MASSACHUSETTS

WholeHealth Living

CHIROPRACTIC SERVICES AUTHORIZATION PROGRAM GUIDE

March 2024

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*Blue Cross Blue Shield of Massachusetts 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.

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INTRODUCTION

This guide is intended to help you with the authorization process for chiropractic services.

Authorization program overview

WholeHealth Living, Inc., a Tivity Health company, 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 affected health plans.
- Members' initial 12 visits within each calendar year do not require prior authorization. If treatment beyond the 12 initial visits is anticipated, prior authorization is necessary and should be submitted before the 13th visit.
- Authorization requests should be submitted to WholeHealth Living within 10 days of evaluating your patient for such additional care.
- Authorization is based on Blue Cross standards for medical necessity and is a requirement for reimbursement.

Each new calendar year, chiropractors who perform services without a prior authorization (for visits beyond the first (12) may receive claim denials. You can only bill the member for these services if the member completed 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.

Blue Cross Blue Shield of Massachusetts health plans affected

Refer to our Chiropractic Services page for information on members who require prior authorization. We recommend using this information only as a guide. Because plans and member benefits may vary, please check member benefits and eligibility using ConnectCenter.

THE AUTHORIZATION PROGRAM

How to request authorization

Checking benefits and eligibility

Check benefits and eligibility for all of your Blue Cross members. This will help you to better understand whether the member requires authorization for chiropractic services. Please refer to our Chiropractic Services page for information on using ConnectCenter to see when authorization is required when checking benefits and eligibility.

Please note that members residing in Rhode Island are not included in the program.

Visits beyond the 12th require authorization.

Remember to track the number of visits members have had with any and all chiropractors within the calendar year period.

Completing the Patient Specific Functional Scale Questionnaire

If you determine that a patient will require additional treatment leading up to or during their 12th visit, you 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 to enter into the Rapid

Response System (web-based authorization system) for the authorization request. Keep a copy for your patient files.

If a member refuses to respond to the PSFS, you may leave this question blank when entering responses online. We recommend that you complete the PSFS with members 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.

We recommend completing the **Patient Specific Functional Scale** with your patient during their first visit of every calendar year. This can serve as a baseline and help you to track patient progress.

Use the Rapid Response System to request additional visits for your patient. For authorization requests that may occur throughout the remainder of the calendar year, please submit your requests to WholeHealth Living online within the recommended time frame (within seven days of evaluating your patient's need for additional care).

Description of the Rapid Response System

To submit pre-authorization requests, please use WholeHealth Living's Rapid Response System , their online tool for submitting pre-authorization requests. You can access the online tool on the Chiro Authorizations page of Provider Central (log in required). Visit **bluecrossma.com/provider** and find this under eTools.

Rapid Response System Authorization Responses

Once information is received, the online tool will processes the data based on patient history, 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 WholeHealth Living's national practice guidelines for practitioners delivering the service.

If the system is unable to provide an immediate response, you will need to submit additional information for peer review. These referrals are **not** denials. Referrals for clinical review indicate that these cases 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.

WholeHealth Living'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.

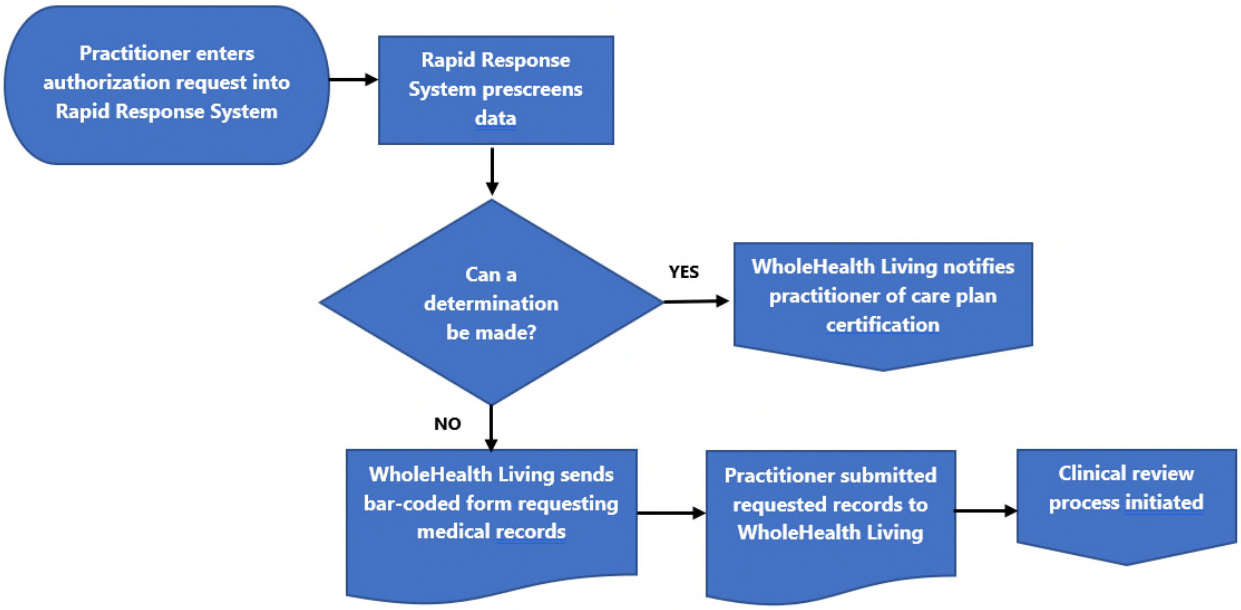
(For group practices)

Request authorization for participating Blue Cross members at the group level. If you have logged on to Provider Central as a group to access the Rapid Response System, 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.

Flow Chart Outlining the Authorization Review Process

The flow chart below helps describe the process WholeHealth Living uses once your request for authorization is 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 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.

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 Whole Health Living within 10 days to be considered timely.

You'll see one of the following responses online 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 WholeHealth Living 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**.**

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 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, notified online or mailed to your office within the applicable regulatory time requirements.

When your treatment request has been approved*, you will be receive by fax, mail, or online.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 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 online.

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 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.

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 WholeHealth Living's clinical guidelines. The Plan Review Determination notice will indicate "denial" and show "zero" visits.

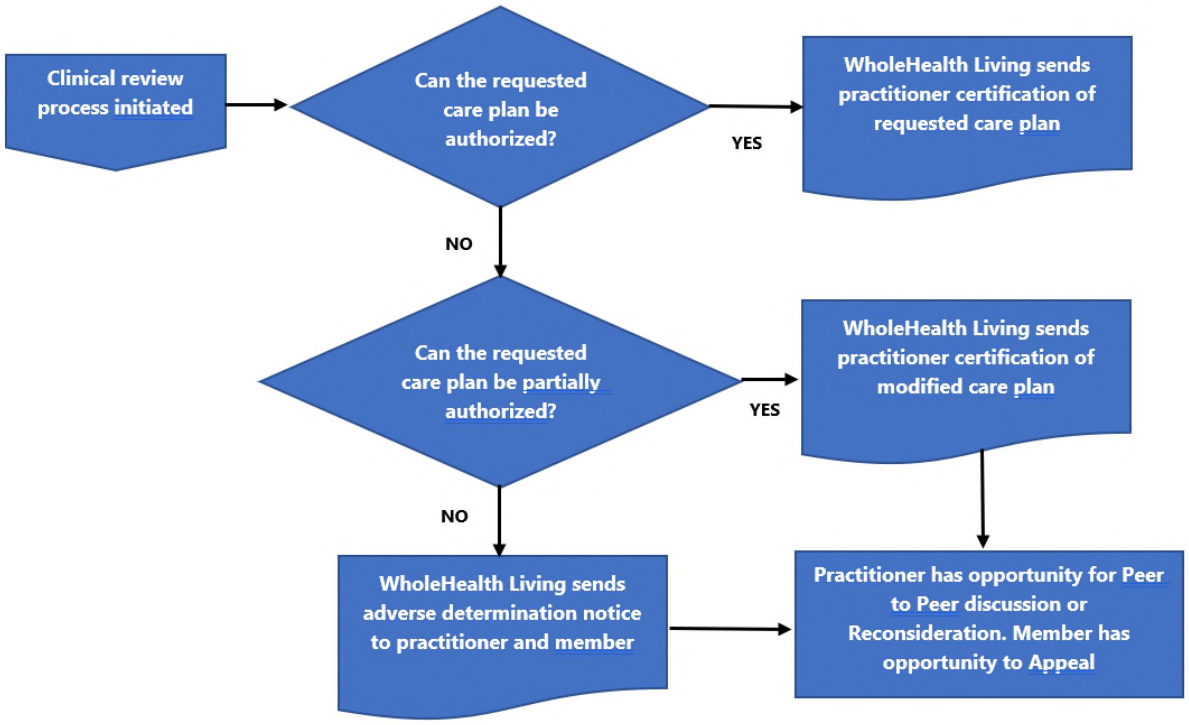
    You may also receive a denial if the information requested for review was not received, or if the patient's benefits do not include coverage for the requested services.

    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, mail, or online. 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 WholeHealth Living's clinical care guidelines, Blue Cross' 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.

Authorization Decisions

Interpreting Information Received from the Rapid Response System

After you have entered information online, WholeHealth Living will respond and provide you with a confirmation via fax, portal, or mail.

Your request will be approved, modified, or denied based upon WholeHealth Living'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.

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 by which the visits must be completed
Modification	Authorization Request Decision	Unable to Certify Decision*	Number of visits approved and the dates by 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 WholeHealth Living via fax, mail, or online.

A peer-to-peer discussion is typically performed via telephone between the practitioner and WholeHealth Living'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* you will need to fill out to submit this request). The WholeHealth Living 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 WholeHealth Living and when submitting claims to Blue Cross:

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

- When you receive a request to submit patient records for clinical review, you must submit them to WholeHealth Living by the due date listed on the request for records notice. The timely receipt of records by WholeHealth Living 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 WholeHealth Living (for example, if your prior authorization request is undergoing peer review), you may experience a claim reject message (M296; HIPAA code 197) on your Blue Cross Provider Detail Advisory (PDA). This is because Blue Cross' claims system searches for an authorization on file before it can adjudicate the claim. If your authorization for care has been approved by WholeHealth Living, Blue Cross will re-adjudicate the claim. If, after sixty (60) days, the claim has not been re-processed, you may submit a replacement claim.

  NOTE: Requests for a retro-authorization received after the claim has been filed may not be retroactively approved or backdated.

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 process your authorization requests correctly 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 WholeHealth Living after the 12th visit	• When PIP exhaust letter is received, submit the next 12 visits, sequentially by date, to Blue Cross
	• Use Blue Cross technologies to verify that claims have been received by Blue Cross
	• Call WholeHealth Living at **1-866-656-6071**:
	  ▪ Tell the representative that you are requesting an authorization for visits 13+ on a PIP case
	  ▪ Indicate the date in which the 13th visit occurred
	• WholeHealth Living'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

WholeHealth Living's 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.

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 WholeHealth Living, 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 notification from WholeHealth Living 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 submit medical records or other requested information back to the WholeHealth Living'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 WholeHealth Living'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 WholeHealth Living'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

- **Provider Information Sheet.** WholeHealth Living has enclosed for your reference, a listing of important phone and fax numbers. Please note that WholeHealth Living'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 WholeHealth Living's UM Department at **1-888-492-1025**.