Physical Medicine Services
Registration and Authorization
Program Guide for Prevea360 Providers
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Introduction

Healthways, in collaboration with Prevea360 has developed this guide to assist you with the authorization process for Physical Medicine services. Please be aware that the following diagnoses and or plan types are exempted from the Healthways process:

- Medicare Select and DeanCare Gold members (authorization is not required with plan providers)
- All members with an Autism Diagnosis (authorizations should be directed to Utilization Management (UM))
- All Members with a Developmental Delay Diagnosis (authorizations should be directed to UM)

Authorization Program Overview

Healthways has been carefully selected by Prevea360 Health Plan (Prevea360) to administer the authorization program for providers. For all Prevea360 members with coverage requiring authorization for Physical Medicine through Healthways, the program requires treating physicians to:

Care Registration Process – EFFECTIVE January 1, 2014

Register the member with Healthways at their initial visit through the Care Registration process each calendar year.

Submit an authorization for additional visits after the member has received eight (8) visits in the calendar year. This program applies to members who are being treated by Prevea360 contracted physicians (some account exclusions apply)

- The member must be registered with Healthways after the initial visit of the calendar year. You must complete a Care Registration to register the patient with Healthways and reserve these initial eight (8) auto-approved visits. Care Registration requests require limited information and should be submitted through the Healthways portal (https://www.wholehealthpro.com) within seven (7) calendar days of evaluating your patient for care in order to be considered timely.

- If additional treatment (beyond the initial 8 visits) is anticipated, pre-authorization is necessary and should be submitted prior to or by the ninth (9) visit. Authorization requests should be submitted through the Healthways web portal (https://www.wholehealthpro.com) within seven (7) calendar days of evaluating your patient for such additional care. Authorization for treatment will be based on Prevea360 standards for medical necessity and is a requirement for reimbursement.

- Not all ASO groups have the same authorization requirements. ASO groups that allow for 8 auto-approved visits will need to follow the Care Registration process and register the member with Healthways at the initial visit.

Practitioners who perform services without a care registration or prior authorization may experience claim denials. You can only bill the member for these services if you had the member complete a standard waiver form that your office uses, and if Prevea360 Health Plan does not allow payment for these services.
Prevea360 Health Plans Affected

The chart below will help you identify members who will be subject to the authorization process. You can recognize these members by looking at the prefix on their Prevea360 Health Plan member ID card. However, we recommend using this chart only as a guide. Because plans and member benefits may vary, we remind you to check member benefits and eligibility using Prevea360 Health Plan technologies before rendering services. These technologies will indicate whether or not the member is required to undergo the authorization process.

<table>
<thead>
<tr>
<th><strong>Name of plan:</strong></th>
<th>Where provider should submit auth</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>If plan, submit to Healthways</td>
</tr>
<tr>
<td></td>
<td>If OON, submit 2 authorizations:</td>
</tr>
<tr>
<td></td>
<td>• To Prevea360 for approval of non-plan provider</td>
</tr>
<tr>
<td></td>
<td>• To Healthways for medical necessity review</td>
</tr>
<tr>
<td>PPO</td>
<td>Submit to Healthways</td>
</tr>
<tr>
<td>POS</td>
<td>If plan, submit to Healthways</td>
</tr>
<tr>
<td></td>
<td>If OON, submit 2 authorizations:</td>
</tr>
<tr>
<td></td>
<td>• To Prevea360 for approval of non-plan provider (indicating in-plan benefit)</td>
</tr>
<tr>
<td></td>
<td>• To Healthways for medical necessity</td>
</tr>
<tr>
<td>ASO</td>
<td>Submit to Healthways</td>
</tr>
<tr>
<td></td>
<td>Not all ASO groups have the same preauth requirements <a href="http://www.deancare.com/aso">www.deancare.com/aso</a></td>
</tr>
<tr>
<td>Medicaid</td>
<td>Submit to Healthways</td>
</tr>
</tbody>
</table>

Please be aware that the following diagnoses and or plan types are exempted from the Healthways process:

- Medicare Select and DeanCare Gold members (authorization is not required with plan providers)
- All members with an Autism Diagnosis (authorizations should be directed to Utilization Management (UM))
- All Members with a Developmental Delay Diagnosis (authorizations should be directed to UM)
The Authorization Program

The Process in Two Steps

Step One: Checking Benefits & Eligibility:

Be sure to check benefits and eligibility for all of your Prevea360 Health Plan members via the number on the back of the member’s benefit card.

Step Two: Care Registration/Authorization:

Care Registration

After your first visit with the patient in the calendar year, access https://www.wholehealthpro.com to register the patient with Healthways and reserve the first 8 auto-approved visits for your patient. You must complete a Care Registration to reserve these visits within seven (7) calendar days of evaluating your patient’s need for additional care or your request will not be considered timely and will not be processed.

The Care Registration is used to document the initial visits in the calendar year to determine when the visit threshold is reached and medical management is needed. The Care Registration will give the patient 8 auto-approved visits for a 60 day time span starting with the initial visit for that calendar year.

Authorization

If, leading up to or during visit number 8, you determine that the patient will require additional treatment (visits 9+), it is recommended that you complete the Preauthorization Request for Physical/Occupational Therapy or Physical Medicine form that outlines the required clinical and demographic information you will need to enter. Filling it out in advance will enable you or your office staff to quickly submit the information into https://www.wholehealthpro.com without having to search through the patient’s medical record to find the information you need.

Next, access https://www.wholehealthpro.com to request additional visits for your patient. Again, this will be for visits 9+. Prior authorization is a requirement for reimbursement. For authorization requests that may occur throughout the remainder of the plan year, please be sure to submit your request via https://www.wholehealthpro.com within the time frame recommended (within seven (7) calendar days of evaluating your patient’s need for additional care). Please Note: if the requested start date is more than 7 calendar days in the past, your preauthorization request will not be considered timely and will not be processed.

For a copy of the Preauthorization Request for Physical/Occupational Therapy or Physical Medicine form, plus instructions for using https://www.wholehealthpro.com for entering authorizations, refer to the Appendix.
Description of the Healthways Authorization System
To submit preauthorization requests or care registrations, you will use https://www.wholehealthpro.com. By automating the authorization request process (which minimizes office paperwork), Healthways expects to shorten the response time needed to initiate care and provide consistent decisions that are applied independent of any other factor.

https://www.wholehealthpro.com Authorization Responses
Once the information is received, Healthways will process the data based on the patient’s history and any prior treatment and, based on the treatment plan submitted and the patient’s condition, the prescreening system may approve a trial of care over a three-to six-week period. The authorization approval is based on clinical situations that fall within Healthways’ national practice guidelines for the practitioners delivering the service.

If, however, the system is unable to provide you with an immediate response, you will be directed to submit additional information for peer review. These referrals are not denials. Rather, referrals for clinical review indicate that these cases will require a professionally appropriate clinical peer to review the treatment plan. In such cases, the practitioner must submit clinical records supporting the specific authorization request that are sufficient for the reviewer to understand the nature and necessity of the care being proposed.
Healthways’ guidelines recognize that therapeutic continuing care may extend for up to three or more months and when additional care is approved, it typically will be for a one-month interval (approximately). The expectation is that the notes provided for subsequent concurrent clinical review will document interval improvement over each such period. Notes submitted for clinical review should meet medical documentation standards and include appropriate outcome measures, including using outcome instruments. Medical record documentation standards can be found in the Appendix.

Accessing the Healthways Authorization System

You may use https://www.wholehealthpro.com to submit authorization requests to Healthways for your Prevea360 Health Plan patients (once you have determined through a benefits and eligibility check that they are required to undergo this process).

<table>
<thead>
<tr>
<th>Use this tool:</th>
<th>By following these instructions:</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="https://www.wholehealthpro.com">https://www.wholehealthpro.com</a> (web-based)</td>
<td>Go to <a href="https://www.wholehealthpro.com">https://www.wholehealthpro.com</a> and log in using the user name and password assigned to you by Healthways. If you need assistance submitting your auth, request your user name or a password reset, contact Healthways at 1-800-500-0997.</td>
</tr>
</tbody>
</table>

Types of Authorization Requests

There are two types of authorizations you may request: initial authorizations and continuation of care authorizations.

**Initial Authorizations**

A prior authorization request must be received when initiating each new episode of care after the first 8 visits in any given plan year. Episodes in the Healthways system will begin on the date of the first treatment of the patient for care of a new illness or injury, or on the date of re-evaluation and re-initiation of treatment for a new or recurring problem after a break in treatment of sixty (60) days or more. Please review the instructions for the Healthways template (available in the Appendix) when completing an authorization request via https://www.wholehealthpro.com.

Each visit to treat an acute episode of care needs to be included in an authorization request, including the initial visit on the date that the clinician evaluated the patient. The request must be submitted to Healthways via https://www.wholehealthpro.com within seven (7) calendar days to be considered timely.

https://www.wholehealthpro.com will provide you with one of the following responses following the pre-screening process:

1. It will determine that the full number of requested visits is appropriate for automated approval and will certify the request;
2. It will determine that the full number of requested visits is not appropriate for automated approval based on the patient information that you submitted. The system will advise you of the modified number of visits that Healthways guidelines can immediately approve for the trial of care.
3. If you accept the authorization guidelines, you will receive an immediate certification for this treatment plan;
4. If the patient situation is such that you decide to decline the authorization’s trial of care, you will be directed to submit clinical records for peer review.
5. The authorization system will notify you that your request is not appropriate for any level of automated approval and you will be directed to submit clinical records for peer review (see the Submitting Records for Clinical Review sub-heading below).
Treatment plan requests may be certified for some level of automated approval through the Healthways prescreening system to allow acute problems to be promptly treated. The patient’s history and prior treatment are factored into consideration. For requests sent for peer review, a certification response will be faxed or mailed to your office within the applicable regulatory time requirements.

When your treatment request has been approved*, you will be faxed a document (Review Determination Notice) indicating the diagnosis codes for which the certification was given, a number of approved visits, and a time period with which the approved services must be delivered. Keep a copy of this document for future reference when billing.

*Please note the following:

- This approval is limited by both the authorized number of visits, diagnosis, and time period.
- In the event that the patient does not need to use all of the requested visits during the specified time period, these authorized visits will “expire.”
- If the patient needs continuing care after the initial request, or if a new problem or complication arises during the initial trial of care, a continuation request must be submitted to Healthways within seven (7) calendar days of evaluating the patient. Please be sure that any additional diagnoses or clinical information are supplied with the continuation request so that a determination can be made about the request for more visits.
- If a period of sixty (60) days has elapsed since the end of any prior treatment plans, another initial request for care should be submitted using https://www.wholehealthpro.com.

**Care Registration**

A Care Registration is a request to register the patient with Healthways for the new calendar year and “reserve” the first 8 auto-approved visits. Care Registration is used to document the initial visits in the calendar year to determine when the visit threshold of auto-approved visits is reached and medical management is needed. Limited information is requested during the registration process.

Submitting a Care Registration will register the patient with Healthways and auto-approved 8 visits to be used within a 60-day period. The first provider/billing entity to receive a Care Registration form (instead of an authorization form) will reserve the first 8 auto-approved visits for that patient. All subsequent providers/billing entities will need to complete a prior authorization form.

Members must be re-registered at the beginning of every calendar year in which they seek services. The Physical Medicine Program applies on a calendar year basis even if the member’s benefit plan runs on a contract year that does not coincide with the calendar year.

**Continuation of Care Authorizations**

A request for additional visits, or “continuation request,” is for the same condition(s) identified at the onset of care in your office. Continuation requests should be for visits beyond a previously approved “initial” time-limited trial of care request.

In addition, continuation requests:

- Should be filed promptly (within seven (7) calendar days)
- Must include the same primary diagnoses previously stated in the initial care request
- Should be for no more than four to six weeks of care.

Use the same https://www.wholehealthpro.com submission process for continuation requests. Typically, 50-70%
of continuation requests will require a clinical review submission. Occasionally, patients will develop other conditions while under an approved care plan. This may affect recovery rates and the additional diagnoses should also be submitted with the continuation request.

If the patient has been stable without care for sixty days (60) or more and presents for a new or recurrent condition requiring diagnostic re-evaluation, the care plan should be filed as an “initial request for a new episode of care” and submitted within seven (7) calendar days of the patient’s evaluation.

**Submitting Records for Clinical Review**

You may be required to submit additional clinical information for peer review following your submission of an authorization request to Healthways and once the pre-screening process through Https://www.wholehealthpro.com is complete. When you are directed to submit clinical records for peer review, a **bar-coded notice** will be faxed to you to be used as a cover sheet for the clinical records that you send to Healthways. This notice has a six-digit reference number and must be used as a cover sheet for your faxed submission of the requested medical records.
Your submission should include medical records pertinent to this episode of care, including your current evaluation and treatment plan, office notes including any care for this patient rendered in the past three to six months, and any relevant supporting documentation.

Please note that you MUST place the bar-coded form on TOP of the faxed records (it should be the first page scanned by the fax). Do NOT start the transmission with your office fax cover sheet. Fax your bar-coded form and medical records to Healthways at 1-888-492-1025.

Peer Review Decisions
An appropriately licensed clinician skilled in your professional practice discipline will review your written request for coverage. After this clinical review, a determination of the number of authorized treatments and time frame will be returned to you. The decision notice will include the peer reviewer’s decision, narrative comments, and clinical rationale as to why an authorization was approved, reduced or denied on the Treatment Certification Notice.

The outcome of review decisions is not used as an objective or a parameter for compensation or incentives for Peer Reviewers, Medical Directors, or Utilization Management (UM) Staff.

You can expect one of three general outcomes from the peer review process:

1. Approval (certification). The request for coverage is approved, as submitted, or with an increase in total treatment intensity (same treatment in a shorter time frame);

2. Denial (Non-certification - Clinical).
   a. Modification of Requested Visits: The request is partially certified because the reviewer determined that the request exceeded a reasonable treatment plan for the clinical condition and patient history being reviewed. In this case, the Plan Review Determination section of the Treatment Certification Notice will have an approved plan of visits and a specific time interval in which to receive the services. You have the option of accepting this recommended plan and delivering the services.

   b. Non-certification: The request for initial visits or continuation of visits was not certified for coverage based on Healthways clinical guidelines. The Plan Review Determination notice will indicate “denial” and show “zero” visits.

   You may also receive a denial if the information requested for review was not received, or if the patient’s benefits do not include coverage for the requested services.

   In all cases of denial (non-certification), if you, the provider, disagree with the determination, you have the right to initiate a peer-to-peer discussion or appeal the initial determination for review and reconsideration by a second peer reviewer.

The Treatment Certification Notice will be sent by fax or by mail. Your patient will also be informed in writing of any approval (certification) and non-certification decisions in accordance with applicable regulatory requirements.

Coverage decisions are made based on Healthways’ clinical care guidelines, Prevea360 Health Plan’s definition of medical necessity, and the information presented for review. The guideline algorithms were developed using nationally accepted standards and with input from actively practicing practitioners. The clinical algorithms are reviewed annually and updated regularly.
**Interim Narrative Reports**

In addition to your clinical records, you may also submit a medical record summary or an interim narrative report outlining the care rendered to date, diagnostic tests or referrals associated with the episode of care, the goals achieved, complications and compliance problems, and expected outcomes of the care plan submitted.

The report should be comprised of the following elements:

- A summary of the history of onset along with the patient’s initial and current subjective complaints
- Initial and current objective examination findings;
- Diagnostic test results (radiology, laboratory, neurology, vascular, etc.)
- Complete diagnosis
- Discussion of any relevant complicating factors to case management
- Documentation of any exacerbation or re-injury
- Summary of care plan to include identification of all services, procedures, and supply items
- Discussion of the patient’s progress to date
- An estimate of future care requirements
- A response to any specific questions asked by the UM clinician’s comments in making the request.

**Interpreting Information Received from Healthways**

After the information is entered via [https://www.wholehealthpro.com](https://www.wholehealthpro.com) you will receive an automated response and Healthways will provide you with a confirmation via fax or mail.

Your request will be approved, modified, or denied based upon Healthways’ clinical criteria and assessment. In the table below, we’ve listed some of the information you will receive from us in your confirmation letter. You can find the fields in the top half of the letter.

<table>
<thead>
<tr>
<th>Type of letter:</th>
<th>In this field name:</th>
<th>The response will be listed as:</th>
<th>And any visits will be listed with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval</td>
<td>Authorization Request Decision</td>
<td>Approval</td>
<td>Number of visits approved and the dates in which the visits must be completed</td>
</tr>
<tr>
<td>Modification*</td>
<td>Authorization Request Decision</td>
<td>Unable to Certify Decision*</td>
<td>Number of visits approved and the dates in which the visits must be completed</td>
</tr>
<tr>
<td>Denial</td>
<td>Authorization Request Decision</td>
<td>Unable to Certify Decision</td>
<td>Fields will be marked as “0” since no visits have been approved</td>
</tr>
</tbody>
</table>

*Regulations require modified approval plans to be categorized as denials or adverse determinations.*
The Clinical Review Appeals Process
If you have received an adverse determination and wish to appeal the determination, you will have two options for reconsideration.
Option One: Peer-to-Peer Discussion
If, upon receiving a denial of coverage determination, you wish to discuss the determination received from the peer reviewer who made the decision, you will be given the opportunity to submit a request for a peer-to-peer discussion. (See the Appendix for the UM Department Request Form you will need to fill out to submit this request.)

This process will also be outlined in the Review Determination Notice letter that you have received from Healthways via fax or via mail.

A peer-to-peer discussion is typically performed via telephone between the practitioner and Healthways’ peer reviewer. Here are the possible outcomes from the peer-to-peer discussion:

1. The request is approved and the provider (and the member) will receive a Review Determination Notice letter via fax or mail indicating the outcome.
2. The request is modified (either for the same or for a different reason). You will receive a Review Determination Notice letter via fax or via mail indicating the outcome. At this point, you will have the option of requesting reconsideration as outlined in the Review Determination Notice letter.
3. The request is denied (either for the same or for a different reason). You will receive a Review Determination Notice letter via fax or via mail indicating the outcome. At this point, you will have the option of requesting reconsideration as outlined in the Review Determination Notice letter.

Option Two: Reconsideration
If you have received an adverse determination, you have the right to request reconsideration. (See the UM Department Request Form in the Appendix for the form you will need to fill out to submit this request.) The Healthways practitioner who will review the reconsideration request will not be the same practitioner who made the initial decision. Here are the possible outcomes from the reconsideration:

1. The reconsideration request is approved and the provider (and the member) will receive a Review Certification Notice letter via fax or mail indicating the outcome.
2. The reconsideration request is modified (either for the same or for a different reason). You will receive a Review Determination Notice letter via fax or mail indicating the outcome. At this point, your reconsideration rights will be exhausted; however, the member will also receive notification of the decision and has the right to an appeal through Prevea360 Health Plan.
3. The reconsideration request is denied (either for the same or for a different reason). You will receive a Review Determination Notice letter via fax or mail indicating the outcome. At this point, your reconsideration rights will be exhausted; however, the member will also receive notification of the decision and has the right to an appeal through Prevea360 Health Plan.

Additional Forms and Information
Below are some of the forms you may receive from Healthways or you may be asked to submit as part of the authorization and/or clinical process.

• Bar-Coded Form requesting submission of documents. When you receive a fax notification from Healthways requesting that you submit medical records for review, referral documents, or additional information that may be required during the utilization review process.
You must use this specific bar coded form as the cover page when you fax medical records or other requested information back to the Healthways’ Utilization Management (UM) Department at 1-888-492-1025. This will enable us to more accurately track the information and quickly link your documents to the specific patient file in our processing system. Clinical records must be received within 12 calendar days of the request.

• **UM Department Request Form (for a peer-to-peer discussion or reconsideration)**
  Please use and complete this form when requesting a peer-to-peer discussion of a clinical review. If the review results in a denial, you may also use this form to request reconsideration. Fax the completed form to Healthways’ Appeals & Grievance Unit’s dedicated fax number, 1-888-492-1029.

You may also use and complete this form when requesting an extension in the time allotted for care. Note: you must include an explanation to support your request for a date change. Fax the completed form to Healthways’ Appeals & Grievance Unit’s dedicated fax number, 1-888-492-1029.

• **Medical Record Summary Form.** This optional form may be utilized for summarizing the patient’s case and included when submitting medical records for review. We encourage you to summarize the care rendered or anticipated for the patient using this form, or by supplying the information referenced in that form.