Musculoskeletal Specialized Therapy Program

For Blue Cross® Blue Shield® of Michigan health plans:

- Blue Cross Commercial PPO
- Medicare Plus Blue℠ PPO
- Blue Care Network HMO
- BCN Advantage℠

December 2019

Physical Therapy Practitioner Performance Summary and Provider Category FAQs

Effective January 2020: Physical therapists are assigned to one category — A, B or C — for all four networks: Blue Cross Blue Shield of Michigan, Medicare Plus Blue℠, Blue Care Network, and BCN Advantage℠. Categories are based on the physical therapy paid claims data for all four networks. The combined Blue Cross and Blue Care Network (BCN) Practitioner Performance Summary dashboards are available on the eviCore provider portal. Select either BCBSMI or Blue Care Network in the eviCore provider portal to access your combined PPS dashboard and utilization management category.

What is the Practitioner Performance Summary?

The PPS is an online dashboard of reports available for you to compare your practice efficiency with your peers on the Blue Cross and BCN networks. eviCore's utilization efficiency profiling uses the following measures:

- ✓ Average per-visit use of therapeutic interventions
- ✓ Average visit utilization over time
- ✓ Average visit utilization by diagnostic category

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What claims data is used in my PPS?

eviCore uses outpatient physical therapy claims data for Blue Cross Blue Shield of Michigan commercial PPO, Medicare Plus Blue℠, Blue Care Network, and BCN Advantage℠ .

Provider profiling

- ✓ PTs in outpatient therapy centers and hospitals are profiled based on the Organization NPI.
- ✓ Independent PTs are profiled based on their Individual NPI.

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How does eviCore assign my utilization management category?

eviCore assesses utilization efficiency based on physical therapy visits per episode. eviCore assigns physical therapy practices a utilization management category by comparing visits per episode to the peer group:

- ✓ Category A practices average visits per episode up to 80 percent of the peer average.
- ✓ Category B practices average visits per episode from 80 to 120 percent of the peer average.
- ✓ Category C practices average visits per episode above 120 percent of the peer average.

Physical therapists with fewer than 10 episodes of care in the 12-month reporting period don't have sufficient claims data for eviCore to make a meaningful comparison to the network average. eviCore places these physical therapists in category B.

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How do I access my PPS dashboard and find out the category eviCore assigned to my practice?

Access eviCore's provider portal and select *Practitioner Performance Summary* from the main menu. If you logged in from the eviCore website, you will be prompted to select the health plan (select either Blue Cross or BCN) and select a provider that you have added to your web user account.

If you logged in from bcbsm.com Provider Secured Services, the PPS dashboards are available for the NPI you selected in web-DENIS. Use the health plan drop-down to select Blue Cross or BCN. Then click the "View PPS" button.

To find out your assigned category, click on the *UM Category* tab in the PPS portal. The portal displays the results of the most recent claims analysis and the key performance benchmark that eviCore used to determine your category.

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How often does eviCore assess providers for a new category?

eviCore reviews claims data twice each year to assign provider categories. You can access your category in the provider portal at least 30 days prior to the effective date. **Category changes for Blue Cross and BCN are effective April 1st and October 1st.**

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How does my category impact my authorization requirements for physical therapy?

Your category determines the amount and frequency of clinical information eviCore requires for you to obtain authorization, for BCN BCNA and MA PPO.

For providers in Category B and C, the clinical information requested by eviCore for prior authorization may differ by patient age and condition, and by request type (i.e., initial request, second, or more). Approved visits vary based on each individual patient's condition, severity and complexity and response to treatment received, once provided. For additional information, refer to the guides available on eviCore's website:

https://www.evicore.com/implementation/healthplan/blue-cross-blue-shield/michigan

evicore.com/healthplan/BCN

eviCore manages providers in Category A with less clinical oversight. Providers in Category A are required to submit limited information about the patient's condition; once the necessary information is provided, these providers are approved for a block of visits over an extended duration. The Category A provider determines the visits that are medically necessary within the approved time period.

Note: When submitting requests, it is important that you select the same rendering site/location that is assigned a utilization management category:

- ✓ **PTs in outpatient therapy centers and hospitals:** search by the facility's Type 2 Organization NPI.
- ✓ **Independent PTs:** search by your Type 1 Individual NPI. Your utilization management category is not assigned to the group practice, so ***please do not select the organization/group NPI as the rendering site***.

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How does my category impact my authorization requirements for occupational therapy?

If you're a hospital or an outpatient therapy center that bills both physical and occupational therapy using the same NPI, your category establishes the review requirements for both therapies. Although your category is based only on your physical therapy claims, the clinical review process is consistent for all your therapy patients.

Because eviCore only assesses physical therapy claims, independent occupational therapists aren't assigned a category. Refer to the guides available on eviCore's website for information about obtaining prior authorization.

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How does category….for Commercial PPO What is the Blue Cross Corrective Action Plan and disaffiliation policy for providers who remain in category C?

Blue Cross will initiate a Corrective Action Program (CAP) if a provider:

- ✓ Remains in category C for three consecutive categorization periods, ***and***
- ✓ Has more than 50% commercial PPO patients in the claim data analyzed for placement in category C

If you are being placed on a CAP, Blue Cross will notify you in writing upon your third consecutive period in category C.

Note to providers placed on a CAP under the 2020 combined categorization program:

You are required to improve your category in the subsequent period to meet Blue Cross compliance standards and avoid disaffiliation from the PPO network. If you do not meet the RAVE requirement to move out of category C for a fourth consecutive period, Blue Cross will send you a disaffiliation letter.

A first- and second-level appeal process through Blue Cross is available to providers who receive a disaffiliation letter.

Providers currently pended at a 1st level appeal will move to a 2nd level appeal if the category does not improve over time. For additional information, refer to the October 2019 issue of *The Record*.

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What changes can my practice incorporate to be considered for a different category?

Modifying your practice patterns may help you achieve a category change. Refer to eviCore's Tips for Improving Treatment Efficiency for opportunities to lower your practice's average visits per episode.

Note: **Accurate ICD coding on your claims is also important** so that eviCore can validate when your patients are treated for multiple episodes or have a surgical procedure during their course of care.

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Can I request a category reconsideration if I don't agree with the category that eviCore assigned?

If you believe there are circumstances adversely affecting your utilization data, you may request reconsideration within 14 days of eviCore's notification. Initiate your reconsideration request in eviCore's PPS portal.

eviCore will email instructions and time frames for submitting the clinical documents needed to review your request. You'll be required to provide information to support an adjustment to your visits per episode for the following circumstances.

Outliers

- ✓ An outlier is a patient who requires higher intensity and/or duration of services due to medical complexity that affects the member's response to therapy. Documentation must demonstrate medical necessity for the services provided.
- ✓ All outliers must be identified at the time information is submitted.

Additional episodes of care

- ✓ A patient had surgery for the involved condition after treatment was started.
- ✓ A patient had a significant event, such as stroke, amputation, etc.
- ✓ Waxing and waning of symptoms are **not** considered additional episodes.

Please only send information relating to episodes that occurred during the 12-month period that eviCore analyzed for your category placement.

All recommendations made by eviCore are sent to Blue Cross/BCN for review and approval. **Your reconsideration decision is final.** If you do not meet the threshold for an improved category, you will remain in your original category for the duration of that categorization.

This reconsideration process applies to your category placement in all four Blue Cross and BCN networks.

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I didn't receive a category notice. How do I know my category?

Log in to the eviCore provider portal to view your PPS dashboard and assigned category.

eviCore profiles providers with at least 10 physical therapy treatment episodes in the 12-month reporting period. Physical therapists who aren't participating in the network, are new to the network, or didn't have claims in the reporting period aren't assigned a category.

Can members or ordering physicians get information about a provider's category?

No. eviCore maintains provider categories in its secure provider portal.

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How does the PPS profiling address more complex cases?

Each provider's visits per episode are risk-adjusted to account for differences in patient age, gender, and condition. eviCore applies an externally validated statistical model to claims data to account for these three factors.

Measuring risk-adjusted visits per episode, or RAVE, allows eviCore to compare providers with different patient populations. Where patient characteristics are shown to increase the number of visits typically used, eviCore adjusts down patients' actual visits. For example, if a physical therapist with a high number of neuro-rehab patients has a 6.9-visit average, the average may fall to 6.4 visits after eviCore applies the risk adjustment.

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What is a patient episode of care?

When determining RAVE, a patient episode of care is all treatment provided to a member for a body part or related body part within a 12-month period.

When the focus of treatment changes from one body part to a distinctly different body part, it counts as two episodes. In this case, eviCore calculates RAVE by splitting the patient's visits between the two distinct episodes.

Note: Your visits per episode calculation determines your category assignment. eviCore uses the primary ICD-10 code billed to determine the focus of treatment for a given visit. When a patient's focus of treatment changes, you must bill the primary ICD-10 code accordingly**. Accurate ICD coding on your claims is required for eviCore to accurately calculate your visits per episode when assigning your utilization management category.**

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What is the network average in eviCore's PPS profiling?

eviCore calculates average utilization separately for each health plan based on the following peer groups:

- ✓ Independent physical therapists and outpatient physical therapy centers (IPTs and OPTs), combined
- ✓ Hospital outpatient physical therapy providers

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Does eviCore adjust for comorbidities?

Comorbidities aren't an explicit adjustment factor. Comorbidities are randomly distributed across a given population, so it is likely you will have as many or as few patients with comorbidities as the next provider.

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How do eviCore's clinical guidelines for physical and occupational therapy define Medically Necessary Services?

To be considered reasonable and necessary, the following conditions must each be met:

- ✓ The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.
- ✓ The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.
- ✓ There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care.
- ✓ The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. For these purposes, "generally acceptable standards of practice" means standards that are based on credible scientific evidence published in the peer-reviewed literature generally recognized by the relevant healthcare community, specialty society evidence-based guidelines or recommendation, or expert clinical consensus in the relevant clinical areas.

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