AETNA Therapy Management Program

Frequently Asked Questions

Listed below are Frequently Asked Questions (FAQs) regarding the clinical policies and procedures for network providers providing therapy services to Aetna HMO, Golden Choice Plan and Golden Medicare Plan members.

1). What is OrthoNet's role in the authorization process?

Aetna has delegated Medical Management and Claim responsibilities for in-network occupational and physical therapy services to OrthoNet for *HMO, Golden Choice Plan and Golden Medicare Plan* members. OrthoNet will process all requests for additional therapy services, other than the initial visit, and perform utilization review services.

2). What is the effective date of this Agreement?

New York Based Membership: Effective July 1, 2005, any outpatient rehabilitation services provided to Aetna New York-based HMO and Golden Medicare members will require an authorization from OrthoNet. Rehabilitation providers may see members upon referral from an Aetna participating physician for an initial evaluation visit. After the initial visit, therapy providers must contact OrthoNet to obtain approval for subsequent visits.

New Jersey Based Membership: Effective August 1, 2005, any outpatient rehabilitation services provided to Aetna New Jersey-based HMO and Golden Medicare members will require an authorization from OrthoNet. Rehabilitation providers may see members upon referral from an Aetna participating physician for an initial evaluation visit. After the initial visit, therapy providers must contact OrthoNet to obtain approval for subsequent visits.

3). What services does this include?

All outpatient physical and occupational therapy is included. Services provided by chiropractors are excluded.

4). What services are not included?

This agreement does not include rehabilitation services performed in the home (provided by a home health care agency) or services provided by chiropractors. This Agreement also does not include speech therapy.

5). Does this change any Aetna member's benefit limits for outpatient rehabilitation?

No, this does not affect any current benefit limits, they will still apply.

Physicians

6). Can physicians refer their Aetna patients to any participating Aetna provider for PT/OT?

Effective July 1, 2005 Aetna physicians may refer their patients to any participating physical or occupational therapist found in Aetna's online provider referral directory. (found by logging on to www.aetna.com, select "Doctors & Hospitals" then "Physician Self-Service". Select "Referrals" and then "Online Provider Referral Directory.")

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Frequently Asked Questions (Continued)

7). Is a referral required?

No, an Aetna referral is not required to request physical or occupational therapy services for an Aetna member. Physicians do <u>not</u> have to contact OrthoNet for approval prior to referring members for a therapy evaluation**.**

8). How does this affect physicians who provide therapy services in their office?

Physicians who have contracts with Aetna to perform office based physical and/or occupational therapy will be required to obtain an authorization from OrthoNet for all visits other than the initial evaluation.

Hospital Outpatient Rehabilitation

9). Will hospital based physical therapy departments be required to obtain authorization?

Yes, all outpatient physical and occupational therapy performed in a hospital must be authorized after the initial evaluation visit. <u>Please note: For New York State hospitals providing care to New York–based HMO members the effective date for the pre-certification requirement is July 15, 2005.</u>

10). Will hospitals be required to contract with OrthoNet for outpatient rehab services?

No, hospitals can continue to participate through their existing Aetna Agreement.

11). Where will hospitals submit their claims for physical and occupational therapy?

Hospitals who are not contracted with OrthoNet will continue to bill Aetna for these services as they do today. Claims for physical and occupational therapy services will be paid according to their existing Aetna agreement.

Rehabilitation Providers

12). How do I join the OrthoNet network?

OrthoNet has sent out an information packet to all Aetna therapy providers which contained the necessary information and application forms needed to join its network. Please complete the information requested and send it back to OrthoNet for processing. If you have not received an information packet please contact us.

If you call us, the OrthoNet Provider Services Representatives will request the following information from all providers requesting membership in the network:

- Contact name
- Facility name
- Facility address (Including City, State and Zip Code)
- Phone number
- Fax Number

This information will be forwarded to the OrthoNet Network Development Department for the mailing of applicable credentialing materials.

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Frequently Asked Questions (Continued)

13). Will I still be able to participate in the Aetna network if I don't join OrthoNet?

The majority of Aetna's participating therapy providers currently are in the OrthoNet network. If a provider is not in the OrthoNet network they are encouraged to join to ensure that they will be able to continue to see Aetna members. OrthoNet will credential new providers during the initial 90 day period of this program and after that time additional providers may not be added, depending upon geographic need or access requirements.

14). How will provider payment change when this agreement becomes effective?

New York Providers: Effective August 1, 2005, outpatient rehabilitation providers will be reimbursed according to their OrthoNet agreement. If a provider is not contracted with OrthoNet as of this date they will continue to receive the applicable capitation payment until they receive notification from Aetna informing them otherwise.

New Jersey Providers: Effective September 1, 2005, outpatient rehabilitation providers will be reimbursed according to their OrthoNet agreement. If an existing Aetna provider is not contracted with OrthoNet as of this date they will continue to receive the applicable reimbursement from Aetna until they receive notification informing them otherwise.

15). What happens if an Aetna member receives outpatient therapy without an authorization?

New York Providers: Effective August 1, 2005, any claim submitted for services, other than the initial evaluation, which does not have a valid authorization will be subject to denial. All providers, both participating and non-participating, will be required to pre-certify additional therapy services under this program.

New Jersey Providers: Effective September 1, 2005, any claim submitted for services, other than the initial evaluation, which does not have a valid authorization will be subject to denial. All providers, both participating and non-participating, will be required to pre-certify additional therapy services under this program.

16). Will this program affect all Aetna members?

Only members in an Aetna HMO-based plan, including the Golden Medicare Plan, will require an authorization for outpatient therapy services. The effective date for New York members is July 1, 2005, for New Jersey members it is August 1, 2005.

17). How do I obtain an authorization from OrthoNet.

Current Aetna and OrthoNet providers will receive a packet from OrthoNet fully explaining the authorization process.

18). What about patients currently undergoing a course of therapy

New York Providers: Any member whose course of therapy treatment began prior to July 1st will only need to pre-certify visits that will occur on or after July 15th. If they will not be continuing with care after July 15th they will not need to have their

visits authorized. Any member commencing their therapy treatment on or after July 1, 2005 will need to have all of their therapy visits (excluding the initial evaluation) pre-certified by OrthoNet.

New Jersey Providers: Any member whose course of therapy treatment began prior to August 1st will only need to pre-certify visits that will occur on or after August 15th. If they will not be continuing with care after August 15th they will not need to have their visits authorized. Any member commencing their therapy treatment on or after August 1, 2005 will need to have all of their therapy visits (excluding the initial evaluation) pre-certified by OrthoNet.

19). Does the initial evaluation need to be authorized?

Initial therapy visits do not require authorization in this program. However, subsequent visits do require authorization from OrthoNet prior to the patient being treated. Although no longer necessary, OrthoNet recognizes that many providers will still wish to verify eligibility/benefits and authorize the patient's initial therapy visit.

Please follow the procedures outlined below for requesting pre-certification of additional visits. Please make sure that you use an OrthoNet-Aetna Fax Request Form for all therapy visit requests.

20). How do I submit a request for additional therapy visits?

A. Complete the Fax Request Form.

In the Therapy Provider Information section provide either the facility name or treating provider name with their corresponding OrthoNet identification number. Also, to identify offices with multiple locations, please complete the address, city, state, and zip fields of the location where the member is to be treated.

In the Member Information section, fill in the member's name, date of birth and AETNA identification number. Please fill in the fields from left to right. In the Request Information section, darken the appropriate request type circle and complete the request type, service type, whether the visits will be used for post-operative therapy, date of initial evaluation, diagnosis, and requested number of visits fields.

B. Submit the Fax Request Form.

Please fax the completed form along with a copy of the completed PT/OT Initial Report Form or its' equivalent, to OrthoNet's Medical Management Fax Server at **1-800-477-4310**. Please submit only Fax Request Forms and any associated documents to this number.

If you do not have any Fax Request Forms they may be obtained by accessing our website at www.orthonet-online.com or by calling OrthoNet's Provider Services Department at **1-800-771-3205** and a package will be mailed to you.

Frequently Asked Questions (Continued)

C. Receive the authorization number.

It is OrthoNet's goal to review the request and supporting clinical data, verify eligibility/benefits, render a determination and assign an authorization number, if approved, within one (1) business day following the receipt of all necessary information.

Providers will be notified via fax of the authorization number assigned and the number of visits approved. Additional information regarding the status of authorizations may be obtained by visiting our website, www.orthonet-online.com, and selecting the "Check the status of authorizations and claims".

21). What will OrthoNet need to render a decision on my request?

In order for OrthoNet to promptly respond to your request, objective clinical data needs to be supplied. Examples of objective clinical data include, but are not limited to: strength, active range of motion, functional status, short and long term treatment goals, and a treatment plan.

This information may be supplied on OrthoNet's PT/OT Initial Report Form, Functional Progress Chart, or on your own forms or clinical notes that would supply the same information.

22). Who will be reviewing my request?

Your request for additional visits will be reviewed by a licensed rehabilitation professional. Furthermore, OrthoNet has board-certified physicians and professionals that are experienced in the areas of orthopedics, neurology, pediatrics and sports medicine.

23). When will the decision be made?

OrthoNet understands the importance of the continuity of care for patients receiving rehabilitation services. In order to maintain this continuity, OrthoNet's goal is to review the request and supporting clinical data, verify eligibility/benefits, render a determination and assign an authorization number, if approved, within one (1) business day following the receipt of all necessary information.

24). How will I find out about the decision?

OrthoNet will fax all decision letters to providers after a decision has been made. These letters will be faxed to the fax number that is on file for each provider. For this reason, it is especially important for facilities that have more than one location to specify the location where the member will be treated on the Fax Request Form.

25). Why do I have to use OrthoNet's Fax Request Form?

Due to the high volume of requests and updates received daily at OrthoNet, it is imperative that all fax submissions be accompanied by an OrthoNet Fax Request Form. This enables OrthoNet to identify, route, track and review all submissions in a prompt and efficient manner. Submissions without the form or incomplete forms can not be processed.

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Frequently Asked Questions (Continued)

26). Can I treat prior to authorization?

If you treat a patient prior to OrthoNet's authorization determination, for those visits, please be advised that authorization may not have been given and that those visits might not be eligible for benefits. Should you need to, you may call OrthoNet's Provider Service Department at **1-800-771-3205** to ascertain the status of a member's authorization request.

Our authorizations all bear expiration dates. Should you wish to request an extension of an unexpired authorization, please call OrthoNet's Provider Service Department at **1-800-771-3205** prior to the authorization's expiration date. OrthoNet's policy is that expiration dates will be extended if calls are received prior to the expiration date as long as it fits within the member's benefit timeframes.

27). Does OrthoNet review and authorize requests for splints, braces, and other DME?

There is no change to the current Aetna policies for dispensing splints, braces, and/or other forms of durable medical equipment. Any item currently requiring pre-certification or pre-notification will continue to require approval by Aetna. Reimbursement will be made by Aetna according to Aetna payment policies and fee schedules. Providers should refer to their Aetna Provider Manual or contact Aetna Provider Services at **1-800-624-0756** if they should have any questions regarding this issue. Supplies, other than the items described above, that would normally be dispensed or utilized during a therapy visit such as Thera-Band ™, exercise putty, home exercise sheets, disposable electrodes, elastic bandages, and iontophoresis/ phonophoresis medications are considered included visit reimbursement fees.

28). Where do we submit claims?

New York Based Membership:

All Claims for Dates of Service **prior to August 1, 2005 should continue to be submitted to Aetna.**

Providers who have signed a 3-way agreement and/or who have a contract with OrthoNet should submit all PT/OT claims for dates of service on or after August 1, 2005 to OrthoNet as described below. [Providers who are not contracted with OrthoNet and/or have not signed a 3-way agreement should continue to submit claims to Aetna as you do today.] *Note: All services will still require a valid authorization from OrthoNet – whether you are contracted (participating) with OrthoNet or not.*

New Jersey Based Membership:

All Claims for Dates of Service **prior to September 1, 2005 should continue to be submitted to Aetna.**

Providers who have signed a 3-way agreement and/or who have a contract with OrthoNet should submit all PT/OT claims for dates of service on or after

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September 1, 2005 to OrthoNet as described below. [Providers who are not contracted with OrthoNet and/or have not signed a 3-way agreement should continue to submit claims to Aetna as you do today.] *Note: All services will still require a valid authorization from OrthoNet – whether you are contracted (participating) with OrthoNet or not.*

Paper claims can be mailed to OrthoNet at the following address:

OrthoNet (Aetna)
Claims Department
P.O. Box 5034
White Plains, NY 10602-5034

OrthoNet can not accept and/or process any faxed claims. Faxed claims will be returned.

Electronic submissions are accepted using WebMD. You must provide # **13383** as the Payor identification number. If you have any questions on electronic submissions, you may contact WebMD directly at **1-800-845-6592**.

28). Where do we send claim appeals?

Only those claims processed by OrthoNet are subject to appeal through OrthoNet.

Claim Appeals can be mailed to OrthoNet at the following address:

OrthoNet (Aetna)
Claims Department
P.O. Box 5053
White Plains, NY 10602-5053

You may also fax the information to OrthoNet's Correspondence Department at **1-914-949-4929**.

29). What is the claims filing time?

Claims with required information must be submitted within 90 days following the date that services are rendered. In those cases where Aetna is secondary payor for any reason (i.e. auto, third party liability, worker's compensation) the claims will be paid if it is submitted within 30 days of receiving a determination of benefits from the other payor, health plan or insurance carrier. Aetna members cannot be billed for claims denied due to late submission.

*New York providers have 120 Days from date of service and 45 Days from the last denied or paid date on the claim.

If you should have additional questions regarding this program please visit our website at www.orthonet-online.com or contact OrthoNet's Provider Services Department at **1-800-771-3205** for further assistance.