MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

# Chiropractic Services Authorization Program Guide

tivity HEALTH

January 2022

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*BCBSMA refers to Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross and Blue Shield of Massachusetts HMO Blue®, Inc., and/or Massachusetts Benefit Administrators, LLC, based on Product participation.

# Introduction

This guide can help you with the authorization process for chiropractic services.

## Authorization Program Overview

WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, administers the authorization program for chiropractors on behalf of Blue Cross Blue Shield of Massachusetts. The program requires treating chiropractors to:

- Request authorization of chiropractic services for visits beyond 12 per calendar year for members enrolled in the affected health plans.
    - The member's initial 12 visits within each calendar year will not require prior authorization.
    - If additional treatment (beyond the initial 12 visits) is anticipated, prior authorization is necessary and should be submitted at the 13th visit. Authorization requests should be submitted to WHN within 10 days of evaluating your patient for such additional care. Authorization for treatment will be based on Blue Cross Blue Shield of Massachusetts standards for medical necessity and is a requirement for reimbursement.

Chiropractors who perform services without a prior authorization (for visits beyond 12) may experience claim denials. You can only bill the member for these services if you had the member complete the *Non-covered Service Waiver Form* (or any other standard waiver form that your office uses) and if Blue Cross Blue Shield of Massachusetts does not allow payment for these services.

You do not need an authorization for the member's first 12 visits within a calendar year and should submit claims according to your standard practice for these visits.

## Blue Cross Blue Shield of Massachusetts Health Plans Affected

Refer to our Chiropractic Services page for information on members who are subject to the authorization process. *However, we recommend using this information only as a guide.* Because plans and member benefits may vary, we remind you to check member benefits and eligibility using Blue Cross technologies before rendering services. These technologies will indicate whether or not the member is required to undergo the authorization process.

# The Authorization Program

## The Process in Two Steps

### *Step One: Checking Benefits & Eligibility*

Be sure to check benefits and eligibility for all of your Blue Cross Blue Shield of Massachusetts members. Taking this step will help you to better understand whether the member requires authorization for chiropractic services. Please note that members who reside in Rhode Island are not included in the program.

### *Step Two: Authorization*

If, leading up to or during visit number 12, you determine that the patient will require additional treatment (visits 13+), you will need to complete the Patient Specific Functional Scale (PSFS) with your patient. This questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopaedic condition. Calculate their scores and maintain a copy for your patient files. You will be able to enter this information into the Rapid Response System (RRS) for the authorization request. If the member refuses to respond to the PSFS, you may leave this question blank when entering responses into the RRS. It is also recommended that you complete the PSFS with the member at their first visit within the calendar year to help establish a baseline for care. If you choose to use a different outcomes measurement tool, please maintain the results in the patient's medical record.

Before using the telephone or web-based RRS to submit your authorization request, complete the standardized template (*Chiropractic Care Plan Authorization Request Form*) that outlines the required clinical and demographic information you will need to enter. Filling it out in advance will enable you or your office staff to quickly submit the information into the RRS without having to search through the patient's medical record to find the information you need.

> Please track the number of visits the member has received from *any and all* chiropractors within the calendar year period. Visits 13+ require authorization.

Next, use the RRS to request additional visits for your patient. Again, this will be for visits 13+. Prior authorization is a requirement for reimbursement. For authorization requests that may occur throughout the remainder of the calendar year, please be sure to submit your request to WHN via the RRS within the time frame recommended (within seven (7) days of evaluating your patient's need for additional care).

For a copy of the *Chiropractic Care Plan Authorization Request Form*, plus instructions for using WHN's RRS for entering authorizations, refer to the Appendix.

#### About the Patient Specific Functional Scale

During the member's first visit within the calendar year, it is recommended that you complete the Patient Specific Functional Scale with your patient, our member. This serves as a baseline and will help you to chart the member's progress with their treatment plan. Please keep a copy of the tool in the patient's record. You can find a copy of the Patient Specific Functional Scale in the Appendix of this guide.

#### Description of the Rapid Response System (RRS)

To submit pre-authorization requests, you will use WHN's Rapid Response System (RRS). This is a telephone or web-based tool. By automating the authorization request process (which minimizes office paperwork), WHN expects to shorten the response time needed to initiate care and provide consistent decisions that are applied independent of any other factor.

## RRS Authorization Responses

Once the information is received, the RRS will process the data based on the patient's history and any prior treatment and, based on the treatment plan submitted and the patient's condition, the prescreening system may approve a **trial of care** over a three-to six-week period. The authorization approval is based on clinical situations that fall within WHN's national practice guidelines for the practitioners delivering the service.

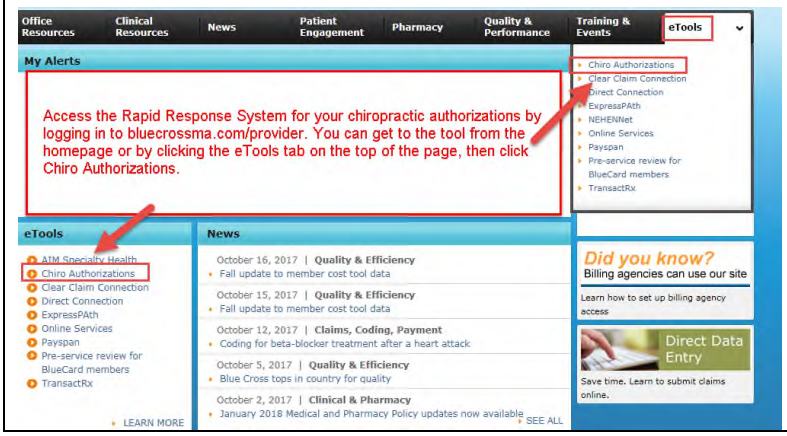
If, however, the system is unable to provide you with an immediate response, you will be directed to submit additional information for peer review. These referrals are **not** denials. Rather, referrals for clinical review indicate that these cases will require a professionally appropriate clinical peer to review the treatment plan. In such cases, the practitioner must submit clinical records supporting the specific authorization request that are sufficient for the reviewer to understand the nature and necessity of the care being proposed.

WHN's guidelines recognize that therapeutic continuing care may extend for up to three or more months and when additional care is approved, it typically will be for a one-month interval (approximately). The expectation is that the notes provided for subsequent concurrent clinical review will document interval improvement over each such period. Notes submitted for clinical review should meet medical documentation standards and include appropriate outcome measures, including using outcome instruments (such as the PSFS tool). Medical record documentation standards can be found in the Appendix.

## Accessing the Rapid Response System (RRS)

You may use the RRS to submit authorization requests to WHN for your Blue Cross Blue Shield of Massachusetts patients (once you have determined through a benefits and eligibility check that they are required to undergo this process). There are two ways to use the system: by phone or through a website link that can be accessed once you are logged on to Blue Cross Blue Shield of Massachusetts' provider website at **bluecrossma.com/provider**.

To get tips for using the RRS, log in to **bluecrossma.com/provider** and go to **Clinical Resources>Prior Authorization>Chiropractic Services**.

| **Once logged in to bluecrossma.com/provider, you can access the RRS from the homepage or by clicking eTools>Chiro Authorizations:** | **To learn more about chiropractic authorizations:** |
|---|---|
|  | Go to our Chiropractic Services page. |

***(For group practices)***

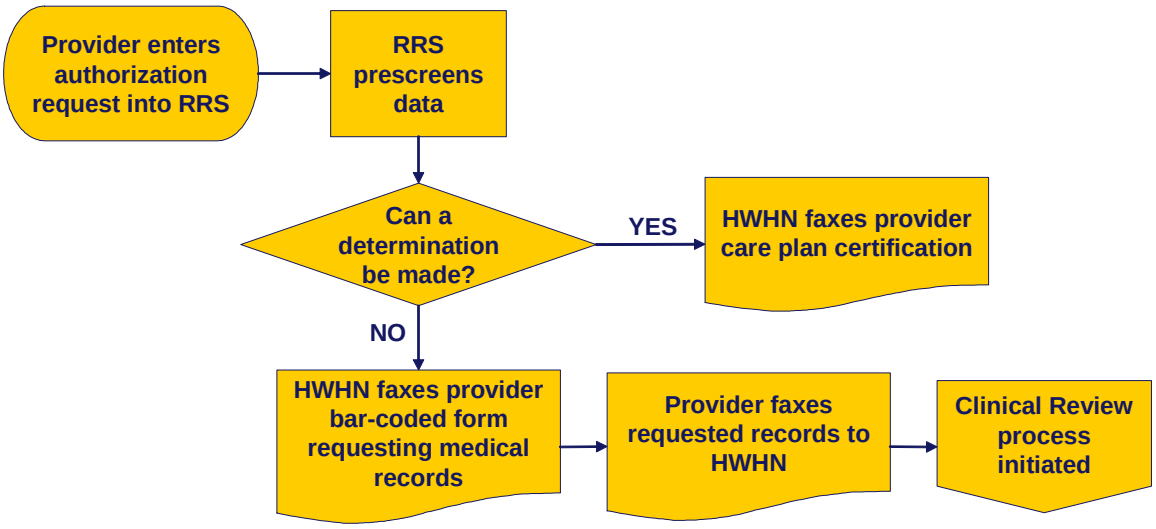
It is recommended that you request authorization for participating Blue Cross members at the group level. If you have logged on to Provider Central as a group to access WHN's web-based RRS, you can only submit authorization for members as part of your group.

Individual providers practicing in multiple groups will have an option to authorize the member as part of your group, or at an individual level (when submitting an authorization request using WHN's web-based RRS).

| **Use this tool:** | **By following these instructions:** |
|---|---|
| RRS<br>(web-based) | • Go to **www.bluecrossma.com/provider**<br>• Log in using your existing user name and password* and then select the link to Chiro authorizations from BCBSMA's home page (see example above).<br>*If you have not yet registered to use Blue Cross' secure provider website, you may sign up by selecting the **Register** button on the site's home page. |
| RRS<br>(telephonic) | • Call 1-866-726-1713<br>• Enter your telephonic RRS access code. This number was assigned to you by WHN and was mailed to your office in a letter from WHN. If you did not receive an access code, please contact WHN at **1-866-656-6071**.<br>• Follow the prompts. |

### *Flow Chart Outlining the Authorization Review Process*

The flow chart below helps describe the process WHN uses once your request for authorization of visits via the RRS has been received.




## Types of Authorization Requests

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

### *Initial Authorizations*

A prior authorization request must be received when initiating **each** new episode of care after the first 12 visits in any given calendar year. Episodes in the RRS system will begin on the date of the first treatment of the patient for care of a new illness or injury, or on the date of re-evaluation and re-initiation of treatment for a new or recurring problem after a break in treatment of sixty (60) days or more. Please review the instructions for the RRS template (available in the Appendix) when completing an authorization request via the RRS.

**Each visit to treat an acute episode of care needs to be included in an authorization request, including the initial visit on the date that the clinician evaluated the patient. The request must be submitted to WHN via the RRS within 10 days to be considered timely.**

The RRS will provide you with one of the following responses following the pre-screening process**:**

1. It will determine that the full number of requested visits is appropriate for automated approval and will certify the request;
2. It will determine that the full number of requested visits is *not* appropriate for automated approval based on the patient information that you submitted. The system will advise you of the modified number of visits that WHN guidelines can immediately approve for the trial of care.
   - If you accept the authorization guidelines, you will receive an immediate certification for this treatment plan;
   - If the patient situation is such that you decide to decline the authorization's trial of care, you will be directed to submit clinical records for peer review**.**

## *Initial Authorizations, continued*

3. It will notify you that your request is not appropriate for any level of automated approval and you will be directed to submit clinical records for peer review (see the *Submitting Records for Clinical Review* sub-heading below).

Treatment plan requests may be certified for some level of automated approval through the RRS prescreening system to allow acute problems to be promptly treated. The patient's history and prior treatment are factored into consideration. For requests sent for peer review, a certification response will be faxed or mailed to your office within the applicable regulatory time requirements.

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

***Please note the following:**

- This approval is limited by both the authorized number of visits, diagnosis, and time period.
- In the event that the patient does not need to use all of the requested visits during the specified time period, these authorized visits will "expire."
- If the patient needs continuing care after the initial request, or if a new problem or complication arises during the initial trial of care, a continuation request **must** be submitted to WHN within 10 days of evaluating the patient. Please be sure that any additional diagnoses or clinical information are supplied with the continuation request so that a determination can be made about the request for more visits.
- If a period of sixty (60) days has elapsed since the end of any prior treatment plans, another *initial* request for care should be submitted using the RRS.

## *Continuation of Care Authorizations*

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

In addition, continuation requests:

- Should be filed promptly (within 10 days)
- Must include the same primary diagnoses previously stated in the initial care request
- Should be for no more than four to six weeks of care.

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

If the patient has been stable without care for sixty days (60) or more and presents for a new or recurrent condition requiring diagnostic re-evaluation, the care plan should be filed as an "initial request for a new episode of care" and submitted within 10 days of the patient's evaluation.

## *Submitting Records for Clinical Review*

You may be required to submit additional clinical information for peer review following your submission of an authorization request to WHN and once the pre-screening process through the RRS is complete. When you are directed to submit clinical records for peer review, a **bar-coded notice** will be faxed to you to be used as a cover sheet for the clinical records that you send to WHN. This notice has a six-digit reference number and must be used as a cover sheet for your faxed submission of the requested medical records. Your submission should include medical records pertinent to this episode of care, including your

current evaluation and treatment plan, office notes including any care for this patient rendered in the past three to six months, initial PSFS score, follow-up PSFS score(s) if available, and any relevant supporting documentation.

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

### *Peer Review Decisions*

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

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

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

1. **Approval (certification).** The request for coverage is approved, as submitted, or with an increase in total treatment intensity (same treatment in a shorter time frame);
2. **Denial (Non-certification- Clinical).**
    a. Modification of Requested Visits: The request is partially certified because the reviewer determined that the request exceeded a reasonable treatment plan for the clinical condition and patient history being reviewed. In this case, the Plan Review Determination section of the *Treatment Certification Notice* will have an approved plan of visits and a specific time interval in which to receive the services. You have the option of accepting this recommended plan and delivering the services.
    b. Non-certification: The request for initial visits or continuation of visits was not certified for coverage based on WHN clinical guidelines. The Plan Review Determination notice will indicate "denial" and show "zero" visits.

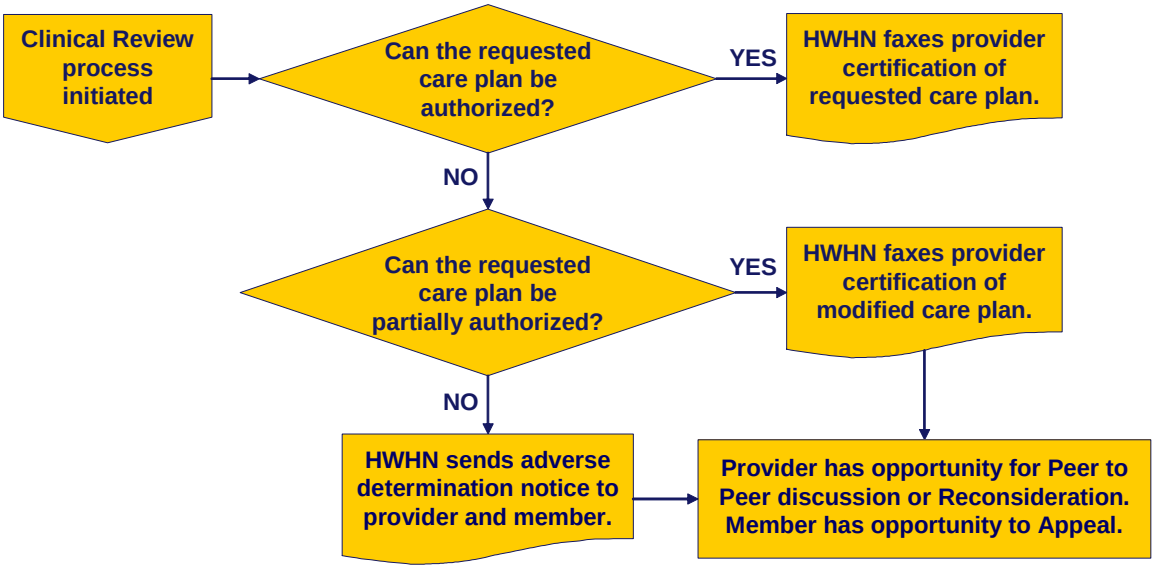
    You may also receive a denial if the information requested for review was not received, or if the patient's benefits do not include coverage for the requested services.

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

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

Coverage decisions are made based on WHN's clinical care guidelines, BCBSMA's definition of medical necessity, and the information presented for review. The guideline algorithms were developed using nationally accepted standards and with input from actively practicing practitioners. The clinical algorithms are reviewed annually and updated regularly.

*Flow Chart Outlining the Clinical Review Process*




### *Interim Narrative Reports*

In addition to your clinical records, you may also submit a medical record summary or an interim narrative report outlining the care rendered to date, diagnostic tests or referrals associated with the episode of care, the goals achieved, complications and compliance problems, and expected outcomes of the care plan submitted as well as the Patient Specific Functional Scale (PSFS) (see Appendix for a copy of the PSFS).

The report should be comprised of the following elements:

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

## Interpreting Information Received from the RRS

After you have entered information (either via phone or the web) into the Rapid Response System (RRS), you will receive an automated response and WHN will provide you with a confirmation via fax or mail.

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

## Interpreting Information Received from the RRS (continued)

| Type of letter: | In this field name: | The response will be listed as: | And any visits will be listed with: |
|---|---|---|---|
| Approval | Authorization Request Decision | Approval | Number of visits approved and the dates in which the visits must be completed |
| Modification | Authorization Request Decision | Unable to Certify Decision* | Number of visits approved and the dates in which the visits must be completed |
| Denial | Authorization Request Decision | Unable to Certify Decision | Fields will be marked as "0" since no visits have been approved |

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

## The Clinical Review Appeals Process

If you have received an adverse determination and wish to appeal the determination, you will have two options for reconsideration.

### *Option One: Peer-to-Peer Discussion*

If, upon receiving a denial of coverage determination, you wish to discuss the determination received from the peer reviewer who made the decision, you will be given the opportunity to submit a request for a peer-to-peer discussion. (See the Appendix for the *UM Department Request Form* you will need to fill out to submit this request.)

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

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

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

### *Option Two: Reconsideration or Appeal*

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

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

## Claims Submission Information

### *Authorization and Claims Submission Requirements*

Please follow these guidelines when submitting authorizations to WHN and when submitting claims to Blue Cross:

- You must submit authorizations for eligible Blue Cross members using the WHN RRS within 10 days (±) of evaluating your patient for additional care beyond the initial 12 visits. If you have any questions, contact WHN at **1-866-656-6071**.

- When you receive a request to submit patient records for clinical review, you must fax them to WHN by the due date listed on the request for records notice. The timely receipt of records by WHN is needed to allow timely utilization review and processing of your request for treatment certification. Failure to submit records within this time frame may result in a denial based on lack of supporting records received.

- Blue Cross Blue Shield of Massachusetts-participating providers should comply with the authorization requirements in order to be reimbursed for visits beyond 12 per calendar year. Chiropractors can only bill the member for visits 13+ if:
    - You follow the prior authorization procedure requirements
    - Blue Cross does not allow payment for the services
    - You had the member complete the *Non-covered Service Waiver Form: Ancillary and Behavioral Health Provider* (or another standard waiver form) before treatment.

- Make sure the diagnoses in the treatment plan request are the same diagnoses that you plan to use on the CMS-1500 claim form or on an electronic filing.

- If you submit claims for services rendered before you have received authorization from WHN (for example, if your prior authorization request is undergoing peer review), you may experience a claim reject message (M296) on your Blue Cross Provider Detail Advisory (PDA). This is because BCBSMA's claims system searches for an authorization on file before it can adjudicate the claim. If your authorization for care has been approved by WHN, Blue Cross will re-adjudicate the claim. If, after sixty (60) days, the claim has not been re-processed, you may call Provider Services at **1-800-451-8124**, to request a claim adjustment.
  **NOTE:** Requests for a retro-authorization received after the claim has been filed may not be retroactively approved or backdated.

## Claims Submission Information (continued)

### *Submitting Claims to Blue Cross Blue Shield of Massachusetts*

Please follow standard claims submission procedures when submitting claims to Blue Cross for members who are required to undergo the authorization process. No additional information is required. When adjudicating claims, Blue Cross' claims processing systems will search for an authorization on file before paying the claim.

## Requesting Authorization and Submitting Claims for Members That Have Personal Injury Protection Benefits

If treating a Blue Cross Blue Shield of Massachusetts member involved in a "No Fault" auto insurance case who has $2,000 Personal Injury Protection (PIP) benefit ($8,000 for self-funded ERISA accounts), we recommend following this process to correctly process your authorization requests and your claims.

| **Member has exhausted their PIP benefit and has not used the initial 12 visits provided in accordance with their Blue Cross benefits for the calendar year:** | **Member has exhausted their PIP benefit, has been treated for 12 visits, and no claims have been submitted to Blue Cross:** |
|---|---|
| Request authorization from WHN after the 12th visit | • When PIP exhaust letter is received, submit the next 12 visits, sequentially by date, to Blue Cross<br>• Use Blue Cross technologies to verify that claims have been received by Blue Cross<br>• Call WHN at **1-866-656-6071**:<br>  ▪ Tell the representative that you are requesting an authorization for visits 13+ on a PIP case<br>  ▪ Indicate the date in which the 13th visit occurred<br>• WHN's Customer Service representative will outline the process necessary for requesting an earlier start date on an authorization involving a PIP case. |

## The Practitioner Service Performance Report

WHN will periodically provide you with a Practitioner Service Performance Report, which serves as a current performance measurement and will assist you in benchmarking the care that you provide to your Blue Cross members compared to your peers. Blue Cross does not make reimbursement decisions based upon this report. As you will see from the report, there are four categories of information:

1. **Claim metrics.** This includes **a**verage number of visits per patient, treatment cost per visit, and distribution of radiology and physical medicine procedures you perform.
2. **Distribution of E & M, manipulation, and physical medicine services.** You'll see E & M, manipulation, and physical medicine services by CPT code as compared to the network averages for each metric.
3. **Utilization review metrics.** This includes data on the number of care authorization requests and approval rates for your requests.
4. **Conditions treated.** Reflect your clinical case load by Management Related Diagnosis Grouping (MRG) compared to the network average.

## Chiropractic Payment Policy

Blue Cross' current *Chiropractic payment policy* contains information on covered and non-covered services and billing guidelines. To obtain a copy, log in to the Blue Cross website at **bluecrossma.com/provider** and go to **Office Resources>Policies & Guidelines>Payment Policies**,

## Additional Forms and Information

Below are some of the forms you may receive from WHN, or you may be asked to submit as part of the authorization and/or clinical process.

- **Bar-Coded Form requesting submission of documents**. When you receive a fax notification from WHN requesting that you submit medical records for review, referral documents, or additional information that may be required during the utilization review process.

  ***You must use this specific bar coded form as the cover page when you fax medical records or other requested information back to the WHN's Utilization Management (UM) Department at* 1-888-492-1025*. This will enable us to more accurately track the information and quickly link your documents to the specific patient file in our processing system. If you do not submit the requested information by the due date indicated on the request for records notice, your authorization request may be denied.***

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

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

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

### *Additional Information*

- **Telephone Prompts**. WHN periodically updates the RRS telephone prompts to ensure security and accuracy of submitted information. To ensure that your request is processed correctly, please pay special attention to update notices WHN sends you when prompts are changed. Prompt changes will be visible on the RRS web interface.

- **Provider Information Sheet.** WHN has enclosed for your reference, a listing of important phone and fax numbers. Please note that WHN's dedicated fax number, **1-888-492-1029** is **only** for our Appeals and Grievance Unit and should not be used for routine submissions. Treatment Authorization requests and/or requested medical records should be faxed to WHN's UM Department at **1-888-492-1025**.

# Frequently Asked Questions (FAQs)

## Frequently Asked Questions about the Authorization Process

**Q:** ***How will I know that it is time to submit an authorization request for affected members?***
A: You will be asked to track the number of visits the member has received from **any and all chiropractors** within that calendar year period. Prior to the member's thirteenth visit (13) for ongoing care, it is recommended that you submit an authorization request to WHN.

Q: ***Who should fill out the Chiropractic Care Plan Authorization request form?***
A: The information on the form serves as a template for the information you will need to enter into the RRS. The information is the responsibility of the treating practitioner, who is attesting to its accuracy by having the information submitted for screening on the RRS. While practitioners may have their office staff enter the basic information about the patient, their history, and current *Patient Specific Functional Scale* (PSFS) scores, all the information needed to complete the *Chiropractic Care Plan Authorization Request Form* is ultimately the responsibility of the practitioner.

Q: ***How can I tell what clinical guidelines are being used to review my treatment plans for preauthorization and certification?***
A: WHN clinical guidelines can be found when you are using the web-based RRS (you will see an online link).

Q: ***I am starting to see some reviews returned in letters as "Denials" (modifications of the original request) but there are still approved visits listed. What does this mean?***
A: When a reviewer authorizes fewer visits than you requested, a modified approval plan will be sent to you. Because a portion of the request has been denied or reduced, it is categorized as a denial or adverse determination. Both you and the patient have the right to appeal this decision. However, if you agree with the reduction in coverage for the visits requested, you may deliver the approved services and reevaluate the patient's status at the end of that approval interval and request another extension of care, if clinically indicated.

Q: ***Can I request authorization date extensions?***
A: Yes. Authorization time periods may be extended once per episode of care. This means that if multiple authorizations are approved for the same, related condition, only one date extension will be considered. While it is understood that occasionally a situation might occur that will prevent a patient from completing treatment within the time frame, multiple instances demonstrate a maintenance pattern rather than acute care. After one date extension, submit a new authorization request with updated information on the member's status.

Q: ***If authorization is obtained following a member's appeal, do I need to resubmit the claim?***
A: No. The claim will be reprocessed automatically.

## Frequently Asked Questions about the Authorization Process (continued)

Q: ***Is coverage continued during a member appeal?***

A: For "Premium" (i.e., fully insured) members, if a grievance is filed concerning the termination of ongoing coverage, the disputed coverage must remain in effect through the completion of the member grievance process, provided that the grievance is filed on a timely basis, based on the course of treatment. Ongoing coverage includes only that medical care that was authorized at the time it was initiated. It does not include medical care that was terminated due to a time- or episode-related exclusion of the member's plan.

The continuation provision applies only to members involved in the Authorization Program for Chiropractors for visits thirteen (13) or more if:

- The thirteenth (13th) or subsequent visit in a calendar year was authorized, *and*
- An authorization request for additional visits in the same calendar year is denied for reasons of medical necessity.

This continuation of coverage provision does ***not*** apply before the member's thirteenth ($13^{th}$) visit in a calendar year since these visits do not require authorization. The provision also does not apply to "ASC" (i.e., self-insured) plans.

Q: ***Will a denial message inform me when member liability applies?***

A: You will receive the message M296 for claims submitted when there is no active authorization on file for the member. This message also states, "The patient has been informed that he or she is responsible for payment only if notified prior to receiving the service it would not be covered by Blue Cross Blue Shield of Massachusetts, Inc., and the member signed a waiver."

Q: ***What happens if I don't follow the procedures for authorization?***

A: You will not be reimbursed by Blue Cross for care you provide to affected members if you do not request prior authorization for visits in excess of 12. For members who require treatment beyond visit 12, Blue Cross will reimburse you, provided that the care is authorized as medically necessary and the member meets benefits and eligibility requirements.

Q: ***What if the member refuses to provide information to complete the*** *Patient Specific Functional Scale* (PSFS)***?***

A: The PSFS questionnaire helps the provider in assessing the patient's current condition, including their level of disability. Completing the PSFS will empower the member to identify and track his/her progress during treatment. If a member has questions about the PSFS, encourage them to call the Member Services phone number on their member ID card. If the member continues to refuse to complete a PSFS, you may bypass this question in the Rapid Response System. You must utilize a validated outcomes measure tool in managing your patients; WHN encourages the use of the Patient Specific Functional Scale.

Q: ***What if a member believes they have unlimited chiropractic visits?***

A: Refer the member to the Member Service phone number on their member ID card.

Q: ***How quickly will I receive notification for an authorization request?***

A: Once you have submitted a *Chiropractic Care Plan Authorization Request Form* to WHN (via the telephonic or web-based RRS), you will receive a response immediately. If WHN cannot make a decision immediately, you will be asked to submit additional documentation. Once WHN has all the information necessary to make a determination, you will typically receive notification within one to two business days. If you receive an adverse determination, you have two options for further review: peer-to-peer discussion (re-review), reconsideration or appeal.

## Frequently Asked Questions about the Authorization Process (continued)

Q: ***What if I disagree with a decision by the reviewer?***
A: Any adverse determination can be appealed either through a peer-to-peer discussion (re-review) or through a reconsideration or appeal. Your rights to a re-review are outlined in the Review Certification Notice you will receive from WHN via fax or via mail. You may also see the Clinical Review Appeals section of this guide for more information about the process. Your patient (the Blue Cross Blue Shield of Massachusetts member) also receives information about decisions and about his/her rights.

Q: ***What should I do if my office location changes?***
A: If you change offices or more your office to a new location, please contact Blue Cross Blue Shield of Massachusetts' Network Management and Credentialing Services area at **1-800-316-BLUE (2583)** to update your information. Your RRS number is tied to your office's physical location and must be updated to ensure timely mailing and changes to your RRS account. Failure to update this information may result in a HIPAA violation if patient information is sent to an incorrect address.

## Frequently Asked Questions about the Practitioner Service Profile Report

### *Cost/Utilization Indicators*

Q: ***What do the visit numbers include?***
A: This data is based on unique dates of service by patient, irrespective of the procedures delivered on those dates. Two visits on the same day would be counted as one, as Blue Cross would not pay for multiple visits on the same day.

Q: ***The average costs in some of these columns do not reflect my actual charges, why?***
A: The "cost" data is taken from the allowed charges for Blue Cross Blue Shield of Massachusetts, so your actual billings are converted to the plan's allowed fee for each procedure code. This method gives a fair comparison of work performed across the BCBSMA network.

Q: ***How will WHN use these reports?***
A: We use these reports to educate our network practitioners as to how their treatment patterns compare with the rest of the doctors in the network. These reports are provided for your convenience and information only; they are not used to determine reimbursement.

Q: ***My visit per patient average was 10, while 80% of the network practitioners averaged less than 5.8 visits per patient. However, I only treated one patient. Will I be considered a poor performer?***
A: Averages are less meaningful when you have fewer than 10 patients treated in the interval, as everyone will get a few very acute or very complicated patients to treat. A practitioner who exceeded the 80th percentile on 30 patients, however, should certainly examine his or her practice patterns as to whether these patients should be receiving so many services under the network's chiropractic medical necessity guidelines.

## Frequently Asked Questions about the Practitioner Service Profile Report (continued)

### *Conditions You Have Treated*

Q: ***When I add up the number of patient visits in this section, the total does not match the unique patient count on the top of the report. Did you make a mistake?***

A: The data for "Conditions Treated" will double count individual patients who are seen for two or more diagnoses. The data here are intended to give you a sense of how you group your Blue Cross patients by diagnoses and how your treatment plans work for patients with symptoms in different body regions.

Q: ***During this period, I had an unusual number of lumbar disc cases; these were harder to treat than the mild sprain/strain and segmental dysfunction cases. Is this information tracked?***

A: Such variations in caseload occur across the whole network, and tend to have little effect on the overall average visits per diagnostic group/region. If you have submitted accurate diagnoses and supportive data for the complicated cases, the authorization process will have tracked and certified your higher visit care plans. Specific diagnostic data from your practice is available for use in clinical and quality care audits. The diagnostic groupings and related data presented here are for your education about your comparative practice patterns compared to your colleagues in the Blue Cross chiropractic network.

# Appendix

# Templates and Instructions for the Rapid Response System

## *Submitting Authorization Requests via the Telephonic Rapid Response System*

You may call your authorizations in each day all at one time (i.e., end of the day, first thing in the morning—whatever schedule works best for you) or before treating each patient. Authorization requests should be submitted within ± 10 days of the patient's first visit. If you are unable to submit your authorization request for the member within this time frame, please call WHN at **1-866-656-6071**.

The call takes between one (1) and three (3) minutes to complete. You do not have to listen to the entire prompt before entering your response. If you wish, you may listen to the start of the prompt and then enter the appropriate response, thus reducing the time spent on the call.

Once you have entered the information, you will be advised if the system has approved your request or is approving fewer visits or a shorter time frame than you are requesting. You will be given an opportunity to modify your request. At the completion of this process you will be advised of:

- The Authorization Reference # for this request
- The approved visits and time frame **OR g**iven a "Referred for Clinical Review" status with a request that records be submitted using a specific bar-coded cover sheet
- The decision. This will also be documented and sent to your office via fax or via mail.

## *Preauthorization Request for Chiropractic or Manipulative Therapy Services*

**Patient Name:** _____ **Provider/Facility:** _____

**Patient ID:** _____ **Location:** _____

**Submitted by:** _____ **Date Submitted (MM/DD/YYYY):** ____ / _____/

| | | |
|---|---|---|
| 1. | What is the requested Start Date for this authorization? | M M / D D / Y Y Y Y |
| 2. | Is this authorization request for a new episode or continuation of care? | X new X continuation |
| 3. | Is this condition new, recurring, or chronic? | X new X recurring X chronic |
| 4. | What type of injury or condition is this request related to? | X work X auto X other injury X post surgery X none |
| 5. | How long has the patient had this condition? | X < 1mo X 1-3 mo X > 3 mo |
| 6. | What is the Initial Date you began treating this patient for this episode of care? | M M / D D / Y Y Y Y |
| 7. | How many treatments (visits) have you, or anyone in your facility, provided to this patient over the past 6 months for any diagnosis? | # # visits |
| 8. | Is this patient's MD/DO currently co-treating the condition? | X yes X no |
| 9. | How many visits are being requested for the current phase of care (including evaluation)? | # # visits |
| 10. | How many weeks will it take to complete the visits? | # # weeks |
| 11. | What is the first (primary) Diagnosis Code? | |
| 12. | What is the second Diagnosis Code? | |
| 13. | What is the third Diagnosis Code? | |
| 14. | What is the patient's average rating of pain over the past 2 weeks? | # # on a scale of 0 to 10 (10 = severe) |
| 15. | Does the patient have a history of pain for > 3 months? | X yes X no |
| 16. | Patient's most recent score for Patient Specific Functional Scale? | # # . # on a scale of 00 to 10 |
| 17. | Does the patient routinely exercise with moderate intensity > 3 times per week? | X yes X no |
| 18. | Does the patient smoke or use tobacco products? | X yes X no |
| 19. | Does the patient have a history of Diabetes? | X yes X no |
| 20. | Does the patient have a history of Stroke? | X yes X no |
| 21. | Does the patient have a history of Cancer? | X yes X no |
| 22. | Is the patient overweight or obese (BMI >25)? | X yes X no |
| 23. | Does the patient currently have significant problems with depression or anxiety? | X yes X no |
| 24. | Are there any factors that limit effective communication with the patient? | X yes X no |

Verify the information is correct, submit the authorization request, and file with the patient's records. When your request is authorized, the approved visits must be delivered within the pre-authorized time limits. Please record the information below.

Auth Reference #: _____ Visits Approved: _____ Approved Through: _____/_____/

**You will receive a fax confirmation of the prescreening results.** The RRS pre-screening will either approve or pend your authorization request. If additional information is required, you will receive a fax request indicating the specific clinical information to submit for utilization review. Use the request form, which is bar-coded for this specific patient, as a cover sheet when faxing clinical records and any other relevant clinical information that will support the present diagnosis(es) and treatment plan to: **1-888-492-1025.**

## Additional Forms and Instructions

# Patient-Specific Functional Scale

Source: Stratford P, Gill C, Westaway M, Binkley J. Assessing disability and change on individual patients: a report of a patient specific measure. *Physiotherapy Canada* 1995;47:258-63.

The Patient-Specific Functional Scale is designed to measure disability in people with an orthopaedic condition.

## Scoring instructions

The patient is asked to identify activities which they find difficult to perform as a result of their condition. The clinician then shows the patient the scale, and asks the patient to give a score out of 10 for each activity.

## Interpretation of scores

Total score = sum of the activity scores/number of activities

Minimum detectable change (90%CI) for average score = 2 points

Minimum detectable change (90%CI) for single activity score = 3 points

# Patient-Specific Functional Scale

This questionnaire can be used to quantify activity limitation and measure functional outcome for patients with an orthopaedic condition.

**Clinician to read and fill in.** Complete at the end of the history and prior to physical examination.

## Initial assessment

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your _____ problem. Today, are there any activities that you are unable to do or having difficulty with because of your _____ problem? (Clinician: show scale to patient and have the patient rate each activity).

## Follow-up assessments

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list). Today, do you still have difficulty with (read and have patient score each item in the list)?

## Patient-specific activity scoring scheme (Point to one number):

0 0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at the same level as before injury or problem

**(Date and score)**

| **Activity** | **Initial** | | | | | |
|---|---|---|---|---|---|---|
| **1.** | | | | | | |
| **2.** | | | | | | |
| **3.** | | | | | | |
| **4.** | | | | | | |
| **5.** | | | | | | |
| **Additional** | | | | | | |
| **Additional** | | | | | | |

**Spanish Version**



# Escala Funcional Específica del Paciente

Este cuestionario se puede utilizar para cuantificar la limitación en las actividades y para medir los resultados funcionales en los pacientes con afecciones ortopédicas.

**El clínico debe leer y llenar este cuestionario** al finalizar el historial clínico y antes de realizar el examen físico.

## Evaluación inicial

Voy a pedirle que identifique como máximo tres actividades importantes que usted no puede realizar o que tiene dificultades para realizar debido a su problema en _____. Actualmente, ¿hay alguna actividad que no pueda realizar o en la que tenga dificultades para realizar debido a su problema en _____? (Clínico: muéstrele la escala al paciente y pídale al paciente que puntúe cada actividad).

## Evaluaciones de seguimiento

Cuando le evalué el (fecha de la última evaluación), usted indicó que había tenido dificultades con (lea todas las actividades de la lista). ¿Sigue teniendo dificultades actualmente con (lea y pídale al paciente que puntúe cada elemento de la lista)?

## Esquema de puntuación de actividades específica del paciente (Señale un número):

0 1 2 3 4 5 6 7 8 9 10

0 = No puede realizar la actividad

10 = Puede realizar la actividad de igual manera que antes de la lesión o problema

**(Fecha y puntuación)**

| Actividad | Inicial | | | | | |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| Adicional | | | | | | |
| Adicional | | | | | | |

# Escala Funcional Específica do Paciente

Este questionário pode ser usado para quantificar a limitação de atividade e medir o resultado funcional para pacientes com uma condição ortopédica.

**O médico deve ler e preencher.** Preencha no fim da anamnese e antes do exame físico.

## Avaliação inicial

Vou solicitar que você identifique até três atividades importantes que não consegue fazer ou está tendo dificuldades para fazer como resultado de seu problema de _____. Hoje, há alguma atividade que você não consegue fazer ou está tendo dificuldades para fazer por causa de seu problema de _____ ? Médico: mostre a escala para o paciente e solicite que o paciente classifique cada atividade).

## Avaliações de acompanhamento

Quando eu avaliei você em (informe a data da avaliação anterior), você disse que tinha dificuldades com (leia todas as atividades na lista). Hoje, você ainda tem dificuldades com (leia e solicite que o paciente classifique cada item na lista)?

## Esquema de pontuação de atividades específico do paciente (Aponte para um número):

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Não é possível fazer a atividade | | | | | | | | | | Não é possível fazer a atividade no mesmo nível de antes da lesão ou problema |

**(Data e pontuação)**

| Atividade | Inicial | | | | | |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| Adicional | | | | | | |
| Adicional | | | | | | |

# UM Department Request Form ~ BCBSMA

**Today's Date:** _____/_____/_____ **Authorization #** _____

**Patient Name:** _____ **Patient ID #** _____

**Practitioner Name:** _____

**Instructions:**
1. Please fax this form to WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC @ **(888) 492-1029.**
2. Please complete **one section only** and **check one box only** prior to submission.
3. If you have any questions please call WHN @ **(866) 656-6071.**

**Extension of Authorization End Date:** 10 Days ☐ 20 Days ☐ 30 Days ☐
*Request to extend treatment timeframe **(end date)** on visits previously authorized but not yet utilized.*

***Please Note: One (1) date extension will be considered per episode of care with a maximum of thirty (30) days. Request must be received within 30 days from end date of prior authorization***

**Request for a Peer to Peer Discussion** ☐

Within 180 days from receipt of an adverse determination, you may request a discussion with the peer reviewer who made the decision. A reviewer will be available within one business day of receipt of the request.

Phone number: _____ Time Zone *Eastern* ☐ *Central* ☐ *Mountain* ☐ *Pacific* ☐

Best days & times to call: (Option 1) _____/_____ (Option 2) _____/_____
*Day Time* *Day Time*

***Please Note: We attempt to accommodate best options to call but cannot guarantee the time for the call.***

**Provider request for a Reconsideration of a Medical Necessity Determination:** ☐

Within 180 days from receipt of an adverse determination <u>for a prospective or concurrent review</u>, you have the right to have the case reviewed by a peer reviewer other than the one that made the original determination.
You may provide any additional clinical documentation which may support your reconsideration request.
Reconsiderations will be completed within one (1) business day
**<u>Please Note</u>: Your patient may have certain grievance or appeal rights available through the Blue Cross Blue Shield of Massachusetts Grievance Program and any such rights will be communicated directly to BCBSMA Patients.**

**Provider request for an Appeal of a Medical Necessity Determination:** ☐

Within 180 days from receipt of an adverse determination <u>for a retrospective review</u>, you have the right to have the case reviewed by a peer reviewer other than the one that made the original determination.
You may provide any additional clinical documentation which may support your appeal.
We will notify you of our decision by letter within 30 days of the receipt of your request for an appeal.

*Total pages if additional medical records are being submitted* _____

## Medical Record Summary (OPTIONAL FORM)

| | | | | | |
|---|---|---|---|---|---|
| Patient | | Patient ID | | Plan | |
| Doctor | | Authorization # | | | |

| | |
|---|---|
| Date and history of onset: _____<br>_____<br>_____ | Number of patient visits over the past 6 months provided by you or anyone in your facility for any diagnosis:<br>_____ |
| Date of first treatment - this Authorization: | Date of first treatment – new authorization: |
| Initial Subjective Complaints:<br>_____<br>_____<br>_____<br>_____ | Current Subjective Complaints:<br>_____<br>_____<br>_____<br>_____ |
| Initial Objective Examination Findings:<br>**(*Please use measured or graded indicators*)**<br>_____<br>_____<br>_____<br>_____ | Current Objective Examination Findings:<br>**(*Please use measured or graded indicators*)**<br>_____<br>_____<br>_____<br>_____ |
| Initial Patient Specific Functional Scale Score(PSFS)<br>Date _____ Score_____ | Current Patient Specific Functional Scale Score(PSFS)<br>Date _____ Score_____ |
| Initial Diagnosis(es):_____<br>_____ | Current Diagnosis(es):_____<br>_____ |

Diagnostic test results (radiology, laboratory, neurology, vascular, etc.):_____

_____

Complicating factors to case management, exacerbations or reinjury: _____

_____

_____

Patient's progress to date and prognosis:_____

_____

Anticipated Number of Visits to Complete Care: _____

Special concerns or additional information: _____

_____

Signature:_____ Date:_____

## Medical Record Documentation Standards

WHN recommends following the documentation standards outlined in this section to serve as guide in creating and maintaining current, detailed, organized, and consistent medical records for your patients (Blue Cross members). This enables WHN to effectively review medical records as needed and promotes efficient and effective treatment.

WHN provides sample medical record formats that meet standards for chiropractors. Use of these forms is not required, but practitioners' records should present equivalent information in a clear and comprehensible format.

These guidelines represent national medical-record audit standards and will be utilized in the evaluation of medical records, including any site visit medical record audits.

### *Privacy, Security, and Business Standards for All Records*

- Records are to be stored in a segregated location that is locked within the file or file room.
- Access to medical records is controlled by the practice's written security and privacy policy that is compliant with state and federal requirements for privacy of electronic as well as paper-based medical records.
- Each page of the medical record contains the patient's name or an identification number.
- Personally identifiable health information, including address, employer, home, work, or cellular telephone number, marital status, and emergency contacts are recorded consistently in the patient's medical record.
- All entries in the medical record are dated and contain the author's legible identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
- The record is legible to someone other than the writer and documents the nature and details of any procedures performed for which charges are submitted.

### *Record Format and Content*

All records should include these minimum standards:

- A problem list showing significant illnesses and medical conditions.
- Medication allergies and adverse reactions to drugs, foods and supplements. If the patient has no known allergies or history of adverse reactions, this is prominently noted in the record.
- Past medical history. This should be easily identified and includes serious accidents, illnesses and surgeries. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, childhood illnesses and any history of alcohol, cigarette or substance use.
- The diagnoses for which care is being rendered. These should be consistent with the findings documented in the history, physical, lab, diagnostic and medical decision-making notes.
- Treatment plans that are consistent with diagnoses.
- Future treatment recommendations. These should be clear and show informed consent when appropriate to ensure that the patient is not being placed at inappropriate risk by any diagnostic or therapeutic procedure.

### *Record Standards for Chiropractic Care*

- Practitioners' initial evaluation notes and re-evaluation interval notes should be created with a problem-oriented record using the **SOAP** format (S = Subjective, O = Objective, A = Assessment, P = Plan).
- Abbreviated treatment notes, or flow charts are acceptable for repeated therapy visits between interval patient treatment plan evaluation visits.
- Patient-based functional outcome measurements, such as functional status tools or pain rating scales are to be used in records of outpatient episodes of care.
- All records that are reviewed for medical necessity or medical appropriateness are expected to be legible and written in English. Transcriptions of notes are acceptable.
- Asian characters are not acceptable for acupuncture and/or herbal treatment notes in an insurance participation contract; use of international alphanumerical designations (not pin yin names) for acupoints and channels are required.
- The original office notes created by the practitioner should accompany records that are transcribed into English for medical audit or review and must be designated as such when submitted for review.
- In the event that a peer reviewer requests a "short report or narrative" from the ordering practitioner to further determine medical necessity, the report should consist of the following elements:
    - a short summary of the patient's initial and current subjective findings
    - initial and current objective findings with PSFS scores if available
    - x-ray and diagnostic findings
    - complete diagnosis
    - discussion of any relevant complicating factors
    - documentation of any exacerbation or re-injuries
    - discussion of the patient's progress to date
    - future treatment plan requirements
- Practitioners are expected to maintain records in keeping with respective state mandates for their profession, if any.

# WholeHealth Networks, Inc.
# Provider Information Sheet

## Please retain this document for future reference

**For Pre-Authorization issues,**

**Please contact us at 1-866-656-6071**

**Important Fax Numbers**

**To better assist you, please refer to the fax numbers below to ensure your information reaches the correct department:**

**Utilization Review: 1-888-492-1025**

**Utilization Review Appeals Unit: 1-888-492-1029**
(This fax number is for Peer-to-Peer Discussions, Reconsideration, and Appeal requests only.)

## Summary of Changes

**August 2010:**
- Updated UM Department Request Form
- Simplified the Rapid Response System template and instructions for submitting requests. There is one, consolidated template and instruction document, rather than having a separate form for web- and telephone-based submissions.

**January 2012:**
- Updated information related to the expansion of the program to certain PPO members, including the "Affected BCBSMA Health Plans" section on page 3 and Step 1 of the "Checking Benefits and Eligibility" section on page 4.

**July 2013**
- Removed all references of the FRI tool and added references to the PSFS tool
- Added new PSFS tools to the Appendix under Additional Forms and Instructions, with English, Spanish, and Portuguese versions of the tool
- Updated current Chiro Rapid Response System template with updated Rapid Response System template for PSFS tool (page 20)

**October 2013**
- Updated with new references to Provider Central website

**April 2014**
- Updated with new phone number for Rapid Response System

**August 2015**
- Updated to remove reference to ICD-9

**June 2016**
- Updated to reflect changes to annual practitioner service performance reports

**April 2017**
- Updated to reflect additional members who are part of the program and need authorization.

**November 2017**
- Updated to reflect name change to WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC and enhancements to Rapid Response System.

**September 2019**
- Renamed section, "Definition of Medical Necessity," to "Chiropractic Payment Policy." Replaced link to Reimbursement Policy and Billing Guidelines for Chiropractic Services with link to Chiropractic payment policy, which includes billing guidelines.

## December 2019

- Updated “BCBSMA Health Plans Affected” section to link to Chiropractic Services page. Updated other website links.

## January 2022

- Revised statements about the due date for requests for medical records or other information for clinical review. The due date is listed on the request for records notice.



MPC_021017-2H-14-O (rev. 1/22)