Provider Update

OrthoNet to conduct professional service coding reviews for musculoskeletal providers

Summary: Effective November 1, 2015, Amerigroup Community Care will collaborate with OrthoNet, LLC to conduct a focused claim review program for musculoskeletal providers.

✦ **What this means to you:** Effective November 1, 2015, OrthoNet will conduct a post-service, prepayment coding review of professional services for all musculoskeletal provider specialties included in the focused claim review program, including but not limited to the specialties below.

Musculoskeletal provider specialties included in the focused claim review program

Cardiology	Pediatric sports medicine
Dermatology	Physiatry/physical medicine and rehabilitation
ENT	Plastic surgery
General surgery	Podiatry
Hand surgery	Neurosurgery
Pain management	Neurology
Pediatric orthopedics	Orthopedic surgery
Pediatric neurosurgery	Sports medicine
Pediatric neurology	Urology

These services may be selected for post-service, prepayment coding review of professional services.

What if I need assistance?

If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services toll free at 1-800-454-3730.

NJPEC-0752-15
Issued September 2015
by Amerigroup Community Care

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Focused claim review program question and answers

Purpose

This document provides important questions and answers regarding the Focused claim review program performed by OrthoNet beginning November 1, 2015.

Overview

Who is OrthoNet?

OrthoNet, LLC is a leading musculoskeletal management company located in White Plains, NY. They are a provider-based company with ties to leading practitioners in the Amerigroup Community Care service areas. OrthoNet has significant experience with inappropriate 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?

Our claims experience shows we are receiving a higher than average number of these services showing atypical billing patterns which may indicate inappropriate billing practices. We need to ensure that claims for our members receiving musculoskeletal procedures are not only medically necessary but are reported accurately.

Review process

What is OrthoNet's role in the review process?

OrthoNet will review selected musculoskeletal claims and compare the claim submitted to the services documented as rendered according to the operative report or office notes. OrthoNet will conduct this review in accordance with CPT and CMS billing guidelines.

What type of documentation will be required for this review?

Since this is a coding review, the operative report or office notes for the service will be required to be provided for OrthoNet review. If the operative report or office notes are not attached to the claim upon submission to Amerigroup, OrthoNet will request these records to be provided to them directly.

Note: If the operative report or office notes are not submitted by the provider, the service will be denied as office notes not received.

Which providers are included in this program?

The provider specialties included in this program include but are not limited to: orthopedic surgery, neurosurgery, podiatry, hand surgery, neurology, pain management, sports medicine, plastic surgery, general surgery, physiatry/physical medicine and rehabilitation (PM & R), ENT, dermatology, cardiology and urology.

Note: This program only applies to professional (CMS1500) claims. Facility claims (UB04) are excluded from this review.

Out-of network providers

If a member receives musculoskeletal services from a provider that is not directly contracted with the plan, will this coding review be required?

Yes. Out-of-network providers are subject to this coding review program.

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 Amerigroup participating provider, then that provider is required to provide the office notes. If the service was rendered by a nonparticipating provider, then the member is required to provide the office notes. OrthoNet will contact the nonparticipating provider in order to obtain these office notes on the member's behalf.

What happens if the operative report or office notes are not attached to the claim upon submission to the plan?

Claims selected for the focused claim review 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 directly and request that the required records be submitted to them directly. The claim will remain suspended for receipt of this additional information.

What happens if the operative report or office notes are not submitted to OrthoNet?

If OrthoNet has not received the records requested from the provider needed to conduct the coding review, the claim will be denied as records not received.

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

Yes. Office notes can be submitted post denial directly to OrthoNet for review. OrthoNet will provide their determination on the claim to an Amerigroup claims examiner who will adjust the claim accordingly.

What happens if the office notes submitted are missing information?

OrthoNet will call the provider to request the additional information.

What process should members follow to submit office notes to OrthoNet for review?

If a member is seeing a nonparticipating provider or a provider not contracted with Amerigroup, the member can request that the provider contact OrthoNet on their behalf to provide the needed records for review. OrthoNet will also directly contact the provider on the member's behalf to secure the necessary information.

Review determination

What types of determination will be issued by OrthoNet?

If the operative report or office notes indicate the service was rendered and was coded appropriately, OrthoNet will advise that it is a payable charge. If the office notes indicate the service billed was not rendered, OrthoNet will advise that it is a non-payable charge and the service will be denied. If the records indicate that the service rendered is not appropriately identified by the procedure code assigned to the claim, they will advise that it is a non-payable charge and the service will be denied.

How will the OrthoNet coding review determinations get into the Amerigroup claim systems?

OrthoNet will provide their determinations to Amerigroup claims examiners in a daily report. The Amerigroup claims examiner will access the determination from OrthoNet and release the claim for adjudication accordingly.

Notification of review results

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

The claim will be processed on the Amerigroup claims platform according to the OrthoNet coding review determination. An explanation of benefits and a remittance advice will be issued to the member and provider advising them of the coding review determination.

Codes subject to review

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

The codes subject to the focused claim review program can differ based on provider specialty. The procedure code categories included in the program are (but not limited to): spine/back surgery, total knee/hip replacement, knee/foot arthroscopy, foot/hand/finger surgery, carpal tunnel, podiatry, nail/skin grafts, nerve conduction studies, injections/trigger points, anthrocentesis, nerve blocks, neurostimulators, neurolytic agents, skin/wound care, breast surgery, nose excision/repair and sinus endoscopy.

Billing requirements

Are there any special billing requirements for this program?

Operative reports or office notes are required to be submitted for review. The provider has the option to provide these records attached to the claim upon submission to Amerigroup or to submit these office notes directly to OrthoNet upon their request.

Grievance and/or appeals

Who can a provider contact to discuss a coding review determination?

If a provider is unhappy with a coding determination made on their musculoskeletal claim, or has a question on how the determination was made, they can contact OrthoNet directly.

How are the administrative grievances and/or appeals handled?
Amerigroup will continue to handle all administrative grievances and/or appeals for our members and providers. OrthoNet will provide their coding review determination and rationale to Grievance and Appeal for their review.

Communications
How are providers notified of the implementation of this focused claim review program?
Providers will be notified of this program, its components and requirements, via the provider network update bulletin.

Claim processing
Will Amerigroup continue to process these claims?
Yes. Amerigroup will continue to process all claims related to musculoskeletal procedures and services and provide member benefit and eligibility information.

Contact numbers
If you have additional questions, please contact OrthoNet by telephone at 1-844-276-4258 or by fax at 1-844-679-4714.