MASSACHUSETTS

CHIROPRACTIC SERVICES AUTHORIZATION PROGRAM FREQUENTLY ASKED QUESTIONS

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 WholeHealth Living.

Q: ***How can I tell what clinical guidelines are being used to review my treatment plans for preauthorization and certification?***

A: You can find WholeHealth Living's clinical guidelines on the Rapid Response System.

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.

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

A: The appeals process for members in a fully insured plan differs from members in a plan that's self-insured.

For fully insured, 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 (13th) visit in a calendar year since these visits do not require authorization.

For self-insured plans, the provision to continue coverage during the appeals process does not apply.

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 benefit and eligibility requirements.

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

A: WholeHealth Living encourages the use of the Patient Specific Functional Scale because it helps the provider assess the patient's current condition, including their level of disability. Please recommend completing the PSFS as it will empower the member to identify and track his/her progress during treatment. If the member continues to refuse to complete a PSFS, you may bypass this question in the Rapid Response System. Be sure to use a validated outcomes measure tool in managing your patients; WholeHealth Living suggests 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 an online authorization request, you will receive a response immediately. If WholeHealth Living cannot make a decision immediately, you will be asked to submit additional documentation. Once WholeHealth Living 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.

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 WholeHealth Living 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 their rights.

Q: ***What should I do if my office location changes?***

A: If you change offices or move 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 Rapid Response System account. Failure to update this information may result in a HIPAA violation if patient information is sent to an incorrect address.