



Nonprofit corporations and independent licensees  
of the Blue Cross and Blue Shield Association

**OUTPATIENT PHYSICAL THERAPY FACILITY  
APPLICATION FOR BCBSM PARTICIPATION FOR THE  
TRADITIONAL PROGRAM AND/OR THE TRUST PROGRAM  
AND/OR THE MEDICARE SUPPLEMENTAL PROGRAM, AND BCN**

**GENERAL INFORMATION**

**I. BCBSM's (Freestanding) Outpatient Physical Therapy Facility Program**

**Information on the Use of this Application**

This application applies *only* to freestanding Outpatient Physical Therapy (OPT) facilities. Blue Cross Blue Shield of Michigan (BCBSM) considers OPT facilities to be "freestanding" if the facility has separate Medicare certification as a rehabilitation agency for outpatient physical therapy services, or as a comprehensive outpatient rehabilitation facility. In contrast, a hospital-based therapy provider is 100% owned and operated by a hospital and functions as a unit/department of the hospital. Its services are included in the hospital's general organizational structure and included in the hospital's Medicare certification. BCBSM reimburses for these covered therapy services under the hospital's BCBSM participation agreement(s). Therefore, separate application as an OPT facility is not necessary for such hospital-based therapy providers.

BCBSM has several program options for freestanding Outpatient Physical Therapy facilities; Traditional, TRUST (effective 1/1/08), and Medicare Supplemental. In addition, there is also a separate Blue Care Network OPT facility network for eligible HMO members and for Medicare-eligible members through its BCN-65 product. This application may be used for all programs and is also used for changes of ownership.

**Traditional**

Participation with BCBSM is on a formal basis only. Services provided in a non-participating OPT facility are not reimbursed by BCBSM to either the facility or the member.

The BCBSM Traditional OPT program is intended to provide benefits for the purpose of improving or restoring the patient's functional level when there has been a loss in musculoskeletal functioning due to illness or injury. Services related to activities for the general good and welfare of the patient do not constitute eligible physical therapy services (e.g., general exercises or therapy to promote overall fitness and flexibility, development therapy to provide diversion or general motivation, etc.). Physical therapy is the use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal function due to an illness, injury or following surgery. Treatments include exercise, physical agents and therapy of the patient's specific muscles or joints to restore or improve the following: muscle strength, joint motion, coordination and general mobility.

OPT facilities must provide physical therapy services and may also provide and be reimbursed by BCBSM for occupational therapy or speech therapy covered services. Pulmonary rehabilitation services are not currently a benefit.

The attached application and required information applies to facilities that want to participate in BCBSM's network for members enrolled in our Traditional program and in other products. Please note, however, that until January 1, 2008 (see TRUST below), members enrolled in BCBSM's PPO and Point of Service products (e.g., Community Blue PPO, Blue Preferred PPO, Blue Preferred Plus PPO, Blue Choice POS, etc.) use the BCBSM Traditional network *unless* the members are required to use a separate non-BCBSM carve-out network for outpatient physical therapy services. Members of other Blue Cross Blue Shield (BCBS) Plans may also be required to use the Traditional network for full benefits, as applicable, when receiving services in Michigan. Be sure to verify benefit and eligibility for all BCBSM or BCBS members *before* providing services.

### **TRUST OPT Facility Network for PPO and POS**

BCBSM will implement a separate network for TRUST OPT facilities effective January 1, 2008. This network applies for covered physical, occupational and speech therapy services for eligible PPO and POS members. Some PPO members may still be required to use a separate non-BCBSM carve-out network. OPT facilities that participated with BCBSM in the Traditional Program as of July 1, 2007 do not need to separately apply for the TRUST network. New OPT facilities can apply to *both* the Traditional and TRUST networks by completing this single application. If approved by BCBSM, the facility will be offered a TRUST OPT Facility Network Affiliation Agreement. BCBSM or BCBS members whose benefit plans require the use of a TRUST network provider may be subject to substantial out-of-network cost sharing (e.g., increased copayments and deductibles, or for some customers there is no benefit), if the member uses a BCBSM participating Traditional OPT facility that is not in the TRUST network. There is no payment made to the facility or the PPO/POS member if the member has services at an out-of-network OPT facility that does *not* participate in the BCBSM Traditional program. PPO and POS members may also receive services from other providers that provide therapy services (i.e., TRUST Independent Physical Therapists, TRUST Hospitals, and TRUST physicians). Be sure to verify benefit and eligibility for all BCBSM or BCBS members *before* providing services.

### **Medicare Supplemental Program**

Patients who have primary coverage through Medicare may also have Medicare Supplemental coverage through BCBSM. The Supplemental program provides for payment of the Medicare (Part A) deductible and copayment amounts that are *not* payable by Medicare. Supplemental payments are made only on behalf of those persons who are both eligible Medicare beneficiaries and eligible BCBSM Supplemental members. In general, the effective date of a facility's eligibility for payment under the BCBSM Medicare Supplemental program coincides with the effective date of the facility's Medicare certification as a rehabilitation agency or as a comprehensive outpatient rehabilitation facility. This date most likely will be different than the facility's Traditional program participation effective date. All OPT facilities that are approved for participation in our Traditional program are approved for Medicare Supplemental payments.

Medicare certified facilities are eligible to obtain a BCBSM facility code for the billing of covered Medicare Supplemental services even if the facility does *not* participate with BCBSM in our Traditional program. However, due to claims filing limitations, BCBSM will generally not assign a BCBSM Medicare Supplemental facility code with a retroactive effective date that exceeds a two year period.

### **Blue Care Network's Program**

Blue Care Network (BCN) is a statewide, non-profit health maintenance organization (HMO) and subsidiary of BCBSM. In addition to its HMO benefit coverage, BCN provides Medicare wrap-around coverage to Medicare-eligible members through its BCN-65 product. OPT facilities wishing to apply for affiliation with BCN should check the appropriate box under Section 1.0 of the Application. If the facility is approved for BCBSM Traditional participation, BCBSM will forward the relevant information to BCN for their consideration. BCN representatives will respond directly to the applicant. If BCN accepts the

applicant for affiliation, separate contracting, enrollment and payment arrangements will apply. Specific questions relating to provider affiliation with BCN may be addressed by calling BCN Provider inquiry at 1-800-255-1690.

## **II. BCBSM's Outpatient Physical Therapy Facility Qualification Requirements**

### Traditional

In order to participate with BCBSM in the Traditional Program, an OPT facility must, at minimum, have and maintain the following:

- Medicare certification as a rehabilitation agency for outpatient physical therapy services, or Medicare participation as a comprehensive outpatient rehabilitation facility (CORF), and the facility can demonstrate it provides services that are restorative and rehabilitative in nature
- The facility, or at least one physical therapist on staff must have membership in a local or national physical therapy professional association
- A Michigan licensed physical therapist on site at all times during facility's established business hours
- Written policies and procedures that meet generally acceptable standards for outpatient physical therapy to assure the quality of patient care, and facility demonstrates compliance with such policies and procedures
- Ability to demonstrate that it conducts program evaluation and utilization review to assess the appropriateness, adequacy, and effectiveness of the program's administrative and clinical components
- Outpatient physical therapy program has been in operation for six months prior to application to BCBSM for participation as an OPT facility
- Sufficient patient volume to enable BCBSM to determine facility's compliance with BCBSM's qualifications standards
- Meets BCBSM's Evidence of Necessity (EON) requirements, as applicable
- Compliance with Certificate of Need (CON) requirements of the Michigan Public Health Code (if applicable)
- A governing board that is legally responsible for the total operation of the facility, and for ensuring that quality care is provided in a safe environment
- An absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review
- An absence of fraud and illegal activities
- Maintenance of adequate patient and financial records

### TRUST OPT Facility Network Requirements

In order to affiliate in BCBSM's TRUST OPT facility network, (for eligible PPO and POS members) the facility must meet all requirements set forth in the TRUST OPT Facility Qualification Standards that are on file with the Michigan Office of Financial and Insurance Services (OFIS), including but not limited, to maintaining participation status in the Traditional program and maintaining satisfactory utilization management performance, as determined by BCBSM. The full set of standards is available in the OPT facility enrollment section of [bcbsm.com](http://bcbsm.com).

BCN Affiliation: If the facility is interested in affiliation with BCN, BCN requires the OPT facility to have and maintain minimum medical liability coverage of \$500,000 per occurrence and \$1 million aggregate for the facility's primary location, all branch locations, and all employees, officers, trustees and agents. If the facility is accepted for affiliation with BCN, BCN will require proof of insurance during the contracting process with BCN.

### BCBSM Recredentialing

Note: It is BCBSM's policy to recredential participating facilities every 2-3 years to verify continued compliance with all qualification requirements for both the Traditional and TRUST OPT facility networks.

### **III. Outpatient Physical Therapy Facility Reimbursement**

#### Traditional and TRUST

For covered services, BCBSM will pay the OPT Facility the lesser of its billed charges or the rate established by BCBSM, less any deductible or copayment for which the member is responsible. BCBSM will reimburse the facility the rate in effect on the date the covered service was provided. Rates are listed on the BCBSM Traditional OPT Facility Participation Agreement Rate Schedule and on the TRUST OPT Facility Network Rate Schedule, or such other fee/rate schedule(s) as BCBSM may publish and designate as applicable to the Traditional or TRUST Agreements in the future.

If you obtained a copy of the application from our corporate website (bcbsm.com) you may contact us for sample rate schedules, or, participating facilities may access them from web-DENIS. If/when the facility is approved for participation, the most current rate schedule(s) will be sent with the participation agreement(s). OPT Facilities that participate in the Traditional and/or TRUST program are required to bill BCBSM for covered services and to accept BCBSM's payment as payment in full for covered services, except for any applicable member copayments and/or deductibles.

### **IV. The BCBSM Participation Agreements (Traditional and TRUST)**

The appropriate BCBSM OPT facility participation agreement(s) (Traditional and/or TRUST) will be sent if/when the facility is approved for participation in the Traditional and/or TRUST network. If, however, the facility would like to review the agreement(s) prior to submitting the application, you may review them by referencing the provider enrollment section of the bcbsm.com website. The participation agreements are on file with OFIS, and their terms and provisions are not negotiable.

**NOTE: The information supplied in this application is general information only and is subject to change without notice. The application does not constitute a provider agreement or a provider manual and members' benefit plans will vary.**

**OUTPATIENT PHYSICAL THERAPY FACILITY  
BCBSM TRADITIONAL AND/OR SUPPLEMENTAL  
APPLICATION INSTRUCTIONS**

Please do not submit the application until the facility believes it meets all BCBSM qualification requirements and has all documents BCBSM requires (e.g., Medicare/CMS certification). Print (in ink) or type the information required in the space provided. If the application was retrieved from the provider enrollment section of the BCBSM website (bcbsm.com), you may print, complete and mail the application. Be certain that the application is complete and all required attachments are enclosed at the time of submission to BCBSM. Please do not put the application in a binder or use sheet protectors, folders or dividers.

Please mail (do not fax) the completed application, along with the required attachments to:

Patricia K. Helfrick, RN  
Provider Contracting - B715  
Blue Cross Blue Shield of Michigan  
27000 W. 11 Mile Road  
Southfield, MI 48034-2200

Upon receipt of the application, we will send you a letter of acknowledgment. Contact the person listed at the end of this section if you do not receive a letter within two weeks from the date you sent the application. It takes approximately two weeks for us to review a complete application. Incomplete applications may be returned, delaying the review process.

After we review the application and accompanying documentation, we may contact the designated representative of the facility to set up an appointment for an on-site visit. The on-site visit includes a review of a sample of medical records to evaluate the applicant's compliance with BCBSM requirements, as outlined in this application. The facility must be ready for the on-site review at the time of submitting the application. If the facility is approved for program participation, the participation agreement will be offered. If the facility is not approved, we will send notification in writing indicating the reason(s) for the denial.

The facility may not submit claims and is not eligible for reimbursement unless and until the application for participation is approved by BCBSM and both parties sign the appropriate participation agreement(s). If the facility is approved and offered a Traditional or TRUST participation agreement, it will be asked to retain the agreement(s) for its record and return the signed Signature Document(s) to BCBSM. The countersigned copy of the Signature Document(s) will be returned to the facility after the facility's BCBSM OPT facility code has been activated for billing purposes, generally within three weeks of our receipt of the signed Signature Document(s). The effective date for participation in the BCBSM Traditional or TRUST Outpatient Physical Therapy facility program will be the date the application is approved by BCBSM. It is not retroactive to the date the application was sent or received. If this application pertains to an ownership change and BCBSM approves an agreement effective date retroactive to the date of the ownership change, this is not in any way a guarantee that old claims will process. The facility is still subject to any applicable claims filing limitations.

A separate BCBSM facility code is assigned to each approved and contracted primary location. Approved branch locations use the same facility code as the primary location when submitting claims to BCBSM. With the full implementation of NPI scheduled to occur in 2008, BCBSM will crosswalk the claims from the facility's NPI to the BCBSM (primary) facility code (i.e., BCBSM's internal identifier) for processing. Therefore, BCBSM recommends obtaining one NPI (in accordance with federal guidelines), for each location and provider type. Federal guidelines also allow for an NPI to be obtained for unique combinations of tax ID, location and taxonomy (specialty) codes. By choosing the same identification

structure for your NPI numbers as your BCBSM provider codes, you will significantly reduce the degree of change required and this will assist us in processing your claims in a timely manner.

For facilities that are approved for the Medicare Supplemental program, the effective date for eligibility in the Medicare Supplemental program will generally coincide with the effective date of the facility's Medicare certification as a rehabilitation agency or CORF. Due to claims filing limitations, BCBSM will generally not assign a BCBSM Medicare Supplemental facility code with a retroactive effective date that exceeds a two year period. Facilities that are approved for the Medicare Supplemental-only program will receive a letter confirming their facility code assignment.

Upon completion of the application and contracting process, the facility will receive a welcome package with information on how to sign up for electronic billing and access to web-DENIS, BCBSM's web-based information system for providers. Through web-DENIS the facility will have access to provider manuals, newsletters (e.g., *The Record*), fee/rate schedules and patient data such as contract eligibility and benefits. It is the facility's responsibility to be familiar with and to adhere to all BCBSM billing and benefit requirements. It is also the responsibility of the facility to ensure its billing department (or billing agency) is compliant with all of BCBSM's billing requirements.

Participating OPT facilities must bill BCBSM on a UB-04 claim form or its electronic equivalent. BCBSM will no longer accept facility paper claims (with some exceptions). Facilities that would like more information about internet claims submission or who wish to bill electronically should contact BCBSM's Electronic Data Input (EDI) Helpline at (800) 542-0945 for electronic billing information *after* their BCBSM facility code has been received.

Facilities that participate in the Traditional program or that are eligible to receive Medicare Supplemental payments from BCBSM must notify BCBSM *immediately* of any change in the facility's ownership, tax identification number, CMS certification number, NPI, addition/deletion of branch locations, address, telephone number, branch additions/deletions, etc.

### **Multiple Locations**

If the facility is applying for participation (or an ownership change), a separate application must be completed for each *primary* location. If the facility has multiple branch locations (extensions), please list them in the appropriate section of this application. Each site must meet all qualification standards in order to be approved. A separate BCBSM provider code is issued for each approved primary location and each approved primary location receives its own participation agreement. This same facility code should also be used when billing for services provided at the primary facility's approved branch locations. Before completing the application, please make/print additional copies. The application for the first primary location must be completed in its entirety (with all attachments submitted). For each additional primary location application submitted, complete the following sections: General Information (1.0), Medicare Certification (5.0), and Staffing (6.0). For all other sections, indicate "same" where there is no difference. Where the information for a location is different than the first location, answer the questions and submit corresponding attachments. Before submitting the applications, please review all sections carefully to be sure appropriate information was completed for each location. If, however, you prefer to submit a "complete" application for each site, you may choose to do so.

**Please direct questions regarding completion of the application to:**

**Patricia K. Helfrick, RN, Qualifications Consultant**

**[phelfrick@bcbsm.com](mailto:phelfrick@bcbsm.com)**

**Telephone: 248-448-7896**

**Fax: 248-448-7888**

**BLUE CROSS BLUE SHIELD OF MICHIGAN  
OUTPATIENT PHYSICAL THERAPY FACILITY  
APPLICATION**

**1.0 General Information**

Indicate the type of application being submitted: (Check all that apply)

- The facility would like to formally participate in BCBSM's Traditional Program and also bill BCBSM for covered Medicare Supplemental services.
- The facility would also like to formally participate in BCBSM's TRUST OPT Facility network for PPO and POS members. (Note: Traditional participation is a requirement for this network).
- The facility is not eligible, or elects *not* to participate in BCBSM's Traditional Program but wishes only to obtain a BCBSM facility code for the billing of Medicare Supplemental services. (Note: Facilities that make this election must complete this application, however, the only attachments the facility must submit are the IRS documents (1.7), and the facility's Medicare certification (5.3 and 5.4.)
- The facility is also interested in being considered for HMO affiliation with Blue Care Network.
- Ownership change involving a change in the facility's federal Tax Identification Number.  
**Please contact the person listed on the previous page regarding the ownership change before completing this application.**

1.1 Business Name (This is the name the facility uses when doing business, or the DBA. It will be used for directories.)

\_\_\_\_\_

1.2 Facility Site Address (for directory)

\_\_\_\_\_

Suite Number \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ State MI Zip code \_\_\_\_\_

1.3 Facility Telephone Number (for directory) (\_\_\_\_) \_\_\_\_\_

1.4 Remittance Address (This is the location where all BCBSM vouchers, checks and remittance advices should be sent.)

\_\_\_\_\_

Suite Number \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

- 1.5 Enter the facility's 10 digit National Provider Identification Number (NPI) if one has been obtained.  
\_\_\_\_\_
- 1.6 Tax Name (This is the name on file with the IRS and may be different from the facility's business name.) \_\_\_\_\_
- 1.7 Enter the facility's federal tax identification number (TIN).  
\_\_\_\_\_
- 1.8 **Attach a copy of Federal Tax Deposit Coupon (form-8109), copy of IRS notification letter (form SS4-147c), EFTPS (form-9787), or another document issued by the IRS with the facility's federal tax identification number (TIN) on it.**
- 1.9 Check applicable field:  
 For Profit  
 Nonprofit/Tax Exempt
- 1.10 If the facility is nonprofit, attach the IRS document authorizing tax exempt status.**
- 1.11 Fiscal year End (MM/DD/YEAR) \_\_\_\_\_
- 1.12 Facility's website (URL), if applicable \_\_\_\_\_
- 1.13 Indicate the date the facility began providing services to patients under the Tax ID indicated in 1.7 (MM/DD/YEAR). \_\_\_\_\_
- 1.14 Is the facility accepting new patients at this time?  
 Yes  
 No
- 1.15 Hours and Days of operation – Indicate when the facility is open to provide patient care.  

M	T	W	TH	F	S	SUN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 Business hours \_\_\_\_\_

**Note:** The percentage of ownership for items 1.16 and 1.17 combined must equal 100%.

- 1.16 List the following information for the facility **if** it is owned by an individual(s). Attach additional pages if necessary.

Name: \_\_\_\_\_ Ownership \_\_\_%  
 Home Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Name: \_\_\_\_\_ Ownership \_\_\_%  
 Home Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Name: \_\_\_\_\_ Ownership \_\_\_%  
 Home Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

- 1.17 Provide the following information for the facility *if* an organization owns it or has managing control (e.g., hospital, corporation, governmental and/or tribal organizations, partnerships and limited partnerships, charitable and/or religious organizations, etc.)

Organization's name Percent ownership (if applicable)

\_\_\_\_\_ Ownership \_\_\_%

\_\_\_\_\_ Ownership \_\_\_%

## 2.0 **Administration**

### 2.1 **Attach a copy of the OPT facility's organizational chart.**

- 2.2 List the name and credentials of the facility's administrator

Name \_\_\_\_\_

Credentials ( Degrees/Certificates, etc) \_\_\_\_\_

- 2.3 Administrator's scheduled number of hours per week at facility \_\_\_\_\_

### 2.4 **Attach a copy of the administrator's job description and qualifications.**

- 2.5 Has the facility or an officer, director, owner (e.g., individuals or parent organizations) or principal (those with significant authority and responsibility) of the facility ever had any convictions, guilty pleas, nolo contendere pleas, remands to diversion programs, civil judgments or settlement of civil actions that are related to the provision or payment of health care services?

Yes

No

If "Yes," please explain:

\_\_\_\_\_

- 2.6 Has the facility or its owner(s) (e.g., individuals or parent organizations) ever been subject to a Corporate Integrity Agreement or been found to have been non-compliant with self-dealing and/or anti-kickback laws and regulations?

Yes

No

If "Yes," please provide a complete explanation below and/or attach additional pages if necessary

\_\_\_\_\_

\_\_\_\_\_

## 3.0 **Governing Board**

- 3.1 Does the facility have a governing board that is legally responsible for the total operation of the facility, and for ensuring that quality care is provided in a safe environment?

Yes

No

**3.2 Attach a list of the names, city and state of residence, and occupations of all members of the governing or advisory board.**

**3.3 Attach a copy of the policies and procedures that outline the functions and responsibilities of the board.**

**4.0 Professional Organization Memberships:**

4.1 Does the facility, or at least one licensed physical therapist on staff at the facility, have current membership in a local or national physical therapy professional association?

- Yes
- No

**4.2 If the answer was "Yes" to 4.1 attach a copy of the professional membership.**

**5.0 Medicare - Centers for Medicare and Medicaid Services (CMS)**

5.1 Indicate below the type of Medicare certification/participation that applies to the facility

- Medicare certified as a rehabilitation agency for outpatient physical therapy services
- Medicare participating as a Comprehensive Outpatient Rehabilitation Facility (CORF)
- Not Medicare certified

5.2 Provide the facility's Medicare number

\_\_\_\_\_

Medicare effective date (MM/DD/YEAR) \_\_\_\_\_

**5.3 If the facility has had a Medicare recertification survey subsequent to the initial CMS certification, attach a copy of the most current state of Michigan survey report, or the follow-up letter (if applicable) that verifies the facility is in substantial compliance with all state and federal regulatory requirements.**

5.4 Has the facility's Medicare number ever been revoked, suspended or terminated for the type of Medicare certification indicated in 5.1?

- Yes
- No

If "Yes," please explain:

\_\_\_\_\_  
\_\_\_\_\_

5.5 Has the facility or any of its owners ever been excluded from state or federal programs?

- Yes
- No

If "Yes," please explain:

\_\_\_\_\_  
\_\_\_\_\_

5.6 List each extension (branch) location(s) that has been approved by CMS and that is to be reviewed as part of this application.

Extension # 1 Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ County \_\_\_\_\_

Medicare Effective Date \_\_\_\_\_

Extension # 2 Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ County \_\_\_\_\_

Medicare Effective Date \_\_\_\_\_

The above information should be taken directly from the CMS approval letters.

**Note: If the facility has additional extensions, attach a list with the above information.**

5.7 **If this application is being submitted due to a change of ownership, attach a copy of the CMS letter indicating authorization of the change of ownership.**

**6.0 Services/Staffing**

6.1 Which of the following skilled services does the facility provide?

- Physical Therapy (required)
- Occupational Therapy (optional)
- Speech and Language Pathology (optional)
- Pulmonary Rehabilitation Therapy (not currently a BCBSM benefit)
- Other (please explain below)

---

---

6.2 Is a Michigan licensed physical therapist on site at all times during the facility's established business hours when physical therapy services are being provided?

- Yes
- No

6.3 **Attach a copy of all physical therapists' scheduled hours at the facility.**

6.4 **Attach a copy of a current staff roster with credentials (e.g. RPT), job titles and scheduled hours per week for all professional/clinical staff (including physicians).**

6.5 **Attach a copy of the current Michigan licenses for all professional/clinical staff listed in 6.4.**

## **7.0 Medical Record Documentation**

The medical record must contain documentation of the need for and the provision of all services rendered. All documentation must be clearly legible, signed and dated.

BCBSM general requirements for medical record documentation include, but are not limited to:

- Patient identification information
- History
- Clinical findings
- Physician orders (certification of treatment)
- Results of diagnostic testing (if applicable)
- Diagnostic assessment
- Progress notes
- Treatment plan
- Periodic review of treatment plan
- Discharge summary

Additionally the BCBSM OPT program requires:

- Documentation of each treatment session must include date of service, time of treatment session and duration, modalities provided at the treatment session, patient's response to treatment and signature and credentials of the therapist providing the service.
- Physical therapist progress notes summarizing patient's response to treatment must be written at least once every 30 days.
- A licensed physical therapist or physician is responsible for supervision of the services provided by physical therapy aides or assistants. The treatment provided by such personnel should be consistent with the therapeutic regimen outlined in the treatment plan. The therapist or physician must be on the premises when supervising the treatment and must co-sign the daily note if completed by an assistant or aide.

### **7.1 Attach a copy of the facility's policies and procedures for each medical record documentation requirement outlined in 7.0.**

### **7.2 Attach a blank copy of all of the facility's medical record forms.**

## **8.0 Utilization Management**

A utilization management system can result in improved member care and improved planning for more appropriate, effective, and efficient use of the facility's resources.

- The program must provide a written utilization evaluation system designed to review the appropriateness of admissions to the program, lengths of stay, discharge practices, use of services, quality, timeliness and completeness of member records, and any other factors that may contribute to the effective utilization of program resources.
- Utilization management must be administered by a multidisciplinary committee of staff who provide direct member services. The committee shall meet at least on a quarterly basis.

- Written utilization management findings and recommendations should be made available to administrative and treatment staff for study and appropriate action.

**8.1 Attach a copy of the facility's current utilization management policies and procedures.**

**8.2 Attach a copy of the names and credentials (i.e., MD, DO, RN, PT, etc.) of the Utilization Management Committee's members.**

**8.3 Attach minutes from the last two quarterly Utilization Management Committee meetings.**

**9.0 Financial and Billing Information**

9.1 Does the facility maintain records of transactions that conform to generally accepted accounting principles?

- Yes  
 No

9.2 Are billing charges uniformly applied? That is, for identical services is the charge the same for all patients?

- Yes  
 No

If "No," provide an explanation below:

---

9.3 Does the facility use a billing department or agency that is located outside Michigan?

- Yes  
 No

If "Yes," please indicate the contact person, company name, address, telephone number, (and e-mail address if available) for the company or billing agency that is responsible for submitting claims for services provided at the facility.

Contact person \_\_\_\_\_

Company Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number ( ) \_\_\_\_\_

E-mail address \_\_\_\_\_

9.4 In the past five years, has the facility filed a petition for relief under the U.S. Bankruptcy Code, or has any action been taken to dissolve, liquidate, terminate, consolidate, merge or sell all or substantially all of facility's assets?

- Yes  
 No

If "Yes," provide an explanation below:

---



---

**10.0 Management Contracts**

- 10.1 Does the facility have management contract(s) with an outside organization for the provision of core services (e.g., administrative services, staffing services, personnel management, etc.)?  
 Yes  
 No

If "Yes," please provide the name of the organization and describe the services provided by this outside organization in the space provided below. BCBSM may request a copy of the management contract at a later date.

---

---

**11.0 Utilization Management Contact Person**

- 11.1 Please identify in the spaces provided below the following information about your facility's utilization management contact person.

Contact person \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone number (\_\_\_\_) \_\_\_\_\_  
E-mail address \_\_\_\_\_

- 11.2 Is the above person the utilization management contact person for all locations (primary and branch sites)?  
 Yes  
 No

If the answer to 11.2 is "no", please attach an additional sheet that identifies the person(s) responsible for this activity for each location.

**12.0 Application Contact Person:**

Please give the following information for a contact person for any questions BCBSM may have regarding this application:

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Telephone number: \_\_\_\_\_  
E-mail address: \_\_\_\_\_

### 13.0 Signature and Attestation

I certify by my signature below that:

- I have reviewed the information in this application and to the best of my knowledge it is a complete and accurate representation of this facility's operations.
- I understand that BCBSM may choose to do an on-site survey after review of this application to verify program compliance and to verify the accuracy of any information provided.
- All licenses, registrations and certifications for professional providers who provide outpatient physical, occupational, and/or speech therapy services for this facility are current and valid in Michigan.
- Facility's Medicare certification as a rehabilitation agency for outpatient physical therapy services, or as a Comprehensive Outpatient Rehabilitation Facility (CORF) is current and valid.
- The enclosed policies and procedures have been implemented and are enforced by this facility.
- The facility maintains financial records that conform to generally accepted accounting principles and practices.
- I understand the effective date of BCBSM participation in the OPT facility Traditional and TRUST program, if approved, is the date the application is actually approved by BCBSM and is *not* the date the application was sent or received.
- For the Traditional and TRUST Program, I understand the facility is not eligible to submit claims for payment under this program until it is approved by BCBSM, both parties sign the participating agreement, BCBSM's claims processing systems are activated, and the facility has received a copy of the countersigned t Signature Document from BCBSM.
- I understand and agree that if the facility has elected not to participate in BCBSM's Traditional OPT Program and that if BCBSM assigns an OPT facility code that is *only* for Medicare Supplemental payments, that BCBSM has the right to audit the facility's patient records to verify that all services billed and paid were benefits and that covered services billed and paid were delivered and documented. I understand and agree that BCBSM will have the right to recover any monies paid for services paid in error, that were not benefits (i.e. not covered services) or that were not appropriately documented in facility's medical records.
- I understand BCBSM's payment rates and the terms of its standard participation agreement are not negotiable.
- **For BCN applicants only:** I give my permission to BCBSM to share this application with BCN and understand that BCN Affiliation will be separately reviewed in accordance with business and service area requirements established by BCN. In the event that BCN accepts my facility's application for affiliation, separate contracting (including submission of proof of insurance), enrollment, and payment arrangements will apply.

Note: This application must be signed by the person at the facility who is responsible for the overall administration of the outpatient psychiatric care program.

#### **Authorized facility representative**

By  X   
\_\_\_\_\_  
(signature - required)

Name \_\_\_\_\_  
(print or type)

Title \_\_\_\_\_  
(print or type)

Date \_\_\_\_\_

Return the completed application with all required attachments to:

Patricia K. Helfrick, RN  
Provider Contracting – MC B715  
Blue Cross Blue Shield of Michigan  
27000 W. 11 Mile Rd.  
Southfield, MI 48034-2200

**Checklist for Outpatient Physical Therapy Facility  
Application Attachments**

- Federal Tax Deposit Coupon (form-8109), copy of the facility's IRS notification letter (form SS4-147c) or EFTPS (form-9787)
- IRS document authorizing tax exempt status (if applicable)
- facility's organizational chart
- facility administrator's job description and qualifications
- copy of policies and procedures outlining the functions and responsibilities of the governing board
- proof of membership in at least one professional organization for at least one licensed physical therapist on staff
- facility's Medicare certification as a rehabilitation agency for outpatient physical therapy services, or as a Comprehensive Outpatient Rehabilitation Facility (CORF)
- If the facility has had a Medicare recertification survey subsequent to the initial CMS certification, attach a copy of the most current state of Michigan survey report, or the follow-up letter (if applicable) that verifies the facility is in substantial compliance with all state and federal regulatory requirements.
- physical therapist staff scheduled hours on site at the facility
- facility's current professional/clinical staffing roster with job titles
- current Michigan licenses for all professional/clinical staff
- facility's policies and procedures pertaining to medical record documentation of OPT services
- facility's medical record forms
- policies and procedures of facility's program evaluation and utilization review
- attestation statement signed by an authorized facility representative