PHYSICAL MEDICINE MANAGEMENT PROGRAM

PROVIDER TIPS & REMINDERS

Chiropractic Services

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AGENDA

- Purpose
- Program Review
- Documentation
- Medicare Advantage
- Routine and Non-Routine Chiropractic Services

PURPOSE

To review important features of the Physical Medicine Management Program, as well as requirements specific to Medicare Advantage members, in order to facilitate, and minimize unnecessary delays in, the delivery of medically necessary chiropractic care.

PROGRAM REVIEW

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CARE REGISTRATION

- A registration is required for physical medicine services provided by physical therapists (PTs), occupational therapists (OTs), and allopathic and osteopathic physicians (MD's and DO's)

- A separate registration is required for manipulation services provided by doctors of chiropractic (DCs).

*For participating PEBTF members, separate registrations are required for each of the three disciplines (physical therapy, occupational therapy, and manipulation services).

CARE REGISTRATION

- Patients are registered annually beginning with their first visit each calendar year
- Care registration is used to document the initial visits in the calendar year in order to determine when medical management is needed
- 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 (6 visits for PEBTF members)
- The provider submits claims to Highmark and the member's benefit is applied

CARE AUTHORIZATION

If the member needs more than 8 visits in the calendar year…

- Prior to the 9th visit, the treating provider must obtain a care authorization from Healthways
- Upon request, the provider's office will submit clinical information, including current functional status, objective progress, and treatment plan.

***An authorization is a determination of medical necessity only and is not a guarantee of coverage or payment**

REQUEST SUBMISSION

Care registration and authorization requests may be submitted to Healthways in one of several ways. The most expeditious methods of submission are:

- **NaviNet** (Rapid Response System) and
- **Telephone** (IVR-RRS)

In the event the provider does not have telephone or computer access, or is having problems using the RRS or NaviNet, Fax or mail may be used.

NAVINET

NaviNet is the preferred method for submission of requests

This electronic submission process provides:

- A single portal of entry and access
- Immediate responses, in some cases auto-authorizations
- Greater efficiency
- Claim and Authorization status
- Eligibility status
- Benefit Accumulator

RAPID RESPONSE SYSTEM (RRS)

NaviNet serves as the portal to Healthways' Rapid Response System

- Following member evaluation, the provider prepares a treatment plan and completes the *Treatment Authorization Template*
- The proposed treatment plan is routed through RRS, processed along specific clinical decision support pathways, and benchmarked against nationally accepted, evidence-based treatment guidelines for specific conditions

RAPID RESPONSE SYSTEM (RRS)

- Provider is immediately aware of the pre-screening outcome in the case. There are three possible outcomes:
  - Approval
  - Opportunity to modify the proposed treatment plan to meet guidelines
  - Pended for peer clinical review; Relevant clinical information will be requested for submission and review
- Written notification is faxed to provider's office within the hour

The program's clinical guidelines and protocols are continually reviewed and updated annually by Healthways' Clinical Oversight Committee and are reviewed and approved by Highmark's Care Management Committee

All decisions regarding medical necessity are governed by Highmark medical policy

PROVIDER DOCUMENTATION

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DOCUMENTATION

Of all requests for chiropractic services that are partially or fully denied, the #1 reason is incomplete or missing documentation.

DOCUMENTATION

Problem Oriented Medical Record (POMR)

- The nationally accepted standard for medical record keeping in the US
- POMR Components:
  - Problem List
  - Diagnoses
  - Treatment Goals for Each Condition
  - Goal-Oriented Treatment Plan
  - S.O.A.P. Notes
  - Dates of Resolution by Diagnosis or Complaint

DOCUMENTATION

Proper documentation is:

- Accurate
- Relevant
- Complete
- Timely

DOCUMENTATION

The Importance of Proper Documentation

PROPER DOCUMENTATION:

- Is an important component of high quality health care delivery, and promotes member safety

- Minimizes errors and facilitates ongoing quality care between episodes of care and between providers (continuity of care)

- Helps prevent medically necessary services from being denied

Poor documentation, including illegible and incomplete entries, may delay necessary care, claims submission, and payment

DOCUMENTATION

Minimum Documentation Requirements

- Chief complaint and history of present illness, including *relevant* past medical history and prior treatment for same condition
- Evaluation of musculoskeletal/nervous system through physical examination including:
  - Specific objective findings
  - Presence of a subluxation
  - Level of dysfunction
  - Functional status

DOCUMENTATION

Minimum Documentation Requirements – cont.

- Diagnosis
  - Is a subluxation present? (CMS requirement)
    - What specific level?
    - Acute? Chronic? Exacerbation?
- Treatment plan
  - Long and short term goals
  - # of visits requested
  - Reasonable estimation of treatment duration

DOCUMENTATION

Current Functional Status

- Subjective (patient description of condition)
- Objective physical findings
- Use of the Patient Specific Functional Scale (PSFS) or other relevant tool for the assessment of functional status
  - PSFS is preferred
  - Utilize the same assessment tool throughout the episode of care

DOCUMENTATION

Objective Progress

- Use objective, verifiable, and reproducible measures
- Compare to previous values
- Update functional status (PSFS or other tool – same tool throughout episode of care)
- Document need for additional visits and the basis for that determination, if applicable

DOCUMENTATION

Most Common Reasons for Partial or Full Denial Related to Documentation

- No documentation of initial examination
- Daily clinical notes do not include all visits within the episode of care since the previous submission
- No documentation of objective measures to evaluate treatment effectiveness, visit to visit (pain scores, ROM, ADL clinical measures, PSFS)
- No documentation of treatment effectiveness, visit to visit
- No documentation of care plan (duration and frequency of visits)

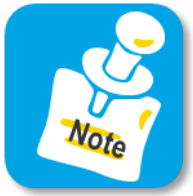
DOCUMENTATION

Most Common Reasons for Partial or Full Denial Related to Documentation

- No documentation of re-examination every 30-45 days during the episode of care
- Illegible chart
- Use of atypical abbreviations
- The number of visits requested does not match the proposed treatment plan
- No revision of the treatment plan based upon the patient's progress

Illegible Chart Entries

- Total legibility is an absolute MUST, whether handwritten or typewritten
- If chart entries are only decipherable by office staff, they are too illegible for submission
- "Passed Away Office" principle: If everyone in the provider's office "passed away" who would be left to decipher the provider's chart entry that is not legible to outside observers?



*Colored or shaded documents **do not** copy well or transmit well via fax
*Use **white paper** and use only **black or dark blue** ink for chart records.

Lack of Demographic Information

- Patient records must contain complete information that identifies the patient and the office encounter
- The patient's ***full name*** and the ***complete date of the encounter*** must be on ***every page*** supplied and be ***clearly visible*** to the reader.

DOCUMENTATION

Extraneous Information

- In order for an outside party to most appropriately and expeditiously review a patient's chart, information ***relevant*** to the current condition and request is necessary
- The submission of multiple pages of information that is clinically irrelevant to the patient encounter serves to distract the reviewer from the germane facts of the case and delay the medical necessity determination

DOCUMENTATION

Use of Subjective Descriptors

- Using phrases such as "Doing well" or "No change" does not tell anyone what happened during that encounter
- Proper documentation must be ***unambiguous*** in order to be properly interpreted and requires the use of objective physical measures that are verifiable and reproducible

Incomplete Chart Entries

Incomplete chart entries:

- May be mistakenly interpreted as gaps in care
- Make the condition, findings, and management of the patient more difficult to understand
- "If it's not documented, it didn't happen."

MEDICARE ADVANTAGE

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MEDICARE ADVANTAGE

Medicare Advantage Medial Policy Z-6 (Chiropractic Services)

- The primary diagnosis must be an ICD-9 spinal subluxation diagnosis code (739.x)
- The secondary diagnosis must be an ICD-9 neuromuscular diagnosis code
- Components required to establish medical necessity
  - Presence of a subluxation
  - Documentation of the subluxation by x-ray or exam (PART)
  - Documentation of initial and subsequent visits

MEDICARE ADVANTAGE

Medicare Advantage Medial Policy Z-6 (Chiropractic Services)

The acronym "PART" must be used to describe the exam components indicating that the patient is suffering from a spinal condition amenable to manipulation

PART

- P Pain/tenderness
- A Asymmetry/misalignment
- R Range of motion abnormality
- T Tissue/tone changes

At least 2 of the 4 PART criteria must be met,
with at least one of them being the "A" or "R" component

ROUTINE & NON-ROUTINE CHIROPRACTIC CARE

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ROUTINE CHIROPRACTIC CARE

When a member's plan offers Routine Chiropractic Care as a benefit:

- Depending upon the type of plan, the member has 8 routine chiropractic visits to use *per calendar year*

  (*Security Blue HMO Deluxe members have 6 routine visits)

Routine visits DO NOT **require an authorization** and can be used at any time **throughout the calendar year.**

NON-ROUTINE CHIROPRACTIC CARE

When the member has an acute condition or exacerbation of a chronic condition Non-Routine chiropractic visits must be used

Non-Routine Chiropractic Care DOES require an authorization

- The participating provider then contacts Healthways to request an authorization for the medically necessary visits, up to 8 visits if approved, to be used in a 60 day time-frame (These are the registered visits that are auto approved)

(Note: Claims coming through BlueCard do not require authorization)

- Once the 8 Non-Routine registered visits are exhausted or the 60 day time-frame has expired, if additional visits are needed, the provider then requests authorization for the additional Non-Routine visits up to a total of 30 in a calendar year.

ROUTINE & NON-ROUTINE CHIROPRACTIC CARE

Member Responsibility

The **member** is responsible for…

- Knowing their benefits and any required co-pays or coinsurance as listed in their Evidence of Coverage manual
- Contacting Customer Service with any questions regarding their benefits

ROUTINE & NON-ROUTINE CHIROPRACTIC CARE

Participating Provider Responsibility

The **participating provider** is responsible for…

- Contacting Provider Services to verify member eligibility and benefits via phone or Navinet
- Requesting any authorizations that may be required
- Utilizing and billing procedures codes correctly

TAKE-AWAY POINTS

- Complete information on the PMMP is available online via the Provider Resource Center
- Contact your Provider Representative if additional assistance is needed
- NaviNet is the most efficient and the preferred method for submission of requests
- Proper documentation is required and helps ensure that medically necessary treatment is not improperly delayed or denied
- There are important differences between commercial and Medicare Advantage members in terms of physical medicine benefits and documentation requirements

PROVIDER RELATIONS REPRESENTATIVES

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Butler		Cambria
Cameron		Clearfield
Clarion		Fayette
Crawford		Greene
Elk		Huntingdon
Erie		Indiana
Forest		Somerset
Jefferson		Washington
Lawrence		Westmoreland
McKean		
Mercer		
Potter		
Warren		
Venango		