-6072**.

    We encourage all providers to take advantage of NaviNet. It is available to you at no cost. If you are interested, visit **nanthealth.com/navinet** to enroll!

20. **Are providers required to submit a care registration request for all of his or her Highmark Delaware patients in anticipation of upcoming visits?**
It is not required to register all of your Highmark Delaware patients at once. Care registration requests should only be completed if a member has an upcoming, scheduled visit.

21. **Do care registrations need to be renewed based on calendar year or contract year?**
The PMMP is administered on a calendar-year basis. Members must be registered with WHN annually beginning with his or her first visit of each calendar year, even if his or her benefit contract is based on contract year instead of calendar year.

22. **If a provider submits a care registration for a member, can that member see another provider during the year?**
Yes, but the initial care registration is assigned to a specific provider. Subsequent visits for additional providers would need to have authorization requests entered and approved. There is no limit on the number of providers that a member can see.

AUTHORIZATIONS

23. **What is the difference between a care registration and an authorization request?**
Care registration is used to document the initial visits in the calendar year to determine when the eight visit limit is reached and when authorization of further treatment is needed. Authorization requests are to receive approval for visits past the initial eight.

24. **When is an authorization required?**
PMMP requires authorization for additional services after the member has received eight physical and/or occupational therapy visits in a calendar year. In addition, after care registration has been completed, authorization is required whenever a different service is requested or a different provider becomes involved in the care, regardless of the number of visits utilized from the original registration (zero to eight).

25. **Should a member have separate authorizations for physical therapy and occupational therapy services?**
If there are two different providers in two different locations involved, then separate authorizations are needed. If a member is receiving both physical therapy and occupational therapy service simultaneously in the same clinic or facility, only one authorization is required. This is true even if there are multiple conditions being treated.

26. **What is the time frame for submitting authorizations?**
Authorization requests for physical medicine services can be submitted to WHN up to thirty (30) calendar days before the proposed start date of the request; requests must be submitted no later than ten (10) calendar days after the start date to be considered timely.

27. **How does a provider submit an authorization request?**
To submit an authorization request, providers should sign into NaviNet and use the **Authorization Submission** function from the Plan Central menu (professional providers choose “Auth Submission” and facilities choose “Inpatient Auth Submission”).

The request will be routed into the WHN Care Registry, which determines if it is a care registration or authorization request. If the provider reaches the clinical questions on the WHN screens in NaviNet, that is an indicator that there is a care registration already on file and the submission will process as an authorization request.

28. **Is there a worksheet or template providers can use to assist with recording the information needed for an authorization request?**
A preauthorization request form and instructions for physical therapy and occupational therapy services can be found on the **Physical Medicine Management Program** page, located under **CARE MANAGEMENT PROGRAMS** on the Provider Resource Center.

29. **What is the difference between a “new” and a “continuation of care” authorization?**
It is a “new” authorization request if the provider is treating the member for the first time, is treating a current member for a new condition, or there has been a break in treatment of at least two (2) months. It is “continuation of care” if a provider is requesting authorization for additional visits to continue treating the member for the same condition.

30. **How long will it take to receive an authorization decision?**
The provider is immediately aware of the prescreening outcome, which can be either **1) approval**, **2)** an **opportunity to modify** the treatment plan to meet guidelines, or **3) pended** for peer clinical review. If the provider elects to modify a patient’s treatment plan following prescreening and prior to submitting the authorization request, the final outcome is considered an approval.

31. **What is the method of notification for authorization decisions?**
WHN will fax a written notification to the requesting provider’s office within approximately twenty (20) minutes of the NaviNet prescreening response. Faxes are attempted ten (10) times, with at least twelve (12) minutes between attempts. If the fax is not transmitted successfully, the default notification method is U.S. mail.

32. **How can a provider electronically check the status of an authorization?**
Providers can check the status of an authorization in NaviNet’s **Referral/Auth Inquiry** by searching by Member ID, member name, or date of service.

Or you can select the **Physical Medicine Portal** option on the fly-out menu under **Referral/Auth Inquiry** to enter WHN’s portal for the status.

33. **What do the letters in front of the authorizations received from WHN indicate?**
A = Auto-approved or authorized; P = Pended; R = NaviNet; H = WHN.

34. **While entering an authorization request in NaviNet, can providers access previous screens to modify a field?**
The “Back” and “Tab” buttons can be used until the point of submission. After the information has been submitted for prescreening, the record cannot be modified.

35. **How far back and how far forward can requests be dated in NaviNet?**
Requests can be dated ten (10) days prior and one (1) year ahead. In the WHN care authorization screen, providers may modify start dates as follows: up to 365 days back (but no earlier than January 1, 2020, for doctors of chiropractic) and no more than thirty (30) days ahead.

36. **What should a provider select from the “Category” options on the NaviNet Selection Form?**
On the NaviNet Selection Form, all providers should select the “Physical Medicine” option in the “Category” dropdown. Once Physical Medicine is chosen, providers will then have the option to select either Physical Medicine or Occupational Therapy from the “Services” dropdown.

37. **What should a provider do if they did not receive a fax notification regarding his or her requested authorization?**
The provider should call WHN at **1-866-656-6072**.

38. **If a provider has multiple locations, how can he or she ensure the fax confirmation will be sent to the correct location?**
The provider can specify a fax number on each authorization request. If the fax number populated on the Collection Form screen in NaviNet is not correct, a provider can enter the correct fax number, and then click **Enter/Edit Fax & Click to Update**.

39. **At what point are authorization requests reviewed by a clinician?**
If the clinical information provided during the authorization process matches up against the clinical decision support pathways and results in an authorization, there is no need for additional clinical review.

    When the clinical information provided does not result in an authorization, the case will be pended, and the provider will be asked to provide additional clinical information to support the authorization request.

40. **Who performs the clinical reviews necessary to obtain an authorization?**
Initial clinical reviews are performed by peer reviewers at WHN, including registered nurse reviewers, physical therapists, occupational therapists, and doctors of chiropractic.

    A physician will render a medical necessity determination if the peer reviewer is unable to approve the request based on WHN’s guidelines and Highmark Delaware Medical Policy.

41. **How long does a clinical review take?**
Clinical reviews for authorization requests are completed within one (1) to two (2) business days of receipt of all relevant clinical information in the member’s medical records; two (2) days for initial requests; and one (1) day for continuation of care requests.

    For retrospective authorization requests, reviews are completed within five (5) business days.

42. **Will a provider receive a fax confirmation after clinical records are faxed back to WHN?**
Providers will not get a fax confirmation from WHN to inform them the documentation was received. WHN's system automatically attaches the notes to the authorization for review. After review, determination faxes will be sent.

43. **What happens when a provider requests an authorization for a member that is not subject to PMMP?**
The provider is responsible for verifying a member's benefits prior to requesting an authorization. Providers can use the Eligibility and Benefits function of NaviNet or the applicable HIPAA transactions to verify benefits.

    If a member's benefit plan is not subject to PMMP, the provider will receive a message that reads, "WholeHealth Networks, Inc. does not manage Physical Medicine authorizations for this member."

44. **How are questions related to a member's use of alcohol, his or her BMI, and level of exercise used in an authorization decision?**
Abuse of alcohol, a high BMI level, and a low fitness level have all been proven to have an overall negative effect on one's health and well-being. Certain pathological disease processes and the ability to recover/resolve functional ability with these additional complicating factors can prolong the duration required for some services.

45. **Which scale should be used to determine if a member is overweight or obese?**
The nationally used scale can be found from a variety of sources, including the American Medical Association (AMA) or Centers for Disease Control and Prevention (CDC).

46. **Do evaluations require authorizations?**
Registration and/or authorization will not be required for physical therapy and occupational therapy evaluation and reevaluation services (97001-97004). Therefore, an authorization will not be required to receive reimbursement for these services.

    However, if an evaluation determines that treatment is required, you must submit a request for registration and/or authorization, as applicable, for the treatment.

47. **If a provider receives a partial approval and wants to request reconsideration, can they treat the member up to the partial visits that were approved?**
Yes.

48. **How long does a provider have to submit a retrospective authorization request?**
Providers may submit these requests up to one year from the date of service.

49. **If the provider is treating a member for one diagnosis, and then the member requires additional services for a second diagnosis, can they use the original authorization for both?**
Claims are not matched with authorizations based on diagnosis code. Only the procedure code, date of service, and provider number are used to determine if the authorization matches. More than one condition or diagnosis may be treated under the same authorization.

    The provider should not submit a new authorization request in this case. The provider should treat the member within the number of visits/duration approved under the current authorization.

50. **If a provider submits a change to a member's treatment plan, will that request deny stating the authorization already exists for this member?**
The provider should treat the patient within the number of visits/duration approved under the current authorization. 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), the provider should submit a new care authorization request clearly indicating the additional diagnosis and overall current clinical status of the patient for all conditions being treated.

51. **How is the Last Covered Date (LCD) on an authorization determined?**
The LCD for authorizations varies and is based on clinical guidelines; the LCD for authorizations will not extend beyond December 31 of any calendar year.

52. **What if a member's care overlaps from the end of one year to the beginning of the next?**
Care authorizations do not extend from the end of one year and into the next. The last covered day of an authorization will not extend beyond Dec. 31 of the current calendar year. The provider must submit a request for a new care registration beginning with a patient's first visit in the new calendar year.

53. **If a member does not complete all of his or her authorized visits within the allowed time frame, can they still complete the number of visits that were approved?**
The provider should use the "Utilization Management Department Request Form" to pursue an extension of the last covered date for the member. This form is located on the PMMP page on the Highmark Delaware Provider Resource Center.

54. **Should a provider request an authorization if they know the member has already used all of the visits under his or her benefit plan?**
Yes, the provider should submit an authorization request. The claim will deny based on exhausted benefits.

55. **How can a provider correct or modify an authorization or treatment plan start or end date?**
Providers can complete the "Utilization Management Department Request Form" located on the Highmark Delaware Provider Resource Center, and fax it to WHN **fax# 1-888-492-1029**. If the provider does not have access to this form, they can call WHN at **1-866-656-6072** to make the necessary changes.

56. **Once a member is being treated by a specific provider for physical medicine services, can they see another provider? Can the member be treated by two different providers, such as a physical therapist and an occupational therapist, at the same time?**
Yes, the member can change providers. Every provider at a different clinic or facility rendering care to the member will need to request a new authorization for services. The member can also be treated by more than one participating provider, as long as all services are authorized.

FACILITIES

57. **Do facilities have to share the physical therapy and occupational therapy visits when given at the same time?**
If two separate authorizations have been issued, they do not have to share the visits.

COORDINATION OF BENEFITS

58. Does the provider need to request an authorization through WHN if workers' compensation is the primary insurance?
The provider can request an authorization through WHN after workers' compensation is exhausted. The worker's compensation case number should be included.

59. Is authorization needed for a member if Highmark Delaware is the member's secondary insurance?
The authorization requirements under a member's benefit plan apply if a claim will be submitted to Highmark Delaware for any portion of payment. Therefore, if the member's primary insurance is with an insurer other than Highmark Delaware, you must register the member and request authorization for the applicable physical medicine services when PMMP applies to the member's coverage.

60. When automobile insurance is primary, what happens if a member was not registered when services started?
To ensure continuity of care and to avoid claim rejections, members should be registered for treatment regardless of another payer, such as automobile insurance, being the primary source of coverage.

61. If the member is covered under two Highmark Delaware policies, is authorization needed for both the primary and secondary insurance?
No, authorization is only required under the primary Highmark Delaware policy.

APPEALS AND EXTENSIONS

62. If an authorization expires before all visits are used and the provider requests an extension by faxing the Utilization Management Department Request Form to WHN, what is the turnaround time and how is the provider notified?
Responses are completed and sent within five (5) business days by fax or U.S. mail.

63. How do I request a peer-to-peer review (reconsideration) after an adverse determination?
To request a peer-to-peer review, please complete the "Utilization Management Department Request Form" (available on the Provider Resource Center) and fax it to WHN's Appeals & Grievance Unit at **fax# 1-888-492-1029**.

A reviewer will be available to discuss the case within one (1) business day of receipt of the request. The requesting provider and the member will be notified of the outcome.

64. Are peer-to-peer reconsiderations performed by a provider of the same specialty as the one that filed the appeal?
Yes, WHN uses clinical peer reviewers of the same practice discipline as the treating provider for peer-to-peer reconsiderations.

CLAIMS

65. **What if the provider is treating more than three areas and needs to show more diagnoses on the claim?**
    HIPAA allows for three diagnosis codes on a claim form. The provider should submit the three that are most appropriate for the member and maintain any additional information in the member's medical record.

66. **Is the evaluation code considered one of the four modalities that can be paid per date of service?**
    No, it is considered a visit, not a modality.

67. **If the member sees a physical therapist for physical therapy and an occupational therapist for occupational therapy on the same date of service, do those services combine to add up to the four units per day?**
    Because these are separate services, each gets the four-modality-per-visit limit.

MEDICAL POLICY

68. **What are Highmark Delaware's medical policies for this program?**
    Commercial policies Y-1, Y-2 and Z-11 apply to PMMP.