Physical & Occupational Therapy Authorization FAQs

1. What are the authorization requirements for the UM program?

The utilization management program requires providers to obtain authorization after the patient's 8th physical and/or occupational therapy visit per calendar year. Submit a Treatment Plan to Landmark to request authorization beginning with the patient's 9th visit. Authorization for services will be based on medical necessity and the need for ongoing care.

2. How do I determine whether the patient has already had 8 visits?

Ask the member if he/she has had physical or occupational visits in the calendar year. If the member is unsure or you want to confirm the number of visits previously used, call Health Partners at (215) 991-4350 to ask if claims for prior visits have been submitted for that member within the calendar year. Keep in mind that there is a lag between the date that therapy services are rendered and the date the claims for such services are paid. When in doubt you should submit a Treatment Plan after the patient's initial therapy visit to specifically request further visits. Note that unused waiver visits are void after the submission of a Treatment Plan.

3. Is there a separate accumulation for therapy waiver visits, or are they combined?

The waiver allows for a combined total of 8 physical and occupational visits per calendar year before authorization is required. There is a separate waiver for speech therapy.

4. How do I request additional care after the patient has 8 visits?

If the patient requires continued care, complete the Treatment Plan to request authorization for additional treatment. Submit your Treatment Plan within 7 days of the first visit that will require authorization, and include all necessary clinical information to support continued care. A copy of the ordering physician's referral is required with faxed Treatment Plans. If the patient is not responding well to therapy, he/she may need to be discharged from service or referred back to the ordering physician.

5. Should the "Start Date" on the Treatment Plan include the first 8 visits that did not require authorization?

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No. The Start Date on the Treatment Plan should be the first visit that requires authorization.

6. If a new calendar year begins during the course of a patient's treatment, can I bill the first 8 visits of the new year without authorization?

Yes, you may use the 8 waiver visits for medically necessary care. Remember to document ongoing medical necessity in your clinical notes in case your records are requested in the future.

7. What are Landmark's available PT/OT Treatment Plans and how do I know which one to send?

Several versions of Landmark's Treatment Plan are available in order for you to report pertinent information based on the patient's primary condition:

- Standard Therapy Treatment Plan - Orthopedic conditions except for the hand/forearm
- Hand Therapy Treatment Plan - Hand, wrist, and elbow conditions
- Lymphedema Management Treatment Plan - Lymphedema
- Neurological Rehabilitation Treatment Plan - Adult and pediatric neurological and developmental conditions
- Vestibular Rehabilitation Treatment Plan - Vestibular and dizziness conditions

When you submit a request electronically, the selection of the proper Treatment Plan form is automated based on the primary diagnosis you entered at the beginning of the form. For example, if you enter 457.1, lymphedema, the e-Form will prompt you to complete the Lymphedema Management Treatment Plan.

When you fax your Treatment Plan, select the form that best fits the patient's primary condition. Landmark will not return a Treatment Plan to you because it does not "match" the patient's primary diagnosis. However, use of the proper form will help ensure that you provide the most relevant information to the clinical peer reviewer.

e-Forms: Login to Landmark Connect at www.LMHealthcare.com

Fax: (888) 565-4225

8. What do I do if I entered the wrong primary ICD-9 code?

The e-Form changes dynamically based on the primary ICD-9 code. Up until the point you submit the e-Form, you can adjust the diagnosis. If your adjustment changes the version of the Treatment Plan to be completed, your responses to the "global" fields (those applicable to every version) will be retained. The e-Form will not retain any responses you entered in the dynamic fields.

For example, you start filling out the standard Therapy Treatment Plan, and then change the ICD-9 code to one that triggers the Hand Therapy Treatment Plan. The global fields (e.g. Date Current Objective Findings Obtained) will be retained because they are always applicable. However, your

condition-specific responses (e.g. spinal ROM) will not be retained since they are not applicable to every Treatment Plan. If your change in diagnosis does not change the version of the Treatment Plan (e.g. from one hand ICD-9 code to another hand ICD-9 code) all of your responses will be retained.

If you need to change the primary ICD-9 code for a previously submitted Treatment Plan, please call Landmark. You will not be required to complete a different version of the Treatment Plan on an already submitted authorization request and/or for an existing authorization.

9. Can I use my own forms when requesting authorization for therapy?

No. To ensure that clinical peer reviewers receive the necessary and complete information, and to make consistent clinical determinations, we only accept requests submitted on a Landmark Treatment Plan. When submitting paper forms, be sure to complete every section. Treatment Plans with incomplete sections or references such as "See attached" in lieu of completing items on Landmark's form will be returned to the requesting therapist for proper resubmission.

10. Am I required to complete the Revised Patient Specific Functional Scale (PSFS)?

The Revised PSFS section is included and required on all Physical/Occupational Therapy Treatment Plan submissions. Enter the scores that the patient gives you in the Revised PSFS section of your Treatment Plan.

The initial PSFS should be completed at the start of care. Record the patient's limited functional activities (a minimum of three) and scores exactly as stated by the patient or when necessary, by the patient's caregiver. Throughout the episode, ask the patient to score the same activities each time you submit a Treatment Plan requesting continuing care. You may include additional activities as the patient progresses in treatment.

11. How do I send supporting clinical documents to be considered in Landmark's review determination?

In most cases, the condition-specific Treatment Plan provides our clinical peer reviewers with the information they need to make a determination. However, if you feel that supporting documentation is required for a particularly complex case, you may fax your Treatment Plan to Landmark along with these documents.

12. How do I report joint range of motion and strength findings?

When you submit a request electronically, the e-Form will prompt you to report findings for each joint that you indicate. If you fax your request, you must include the Supplemental Joint Form if you have more joint findings to report than will fit on the Treatment Plan. The Treatment Plan and the Supplemental Joint Form must be faxed to Landmark together.

On the Standard Therapy Treatment Plan, report primary joint findings on the Treatment Plan form. If you have additional joints to report, select the "Multiple joints" checkbox and complete the Supplemental Joint Form.

For the Lymphedema Management, Neurological Rehabilitation, and Vestibular Rehabilitation Treatment Plans, all joint findings must be documented on the Supplemental Joint Form. For these cases, select the "Supplemental Joint Form attached for extremity ROM/strength" checkbox on the Treatment Plan form.

13. How do I report bilateral findings on the Hand Therapy Treatment Plan?

Submit bilateral hand requests electronically. The e-Form will prompt you to report findings for each hand. Bilateral findings will be reported on the completed version of your Hand Therapy Treatment Plan as a two-page document.

When you fax your request, include your additional findings along with your completed Treatment Plan.

14. How far in advance can I submit a Treatment Plan?

Submit Treatment Plans no more than 7 days prior to the proposed Start Date. Requesting care too far in advance does not allow you to report up-to-date clinical findings. For a surgical patient, hold your request until 7 days before the proposed Start Date of post-operative treatment.

The Date Current Objective Findings Obtained that you report should be within 7 days of your requested Start Date. To avoid a delay in receiving a review determination, include the current objective findings paying particular attention to the patient's progress for the services you have already provided.

15. Can I include DME supplies on an authorization request to Landmark?

You may document that a patient requires specialized DME equipment; however, orthotics, DME and supplies will not be authorized by Landmark. Follow the normal Health Partners process for all DME authorization requests.

16. How do I print a copy of my completed e-Form?

All submitted e-Forms are available on Landmark Connect in a print-friendly format. Landmark transfers the information you provide to a PDF document for you to view and print for your records. You will be prompted to print the Treatment Plan after it's been submitted electronically.

17. How quickly will Landmark review my Treatment Plan and how can I track the status?

Landmark will typically review your Treatment Plan and respond with a determination within two business days. You may check the status of a Treatment Plan review online by logging in to

Landmark Connect. Select “Patient Status” from the menu to access the Treatment Plan inquiry feature.

Or, call Landmark at (877) 531-9139.

18. How will I be notified of Landmark’s review determination?

Written notifications of clinical review determinations are provided online on Landmark Connect. Select “Patient Status” from the menu to access the Treatment Plan inquiry feature. Click the "View Letters" button to download review determination documents.

We will also fax or mail you a copy of each letter.

19. What is an Approved Time Period?

The Approved Time Period is the period of time (duration) to use authorized visits. Visits must be spread through the Approved Time Period to avoid a gap in care at the end of that 30-day duration.

20. Why are Approved Time Periods limited to 30 days?

Medical necessity authorizations for a 30-day timeframe allow time for tissue healing to occur, the therapist to instruct the patient in a home management program and the patient to show meaningful progress. Ongoing approval of visits is based on the patient’s response to treatment. If additional care is required, updated clinical information must be submitted on a new Treatment Plan.

21. Can I change the Start Date of an authorization?

You may change the Start Date up to 7 calendar days prior to the original Start Date of an authorization, provided that the adjustment does not cause it to overlap with another Approved Time Period. Contact Landmark at (877) 531-9139 to request the adjustment. The Start Date of an authorization cannot be adjusted to a later date.

22. How do I extend the End Date of an authorization?

To extend the expiration date of an existing authorization, submit a Date Extension Request within 30 days after the expiration of that authorization.

- One date extension, up to 30 days beyond the authorization end date, will be allowed per authorization for patients aged 21 years and over. If additional care is required beyond the first date extension, submit a new Treatment Plan with updated clinical information.
- Two date extensions, up to 30 days each beyond the authorization end date, will be allowed per authorization for patients under the age of 21. If additional care is required beyond the second date extension, submit a new Treatment Plan with updated clinical information.

23. Can I request more treatment after my Approved Time Period expires?

Yes. If you believe a patient will require therapy after the Approved Time Period expires, submit an updated Treatment Plan to request continuing care. Keep in mind that Treatment Plan periods cannot overlap. Therefore, be sure the Start Date of your request for continuing care is after the End Date of your previous authorization.

24. How do I request additional visits before an Approved Time Period expires?

When you receive authorization from Landmark, visits should be spread out over the Approved Time Period. In the event you utilize the visits before the authorization expires, submit a new Treatment Plan. Indicate the first visit that exceeds the number authorized in the "Start Date for This Treatment Plan" field. If medical necessity cannot be established, Landmark will send a Request for Information (RFI) letter. Provide the requested information to describe the patient's progress since the previously submitted Treatment Plan and explain why you are requesting more visits before the authorization expiration date.

When you use e-Forms, you will be prompted to include this information before you submit the Treatment Plan. When your "Start Date for This Treatment Plan" is within a previously Approved Time Period, the e-Form will ask you to select one of the following options:

- Complete additional fields to describe the patient's progress since the previous Treatment Plan and explain why you are requesting more visits before the authorization expiration date, or
- Modify the Start Date so that it is not within the existing Approved Time Period.

25. What is a Request for Information (RFI)?

Landmark responds to an authorization request with an RFI letter when additional information is needed to make a review determination. When you receive an RFI, send a copy of the RFI letter back to Landmark with the requested information. The RFI letter will state the time frame during which you are required to respond. Following are some common causes for RFI's and tips to help you avoid them:

- Sufficient objective clinical information is not included on the Treatment Plan, or the information provided is greater than 7 days before the requested Start Date. If you have been treating the patient over that period of time, the objective findings may have changed.
  Tip: Be sure that the Treatment Plan reflects objective clinical information that is no greater than 7 days old, and that it includes all significant changes in function, motion, strength, pain, and edema.

- The requested Start Date is prior to the End Date of an existing Approved Time Period. Visits were used too quickly.
  Tip: Spread the authorized visits over the approved duration to avoid gaps in care.

- The diagnosis code used is nonspecific and we are unable to determine what condition the therapy is for.

Tip: Use the most specific diagnostic code available to describe the patient's condition. On the request, indicate any recent surgeries affecting that part of the body and whether you are treating the left or right side of the body.

26. Is a new Treatment Plan required if a patient has surgery on the body part being treated in therapy?

Yes. If a patient has surgery on the body part being treated in therapy, and therapy is required post-surgery, submit a new Treatment Plan request.

Landmark will review your new Treatment Plan and approve services based on the start date reported. The previous authorization period will be updated and closed showing an expiration date prior to the start date of your new authorization.

27. How do clinical peer reviewers decide on the number of visits they authorize?

Landmark's clinical peer reviewers use proprietary Clinical Practice Guidelines and available evidence to decide the number of visits authorized for each request. Clinical peer reviewers take into account the complexity and severity of a member's condition when rendering a clinical review. See the Utilization Management Guide for a detailed description of the review determination process.

28. What determines medical necessity?

Refer to the Utilization Management Guide for a detailed description of medical necessity.

Landmark uses the Clinical Practice Guidelines available at www.LMHealthcare.com along with the DPW and DOH's definitions of medical necessity. Determination of "clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease" is reviewed against these criteria:

- 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, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function.

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- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice and supported by evidence.

For these purposes, "accepted standards of medical 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.

29. May I call in to request authorization?

No. Treatment Plans must be either completed online via Landmark's secure web site or faxed utilizing Landmark's Treatment Plan to (888) 565-4225.

30. What if I forget to submit a request for authorization until after I have delivered care?

Retrospective authorization requests occur when all requested visits for a member have already been provided. If you do not obtain authorization after the patient's 8th visit, payment will be denied. Retrospective review requests may be submitted up to 180 days from the date of service. Typically providers must have compelling reasons, such as situations where they had no control over the circumstances, before a retrospective review will be considered. To request authorization for retrospective care, fax a copy of all applicable documents (i.e., Treatment Plan, evaluations and reassessments, daily progress notes, outcomes assessments, flow sheets) for the services provided along with the reasons why prior authorization was not obtained. Attach a copy of the ordering physician's referral (required documentation). If information is missing, medical necessity cannot be determined and visits will not be authorized for those dates of service.

31. How do I appeal services not approved as medically necessary?

The ordering physician may speak with a physician peer reviewer by calling Landmark's Customer Service number (877) 531-9139 and asking to speak with a physician peer reviewer for a peer-to-peer reconsideration.

You may submit a standard written appeal for an adverse authorization determination; the review determination letter provides appeal information.

32. Who do I call to verify member benefits?

Member benefits for therapy can be verified by following the normal Health Partners process for eligibility of Benefits. Please contact Health Partners at (215) 991-4350.

33. Where do I submit claims?

Submit claims directly to Health Partners.