EmblemHealth

Chapter 12: EmblemHealth Spine Surgery and Pain Management Therapies Program

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Chapter Summary

OrthoNet, LLC reviews preauthorization requests for EmblemHealth's Spine Surgery and Pain Management Therapies Program for select spine surgery and interventional pain management therapy procedures.

This chapter covers:

- Service locations
- Program inclusions and exclusions
- ICD-10 Procedure/Diagnosis codes
- Preauthorization requirements and process
- Appeal process

A preauthorization does not guarantee payment for services. Payment of claims is dependent on eligibility, covered benefits, provider contracts, and correct coding and billing practices.

Exempt Members

- All GHI members
- HealthCare Partners members

No Referrals Required

While many plans require referrals to access network specialists, the EmblemHealth Spine Surgery and Pain Management Therapies Program does not require referrals.

Refer to Clinical Corner for services requiring preauthorization. Procedure codes are subject to change; always refer to Clinical

Corner for the current list.

Service Locations

Preauthorization is required when services are performed in the following settings:

- Practitioner's office (POS 11)
- Outpatient hospital setting (POS 22)
- Inpatient hospital (POS 21)
- Ambulatory surgery center (POS 24)

How to Request Preauthorizations

Complete the applicable form and fax it with supporting clinical documentation to: 844-296-4440:

- Pain Management Prior Authorization Request Form
- Spinal Surgery Prior Authorization Request Form

Supporting Clinical Documentation

OrthoNet needs sufficiently detailed, patient-specific clinical information. At minimum, this should include:

- Relevant patient history including priortreatments for this condition(s), surgeries, pain management, etc.
- Copie sof significant imaging reports such as MRI and CT scans, plain films and, if performed, copies of relevant electrodiagnostic studies.
- A proposed treatment plan/descriptionof the proposed surgery, including the use of any implants. While awritten statement of the proposed clinical procedure(s) is preferred, alist ofpossible CPT-4 codes can be submitted.

In addition, a contact telephone number and fax number will help expedite requests for additionalinformation.

Time Frame For Decisions

All utilization management decisions meet accreditation (National Committee for Quality Assurance (NCQA)) and regulatory

time frames.

- Pre-service requests: within one (1) to two (2) business days following the receipt of all necessary information.
- Urgent pre-service Medicaid requests: within 72 hours of receiving the request.

OrthoNet notifies physicians (and applicable facilities) on the day the decision is made, and gives the following information both verbally and via fax:

- Authorization number
- Number of approved visits and/or units
- Next review date

Length of Authorizations

Preauthorizations are valid for 90 days from the date they are issued.

Checking Status of Preauthorization Requests

Contact OrthoNet's Customer Service department at 844-730-8503, Monday through Friday, 8:30 a.m. to 5:30 p.m.

Peer-to-Peer Review Requests

For Commercial and Medicaid members, providers may ask for a reconsideration or peer-to-peer discussion upon receipt of the denial of service notice by calling OrthoNet's Customer Service department at 844-730-8503.

For Medicare members, providers may request a peer-to-peer discussion, but the decision cannot be changed. However, providers may submit a written request to OrthoNet to "Re-Open" the case. Providers should include additional clinical information supporting the request for OrthoNet to review. Written requests must be faxed to OrthoNet at 844-296-4440.

Preauthorization Denial and Appeal

Practitioners may submit an appeal of a denied preauthorization request to:

OrthoNet
EmblemHealth Appeals
P.O. Box 5046
White Plains, NY 10602-5046

Fax: 844-296-4440

OrthoNet reviews all Commercial and Medicaid member appeals. If a provider still disagrees with the decision, the provider may exercise their rights as outlined in the adverse determination notice.

For Medicare, the member, or practitioner on behalf of the member, may file a clinical appeal with EmblemHealth in accordance with the instructions included with the denial.

Claims Submission

OrthoNet only oversees utilization management. Refer to the Claims Contacts section of the Directory Chapter in the Provider Manual for instructions on submitting claims.

Note: Claims submitted without the required authorization will be denied.

Program Frequently Asked Questions

Purpose
This document provides important questions and answers regarding the focused claim review (FCR) program performed by OrthoNet, LLC.

Overview:

What is the FCR?
The FCR affords a review of claim history identifying any claims with atypical billing patterns. Such claims are selected for focused review of operative/office notes in comparison to the billed services. This program ensures appropriate services have been rendered for members and helps keep care affordable.

What is OrthoNet?
OrthoNet is a leading musculoskeletal management company located in White Plains, NY. OrthoNet has significant experience with billing practices associated with musculoskeletal services and procedures.

Why are we looking to implement a coding review program for musculoskeletal procedures? Isn't a medical necessity determination enough?
The primary goal of the pre-payment review process is to promote quality and cost-effective health care and to assist our members in achieving and maintaining optimal health at affordable rates. The FCR program also helps confirm claims billed for our members are medically necessary and reported accurately.

When was the FCR program implemented?
The FCR Program has been in place with EmblemHealth since July 2010.

How are providers chosen for the FCR program?
Providers are chosen for pre-payment review upon analysis of specific procedures they perform. The codes subject to the FCR program are specific for each provider specialty.

Can the provider opt out of these programs?
No. A provider cannot "opt out" of the FCR.

When will the provider be removed from the FCR?
An annual review is done on each specialty to determine whether providers will be added or removed from the program.

Review process

What is OrthoNet's role in the review process?
OrthoNet will review selected claims and compare the claim with the submitted medical records. OrthoNet will conduct this review in accordance with CPT and the Centers for Medicare & Medicaid Services (CMS) billing guidelines.

What type of documentation will be required for this review?

OrthoNet will require the operative report or completed medical records for the billed services. If the operative report or medical records are not attached to the claim upon submission, OrthoNet will request that these records be provided to them directly.

Note: If the operative report or completed medical records are not submitted by the provider, the service will be denied as "records not received".

Impacted members and providers

Which members are impacted in this program?

The following member groups are included in the OrthoNet FCR program:
· Health Insurance Plan of Greater New York (HIP) Plans
o Commercial HMO and POS
o Medicaid/HARP
o Medicare
· EXCLUSIONS
o EmblemHealth Insurance Company and EmblemHealth Plan, Inc. Members
o HIP Members assigned to a primary care provider affiliated with:
§ Advantage Care Physicians
§ HealthCare Partners
· OTHER EXCLUSIONS:
o Claims with Preauthorization status 49, special pricing instructions, i.e. single case agreement
o Podiatrist Services

Which providers are included in this program?

This program includes, but is not limited to, the following provider specialties: cardiology, dermatology, general surgery, plastic surgery, urology, and spinal surgery.

Note: only applies to professional (CMS 1500) claims. *Facility claims are excluded from this review.*

Operative reports/office notes

Who is responsible for submitting the operative report or office notes to OrthoNet for review?

If the service was rendered by an EmblemHealth participating provider, then that provider is required to provide the operative

reports or full medical records. If the service was rendered by a non-participating provider, OrthoNet will contact the non-participating provider to obtain these records on the member's behalf.

How will I know if I need to submit the operative report or office notes to OrthoNet?

Claims selected for the FCR program will be suspended in the claims processing system to an OrthoNet queue. OrthoNet will be sent a daily report of the claims suspended in the claims processing system for their review along with all claim attachments. If the required operative report or office note is not on file, OrthoNet will contact the provider and request that the required records be submitted to them directly. The claim will remain suspended for receipt of this additional information.

Will operative reports or office notes be accepted after a claim has been denied as "records not received"?

Yes. Post-denial operative reports or full medical records can be submitted directly to OrthoNet for review. OrthoNet will review the records, provide their determination on the claim, and prompt to EmblemHealth to adjust the claim accordingly.

What happens if the medical records submitted are missing information?

OrthoNet will call the provider to request the additional information.

What process should members follow to submit medical records to OrthoNet for review?

Members are not required to submit medical records. Their providers should be sending the medical records and following up directly with OrthoNet. A narrative operative report/medical records are required for OrthoNet to review. Providers may request a re-review or peer-to-peer review directly with OrthoNet.

OrthoNet Contact Information:
- Customer Service: 877- 499-9537
- Fax: 877-499-9538
- Portal: provider.orthonet-online.com/ProviderDocumentPortal/

Notification of review results

How are providers and members notified of the results of the review?

The claim will be processed on the EmblemHealth claims platform according to the OrthoNet coding review determination. An explanation of benefits will be issued to the member, and an explanation of payment will be sent to the provider advising them of the coding review determination. Providers who submit medical records through the OrthoNet provider portal will be able to track submission of operative reports or medical records, and when a decision has been submitted to EmblemHealth.

Codes subject to review

Do we have a list of the procedure codes that will be subject to the coding review?

The codes subject to the FCR program can differ based on provider specialty. This program includes, but is not limited to, the following procedure code categories:

- spine/back surgery
- total knee/hip replacement
- knee/foot arthroscopy
- hand/finger surgery
- carpal tunnel
- nail/skin grafts
- nerve conduction studies
- injections/trigger points
- arthrocentesis
- nerve blocks
- neurostimulators

- neurolytic agents
- skin/wound care
- breast surgery
- nose excision/repair
- sinus endoscopy

Communications

How are providers notified of the implementation of this FCR program?

Impacted Providers will receive notification from OrthoNet indicating which services are likely to be reviewed. In addition, EmblemHealth may notify the broader network of providers about this program.

Claim processing

Will EmblemHealth continue to process these claims?

Yes. EmblemHealth will continue to process all claims related to this program. Member benefit and eligibility information is available on EmblemHealth's Provider Portal.

Are members affected by the review process?

Members are not affected, as reviews take place after services are rendered.

If a provider wants more information regarding the pre-payment review process, whom should he/she contact?

Providers who want more information regarding this process should call OrthoNet Medical Department Service Center:
- Customer Service: 877-499-9537
- Fax: 877-499-9538

OrthoNet staff will be available to speak to the program operations and, if requested, arrange a time for a discussion with OrthoNet's specialist physician medical director.

Questions not addressed above

If you should have additional questions regarding this program, please visit the OrthoNet website at orthonet-online.com or contact OrthoNet's Provider Services department at 844-604-6767 for further assistance.

The OrthoNet Focused Review Program consists of the following stages:

If you have concerns about:

Stage	If you have concerns about:	Please contact:
1. Identification of Claims for review. Claims are identified for review. Adjudication of the claim is suspended.	The frequency of review of your claims, or the selection of your claims for review.	EmblemHealth Provider Customer Service using the **Message Center in the Provider Portal** or call **866-447-9717.**
2. Request for Medical Records	The letter is sent to the wrong department.	OrthoNet at **877-499-9537** and advise OrthoNet of the appropriate recipient, request confirmation, etc.

OrthoNet sends a letter to the provider requesting medical records. The provider has 8 calendar days to submit records to OrthoNet. Claims may be denied if the provider does not supply the records within 365 calendar days. *	Confirmation medical records were received. Additional explanation of what records are required. An extension of time. Reopening a denied claim.	Providers may re-open a denied claim any time within 365 calendar days* by supplying the requested records to OrthoNet. After 365 calendar days* providers should contact EmblemHealth Provider Customer Service using the **Message Center in the Provider Portal** or call **866-447-9717.**
3. Review of Medical Records OrthoNet will review medical records within 3 business days of receipt. OrthoNet will recommend that EmblemHealth pay the claim, deny the claim, or pay the claim in part and deny the claim in part.	The status of the review. The length of the review.	OrthoNet at **877-499-9537** and request an update. EmblemHealth Provider Customer Service using the **Message Center in the Provider Portal** or call **866-447-9717.**
4. Claim Determination If a claim has been denied or partially denied, your explanation of payment from EmblemHealth will include a two-character denial message code.	The grounds for denial. Delay in review.	OrthoNet at **877-499-9537** to request a re-review and peer to peer review or to request an update. EmblemHealth Provider Customer Service using the **Message Center in the Provider Portal** or call **866-447-9717.**
5. Provider Re-review and Rebuttal (Peer to Peer with OrthoNet) Providers may contact OrthoNet at **877-499-9537** to receive an explanation of the grounds for denial. Providers may request a “re-review.” Providers may also supply additional documentation or provide information to rebut OrthoNet’s conclusion. Providers may request a “peer to peer” discussion of the grounds for denial and rebut OrthoNet’s conclusion. Providers should be contacted to set a time for peer review within 2 days of requesting a peer review.	Delay in scheduling a peer to peer review. The result of the peer to peer.	OrthoNet at **877-499-9537** to request an update. Providers who wish to appeal a denial following a peer to peer should follow the EmblemHealth Appeals process detailed in the applicable Dispute Resolution chapter of the EmblemHealth Provider Manual. EmblemHealth Provider Customer Service can assist you in requesting an appeal.
6. Claim Redetermination based		Providers who wish to appeal a denial following a peer to peer review should follow the EmblemHealth Appeals process detailed in the applicable

6. Claim Redetermination, based upon Peer to Peer Based upon the peer review, OrthoNet and EmblemHealth may pay all or additional portions of the claim.	The grounds for denial.	process detailed in the applicable Dispute Resolution chapter of the EmblemHealth Provider Manual. Your EmblemHealth Relationship Manager or EmblemHealth Provider Customer Services can assist you in requesting an appeal. Contact them Service by using the **Message Center in the Provider Portal** or call **866-447-9717.**
7. Provider Appeal Providers may appeal any denied claims after the peer to peer discussion by following the applicable Dispute Resolution chapter of the EmblemHealth Provider Manual.	The status of the appeal.	EmblemHealth Provider Customer Service using the **Message Center in the Provider Portal** or call **866-447-9717.**

*365 days from the timeout denial which starts on the 8 th day for failure to send medical records.

Allotted Time for providers to submit medical records	8 Business Days from the date of the request letter.
Total timeframe for provider to submit records?	Providers have 365 days to submit medical records from the date of the timeout denial.
Process for medical records not received within timeframe.	If records are not received within 8 business days, the claim will time out and a 'notes expired' denial will be sent back via the reply file.