PROGRAM EFFECTIVE WITH SERVICE DATES BEGINNING SEPTEMBER 1, 2012

© 2012-2014 Highmark Inc. All rights reserved.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>SEE PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Program Guidelines</td>
<td>4</td>
</tr>
<tr>
<td>Verification and Application of Benefits</td>
<td>9</td>
</tr>
<tr>
<td>Healthways’ Forms for Physical Medicine Management</td>
<td>2</td>
</tr>
<tr>
<td>Care Registration Process</td>
<td>24</td>
</tr>
<tr>
<td>Care Authorization Process</td>
<td>29</td>
</tr>
<tr>
<td>Retrospective Review Requests</td>
<td>36</td>
</tr>
<tr>
<td>Clinical Review Process and Determinations</td>
<td>37</td>
</tr>
<tr>
<td>Medical Records Documentation</td>
<td>42</td>
</tr>
<tr>
<td>Claim Submission and Reimbursement</td>
<td>44</td>
</tr>
<tr>
<td>Reconsiderations and Appeals</td>
<td>46</td>
</tr>
</tbody>
</table>

## APPENDIX

<table>
<thead>
<tr>
<th>Submitting Registrations/Authorizations Via NaviNet®</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NaviNet Plan Central</td>
<td>51</td>
</tr>
<tr>
<td>• NaviNet Selection Form</td>
<td>52</td>
</tr>
<tr>
<td>• NaviNet Request Form</td>
<td>53</td>
</tr>
<tr>
<td>• Registration Pathway:</td>
<td>54</td>
</tr>
<tr>
<td>▪ Welcome to Healthways Care Registration</td>
<td>55</td>
</tr>
<tr>
<td>• Registration Response Form</td>
<td>55</td>
</tr>
<tr>
<td>• Authorization Pathway:</td>
<td>56</td>
</tr>
<tr>
<td>▪ Fax Tab</td>
<td>56</td>
</tr>
<tr>
<td>▪ Welcome to Healthways Pre-Authorization System</td>
<td>58</td>
</tr>
<tr>
<td>▪ Condition Tab</td>
<td>59</td>
</tr>
<tr>
<td>▪ Treatment Plan Tab</td>
<td>60</td>
</tr>
<tr>
<td>▪ History Tab</td>
<td>61</td>
</tr>
<tr>
<td>▪ Summary Tab to Review Your Input</td>
<td>62</td>
</tr>
<tr>
<td>▪ Your Review is Complete – Submit For Prescreening</td>
<td>63</td>
</tr>
<tr>
<td>Prescreening Outcome Responses</td>
<td>64</td>
</tr>
<tr>
<td>Sample Bar-Coded Notification/Cover Sheet</td>
<td>67</td>
</tr>
<tr>
<td>NaviNet Authorization Inquiries</td>
<td>68</td>
</tr>
<tr>
<td>Healthways Clinical Reference Sources</td>
<td>69</td>
</tr>
<tr>
<td>Procedure Codes and Descriptions</td>
<td>70</td>
</tr>
</tbody>
</table>
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.

Highmark’s data indicates that claims utilization associated with physical therapy, occupational therapy, and manipulation services shows wide variations in the delivery of these services. The goal of this 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 holding down health care costs for our members and group customers.

Program overview

Effective with dates of service on or after September 1, 2012, Highmark commercial and Medicare Advantage members must be registered each calendar year in which they receive outpatient physical therapy, occupational therapy, and manipulation services from network participating providers. Services beyond an eight (8) visit threshold in a calendar year will require pre-authorization.*

Highmark has contracted with Healthways WholeHealth Networks, Inc. (“Healthways”) to administer the registration process and provide medical necessity review and authorization, when applicable, for these services under the Physical Medicine Management Program. The guidelines utilized by Healthways were developed using nationally accepted standards and with input from actively practicing practitioners.

Highmark will continue to process claims and provide reimbursement for covered services. Highmark will also continue to manage our networks of participating providers.

* Please see program variations for Pennsylvania Employee Benefit Trust Fund (PEBTF) members on Page 5.

About Healthways

Healthways is a leading national integrative medicine company offering comprehensive solutions that improve well-being, decrease health care costs, enhance performance, and generate economic value. Healthways has more than 20 years of experience in physical medicine management. The program is fully accredited by URAC.
Program components

Effective for dates of service beginning September 1, 2012,* the Highmark Physical Medicine Management Program, managed by Healthways, involves two key components: Care Registration and Care Authorization.

- **Care Registration:** Patients are registered with Healthways annually beginning with their first visit each calendar year. Care registration is used to document the initial visits in the calendar year to determine when medical management is needed.

- **Care Authorization:** Services beyond a visit threshold in a calendar year will require prior authorization from Healthways.

The services included in the Physical Medicine Management Program are: physical therapy, occupational therapy, and manipulation services. This program applies to these services when provided in an **outpatient setting only**; the program is not applicable to inpatient care.

*Pennsylvania Employee Benefit Trust Fund (PEBTF) participation effective January 1, 2013.

Electronic submissions via NaviNet®

Care registration and authorization requests are submitted to Healthways through NaviNet®. This electronic submission process provides immediate responses, consistency, and greater efficiency in managing these services. Providers log into NaviNet using their NaviNet username and password.

**IMPORTANT**

Care Registry resets each calendar year

The Physical Medicine Management Program is administered on a calendar year basis. **Patients must be registered with Healthways annually beginning with their first visit each calendar year.** Registration provides for auto-approved visits to be used within the current calendar year. Care registrations will be issued with a Last Covered Date (LCD) of December 31 of the same year as the start date of services.*

If the visits approved through registration are used and additional treatment is needed in the same calendar year, authorization is required. The LCD of the Care Registration will be modified when an authorization is given for additional visits -- from 12/31 to the day before the start date of the new authorization. This is done to prevent overlapping authorizations that could cause problems for claim payment.

**Please note that 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.** For patients receiving treatment that extends from one calendar year into the next, you must submit a request for a new Care Registration beginning with their first visit in the new calendar year. The patient is then eligible for the applicable auto-approved visits in the new year prior to authorization being required.

* **Exception:** For manipulation services for Medicare Advantage members, registrations will be issued for a sixty (60) day period.

*Continued on next page*
A “visit” is based on the care rendered on a single date of service. 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 visit threshold prior to requiring authorization from Healthways is based on the discipline.

Each calendar year, a member is eligible for “auto-approved” visits under care registrations for each of the two service categories, if needed (see exceptions for PEBTF below):

- **Manipulation**: A care registration is available for eight (8) visits for manipulation services provided by doctors of chiropractic (DCs).
- **Physical Therapy/Occupational Therapy**: A care registration is available for eight (8) visits combined for physical/occupational therapy services provided by physical therapists (PTs), occupational therapists (OTs), medical doctors (MDs), and/or doctors of osteopathy (DOs).

**Note**: Independent licensed massage therapists and independent athletic trainers are out of scope for this program.

The Pennsylvania Employee Benefit Trust Fund (PEBTF) has managed therapy and manipulation services for a number of years as part of their standard benefit package. Effective January 1, 2013, management of physical therapy, occupational therapy, and manipulation services for PEBTF PPO members is administered by Healthways. Participating PEBTF members can be identified by an OPB alpha prefix on their ID cards.

The Physical Medicine Management Program guidelines, as outlined in this guide, are applicable to participating PEBTF members except for the following variations:

- Authorization is required beginning with the seventh visit for each discipline within the calendar year.
- Registration and authorization requirements for physical medicine services provided to participating PEBTF members are not limited to the procedure codes applicable under the Physical Medicine Management Program. Additional physical medicine, occupational therapy, and manipulation services will require registration and/or authorization for participating PEBTF members, as per the PEBTF benefit plan.
- PEBTF benefits require care registration and/or authorization for autism/autism spectrum disorder.

**Continued on next page**
Note: There is no change to the authorization process for respiratory therapy and speech therapy services provided to PEBTF members; these services continue to be authorized by Highmark’s Medical Management & Policy (MM&P) department after the sixth visit. Providers can continue to request authorization for these services via NaviNet or by telephone.

The visit threshold for each service category applies on a calendar year basis – January 1 through December 31. For example, a patient with an eight (8) visit threshold has ten (10) physical therapy visits in November and December of this year, and then returns to your office for additional physical therapy in January of next year. You must register the patient with the first visit in January, and then the patient will have eight (8) physical/occupational therapy visits “auto-approved” for the new year before authorization is required for any additional physical and/or occupational therapy visits.

Care Registration visit threshold applies to all episodes of care for a particular service within the calendar year. For example, a patient received treatment for a lower back problem which required eight (8) visits for manipulation services in February and March. The patient returns to your office in September of the same year following a neck injury. Since the patient had already reached the eight (8) visit threshold for manipulation services for the calendar year, any manipulation treatment for this new episode of care will now require authorization.

Combined physical therapy/occupational therapy Care Registration: The visit threshold for physical/occupational therapy may be met with services provided for just one of the services (e.g., eight visits for physical therapy or eight visits for occupational therapy). The visit threshold may also be met through a combination of visits for physical therapy and occupational therapy (e.g., four visits for physical therapy and four visits for occupational therapy). (Not applicable to PEBTF.)

Treatment from more than one provider of the same discipline in a calendar year: If a member has received treatment from more than one provider of the same discipline in a calendar year, visits to all providers will be counted toward the Care Registry threshold for the applicable service category. It is not necessary for a provider to try to track a member’s treatment with another provider to determine whether registration or authorization is necessary; the Healthways care management system will direct the request accordingly. If the member has reached the visit threshold through visits to one or more providers, the system will automatically route requests through the Healthways Rapid Response System (RRS) for Care Authorization.

Continued on next page
For doctors of chiropractic who primarily provide manipulation services, care registration and authorization requests are submitted under the manipulation services category. A separate registration or authorization is not required for any physical medicine procedures that may be performed in conjunction with the manipulation treatment.

Doctors of osteopathy may provide manipulation and/or physical medicine procedures; however, care registration/authorization is obtained only under the physical/occupational therapy category.

NaviNet makes it easy to register and request authorization for members in the Physical Medicine Management Program. The pathway in NaviNet is the same for both registration and authorization submissions; and the system will determine whether registration or authorization is required.

Once the member information is entered into NaviNet’s Selection Form and Request Form, the submission will be automatically directed to the Healthways Care Registry when the applicable threshold has not been reached. If the member has reached the visit threshold for the applicable discipline in the current calendar year or a registration is already on file for the discipline, the submission will be directed to the Healthways RRS for Care Authorization.

For step-by-step instructions with screen prints of the submission process through NaviNet, please see “Submitting Registrations/Authorizations Via NaviNet” in the Appendix of this guide.

For Healthways’ Care Registration, visits are counted toward the applicable Care Registry threshold based on the provider’s discipline. A single date of service with a single provider will be counted as a single visit to one of the two Care Registries:

1. **Manipulation** for services provided by doctors of chiropractic (DCs).
2. **Physical/occupational therapy** for services provided by physical therapists (PTs), occupational therapists (OTs), medical doctors (MDs), and/or doctors of osteopathy (DOs).

* Three registries for PEBTF members: manipulation, physical medicine, and occupational therapy.

**Continued on next page**
How visits are counted for Healthways (continued)

The following examples illustrate how Healthways will apply the visits:

- If a doctor of chiropractic (DC) performs both manipulation and physical therapy procedures during a single session, it will count as one visit toward the Care Registry for manipulation.

- If a doctor of osteopathy (DO), whose primary discipline is physical medicine, provides both physical medicine and manipulation on a single date of service, then one visit will be counted to the Care Registry for physical/occupational therapy.

- When a member receives both physical therapy and occupational therapy at a facility on the same date of service, one visit is applied to the Care Registry for physical/occupational therapy (for PEBTF members, one visit for physical medicine and one visit for occupational therapy).

Please note that this is also applicable to counting visits for care authorizations.

Copayments and visits applied to benefit limits

Effective for dates of service on or after September 1, 2013, our method for applying copayments and counting visits for physical medicine services has been simplified for all of our commercial health plans. Only one copayment will be applied and one visit will be counted when a provider bills for multiple physical medicine services or physical medicine services and office visits on the same date of service.

The highest copayment will apply when copayment amounts differ for services. When determining the service to which the visit will be counted, the processing logic will start with the initial line of a claim and continue down the billed lines. The visit will be applied to the first line with a service type having available visits.

As always, please use the NaviNet Eligibility and Benefits function or the applicable HIPAA transaction to verify a member’s benefits prior to providing services. In NaviNet, you will see the following language when verifying copayments for services under benefit plans affected by this change: Apply 1 copayment, per date of service, per provider when performed with therapy or office visit services.

Please Note: Many employer groups were already applying a single copayment per date of service prior to this date. In addition, self-funded employer groups may continue to apply multiple copayments per date of service.

IMPORTANT: This change does not apply to Medicare Advantage plans for which copayments are applied per therapy type, per provider, per day.
Effective January 1, 2013, registration and/or authorization are not required for physical therapy and occupational therapy evaluation and re-evaluation services (97001-97004). Therefore, an authorization is not 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.

Visits for evaluations and re-evaluations apply toward visit counts for a member’s benefit limits. However, they may or may not apply toward visit counts for Healthways’ care registration/authorization depending on whether the evaluation/re-evaluation visits include physical medicine treatment.

The following examples outline how visits would accumulate for physical therapy (PT) and occupational therapy (OT) services:

- If an evaluation/re-evaluation only is performed on a given date of service (e.g., PT evaluation), it is not counted as a visit toward the Healthways Care Registry/Authorization for physical/occupational therapy (physical medicine for PEBTF). It does, however, count as one (1) visit toward the member’s physical therapy benefit limit.

- If evaluations/re-evaluations only are performed for both disciplines on a given date of service (e.g., PT evaluation and OT evaluation), they do not count as a visit toward the Care Registry/Authorization for physical/occupational therapy. However, one (1) visit is counted toward the member’s benefit limits, if applicable. The service to which it applies will be determined as outlined above.

- If a provider evaluates and treats a member in one discipline (e.g., PT evaluation and PT treatment) on the same day, it counts as one (1) visit for care registration/authorization and as one (1) visit toward the member’s physical therapy benefit limit.

- If a provider evaluates and treats a member in both disciplines on a given date of service (e.g., PT evaluation, PT treatment, OT evaluation, and OT treatment), one (1) visit is applied to the Care Registry/Authorization for physical/occupational therapy (one [1] visit for physical medicine and one [1] visit for occupational therapy for PEBTF members). For benefits, one (1) visit would be applied to the member’s benefit limits, if applicable. The service to which it applies will be determined as outlined on the previous page.

Continued on next page
Effective January 1, 2013, the following procedure codes require registration and/or authorization under the Physical Medicine Management Program:

<table>
<thead>
<tr>
<th>Procedure codes</th>
<th>Physical Medicine</th>
<th>Occupational Therapy</th>
<th>Manipulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>97010</td>
<td>97022</td>
<td>97033</td>
<td>97112</td>
</tr>
<tr>
<td>97012</td>
<td>97024</td>
<td>97034</td>
<td>97113</td>
</tr>
<tr>
<td>97014</td>
<td>97026</td>
<td>97035</td>
<td>97116</td>
</tr>
<tr>
<td>97016</td>
<td>97028</td>
<td>97036</td>
<td>97124</td>
</tr>
<tr>
<td>97018</td>
<td>97032</td>
<td>97110</td>
<td>97140</td>
</tr>
<tr>
<td>97530</td>
<td>97533</td>
<td>97542</td>
<td>97755</td>
</tr>
<tr>
<td>97532</td>
<td>97535</td>
<td>97750</td>
<td></td>
</tr>
<tr>
<td>98925</td>
<td>98927</td>
<td>98929</td>
<td>98941</td>
</tr>
<tr>
<td>98926</td>
<td>98928</td>
<td>98940</td>
<td></td>
</tr>
</tbody>
</table>

* Please see the Appendix of this guide for a list of these procedure codes with accompanying descriptions.

**Note:** For participating PEBTF members, additional physical medicine, occupational therapy, and manipulation services will require registration/authorization, as per the PEBTF benefit plan.

The following services are not impacted by the requirements of the Physical Medicine Management Program:

- Speech therapy
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Inpatient care
- Emergency services
- Observation services
- Autism mandated services*

* Please see the next page for additional information on services for autism diagnoses.

In addition, the program is not applicable to physical therapy, occupational therapy, and manipulation services when provided:

- By non-participating, out-of-network, or out-of-area providers
- In a comprehensive outpatient rehab facility (CORF)
- By a home health agency
- By facilities outside of Highmark's 49-county Western and Central Regions in Pennsylvania for members covered under Highmark commercial products
- By facilities outside of Highmark's 62-county Medicare Advantage service area (Pennsylvania’s Western, Central, and Northeastern Regions) for Medicare Advantage members
- To members whose primary coverage is traditional Medicare (unless their Medicare benefits are exhausted)

*Continued on next page*
PROGRAM GUIDELINES, Continued

Autism mandated services
Registration and/or authorization requirements under the Physical Medicine Management Program do not apply when autism/autism spectrum disorder (299 - 299.91) is the only diagnosis for services billed by a professional provider or is the principle diagnosis for facility-billed services.*

However, if a member with autism receives services for a non-related diagnosis (e.g., a broken arm), the services would be subject to the registration and authorization requirements of the Physical Medicine Management Program.

* Not applicable to PEBTF or to groups for which the autism mandate does not apply.

“Facility” or “professional” provider?
In this guide, references to “facilities” are intended for those providers billing services in the UB-04/HIPAA 837I format. Information and instructions directed to “professional” providers are intended for those providers who bill their services in the CMS-1500/HIPAA 837P format.

Applicable products
The Physical Medicine Management Program applies to Highmark’s commercial health plans including individual products, the Children’s Health Insurance Program (CHIP), and Highmark’s Medicare Advantage products.* Applicable products include:

- PPO Blue
- EPO Blue
- Community Blue PPO
- Community Blue EPO
- PA Western Region HMO
- Choice Blue
- PPO Plus
- Freedom Blue PPO
- Direct Blue*
- PA Western Region Medicare Advantage HMO (including the Special Needs Plan)

The program’s requirements will not apply for Highmark’s indemnity and comprehensive products and also for BlueCard® out-of-area members and Federal Employee Program (FEP) members.

* Certain employer groups (e.g., self-funded employer groups) may choose to opt out of participation in the Physical Medicine Management Program.

REMINDER Always verify benefits
Providers are reminded to always verify a member’s eligibility and benefits prior to rendering services. It is the provider’s responsibility to confirm that the member’s benefit plan provides the appropriate benefits for the anticipated date of service.

Continued on next page
PROGRAM GUIDELINES, Continued

Special note to SNFs

Skilled nursing facilities (SNFs) are reminded that the Physical Medicine Management Program requirements are not applicable to Medicare Part A inpatient services. However, if Part A benefits are exhausted or the patient is no longer receiving a Medicare skilled level of care, registration and/or authorization requirements would apply for “Medicare Part B-type” services.

Highmark Medical Policy

Manipulation services and physical/occupational therapy can consist of multiple treatment modalities on the same date of service. Healthways will authorize the number of visits. The number of modalities that can be performed in a visit is defined within Highmark Medical Policy.

For more information, please refer to the applicable commercial or Medicare Advantage Medical Policy:

<table>
<thead>
<tr>
<th>COMMERCIAL</th>
<th>MEDICARE ADVANTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Y-1 Physical Medicine</td>
<td>• Y-1 Physical Medicine and Rehabilitation Services, PT and OT</td>
</tr>
<tr>
<td>• Y-2 Occupational Therapy</td>
<td>• Z-6 Chiropractic Services</td>
</tr>
<tr>
<td>• Y-9 Manipulation Services</td>
<td></td>
</tr>
</tbody>
</table>

Highmark’s current medical policies are accessible on the Provider Resource Center under Medical & Claims Payment Guidelines. A link to Medical Policy is also available through the Highmark Blue Shield Office Manual’s Chapter 6, Unit 2.

Note: The Medical Policy guidelines for physical medicine, occupational therapy, and manipulation services are applicable to services for Highmark members regardless of participation in the Physical Medicine Management Program.

IMPORTANT Special note to facilities

Effective September 1, 2012, commercial Medical Policies Y-1, Y-2, and Y-9 and Medicare Advantage Medical Policy Y-1 apply to facility business for claims for applicable physical medicine services.

For additional information, please refer to the applicable Facility Bulletins published on August 31, 2012.
Services that do not meet medical necessity criteria will be denied as not medically necessary. A participating, preferred, or network provider cannot bill the member for the denied service unless the provider has given advance written notice, informing the member that the service may be deemed not medically necessary and providing an estimate of cost. The member must agree in writing to assume financial responsibility in advance of receiving the service. The signed agreement should be maintained in the provider’s records.

Highmark participating providers must register Highmark patients (with benefit plans requiring registration and authorization) with their first visit for applicable physical medicine services each calendar year. 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. Limited information is requested during the registration process.

Registration with Healthways is accomplished by using the Authorization Submission transaction in NaviNet which routes the request to Healthways’ 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. A registration is required for physical medicine services provided by physical therapists (PTs), occupational therapists (OTs), medical doctors (MDs), and/or doctors of osteopathy (DOs); and a separate registration is required for manipulation services provided by doctors of chiropractic (DCs).*

Members must be re-registered at the beginning of every calendar year in which they seek services. The Physical Medicine Management 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.

During the submission process via NaviNet, the request will be automatically routed to the Healthways Rapid Response System (RRS) for Care Authorization if Healthways’ records indicate that the member has reached the visit threshold for the services. If the member’s plan does not require registration and authorization, a NaviNet response will advise that Healthways does not provide utilization management for the member.

* For participating PEBTF members, separate registrations are required for each of the three disciplines (physical medicine, occupational therapy, and manipulation services) with a six (6) visit threshold for each discipline.
Once the member reaches the eight (8) visit threshold for manipulation services or the eight (8) visit threshold for physical/occupational therapy combined in a given calendar year, additional treatment requires pre-authorization from Healthways.*

After the member has received the treatment that was auto-approved in registration (used all or most of the initial visits), an authorization request is submitted when it is determined that additional visits will be needed. The number of visits requested for authorization should be for any additional visits, including evaluations or re-evaluations, that are anticipated to be needed for continued treatment of the patient within this episode of care.

Information about the patient’s history and the proposed treatment plan are submitted to Healthways through NaviNet using the Authorization Submission transaction. The request is routed through Healthways Rapid Response System (RRS) prescreening process and benchmarked against clinical decision support pathways.

The provider is immediately aware of the prescreening outcome which can be either approval, an opportunity to modify the treatment plan to meet guidelines, or pended for peer clinical review. If the provider elects to modify their treatment plan following prescreening and prior to submitting their authorization request, the final outcome is considered an approval.

In addition to the NaviNet response, Healthways will fax a written notification to the provider’s office within approximately twenty (20) minutes.

- If an approval can be provided through the automated prescreening process, Healthways will fax an approval notification to the provider.
- If a determination (approval) cannot be made in the prescreening process, Healthways will fax the provider a bar-coded form requesting medical records for clinical review.**

Healthways uses an electronic document management process which includes the barcode technology to link submitted medical records to the member’s file within the system. When Healthways receives the requested information from the provider, clinical review will be initiated. The review will be conducted by an appropriately licensed clinician skilled in the applicable discipline and completed in one (1) to two (2) business days. The decision notification is sent to the provider. The provider can expect one of three possible decisions from the clinical review process: approval, modification (partial approval), or denial. For additional details, please see the section in this guide titled Clinical Review Process and Determinations.

* The visit thresholds for participating PEBTF members are: six (6) visits for physical medicine, six (6) visits for occupational therapy, and six (6) visits for manipulation services.

** Please see the Medical Records Documentation section in this guide for helpful information outlining the supporting documentation needed for clinical review.
PROGRAM GUIDELINES, Continued

**IMPORTANT!**
Check your fax settings

To assure timely receipt of Healthways’ notifications, please have your fax machine set to answer in no more than four (4) rings. Healthways’ system attempts to fax the provider notification a total of ten (10) times, waiting at least twelve (12) minutes between attempts. If all attempts to send the fax fail, the notification will be mailed to the provider.

---

If NaviNet is not available

NaviNet is the preferred method for registration and authorization request submissions for the Physical Medicine Management Program. If you are unable to access NaviNet or the NaviNet Authorization Submission function, you may contact Healthways to submit your request by calling your regional Highmark Provider Service telephone number.

- PA Western Region: 1-800-547-3627
- PA Central, Eastern, and Northeastern Regions: 1-866-731-8080

Please listen carefully to the available options to be directed to Healthways:

1. First, select Option 2 from the main menu options (“To request an authorization for an inpatient or outpatient service”).
2. Next, you will be asked to select an option based on your provider type:
   - If you are a facility, select Option 1.
   - If you are a professional provider, select Option 2.
3. And then select Option 3 to speak with Healthways.

The standard business hours for the Provider Service phone lines are:

- Monday through Friday 8:30 a.m. to 7 p.m.
- Saturday and Sunday from 8:30 a.m. to 4:30 p.m.

---

**IMPORTANT**
Authorization is not a guarantee of payment

Authorization is a determination of medical necessity; it is not a guarantee of payment. Payment is dependent upon the member having coverage at the time the service is rendered and the type of coverage available under the member’s benefit plan. It is the provider’s responsibility to verify that the member’s benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering service.

---

If an authorization expires

If an authorization expires before all visits are used, the Healthways’ Utilization Management (UM) Department Request Form - Highmark can be used to request an extension in the time allotted for care. (This form is also available on the Physical Medicine Management Program page of the Provider Resource Center, under Clinical Reference Materials).

Complete the appropriate section of the form and fax the form to Healthways at 1-888-492-1029. You must include an explanation to support your request for a change of the date by which approved visits are to be completed.

Continued on next page
If an approved treatment plan requires modification

If a provider determines that it is necessary to change a patient’s plan of treatment after an authorization is received, the provider should submit a new authorization request to Healthways via the Authorization Submission transaction in NaviNet.

Concurrent treatment for two separate conditions

More than one condition or diagnosis may be treated under the same care authorization. If a patient is currently receiving therapy and a new condition emerges that requires additional treatment, the provider should not submit a new authorization request at that time. To avoid creating overlapping authorizations in Highmark’s systems, 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.

EXAMPLE:

An authorization is issued for 10 visits from June 5 through July 20 for treatment of a shoulder condition. On June 25, with five visits remaining on the authorization, the patient presents with a new condition of low back pain. If an evaluation determines treatment is also required for the back pain, the provider should continue treating the patient for both the shoulder and low back pain under the existing authorization. The patient’s medical record should be documented for both conditions.

By July 15, the patient has used nine visits and has one visit remaining; the shoulder condition has been resolved but the low back pain will require additional care. The provider should submit a continuation of care authorization request for additional treatment of the patient’s low back pain.

Consultations and appeals

If clinical review results in an adverse determination (modification* or denial), the provider has two options available for reconsideration by Healthways:

- Peer-to-peer discussion with a Healthways’ peer reviewer; or
- An appeal in which a Healthways’ reviewer other than the person who made the initial determination will review the request.

* Regulations require modified approvals to be categorized as denials or “adverse determinations.”
PROGRAM GUIDELINES, Continued

Consultations and appeals (continued)

The possible outcomes for these reconsideration options are: approval, modification, or denial. If a peer-to-peer discussion results in an adverse determination, the provider then has the option of requesting an appeal from Healthways. If an appeal results in an adverse determination, the provider’s reconsideration rights with Healthways will be exhausted; however, Healthways will coordinate and collaborate with Highmark in administering the external appeal process as required by state and federal regulations.

In addition, the member has the right to appeal an adverse determination through Highmark’s member appeal process.

FOR MORE INFORMATION

For additional information, please see the section within this guide titled Reconsiderations and Appeals.

Claims, payment, and member responsibility

Highmark will continue to process claims for services managed under the Physical Medicine Management Program and reimburse providers for eligible services. Highmark encourages electronic submission of claims via NaviNet or the applicable HIPAA transactions.

Claims for services performed without required registrations and authorizations will be rejected; the member will be held harmless and will not be responsible for payment. If a claim is denied for no authorization, an authorization request can be submitted. However, untimely requests will pend for retrospective review; medical records will be required.

Your requests for retrospective review can be submitted electronically via NaviNet, including those with a start date for services more than ten (10) days before the date you are submitting your request. For more information, please see the Retrospective Review Requests section in this guide.

The member would be financially liable if an authorization was requested and denied, and then the member still chose to receive the service after being informed that it was not approved. The member must agree in writing to assume financial responsibility before receiving the service; and the signed agreement should be maintained in the provider’s records.

Continued on next page
For details of specific topics and processes, please see the applicable sections within this guide.

Additional information related to the program, including links to Healthways’ forms and Highmark communications, is available on the dedicated page of the Provider Resource Center. Select Clinical Reference Materials, and then Physical Medicine Management Program.

Questions not addressed in this guide can be directed to your Provider Relations representative.
VERIFICATION AND APPLICATION OF BENEFITS

Overview
When an authorization number is provided, it serves as a statement about medical necessity and appropriateness; it is not a guarantee of payment. Payment is dependent upon the member having coverage at the time the service is rendered and the type of coverage available under the member’s benefit plan. It is the provider’s responsibility to verify that the member’s benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering service.

The NaviNet® Eligibility and Benefits transaction or the appropriate HIPAA electronic transaction can be used to determine if a member’s plan requires registration and authorization for physical therapy, occupational therapy, and manipulation services.

NaviNet® Eligibility & Benefits
The Physical Medicine Management Program indicator will display in the Group Information section of the Eligibility and Benefits Details screen in NaviNet.

If the member’s coverage requires registration and authorization under the Physical Medicine Management Program, the indicator will say “YES.”

<table>
<thead>
<tr>
<th>Group Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date:</td>
</tr>
<tr>
<td>Group Number:</td>
</tr>
<tr>
<td>Product:</td>
</tr>
<tr>
<td>Plan Area:</td>
</tr>
<tr>
<td>Group Renewal:</td>
</tr>
<tr>
<td>Alpha Prefix:</td>
</tr>
<tr>
<td>Term Date:</td>
</tr>
<tr>
<td>Group Name:</td>
</tr>
<tr>
<td>Advanced Imaging UM by NDA:</td>
</tr>
<tr>
<td>Radiation Therapy Management:</td>
</tr>
<tr>
<td>Physical Medicine Management:</td>
</tr>
<tr>
<td>Current ID Card Info:</td>
</tr>
</tbody>
</table>

To determine the member’s coverage for physical medicine services, please access the applicable benefit category based on your provider type: Professional Therapy and Rehabilitation Services or Outpatient Facility Services.

IMPORTANT Benefit plan visit limits still apply
If a member’s benefit plan has limits on the number of visits for physical therapy, occupational therapy, and manipulation services, the visit limits will still apply. For example, a member has a twenty (20) visit limit per a calendar year benefit period for physical/occupational therapy combined and has already had eight (8) visits for physical therapy in the calendar year. If a provider requests and receives approval for sixteen (16) visits for occupational therapy, only twelve (12) of those visits will be eligible for payment under the member’s benefit plan.

Continued on next page
We have simplified our method of applying copayments and counting visits for physical therapy, occupational therapy, speech therapy, and spinal manipulation for our commercial health plans. Effective for dates of service on or after September 1, 2013, only one copayment will be applied and one visit counted when a provider bills for multiple physical medicine services or physical medicine services and office visits on the same day.*

In the event that copayments differ in amount by service, the highest copayment will apply. And, to determine the service to which the visit will be counted, the processing logic will start with the initial line of a claim and continue down the billed lines; the visit will be applied to the first line with a service type having available visits.

As always, please use the NaviNet Eligibility and Benefits function or the applicable HIPAA transaction to verify a member’s benefits prior to providing services. In NaviNet, you will see the following language when verifying copayments for services under benefit plans affected by this change: Apply 1 copayment, per date of service, per provider when performed with therapy or office visit services.

Please Note: Many employer groups were already applying a single copayment per date of service prior to this date. In addition, self-funded employer groups may continue to apply multiple copayments per date of service.

IMPORTANT: This change does not apply to Medicare Advantage plans for which copayments are applied per therapy type, per provider, per day.

*Speech therapy is not included in the Physical Medicine Management Program.
For inquiries about eligibility and benefits, Highmark encourages providers to use the electronic resources available to them -- NaviNet and the applicable HIPAA transactions -- prior to placing a telephone call to Highmark's Provider Services. Providers without electronic access may call Provider Services to speak to a customer service representative.

**Professional Providers:**
- PA Western Region: 1-800-547-3627, Option 6
- PA Central, Eastern, and Northeastern Regions: 1-866-731-8080, Option 6

**Facilities:**
- PA Western Region: 1-800-242-0514, Option 6
- PA Central Region: 1-866-803-3708, Option 6

**Medicare Advantage:**
- Freedom Blue PPO: 1-866-588-6967, Option 4
- PA Western Region HMO: 1-866-517-8585, Option 4

**IMPORTANT!**
Many of Highmark's benefit plans are administered on a contract year which is not necessarily a calendar year. **The Physical Medicine Management Program is administered 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.**

The authorization requirements under a member's benefit plan apply if a claim will be submitted to Highmark for any portion of payment. Therefore, if the member's primary insurance is with an insurer other than Highmark, you must register the member and request authorization for the applicable physical medicine services when the Physical Medicine Management Program applies to the member’s coverage.

However, if traditional Medicare is primary, registration and authorization is required only if the member’s Medicare benefits have been exhausted.
HEALTHWAYS FORMS FOR PHYSICAL MEDICINE MANAGEMENT

Healthways provides forms for your use in the care registration and authorization process (forms were last updated July 1, 2013). These forms are also available on the Physical Medicine Management Program page on the Provider Resource Center (under Clinical Reference Materials).

Effective July 1, 2013, Healthways discontinued use of the Functional Rating Index (FRI) for manipulation services, and expanded use of the Patient Specific Functional Scale (PSFS) as its preferred outcomes measure tool for all physical medicine services. Although using the PSFS is not mandatory, its use is strongly encouraged due to its broad applicability, ease of administration, and proven validity.

When submitting care authorization requests for physical therapy, occupational therapy, and manipulation services, the patient’s most recent PSFS score will be requested. Healthways’ Rapid Response System (RRS) will only accept a PSFS score. If a PSFS score is not available, you may leave the field blank.

<table>
<thead>
<tr>
<th>FORM</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| Preauthorization Request for Physical/Occupational Therapy | It is recommended that you complete this form before using NaviNet® to submit your authorization request for physical or occupational therapy. It outlines the clinical and demographic information that will be requested when submitting an authorization request for physical or occupational therapy.  
  Click on this link for helpful instructions for completing the form: [Preauthorization Request Instructions for Physical/Occupational Therapy](#) |
| Preauthorization Request for Manipulation Services | It is recommended that you complete this form before using NaviNet to submit your authorization request for manipulation services. It outlines the clinical and demographic information that will be requested when submitting an authorization request for manipulation services.  
  Click on this link for helpful instructions for completing this form: [Preauthorization Request Instructions for Manipulation Services](#) |

Continued on next page
**HEALTHWAYS FORMS FOR PHYSICAL MEDICINE MANAGEMENT, Continued**

<table>
<thead>
<tr>
<th>FORM</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| **Patient-Specific Functional Scale (PSFS)** | This questionnaire is used to quantify the patient’s activity limitations and measure functional outcome. The patient is asked to identify important activities he or she finds difficult or is unable to do. The clinician records the patient’s self-determined difficulty level on a scale from 0 to 10.  

At the initial assessment, the clinician administers the questionnaire at the end of history-taking and prior to physical examination. The patient is asked to again rate the difficulty level of their activities at follow-up visits for re-assessment. Copies should be maintained in the patient’s file. **The patient’s most recent PSFS score will be requested when submitting an authorization request for physical therapy, occupational therapy, or manipulation services.** |
| **Utilization Management (UM) Department Request Form - Highmark** | The applicable section of this form is completed and faxed to Healthways to request reconsideration of a determination. It is to be used for both peer-to-peer discussions and appeals.  

This form is also used to request an extension in the time allotted for care. You must include an explanation to support your request for a change of the date by which approved visits are to be completed.  

The completed form is faxed to Healthways at 1-888-492-1029. |
CARE REGISTRATION PROCESS

Introduction

Highmark members with coverage requiring registration and authorization of physical therapy, occupational therapy, and manipulation services under the Physical Medicine Management Program must be registered with Healthways at their initial visit each calendar year. Limited information is needed for care registration.

Registration of physical medicine services is accomplished by selecting Authorization Submission from Highmark’s Plan Central menu in NaviNet.® Providers then select the option from the fly-out menu based on their provider type – professional providers click on Auth Submission, and facilities must select Inpatient Auth Submission.

Timely submissions

The registration must be submitted within ten (10) calendar days of the patient’s initial evaluation to be considered timely. The member can be registered up to ten (10) calendar days before their initial visit. Registrations must be submitted no later than ten (10) calendar days after the initial evaluation to be considered timely.

NaviNet hours of availability

NaviNet has extended hours of system availability for all of your inquiry and transaction needs:

- Monday through Friday from 5 a.m. to 3 a.m.
- Saturday from 5 a.m. to 11 p.m.
- Sunday from 5 a.m. to 9 p.m.

Before you begin...

Before beginning your registration submission in NaviNet, please be sure to verify the member’s eligibility and benefits.

Please have the following information readily available to enter during the registration process:

- Member ID; patient name and date of birth
- Type of care (physical therapy, occupational therapy, or manipulation)
- Start date for the services related to this request
- Primary diagnosis code (up to two additional codes can be entered)
- Number of visits you are requesting for services for this episode of care
- Name and phone number of the person at your office who can be contacted about this request

Continued on next page
To register a Highmark member for care, sign into NaviNet using your NaviNet username and password, and then follow these steps:

1. Select **Authorization Submission** from the Highmark Plan Central menu, and then click on the applicable option on the fly-out menu based on your provider type:
   - **Professionals**: Click on **Auth Submission** on the fly-out menu.
   - **Facilities**: Click on **Inpatient Auth Submission** on the fly-out menu.

2. Complete the required fields on the NaviNet **Selection Form** as instructed in the table below, and then click **Submit**.

<table>
<thead>
<tr>
<th>Step</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Select the applicable provider from the dropdown options, and enter the proposed date of service (both fields are required). <strong>The proposed date of service is the start date for services related to this request</strong> (including any applicable evaluations). It is not the date the member was first seen at your office. <strong>Note</strong>: NaviNet can accept a proposed date of service up to ten (10) days in the past. If your proposed date of service is more than 10 days prior to the date you are submitting your request, enter the current date. You will be able to edit the start date later in the process.</td>
</tr>
<tr>
<td>Step 2</td>
<td>The Member ID alone will be accepted. If the Member ID is not used, you must enter all of the following: member’s first name, last name, and date of birth.</td>
</tr>
</tbody>
</table>
| Step 3 | • From the **Category** dropdown, select **Physical Medicine**.  
• From the **Service** dropdown, select the applicable discipline: Physical Medicine, Occupational Therapy, or Spinal Manipulation.* |

* **Doctors of chiropractic should select Spinal Manipulation only.** Providers who provide both physical and occupational therapy can select both options if necessary – select one discipline and then click on the **Add Category/Service** button to enter the other (not applicable for PEBTF – separate registrations are required for physical medicine and occupational therapy for PEBTF). Doctors of osteopathy are not required to obtain a separate registration for manipulation treatment provided. **Note**: If the member’s benefit plan does not require registration and authorization under the Physical Medicine Management Program, you will receive a message from NaviNet after you submit the **Selection Form**. The screen message will indicate that Healthways does not provide utilization management for the member.

Continued on next page
CARE REGISTRATION PROCESS, Continued

3. Complete only the required fields highlighted in yellow on the NaviNet Request Form. (Any information entered in the Comments boxes will not be used in this process.) Once all required information is entered, click Submit.

   **Note:** NaviNet can accept a discipline start date up to ten (10) days in the past. If your start date of service is more than 10 days prior to the date you are submitting your request, enter the current date. You will be able to edit the start date on the next screen.

4. The request will be routed to Healthways’ Care Registry and a screen with the Care Registration tab will appear.
   - For services with a start date more than ten (10) days in the past, you may edit the start date here.
   - Click Next.

   **Note:** If the member has already reached the visit threshold for the services, the system will automatically direct the submission to the Healthways Rapid Response System (RRS) for Care Authorization. (See the next section in this guide, Care Authorization Process.)

5. You will receive an immediate confirmation response from NaviNet. This “auto-approval” will allow claims to process. Healthways will not provide written verification for registrations. The registration confirmation will be available in NaviNet’s Referral/Auth Inquiry and the Ref/Auth Log.

---

**FOR MORE INFORMATION**

For step-by-step instructions with screen images of the submission process through NaviNet, please see Submitting Registrations/Authorizations Via NaviNet in the Appendix of this guide.

---

**Special note about manipulation services**

For doctors of chiropractic, care registration and authorization requests are submitted under the **manipulation services category only**. A separate registration or authorization is not required for any physical medicine procedures that may be performed in conjunction with the manipulation treatment. **When selecting the “Service” on the NaviNet Selection Form, select “Spinal Manipulation” only.**

Care registrations and authorizations for services provided by doctors of osteopathy are obtained under the **physical medicine service category only**. A separate registration or authorization is not required for manipulation treatment provided by a doctor of osteopathy.

---

Continued on next page
CARE REGISTRATION PROCESS, Continued

NaviNet® authorization inquiries

Care registrations for physical medicine services under the Physical Medicine Management Program will be available for viewing in NaviNet.

The **Referral/Auth Inquiry** function, accessed from the main menu (see red arrow below), is **recommended for accessing all registration/authorization information for a particular member**. It provides information for requests submitted through NaviNet and also by telephone. The **Referral/Auth Inquiry** is a real-time look at the information on file in Highmark’s database; the information available to providers here is the same information available to Highmark and Healthways staff. (*Please note that there may be a slight delay between the submission to Healthways and the availability of the information in the Highmark database.*)

**The Referral/Auth Log**, accessed through **Office Central** in the task bar, makes it easy to review what you have recently submitted in NaviNet. This function provides numerous search options and is most helpful in accessing incomplete authorizations saved prior to submission. It provides a summary of the original submission with minimal update.

Continued on next page
CARE REGISTRATION PROCESS, Continued

If NaviNet is not available

NaviNet is the preferred method for registration for the Physical Medicine Management Program. If you are not able to access NaviNet or the NaviNet Authorization Submission transaction, you may contact Healthways to submit your request by calling your regional Highmark Provider Service telephone number.

- PA Western Region: 1-800-547-3627
- PA Central, Eastern, and Northeastern Regions: 1-866-731-8080

Please listen carefully to the available options to be directed to Healthways:

1. First, select Option 2 from the main menu options (“To request an authorization for an inpatient or outpatient service”).
2. Next, you will be asked to select an option based on your provider type:
   - If you are a facility, select Option 1.
   - If you are a professional provider, select Option 2.
3. And then select Option 3 to speak with Healthways.

The standard business hours for the Provider Services phone lines are:
- Monday through Friday 8:30 a.m. to 7 p.m.
- Saturday and Sunday from 8:30 a.m. to 4:30 p.m.
CARE AUTHORIZATION PROCESS

Overview

The Physical Medicine Management Program requires pre-authorization for additional visits after the member has received eight (8) visits for manipulation services or eight (8) visits combined for physical and/or occupational therapy services in a calendar year.*

The Authorization Submission transaction in NaviNet® is used to transmit the information to Healthways. By automating the authorization request process, Healthways expects to shorten the response time needed to initiate care and provide consistent decisions.

* The visit thresholds for PEBTF members are six (6) visits for physical medicine, six (6) visits for occupational therapy, and six (6) visits for manipulation services.

Types of authorizations for an episode of care

An “episode” of care begins with the first treatment of the patient at the onset of care in your office and ends after a break of sixty (60) days or more for treatment of the presenting condition.

There are two types of authorizations you may request for an episode of care: initial (or “new”) and continuation of care.

- An initial request is your first request for authorization to treat an episode of care in the given calendar year.
- A continuation of care request is a request for additional visits beyond those previously approved for the same condition(s) and must include the same primary diagnosis as the initial authorization request.

If a patient returns to your office for treatment of a new or recurring condition after being without care from you for sixty (60) days or more, an authorization request would be filed as an initial (or “new”) request for a new episode of care. The authorization submission process is the same for initial authorizations and for continuation of care requests.

Timely submissions

Untimely requests will be pended for retrospective review and medical records will be requested. Authorization requests can be submitted to Healthways up to ten (10) calendar days before the proposed start date of the authorization request; requests must be submitted no later than ten (10) calendar days after the start date to be considered timely.
When an authorization number is provided, it serves as a statement about medical necessity and appropriateness; **it is not a guarantee of payment**. Payment is dependent upon the member having coverage at the time the service is rendered and the type of coverage available under the member’s benefit plan. It is the provider’s responsibility to verify that the member’s benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering service.

Assessment tool

The [Patient-Specific Functional Scale (PSFS)](#) is a self-reported, patient-specific measure designed to assess functional change in patients presenting with musculoskeletal conditions and other types of disorders. The questionnaire should be completed at initial evaluations and again at patient re-assessment. It is administered by providers to assess the patient’s activity level. You will be asked to enter the patient’s most recent PSFS score when submitting an authorization request.*

The advantages of the PSFS include its wide applicability and ease of use clinically, both desirable attributes in an outcome measure tool. The PSFS tool and supporting documents are available on the [Physical Medicine Management Program](#) page on the Provider Resource Center (under Clinical Reference Materials).

* You may use an assessment tool of your choice; the PSFS is not required. If you choose to use another assessment, do not enter a value when requested to enter a PSFS score on an authorization request.

Before you begin…

Before using NaviNet to submit your authorization request, it is recommended that you complete the appropriate standardized template that outlines the required clinical and demographic information that will be requested: *

- [Preauthorization Request for Physical/Occupational Therapy](#)
- [Preauthorization Request for Manipulation Services](#)

Helpful instructions for completing the forms are also provided:

- [Preauthorization Request Instructions for Physical/Occupational Therapy](#)
- [Preauthorization Request Instructions for Manipulation Services](#)

Completing the applicable form in advance will enable you to quickly enter the information into NaviNet without having to search through the patient’s medical records to find the information you need.

* These forms and instructions are also available on the [Physical Medicine Management Program](#) page on the Provider Resource Center (under Clinical Reference Materials).

Continued on next page
CARE AUTHORIZATION PROCESS, Continued

NaviNet hours of availability

NaviNet has extended hours of system availability for all of your inquiry and transaction needs.

- Monday through Friday from 5 a.m. to 3 a.m.
- Saturday from 5 a.m. to 11 p.m.
- Sunday from 5 a.m. to 9 p.m.

NaviNet® authorization submission process

To submit an authorization request, sign into NaviNet using your NaviNet username and password, and then follow these steps:

1. Select Authorization Submission from the Highmark Plan Central menu, and then click on the applicable option on the fly-out menu based on your provider type:
   - Professionals: Click on Auth Submission on the fly-out menu.
   - Facilities: Click on Inpatient Auth Submission on the fly-out menu.

2. Complete the required fields on the NaviNet Selection Form as instructed in the table below, and then click Submit.

<table>
<thead>
<tr>
<th>Step</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Select the applicable provider from the dropdown options, and enter the proposed date of service (both fields are required). The proposed date of service is the start date for services related to this request (including any applicable evaluations). It is not the date the member was first seen at your office. <strong>Note:</strong> NaviNet can accept a proposed date of service up to ten (10) days in the past. If your proposed date of service is more than 10 days prior to the date you are submitting your request, enter the current date. You will be able to edit the start date later in the process.</td>
</tr>
<tr>
<td>Step 2</td>
<td>The Member ID alone will be accepted. If the Member ID is not used, you must enter all of the following: member’s first name, last name, and date of birth.</td>
</tr>
<tr>
<td>Step 3</td>
<td>• From the Category dropdown, select Physical Medicine.  • From the Service dropdown, select the applicable discipline: Physical Medicine, Occupational Therapy, or Spinal Manipulation.*</td>
</tr>
</tbody>
</table>

*Doctors of chiropractic should select Spinal Manipulation only.* Providers who provide both physical and occupational therapy can select both options if necessary – select one discipline and then click on the Add Category/Service button to enter the other (not applicable for PEBTF – separate registrations are required for physical medicine and occupational therapy for PEBTF). Doctors of osteopathy are not required to obtain a separate registration for manipulation treatment provided.

**Note:** If the member’s benefit plan does not require registration and authorization under the Physical Medicine Management Program, you will receive a message from NaviNet after you submit the Selection Form. The screen message will indicate that Healthways does not provide utilization management for the member.

Continued on next page
3. Complete only the required fields highlighted in yellow on the NaviNet Request Form. (Any information entered in the Comments boxes will not be used in this process.) And then click Submit.

   **Note:** NaviNet can accept a discipline start date up to ten (10) days in the past. If your start date of service is more than 10 days prior to the date you are submitting your request, enter the current date. You will be able to edit the start date on the next screen.

4. The request will be routed to Healthways’ Rapid Response System (RRS) for Care Authorization.

   **Note:** If our records show that the member has not reached the applicable visit threshold for the services, the system will automatically direct the submission to the Healthways’ Care Registry. (See the previous section in this guide, Care Registration Process.)

5. You will now complete the required information on the following four screens: Fax, Condition, Treatment Plan, and History tabs. Click on Next after completing each screen.

   **Note:** On the Fax tab, you will be able to select your office location (for providers with more than one physical location); edit the fax number on file with Healthways; and edit the start date for services. **If the requested start date is more than 10 days in the past, your authorization request will be pended for retrospective review which will require submission of clinical records.**

6. On the Summary tab, you will review the information you have entered that is populated in the Summary Review panel on the right side of the screen. You may make any necessary corrections on previous screens by clicking on the appropriate tab. Click on the Review Complete button to verify that the information is correct.

7. By clicking on Submit for Prescreening on the next screen you are submitting your request into Healthways’ RRS automated prescreening process where the information you have entered will be compared to clinical guidelines.

8. Once the automated prescreening process is complete, you will be notified immediately of the outcome. NaviNet will display one of the following Healthways’ responses: approval; opportunity to modify treatment plan to meet guidelines; or pended for clinical review. **Please see the next page for additional information about these responses.**

   Healthways will fax written notification to the provider’s office within approximately twenty (20) minutes of the NaviNet prescreening response.
CARE AUTHORIZATION PROCESS, Continued

For step-by-step instructions with screen prints of the submission process through NaviNet, please see Submitting Registrations/Authorizations Via NaviNet in the Appendix of this guide.

Special note about manipulation services
For doctors of chiropractic, care registration and authorization requests are submitted under the manipulation services category only. A separate registration or authorization is not required for any physical medicine procedures that may be performed in conjunction with the manipulation treatment. When selecting the “Service” on the NaviNet Selection Form, select “Spinal Manipulation” only.

Doctors of osteopathy may provide manipulation and/or physical medicine services; however, doctors of osteopathy are not required to obtain a separate registration for manipulation treatment provided.

Prescreening response: Approved
If the full number of requested visits is appropriate for automated approval, the provider will receive a response via NaviNet with the status “Approved.” The notification will indicate the approved number of visits and the date by which the plan of care is to be completed (see Appendix - Page 64).

The provider will also receive written notification of the decision outcome by fax from Healthways within twenty (20) minutes of the prescreening response.

Prescreening response: Modification option
If the NaviNet response advises that a modified number of visits can be approved through the automated prescreening process, the provider may elect to: 1) accept visits and modify the treatment plan prior to submission; or 2) send the request for review (see Appendix - Page 65).

- If the provider modifies the treatment plan to meet guidelines, Healthways will fax a notification to the provider with the approved number of visits and the date by which treatment is to be completed. (If it is determined that more visits are needed after the approved visits are completed, a new authorization request can be submitted for continuation of care.)
- If the provider wishes to have the pre-authorization request reviewed by a clinical peer reviewer, the request will be pended. Healthways will fax a bar-coded notification to the provider requesting medical records. The bar-coded form must be used as a cover sheet when faxing medical records to Healthways. Medical records must be submitted to Healthways within twelve (12) days of receipt of the request.

Continued on next page
Prescreening response: Pended

If a determination cannot be made in the automated prescreening process, the response via NaviNet will indicate the status as “Pended” with zero (0) visits approved (see Appendix – Page 66).

Healthways will fax a determination notice to the provider within twenty (20) minutes of the prescreening response with a request for medical records. The bar-coded form is specific to the patient and must be used as a cover sheet when faxing the medical records to Healthways. Medical records must be submitted to Healthways within twelve (12) days of receipt of the request.

For an example of a bar-coded form, please see Page 67 of the Appendix.

IMPORTANT! Check your fax settings

To assure timely receipt of Healthways’ notifications, please have your fax machine set to answer in no more than four (4) rings. Healthways’ system attempts to fax the provider notification a total of ten (10) times, waiting at least twelve (12) minutes between attempts. If all attempts to send the fax fail, the notification will be mailed to the provider.

Clinical review for pended requests

For requests that are pended following the automated prescreening process, Healthways will initiate the clinical review process once the requested medical records are received from the provider. Clinical reviews are completed within one (1) to two (2) business days of receipt of medical records.

Please see the next section of this guide, Clinical Review Process and Determinations, for more detailed information about the clinical review process and determinations.

If the NaviNet option is not available

NaviNet is the preferred method for submitting your authorization requests under the Physical Medicine Management Program. If you are not able to access NaviNet or the NaviNet Authorization Submission transaction, you may contact Healthways by calling your regional Highmark Delaware Provider Service telephone number.

- PA Western Region: 1-800-547-3627
- PA Central, Eastern, and Northeastern Regions: 1-866-731-8080

Please listen carefully to the available options to be directed to Healthways:

1. First, select Option 2 from the main menu options (“To request an authorization for an inpatient or outpatient service”).

Continued on next page
If the NaviNet option is not available (continued)

2. Next, you will be asked to select an option based on your provider type:
   • If you are a facility, select Option 1.
   • If you are a professional provider, select Option 2.
3. And then select Option 3 to speak with Healthways.

The standard business hours for the Provider Service phone lines are:
   • Monday through Friday 8:30 a.m. to 7 p.m.
   • Saturday and Sunday from 8:30 a.m. to 4:30 p.m.

Healthways’ availability

A Healthways’ clinical peer reviewer or Medical Director is available twenty-four (24) hours per day/seven (7) days per week. During the hours when NaviNet is not available, or outside the standard business hours for the Provider Service phone lines, providers may telephone Healthways at 1-866-656-6072.

NaviNet® authorization inquiries

Care authorizations for physical medicine services under the Physical Medicine Management Program will be available for viewing in NaviNet.

The Referral/Auth Inquiry function, accessed from the main menu (see red arrow below), is recommended for accessing all registration/authorization information for a particular member. It provides information for requests submitted through NaviNet and also by telephone. The Referral/Auth Inquiry is a real-time look at the information on file in Highmark’s database; the information available to providers here is the same information available to Highmark and Healthways staff. (Please note that there may be a slight delay between the submission to Healthways and the availability of the information in the Highmark database.)

The Referral/Auth Log, accessed through Office Central in the task bar, makes it easy to review what you have recently submitted in NaviNet. This function provides numerous search options and is most helpful in accessing incomplete authorizations saved prior to submission. It provides a summary of the original submission with minimal update.
RETROSPECTIVE REVIEW REQUESTS

Overview
Registrations and authorization requests for physical medicine services can be submitted to Healthways up to ten (10) 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.

If the requested start date for authorization requests is more than ten (10) days in the past, your request will be pended for retrospective review which will require submission of clinical records.

Submit retrospective review requests via NaviNet®
NaviNet® is the preferred method for submitting registration and authorization requests for the Physical Medicine Management Program. And with recent updates to the system, all of your requests can be submitted electronically via NaviNet, including those with start dates more than ten (10) days in the past that will require retrospective review.

Retrospective review requests are accepted with start dates up to 365 days prior to the date you are submitting the request. However, the start date can be no earlier than the program’s implementation date of September 1, 2012.*

* January 1, 2013, for Pennsylvania Employee Benefit Trust Fund (PEBTF) members.

Submission process for retrospective review
If the treatment start date is more than ten (10) days prior to the date you are submitting a request, you will follow the same submission process as for other requests. However, because neither the NaviNet Selection Form nor the Request Form will accept a treatment start date more than ten (10) days before the date you are submitting your request, you will need to edit the start date when you reach the Healthways screens.

- On the NaviNet Selection Form, enter the current date for the Proposed Date of Service.
- On the NaviNet Request Form, enter the current date for the Discipline Start Date.
- If your submission is directed to Care Registration, you can edit the start date on the Care Registration tab.
- If your submission is directed to the Healthways Rapid Response System (RRS) for Care Authorization, you can edit the start date on the Fax tab.

For step-by-step instructions with screen prints of the submission process through NaviNet, please see Submitting Registrations/Authorizations Via NaviNet in the Appendix of this guide.
CLINICAL REVIEW PROCESS AND DETERMINATIONS

Overview

If an authorization request submitted for services under the Physical Medicine Management Program is pended as a result of the prescreening process, additional clinical information must be submitted for medical necessity review. Clinical review determinations are made based on Healthways’ clinical care guidelines, Highmark’s definition of medical necessity, and the information presented for review.

IMPORTANT
Bar-coded cover sheet must be used

Healthways will fax written notification to the provider’s office within twenty (20) minutes of the prescreening response from NaviNet.® For pended requests, the provider will receive a bar-coded notification containing a 6-digit reference number and a request for medical records.

The barcode is unique to the patient and the current request; the bar-coded notice must be used as a cover sheet (placed on top of the medical records) and be the first page scanned by the fax. Fax the bar-coded cover sheet and medical records to Healthways at 1-888-492-1025.

Timely submission of medical records

Medical records must be submitted within twelve (12) calendar days of receipt of the request for medical records from Healthways. An untimely submission of medical records may result in denial of the request for pre-authorization.

Healthways clinical review staff

The Healthways physical medicine management process is supported by their skilled clinical and professional staff. Clinical reviews are managed by clinical managers, nurse review specialists, peer reviewers, physicians, and contracted clinical peer reviewers. All clinicians involved in utilization review are credentialed, receive ongoing training, and are regularly monitored for quality and performance.

The Healthways Clinical Oversight Committee (COC) oversees the utilization management process and staff. The COC may delegate projects and functions to the Clinical Peer Review Committee (CPRC) as necessary.

Continued on next page
Initial clinical reviews are performed by registered nurse reviewers for physical therapy and occupational therapy services when medical necessity criteria are met. If the nurse reviewer cannot approve a request, the requests are reviewed by a like-licensed peer reviewer. A physician will render a medical necessity determination if the peer reviewer is unable to approve the request based on Healthways’ guidelines and Highmark Medical Policy.

All authorization requests for manipulation services that cannot be approved during the prescreening process are reviewed by a doctor of chiropractic. As per Pennsylvania regulations, requests resulting in adverse medical necessity determinations are reviewed by a physician prior to rendering the adverse determination.

Authorization determinations will be made in compliance with regulatory guidelines. Once medical records have been received, clinical reviews are typically completed within the following time frames:

- Two (2) business days for initial requests
- One (1) business day for continuation of care requests
- Five (5) business days for retrospective requests

When considering an initial or continuation of care request for authorization of physical medicine services, the following data elements are evaluated by Healthways’ peer reviewers to ensure correlation to the presenting diagnosis and proposed plan of care:

- Chief complaint(s)
- Past medical history
- Mechanism of onset
- Duration of symptoms (acute or chronic)
- Severity of condition (mild, moderate, or severe)
- Examination findings
- Results of diagnostic testing
- Co-morbidities or complication factors (conditions or circumstances that may affect the patient’s response to care)
- Prior and/or concurrent history of treatment
- Prognosis and provider comments
- Changes in outcome assessment tools

Continued on next page
CLINICAL REVIEW PROCESS AND DETERMINATIONS, Continued

<table>
<thead>
<tr>
<th>Assessment of patient response</th>
<th>The patient’s response to treatment is assessed for clinically significant improvement as measured by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Clinical and functional improvement in a patient’s net health as reflected by a decrease in symptoms, positive correlation in reduction of objective findings, and an increase in function.</td>
</tr>
<tr>
<td></td>
<td>• Assessment questionnaire scores that indicate qualitative and/or quantifiable improvement in the patient’s ability to perform functional tasks and/or activities of daily living.</td>
</tr>
<tr>
<td></td>
<td>It is taken into consideration that the expected level of improvement, rate of change, and required duration and frequency of care vary by diagnosis in concert with the age of the patient, mechanism of onset, duration of condition, contributing past history, and the presence or absence of complicating factors.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial requests</th>
<th>Determinations for initial requests are dependent on the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The diagnosis should be substantiated by history, symptoms, and clinical information.</td>
</tr>
<tr>
<td></td>
<td>• The diagnosis should be for a condition which the provider of record can effectively treat based on scope of license.</td>
</tr>
<tr>
<td></td>
<td>• All body regions of treatment must coincide with a diagnosis established and supported within the clinical record.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continuation of care requests</th>
<th>When a provider determines that additional or continued treatment is indicated within an episode of care, the following criteria are reviewed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Initial and current symptoms as described by the patient including severity, frequency, and character;</td>
</tr>
<tr>
<td></td>
<td>• Examination and re-examination findings, results of diagnostic tests, daily office notes, and other objective data submitted by the provider;</td>
</tr>
<tr>
<td></td>
<td>• The complete initial and current diagnostic impression.</td>
</tr>
<tr>
<td></td>
<td>Determination of coverage for requested services is based on review of a member’s clinical improvement (i.e., response to care) following a course of treatment provided under an approved plan of care. A comprehensive review of the clinical outcomes specific to the condition for which services are requested is considered in making this decision.</td>
</tr>
</tbody>
</table>

Continued on next page
Maintenance care defined

Physical medicine services performed repetitively to maintain a level of function are not eligible for payment. A maintenance program consists of activities that preserve the patient’s present level of function and prevent regression of that function. These services generally would not involve complex physical medicine and rehabilitative procedures, nor would they require clinical judgment and skill for safety and effectiveness. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

Care management worksheet available

Healthways’ Physical Medicine Care Management Worksheet provides an overview of key care management components. Reviewing this information will help to develop an understanding and expectation of how information is to be used in the clinical review process. (This worksheet is also available on the Physical Medicine Management Program page on the Provider Resource Center.)

Review outcomes

One of three general outcomes can be expected from the peer review process: approved, modified, or denied.

- Approval (or “certification”): The request for authorization is approved as submitted or with an increase in total intensity (same treatment in a shorter time frame).
- Modification (or “partial approval”): The request is partially approved with a modification to the number of visits requested. The reviewer determined that the request exceeded a reasonable treatment plan based on the clinical condition and patient history.
- Denial (or “non-certification”): The request cannot be authorized based on Healthways’ clinical guidelines.

Continued on next page
CLINICAL REVIEW PROCESS AND DETERMINATIONS, Continued

Notification of decision

The requesting provider will receive prompt written notification from Healthways about the outcome of the clinical peer review process.

- If the requested care plan can be authorized, Healthways will fax a determination notice to the requesting provider.
- If the requested care plan can be partially authorized with a modification in the number of visits approved, Healthways sends an adverse determination* notice to the requesting provider indicating the number of visits that are approved and the time frame for treatment.
- If the requested care plan cannot be authorized, Healthways will fax an adverse determination notice to the requesting provider indicating denial.

* Regulations require modified approval plans to be categorized as denials or “adverse determinations.”

Healthways will also notify the member of the outcome of the clinical review.

The information that the requesting provider will receive from Healthways in the determination notice is listed in the table below:

<table>
<thead>
<tr>
<th>TYPE OF NOTICE</th>
<th>In the “Authorization Request Decision” field, the response will be listed as…</th>
<th>And “Visits” will be listed with…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval</td>
<td>Approval</td>
<td>Number of visits approved and the dates in which the visits must be completed.</td>
</tr>
<tr>
<td>Modification (partial approval)</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>Unable to Certify Decision</td>
<td>Field will be marked as “0” (zero) since no visits have been approved.</td>
</tr>
</tbody>
</table>

Options for reconsideration of an adverse determination

If a clinical peer review results in an adverse determination (modification or denial), the requesting provider has two options for reconsideration: peer-to-peer discussion and appeal. For additional information on these options, please see the section within this guide titled Reconsiderations and Appeals.
MEDICAL RECORDS DOCUMENTATION

Overview

When a provider is required to submit additional clinical information for peer review for physical medicine services, the submission should include medical records pertinent to the episode of care pertaining to the current authorization request.

Medical records submission

When requested, the medical records submission should include the current evaluation and treatment plan for the patient as well as office notes for any care in the past three to six months. This includes, but is not limited to, the following:

- Chief complaint(s)
- Patient’s case history
- Findings of all medical examinations performed
- Findings of special studies including, but not limited to, X-ray studies taken or reviewed
- Clinical impression (including rationale for changes in diagnosis)
- Treatment plan (including rationale for changes in duration or frequency)
- Informed consent or terms of acceptance
- Progress notes for each patient encounter in a Problem-Oriented Medical Record (POMR), or similar charting format – manually dated and signed by the provider who rendered the services. Electronic signatures will be accepted as long as the rendering provider is identifiable.
- Details of (and rationale for) supportive procedures or therapies when administered, dispensed, or prescribed
- Specific description of anatomical sites or regions of all treatment services
- Initial Patient-Specific Functional Scale (PSFS) score and any follow-up PSFS scores, if available

Interim narrative reports

In addition to clinical records, the submission may also include a medical record summary or an interim narrative report outlining the following: care rendered to date; diagnostic tests or referrals associated with the episode of care; the goals achieved; complications and compliance problems; expected outcomes of the care plan submitted; and the initial and any follow-up PSFS form(s).

This 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
- PSFS form(s)
- Initial and current objective findings
- Diagnostic test results (radiology, laboratory, neurology, vascular, etc.)

Continued on next page
**MEDICAL RECORDS DOCUMENTATION, Continued**

<table>
<thead>
<tr>
<th>Interim narrative reports (continued)</th>
<th>• Complete diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Discussion of any relevant complicating factors to case management</td>
</tr>
<tr>
<td></td>
<td>• Documentation of any exacerbation or re-injury summary of care plan to include identification of all services, procedures, and supply items</td>
</tr>
<tr>
<td></td>
<td>• Discussion of the patient’s progress to date</td>
</tr>
<tr>
<td></td>
<td>• An estimate of future care requirements</td>
</tr>
<tr>
<td></td>
<td>• A response to any specific questions asked by the Healthways utilization management clinician’s comments in making the request</td>
</tr>
</tbody>
</table>
CLAIM SUBMISSION AND REIMBURSEMENT

Overview
Highmark will process claims for services managed by Healthways under the Physical Medicine Management Program and providers will receive payment from Highmark for eligible services. Registration and prior authorization are requirements for reimbursement.

Claim submission
Highmark encourages electronic submission of claims via NaviNet® or the applicable HIPAA transactions. Providers will follow normal procedures for submission of claims for physical medicine services managed by Healthways.

Highmark's claims processing system does not require the provider to enter an authorization number when submitting a claim. Authorizations are entered in Highmark's systems and the claim is matched with the applicable authorization on file during processing.

If no authorization on file
Authorizations for services approved by Healthways are entered into Highmark's systems. An “authorization” is also entered for the registration (“auto-approval”) of the initial eight (8) visits in the calendar year.*

Any claims submitted for services performed without the required registration or authorization will be rejected with the following message: “The patient’s coverage required an authorization for the reported service. Since the appropriate managed care record was not on file, no payment can be made.” The member will be held harmless and will not be responsible for payment.

If a claim is denied because services were not registered or the required authorization was not obtained in a timely manner, an authorization request can be submitted for retrospective review; medical records will be required.

Note: Please see the Retrospective Review Requests section of this guide for direction on submitting requests via NaviNet for services with treatment start dates greater than ten (10) days in the past.

* Six (6) visits for Pennsylvania Employee Benefit Trust Fund (PEBTF) members.
CLAIM SUBMISSION AND REIMBURSEMENT, Continued

Medical necessity denials
If a claim is submitted for services for which Healthways denied authorization, the claim will reject for "Authorization denied."

The member will be held harmless and will not be responsible for payment. However, the member would be financially liable if an authorization was requested and denied, and then the member still chose to receive the service after being informed that it was not approved. The member must agree in writing to assume financial responsibility before receiving the service; and the signed agreement should be maintained in the provider’s records.

Claim denials for other reasons
If the claim has denied for reasons other than medical necessity or required authorization not on file, the provider should submit an inquiry via NaviNet.

Appeal rights
For any service that is not approved for payment, Highmark will offer all appropriate rights of appeal.
RECONSIDERATIONS AND APPEALS

Overview

If clinical peer review results in an adverse determination, Healthways offers two options for reconsideration: peer-to-peer discussion and appeal. These are administered by Healthways with communication of outcome to both the provider and the member.

Member appeals of adverse determinations are administered by Highmark. Healthways coordinates with Highmark in administering the external appeals process as required by state and federal regulations.

Time frame

Requests for reconsideration, peer-to-peer discussions or appeals, must be filed within one hundred eighty (180) days from receipt of an adverse determination.

Peer-to-peer discussions

If you receive an adverse determination (modification* or denial), you may discuss the outcome of the clinical review with the Healthways’ clinical peer reviewer who made the initial determination (or with another peer reviewer skilled in the applicable discipline if the original reviewer cannot be available).

To request a peer-to-peer discussion, please complete the Utilization Management (UM) Department Request Form - Highmark and fax to Healthways’ Appeals & Grievance Unit at 1-888-492-1029.

A reviewer will be available to discuss the case within one (1) business day of receipt of the request. The Healthways peer reviewer will attempt to accommodate the best days and times you indicate on the form. The requesting provider and the member will be notified of the outcome.

The possible outcomes from the peer-to-peer discussion are as follows:

- Approved: A determination notice indicating the outcome of the discussion is faxed to the provider.
- Modified: Your request is modified either for the same or for a different reason and you will receive a determination notice indicating the outcome. At this point, you will have the option of requesting an appeal which will be outlined in the letter.
- Denied: You will receive a determination notice indicating that the request has been denied either for the same or for a different reason. The appeal option is also available following this determination.

* Regulations require modified approval plans to be categorized as denials or “adverse determinations.”

Continued on next page
If you disagree with a clinical review outcome or receive an adverse determination following a peer-to-peer discussion, you have the right to appeal the medical necessity determination. The review will be completed by a Healthways reviewer who was not involved in the initial review and determination. You may provide additional information to support your request. Healthways will send notification of the decision to both the provider and the member.

To request an appeal, please complete the [Utilization Management (UM) Department Request Form - Highmark](#) and fax to Healthways’ Appeals & Grievance Unit at 1-888-492-1029.

As per Pennsylvania regulations, reconsideration and appeal reviews of adverse determinations for physical therapy, occupational therapy, and manipulation services will be reviewed by a physician prior to the rendering of a decision.

Clinical appeals are reviewed within thirty (30) calendar days of receipt of all necessary information. Healthways acknowledges receipt of the appeal by phone or in writing within fifteen (15) calendar days of receiving a request for a clinical appeal if the appeal determination has not been made by that time.

Healthways also maintains a process for expedited (fast-track) appeals, if the patient’s condition warrants, which are typically handled within one (1) business day and in no case more than seventy-two (72) hours.

The possible outcomes of a formal appeal include:

- Approved: A determination notice indicating the outcome is faxed to the provider.
- Modified: Your request is modified either for the same or for a different reason and you will receive a determination notice indicating the outcome. At this point, your reconsideration rights through Healthways are exhausted; however, the member has the right to appeal. Highmark retains responsibility for the member appeal process.
- Denied: You will receive a determination notice indicating that the request has been denied either for the same or for a different reason. At this point, your reconsideration rights through Healthways are exhausted; however, the member has the right to appeal through Highmark.

Healthways coordinates with Highmark in administering the external appeals process as required by state and federal regulations.
RECONSIDERATIONS AND APPEALS, Continued

**Member appeals**

The member’s appeal rights are communicated in the notice they receive advising of an adverse determination (modifications or denials). Member appeals of adverse determinations are administered by Highmark.
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®

Introduction

NaviNet® makes it easy to register and request authorizations for members in the Physical Medicine Management Program. The workflow in NaviNet is the same for both registration and authorization submissions.

And there is no need to try to determine whether registration or authorization is needed -- the system will automatically route your submission. If the patient has not yet been registered for the current calendar year, your request will be directed to the Healthways Care Registry. If the patient has already reached the eight (8) visit threshold (six [6] visits for PEBTF) for the services requested in the current calendar year, your request will be automatically routed to Healthways’ Rapid Response System (RRS) for Care Authorization.

Before you begin...

Before beginning the NaviNet submission process, please be sure to verify the member’s coverage through NaviNet’s Eligibility and Benefits Inquiry. (For more information on eligibility and benefit verification, please see the section of this guide titled Verification and Application of Benefits.)

For registration submissions, minimal information will be requested. Please have the following information readily available to enter for member registration:

- Patient name and Member ID
- Type of care (physical therapy, occupational therapy, or manipulation)
- Start date for the services related to this request
- Primary diagnosis code (up to two additional codes can be entered)
- Number of visits you are requesting for services for this episode of care
- Name and phone number of the person at your office who can be contacted about this request

The system will automatically direct your submission to the authorization process if our records show that the member has reached the eight (8) visit threshold (six [6] visits for PEBTF members) for the services in the current calendar year. If you anticipate that authorization may be required, it is recommended that you complete and have available the appropriate Healthways form that outlines the required clinical and demographic information that will be requested for authorizations:

- Preauthorization Request for Physical/Occupational Therapy
- Preauthorization Request for Manipulation Services

Continued on next page
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

Before you begin…

Completing the applicable form in advance will enable you to quickly enter the information into NaviNet. These forms, along with helpful instructions, are also available on in the Healthways Forms for Physical Medicine Management section of this guide.

A word about pop-up blockers…

A pop-up is a graphical display area, usually a small window, which suddenly appears ("pops up"). It is initiated by a single or double mouse click or rollover. A pop-up blocker is a program that prevents pop-ups from displaying in a user’s Web browser. Pop-up blockers work in a number of ways – some disable the command that calls the pop-up and some close the window before it appears.

Because pop-up windows must be enabled to use many online services, you may have to turn off your pop-up blocker or adjust your pop-up settings to allow pop-ups from specific websites.

To avoid issues that could occur when submitting registration/authorization requests for physical medicine services, we recommend you disable your pop-up blocker or adjust your pop-up blocker settings to allow pop-ups from NaviNet. This setting is commonly found under Tools, Internet Options, and the Privacy tab in your Internet browser.

To allow pop-ups from NaviNet, add the following address (URL) to your list of websites that you want to see pop-ups from:

https://navinet.navimedix.com/Main.aspx

Please contact your Information Technology (IT) department or your office’s IT support staff for assistance in adding the URL to the Privacy tab.

And also a word about fax machine settings…

For authorization submissions, Healthways will fax notification of the prescreening outcome to your office. To assure timely receipt of the notifications, please have your fax machine set to answer in no more than four (4) rings. Healthways’ system attempts to fax the provider notification a total of ten (10) times, waiting at least twelve (12) minutes between attempts. If all attempts to send the fax fail, the notification will be mailed to the provider.

Now that you are ready…

Step-by-step instructions for submitting your registration/authorization requests for physical medicine services in NaviNet begins on the next page.
IMPORTANT! The workflow in NaviNet is the same whether the member requires registration or authorization. You will use the Authorization Submission transaction in NaviNet and complete the NaviNet Selection Form and the NaviNet Request Form. Based on the member’s history, the system will then automatically route your request to either the Healthways Care Registry or through the Healthways Rapid Response System (RRS) for Care Authorization.

You will begin your submission by signing into NaviNet using your NaviNet username and password. On Highmark’s Plan Central, hover over Authorization Submission in the main menu on the left to display the options on the fly-out menu (see below). You will then click on the applicable option on the fly-out menu based on your provider type:

- **Professionals:** Click on Auth Submission.
- **Facilities:** Click on Inpatient Auth Submission.

**APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued**
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

You will complete the NaviNet Selection Form by entering the required information.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Select the applicable provider from the dropdown options, and enter the proposed date of service (both fields are required). The proposed date of service is the start date for services related to this request (including any applicable evaluations). It is not the date the member was first seen in your office.</td>
</tr>
<tr>
<td>Step 2</td>
<td>The Member ID alone will be accepted. If the Member ID is not used, you must enter all of the following: member’s first name, last name, and date of birth.</td>
</tr>
</tbody>
</table>
| Step 3 | • From the Category dropdown, select Physical Medicine.  
• From the Service dropdown, select the applicable discipline – Physical Medicine, Occupational Therapy, or Spinal Manipulation.*  
\* Doctors of chiropractic should select Spinal Manipulation only. Providers who provide both physical and occupational therapy can select both options if necessary – select one discipline and then click on the Add Category/Service button to enter the other (not applicable to PEBTF – separate registrations are required for physical medicine and occupational therapy for PEBTF). Although doctors of osteopathy may provide manipulation and/or physical medicine procedures, care registrations and authorizations are obtained only under the physical/occupational therapy category; spinal manipulation should not be selected. |

Note: If a member’s plan does not require registration and authorization, you will receive a message from NaviNet after you submit the Selection Form. The screen message will indicate that Healthways does not provide utilization management for the member.

Note: This image is an example and may not appear exactly as shown based on your provider type; however, the steps and information requested will be the same.

IMPORTANT! NaviNet will accept a Proposed Date of Service that is up to 10 days in the past. If your proposed date of service is more than 10 days in the past, enter the current date here and you will be able to edit the Start Date later in the process.

Note: If a member’s plan does not require registration and authorization, you will receive a message from NaviNet after you submit the Selection Form. The screen message will indicate that Healthways does not provide utilization management for the member.

* Doctors of chiropractic should select Spinal Manipulation only. Providers who provide both physical and occupational therapy can select both options if necessary – select one discipline and then click on the Add Category/Service button to enter the other (does not apply for PEBTF members).
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

NaviNet® Request Form

Enter the required information on the NaviNet Request Form. You must use the scroll bar to view the entire Request Form. Note: This image is an example and may not appear exactly as shown based on your provider type and the services being requested.

IMPORTANT! Complete only the required fields highlighted in yellow. It is not necessary to enter information in the Comments text boxes – information entered in those fields is not used in this process for physical medicine services.

- Once the information is entered, click Submit (see red arrow below).
- The system will now automatically route your request through either the Healthways Care Registry or to the Healthways RRS for Care Authorization (see next page).

Use the scroll bar to view the entire page.

IMPORTANT! Be sure to enter the name and phone number for the person at your office who should be contacted about this request.

Please enter the primary diagnosis in this box. Click on the Add Diagnosis Code button to enter up to two additional codes.

- The Discipline Start Date is the date services related to this request are expected to begin for this discipline. And it is included in the total Number of Visits you are requesting for this discipline.
- If you are requesting services for one discipline, the Discipline Start Date is the same as the Proposed Date of Service on the Selection Form.
- If you chose two disciplines (e.g., PT and OT), the discipline start date for each may be different but one should match the Proposed Date of Service.

IMPORTANT! NaviNet will accept a Discipline Start Date that is up to 10 days in the past. If your start date for services is more than 10 days in the past, enter the current date here and you will be able to edit the Start Date later in the process.

Select applicable address from dropdown options.

Continued on next page
The system determines the next step…

Once you submit the NaviNet Request Form, the system automatically routes your request through either the Healthways Care Registry or to the Healthways Rapid Response System (RRS) for Care Authorization.

Registration pathway – Care Registration tab

If you receive the screen below with the “Care Registration” tab (see red arrow below), the member has not yet reached the visit threshold for the services requested and your submission has been entered into Healthways Care Registry.

- You may edit the start date on this screen if the NaviNet Selection Form and Request Form could not accept the start date for the requested services (if the start date is more than ten [10] days in the past).*
- You must click the Next button.
- You will then receive a Response Form confirming your registration and providing an authorization number for the “auto-approved” visits (see next page).
- Your submission will be available for viewing immediately in the NaviNet Referral/Auth Log and will be available promptly in the Referral/Auth Inquiry.

IMPORTANT! If you did not receive the screen below after submitting the NaviNet Request Form and received instead a screen with a “Fax” tab, authorization will be required. Please proceed to Page 56 of this guide for information to assist you in continuing your submission through the Care Authorization pathway.

* Retrospective submissions are accepted with start dates up to 365 days prior to the date you are submitting the request, but no earlier than September 1, 2012 (the program’s implementation date). The start date for services for PEBTF members can be no earlier than January 1, 2013.
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

Registration pathway – Response Form

The Response Form* is your confirmation that the member has been registered with Healthways and the requested visits have been “auto-approved.” An authorization number is provided. The registration submission is now complete.

* The Response Form may vary slightly from what appears here depending on your browser.

Note: If our records show that a registration is not on file or the member has not had visits for the requested services, 8 visits will be automatically approved (6 visits for PEBTF members) even if your request is for less than 8 visits (or 6 visits for PEBTF).

Continued on next page
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

Authorization pathway

If you see a screen with a Fax tab after submitting the NaviNet Request Form (see red arrow below), your submission has been routed to the Healthways Rapid Response System (RRS) for Care Authorization. The member has reached the visit threshold for the services you are requesting and authorization is required.

You will enter information on four tabs: Fax, Condition, Treatment Plan, and History. The information entered will populate in the Summary Preview panel on the right side of the screen.

Authorization pathway – Fax tab

For providers with more than one physical location where services are provided, you will first select your office location on the Fax tab. This step will ensure that the documents faxed by Healthways are directed to the correct location.

IMPORTANT! Select your office location from the options available in the dropdown.

Continued on next page
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

Authorization pathway – Fax tab (continued)

On the Fax tab, you are also able to edit the start date for services related to this request and your fax number.

- **The NaviNet Selection and Request Forms allow entry of a start date up to ten (10) days prior to the date you are submitting the request.** If you are submitting a request for services with a start date more than ten (10) days in the past, you can change the start date by editing the date on this Healthways’ screen.

  **Note:** Retrospective submissions are accepted with start dates up to 365 days prior to the date you are submitting the request, but no earlier than the program’s implementation date of September 1, 2012. (The start date for services for PEBTF members can be no earlier than January 1, 2013.)

- **If the fax number populated on this screen is not the correct number for your office location,** enter the correct fax number and then click on the **ENTER/EDIT FAX & CLICK TO UPDATE** bar to update. This is the fax number that Healthways will use to fax written notification to the provider’s office following the NaviNet prescreening response and for additional communication as needed. Please make certain that the fax number is accurate.

- After making any necessary edits on the Fax tab, click on **Next**. You will be directed to the “Welcome to Healthways” screen (see next page).

**IMPORTANT!** If you enter a start date more than 10 days in the past, you will receive the following message:

*If the requested start date is more than 10 days in the past, your authorization request will be pended for retrospective review which will require submission of clinical records.*
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

Authorization pathway – Welcome to Healthways

After you click Next on the Fax tab, the screen below will appear which says Welcome to the Healthways pre-authorization system.

• You must click the Next button.
• The system will advance to the Condition tab (see next page).

Continued on next page
AUTHORIZATION pathway – Condition tab

On the **Condition tab**, you will be asked questions about the patient’s condition.

- Answer all questions.
- And then click **Next**.
- The submission will advance to the **Treatment Plan** tab (see next page).

 Helpful tips are available by clicking on this symbol for each question.

**Note:** This image of the Condition tab is an example and may not appear exactly as shown. The questions on this tab may vary based on the services being requested.
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

Authorization pathway – Treatment Plan tab

On the Treatment Plan tab, you will be asked questions about the patient’s diagnosis and the proposed treatment.

- Answer all questions.
- And then click Next.
- The submission will advance to the History tab (see next page).

Helpful tips are available by clicking on this symbol for each question.

Special Note about the Patient Specific Functional Scale:
The Patient Specific Functional Scale (PSFS) is a tool used by physical medicine providers to assess patient outcomes. The most recent PSFS score is requested when authorization requests are submitted for physical therapy, occupational therapy, and manipulation services. If a PSFS score is not available, you may leave the field blank.

Note: This image of the Treatment Plan tab is an example and may not appear exactly as shown. The questions on this tab may vary based on the services being requested.

Continued on next page
Authorization pathway – History tab

On the **History tab**, you will be asked questions about the patient’s medical history.

- Answer all questions.
- And then click **Next**.
- The submission will advance to the **Summary tab** (see next page).

Helpful tips are available by clicking on this symbol for each question.

**Note:** This image of the Treatment Plan tab is an example and may not appear exactly as shown. The questions on this tab may vary based on the services being requested.
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

Authorization pathway – Summary tab

On the **Summary tab**, you will review the information in the **Summary Review** panel on the right side of the screen.

- Corrections can be made on previous screens by clicking on the appropriate tab – Condition, Treatment Plan, and/or History.
- Click on the **Review Complete** button to verify that you have reviewed the information and that it is correct.
- The submission will advance to a screen indicating that “Your Review is Complete” (see next page).
APPENDIX: SUBMITTING REGISTRATIONS/AUTHORIZATIONS VIA NAVINET®, Continued

Authorization pathway – Submission

By clicking on Submit For Prescreening (see image below), you are submitting your request into the Healthways RRS prescreening process where the information you have entered will be compared to clinical guidelines.

Prescreening outcome notification

You will receive an immediate response from NaviNet indicating the outcome of the prescreening process. There are three possible responses:

- Approved;
- Opportunity to modify treatment plan to meet guidelines; or
- Pended.

In the next section of this guide, Prescreening Outcome Responses, examples of the prescreening outcome responses that you will receive from NaviNet are provided. (Please see the next page.)
APPENDIX: PRESCREENING OUTCOME RESPONSES

Overview
Once the Healthways prescreening process is complete, you will receive one of three responses from NaviNet:
- Approved;
- Opportunity to modify treatment plan to meet guidelines; or
- Pended.

Approved
If your request is approved through the prescreening process, you will receive a response via NaviNet that indicates the number of visits approved and the time frame for completion of the approved plan of care.

You will also receive a determination notice from Healthways by fax within approximately twenty (20) minutes of the prescreening response.

Note: This image provides an example of the location of the “Approved” status and the “Authorization Number” at the top of the form. Information will be populated in all necessary fields on the actual responses that you will receive.

Continued on next page
APPENDIX: PRESCREENING OUTCOME RESPONSES, Continued

Modified

If the full number of visits initially entered cannot be approved through the prescreening process, you may receive the response below indicating how many visits can be approved within the guidelines. Prior to completion of the process, you may elect to “Accept Visits Allowed Per Guidelines” to modify your treatment plan to meet guidelines, or select “Send To Review.”

- If Accept Visits Allowed Per Guidelines is selected, Healthways will fax a notification to the provider with the approved number of visits and the date by which treatment is to be completed. (If it is determined that more visits are needed after the approved visits are completed, a new authorization request can be submitted for continuation of care.)
- If Send To Review is selected, the request will be pended. Healthways will fax a bar-coded notification to the provider requesting medical records. The bar-coded form must be used as a cover sheet when faxing medical records to Healthways. Medical records must be submitted to Healthways within twelve (12) days of receipt of the request.

Note: This image is an example and may not appear exactly as shown.
APPENDIX: PRESCREENING OUTCOME RESPONSES, Continued

Pended

If a determination cannot be made in the automated prescreening process, the request will be pended for clinical review. Healthways will fax a determination notice to you within approximately twenty (20) minutes of the prescreening response with a request for medical records.

The bar-coded notification form that you receive is specific to the patient and must be used as a cover sheet when faxing the medical records to Healthways. The medical records must be faxed to Healthways within twelve (12) days of the request to be considered timely.

**Note:** This image provides an example of the location of the “Pended” status at the top of the form. Information will be populated in all necessary fields on the actual responses that you will receive.
APPENDIX: SAMPLE BAR-CODED NOTIFICATION/COVER SHEET

Bar-coded cover sheet must be used when faxing medical records

Following the Healthways Rapid Response System (RRS) prescreening process, a determination notification is faxed to the requesting provider. Healthways uses barcode technology that securely links the member’s medical records to the electronic file.

If an authorization request is pended for clinical peer review, the bar-coded notification must be used as the cover sheet when faxing the requested medical records to Healthways.

Note: This image is an example and may not appear exactly as shown.
APPENDIX: NAVINET® AUTHORIZATION INQUIRIES

NaviNet® Referral/Auth Inquiry and Referral/Auth Log

Your registration and authorization submissions for services under the Physical Medicine Management Program will be available for viewing in NaviNet.

The **Referral/Auth Inquiry** function, accessed from the main menu (see red arrow below), is recommended for accessing all registration/authorization information for a particular member. It provides information for requests submitted through NaviNet and also by telephone. The **Referral/Auth Inquiry** is a real-time look at the information on file in Highmark’s database; the information available to providers here is the same information available to Highmark and Healthways staff. *(Please note that there may be a slight delay between the submission to Healthways and the availability of the information in the Highmark database.)*

The **Referral/Auth Log**, accessed through **Office Central** in the task bar, makes it easy to review what you have recently submitted in NaviNet. This function provides numerous search options and is most helpful in accessing incomplete authorizations saved prior to submission. It provides a summary of the original submission with minimal update.
APPENDIX: HEALTHWAYS CLINICAL REFERENCE SOURCES

Overview

When providers submit their authorization requests for physical medicine services via NaviNet®, the proposed treatment plan is routed through Healthways’ Rapid Response System (RRS) and processed along specific clinical decision support pathways. A member’s unique case history is assessed for severity of condition or injury, potential clinical red flags, complicating factors, co-morbidities, and cross-referenced with treatment protocols for specific conditions.

Healthways utilizes multiple sources of nationally accepted, evidence-based treatment guidelines in addition to ongoing analysis of their own large database of historical claims and treatment authorizations to develop their clinical decision support pathways and protocols. The program’s clinical guidelines and protocols are continually reviewed and updated annually by Healthways’ Clinical Oversight Committee to reflect best practice clinical outcomes and industry standards.

Resource examples

Healthways’ clinical reference sources include, but are not limited to, the following:

- Official Disability Guidelines (ODG), Work Loss Data Institute, LLC, 2013
- Apollo Managed Care Guidelines, Physical/Occupational/Speech Therapy and Rehabilitation Care, 8th Edition
- Centers for Medicare & Medicaid Services (CMS): Outpatient Physical and Occupational Therapy Services (L26884)
- Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society
- Institute for Clinical Systems Improvement (ICSI) Health Care Guideline for Adult Low Back Pain, 13th Edition
- Clinical Practice Guidelines linked to the International Classification of Functioning, Disability, and Health from the Orthopaedic Section of the American Physical Therapy Association
- Chiropractic management of low back pain and low back-related leg complaints: a literature synthesis; Journal of Manipulative Physical Therapy, November/December 2008

For additional sources

For a more extensive list of clinical reference sources utilized in Healthways RRS and clinical reviews, please refer to the Physical Medicine Management Program page on the Highmark Provider Resource Center (under Clinical Reference Materials).
The procedure codes listed below require registration and/or authorization under the Physical Therapy Management Program. **Please Note:** Effective January 1, 2013, physical/occupational therapy evaluations and re-evaluations (97001-97004) do not require registration and authorization.

**IMPORTANT!** Registration and authorization requirements for participating Pennsylvania Employee Benefit Trust Fund (PEBTF) members are not limited to the list of procedure codes applicable under the Physical Medicine Management Program. Additional physical medicine, occupational therapy, and manipulation services will require care registration and/or authorization for PEBTF members, as per the PEBTF benefit plan. However, PEBTF will follow the program’s guidelines for physical/occupational therapy evaluations and re-evaluations.

For questions concerning services requiring authorization under the PEBTF benefit plan, please contact Highmark’s Provider Services to speak to a customer service representative. (For contact information, please see the Verification and Application of Benefits section of this guide.)

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>97010</td>
<td>Application of a modality to one (1) or more areas; hot or cold packs</td>
</tr>
<tr>
<td>97012</td>
<td>Application of a modality to one (1) or more areas; traction, mechanical</td>
</tr>
<tr>
<td>97014</td>
<td>Application of a modality to one (1) or more areas; electrical stimulation (unattended)</td>
</tr>
<tr>
<td>97016</td>
<td>Application of a modality to one (1) or more areas; vasopneumatic devices</td>
</tr>
<tr>
<td>97018</td>
<td>Application of a modality to one (1) or more areas; paraffin bath</td>
</tr>
<tr>
<td>97022</td>
<td>Application of a modality to one (1) or more areas; whirlpool</td>
</tr>
<tr>
<td>97024</td>
<td>Application of a modality to one (1) or more areas; diathermy (e.g., microwave)</td>
</tr>
<tr>
<td>97026</td>
<td>Application of a modality to one (1) or more areas; infrared</td>
</tr>
<tr>
<td>97028</td>
<td>Application of a modality to one (1) or more areas; ultraviolet</td>
</tr>
<tr>
<td>97032</td>
<td>Application of a modality to one (1) or more areas; electrical stimulation (manual), each 15 minutes</td>
</tr>
<tr>
<td>97033</td>
<td>Application of a modality to one (1) or more areas; iontophoresis, each 15 minutes</td>
</tr>
<tr>
<td>97034</td>
<td>Application of a modality to one (1) or more areas; contrast baths, each 15 minutes</td>
</tr>
<tr>
<td>97035</td>
<td>Application of a modality to one (1) or more areas; ultrasound, each 15 minutes</td>
</tr>
<tr>
<td>97036</td>
<td>Application of a modality to one (1) or more areas; hubbard tank, each 15 minutes</td>
</tr>
<tr>
<td>97110</td>
<td>Therapeutic procedure, one (1) or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility</td>
</tr>
<tr>
<td>97112</td>
<td>Therapeutic procedure, one (1) or more areas, each fifteen minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities</td>
</tr>
<tr>
<td>97113</td>
<td>Therapeutic procedure, one (1) or more areas, each 15 minutes; aquatic therapy with therapeutic exercises</td>
</tr>
</tbody>
</table>

*Continued on next page*
<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>97116</td>
<td>Therapeutic procedure, one (1) or more areas, each 15 minutes; gait training (includes stair climbing)</td>
</tr>
<tr>
<td>97124</td>
<td>Therapeutic procedure, one (1) or more areas, each 15 minutes; massage including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy techniques, (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one (1) or more regions, each 15 minutes</td>
</tr>
<tr>
<td>97150</td>
<td>Therapeutic procedure(s), group (two [2] or more individuals)</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes</td>
</tr>
<tr>
<td>97532</td>
<td>Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes</td>
</tr>
<tr>
<td>97533</td>
<td>Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by provider, each 15 minutes</td>
</tr>
<tr>
<td>97535</td>
<td>Self-care/home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes</td>
</tr>
<tr>
<td>97542</td>
<td>Wheelchair management (e.g., assessment, fitting, training), each 15 minutes</td>
</tr>
<tr>
<td>97750</td>
<td>Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes</td>
</tr>
<tr>
<td>97755</td>
<td>Assistive technology assessment (e.g., to restore, augment, or compensate for existing function, optimize functional tasks, and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes</td>
</tr>
<tr>
<td>98925</td>
<td>Osteopathic manipulative treatment (OMT); one (1) to two (2) body regions involved</td>
</tr>
<tr>
<td>98926</td>
<td>Osteopathic manipulative treatment (OMT); three (3) to four (4) body regions involved</td>
</tr>
<tr>
<td>98927</td>
<td>Osteopathic manipulative treatment (OMT); five (5) to six (6) body regions involved</td>
</tr>
<tr>
<td>98928</td>
<td>Osteopathic manipulative treatment (OMT); seven (7) to eight (8) body regions involved</td>
</tr>
<tr>
<td>98929</td>
<td>Osteopathic manipulative treatment (OMT); nine (9) to ten (10) body regions involved</td>
</tr>
<tr>
<td>98940</td>
<td>Chiropractic manipulative treatment (CMT); spinal, one (1) to two (2) regions</td>
</tr>
<tr>
<td>98941</td>
<td>Chiropractic manipulative treatment (CMT); spinal, three (3) to four (4) regions</td>
</tr>
<tr>
<td>98942</td>
<td>Chiropractic manipulative treatment (CMT); spinal, five (5) regions</td>
</tr>
<tr>
<td>98943</td>
<td>Chiropractic manipulative treatment (CMT); extraspinal, one (1) or more regions</td>
</tr>
</tbody>
</table>
Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Shield, the Shield symbol, Direct Blue, BlueCard, and the Federal Employee Program are registered service marks of the Blue Cross and Blue Shield Association. Freedom Blue, PPO Blue, and EPO Blue are service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

Healthways WholeHealth Networks, Inc. is an independent company that provides physical medicine management services.

NaviNet, Inc. and Healthways are solely responsible for the products and services they provide and that are referenced in this administrative guide.

© 2012-2014 Highmark Inc. All rights reserved.