Physical Therapy/Occupational Therapy Utilization Management Program
FAQs

Background
Effective November 1, 2015, Anthem Blue Cross and Blue Shield (Anthem) implemented a physical therapy (PT) and occupational therapy (OT) benefit management program for outpatient and office services. In order to help us effectively administer this program, we have contracted with an external vendor, OrthoNet LLC, to work with us on this initiative. The program includes Indiana, Kentucky, Missouri, Ohio and Wisconsin.

What is OrthoNet?
OrthoNet is a leading musculoskeletal management company located in White Plains, NY. OrthoNet is a provider-based company with collaborative relationships with leading practitioners in the Anthem service areas. OrthoNet has significant experience in promoting best practices and evidence-based health care for therapy services. OrthoNet works with physical and occupational therapists as well as other providers of therapy services and their patients.

When will providers be notified?
Providers were sent an initial 90 day notification in July 2015. Follow-up information was included in the provider newsletter, Network Update, and online.

What is OrthoNet’s role in the review process?
OrthoNet will receive all requests for office and outpatient physical and occupational therapy services and review those requests for medical necessity. Providers should contact OrthoNet for prior authorization requests. Providers will be notified by OrthoNet of the determination via mail and fax.

How can providers contact OrthoNet?
Members and providers may contact the OrthoNet call center at 844-282-6994 (fax: 844-216-1599) to begin the review process. The OrthoNet call center is open from 8am to 5:30pm in all time zones. Providers can also sign up for access to the OrthoNet website at www.orthonet-online.com to be able to submit authorizations and check the status of an authorization online.

What type of authorization will be required for PT/OT services?
This PT/OT program requires a utilization management (UM) precertification review. All outpatient and office PT and OT services following the initial evaluation will require pre-certification through OrthoNet. OrthoNet will also perform retrospective reviews as applicable in accordance with your contract.

What providers are excluded from this program?
Services rendered by the following providers are not reviewed in this program: Chiropractors, Acupuncturists, Massage Therapists, Home Health Centers or Agencies, and Skilled Nursing Facilities Inpatient Services.

What settings are excluded from this program?
Services rendered in the following settings are not reviewed in this program: services rendered as part of emergency room services, services rendered in a hospital inpatient setting, services rendered in an urgent care setting, services rendered as part of observation room services, services rendered in a home setting, and services rendered in a skilled nursing facility inpatient setting.
What products are included in this program?
Local Fully Insured Large Group, Small Group, and Individual products for both public and private exchange business including: HMO, PPO, POS, Traditional, and ASO (as a buy up option). (Note: A precertification requirement for Individual Medicare Advantage products was implemented in January 2015 and this requirement continues to be in effect.)

What products are excluded from this program?
Products that are excluded include Group Medicare Advantage, Medicaid, Medicare supplement, Medicare Part D, Anthem National Accounts (ANA), Federal Employee Program (FEP), and BlueCard.

Who is responsible for obtaining an authorization from OrthoNet?
- If a member is receiving care from an Anthem participating provider, that provider is required to secure the authorization from OrthoNet.
- If a member is receiving care from a non-participating provider, the member is responsible for ensuring the non-participating provider secures the authorization from OrthoNet.
- If a member is receiving care from an In Network provider located out of state (FL, TX, etc.) the member is responsible for ensuring the out of state provider secures the authorization from OrthoNet.

How will providers know which members require an authorization?
Providers may verify eligibility and benefits online through the Availity Web Portal. Go to www.availity.com, enter your Availity User ID and Password, click the Eligibility & Benefits box, from the Top Applications menu, complete requested information. Providers may also contact the Anthem Provider Services phone number on the back of the member’s ID card for benefit information. They will be informed whether the OrthoNet program applies. If providers use ICR to pre-certify an outpatient PT/OT service, ICR will produce a message referring the provider to OrthoNet. (Note: ICR cannot accept pre-certification requests.)

What process should providers follow to request authorizations?
Beginning October 19, 2015 providers can request authorizations in any of three ways.

1. **By fax**: Providers may complete the OrthoNet Fax Request Form (containing the member’s demographics and insurance information) and the PT/OT Initial Report Form or Functional Progress Chart (containing the member’s supporting clinical information). These documents are available on the OrthoNet website, www.orthonet-online.com. Providers may also use their own forms or clinical notes that will supply the same information. These documents need to be faxed to the OrthoNet Medical Management Automated Fax Request line, 844-216-1599.

2. **By Phone**: Providers may contact the OrthoNet call center at 844-282-6994 in order to start the authorization request by supplying the member’s information. The provider may then complete the PT/OT Initial Report Form or Functional Progress Chart (containing the member’s supporting clinical information), available on the OrthoNet website, www.orthonet-online.com. Providers may also use their own forms or clinical notes that will supply the same information. The provider will then complete the request by faxing these documents to the OrthoNet Medical Management Automated Fax Request line, 844-216-1599.

3. **By website**: Providers may go to OrthoNet’s website (www.orthonet-online.com) to start the authorization process by supplying the member’s information. Providers must request a New User Account in order to submit authorization requests online. The provider may then complete the PT/OT Initial Report Form or Functional Progress Chart (containing the member’s supporting clinical information), available on the OrthoNet website, www.orthonet-online.com. Providers may also use their own forms or clinical notes that will supply the same information.

What happens if the OrthoNet Fax Request Form and/or the clinical documentation are missing information?
OrthoNet will call the provider to request the additional information.
What are the levels of review for an authorization request?
OrthoNet employs a variety of clinicians to render review requests (PTs, OTs, RNs, etc.). If a clinician reviews a particular case and is unable to approve the authorization request, the case is directed to a licensed MD or DO. That physician will review the medical necessity criteria along with all clinical information sent from the provider and will issue the determination according to his/her findings.

Do providers who are currently in the middle of therapy treatment with a patient need to obtain authorization?
Yes. Providers are required to obtain pre-certification for members already in a course of treatment for services that are scheduled to occur on and/or after date of service November 1, 2015.

Can providers request an authorization after a PT/OT service is provided?
Yes. Providers should make every effort to submit authorization requests in a timely manner, but do have 48 hours after the service is provided to submit an authorization request. Anything after that 48 hour timeframe would need to be submitted as a retrospective review. As of 10/17/16, OrthoNet will perform retrospective reviews as applicable in accordance with your contract.

How are providers and members notified of the results of the request?
OrthoNet will review the request and its supporting clinical data and assign an authorization number as appropriate within two business days of the receipt of all required clinical information. OrthoNet authorization numbers will be stored in the Anthem system. Providers will be notified via mail and fax of the authorization number and the number of visits approved. Members will be notified by mail.

How can providers check the status of an authorization request?
Providers can contact the OrthoNet call center at 844-282-6994. If a provider has been set up for online access, they can also log into the OrthoNet website (www.orthonet-online.com) in order to check the authorization status.

Does the initial PT/OT evaluation require pre-certification?
No. The initial evaluation, or any associated therapy service(s) provided during that same visit, does not require review. To ensure proper reimbursement, initial evaluation codes below should be submitted on the claim.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>97001</td>
<td>PHYSICAL THERAPY EVALUATION</td>
</tr>
<tr>
<td>97003</td>
<td>OCCUPATIONAL THERAPY EVALUATION</td>
</tr>
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Is the pre-certification number required to be submitted on the claim?
No. Anthem’s system will automatically align the claim with the appropriate authorization.

How do authorizations get into the Anthem system – electronically or manually?
OrthoNet transmits a nightly authorization file to us Monday through Friday which is then loaded into the claims system.

What are the pre-certification requirements when Anthem is the secondary insurer?
Pre-certification is not required when Anthem is secondary to any commercial insurer or any Medicare product, program or plan.

Are there any special billing requirements?
For Medicare Advantage, CMS requires that modifier GP be appended to all physical therapy services and modifier GO be appended to all occupational therapy services. For Commercial, although not required, these modifiers are requested to be appended to all physical and occupational therapy services when submitting claims on a CMS-1500 form for services delivered under an outpatient or office occupational or physical therapy plan of care. Providers billing on a UB-04 form are not required to bill with the GP or GO modifiers.
What happens if a provider/member has an authorization from OrthoNet but the member’s benefits have been exceeded?
An authorization number is not a guarantee of payment. An authorization is a statement that the service meets the medical necessity requirements. Compensation is based on the provider’s agreement with Anthem and terms of the member’s certificate of coverage.

How are member and physician appeals handled?
Anthem will continue to handle all administrative and clinical appeals for members and providers.

Will providers have access to the OrthoNet review criteria?
If a provider receives a pre-certification denial, the provider can request the specific criteria applied to that member and OrthoNet will make it available.

Will Anthem continue to process these claims?
Yes. Anthem will continue to process all claims related to outpatient and office physical and occupational therapy services and provide member benefit and eligibility information.

Do we have a list of PT/OT procedure codes that will be subject to the pre-certification program?
Yes. The codes subject to the pre-certification program are available online at www.anthem.com.