Focused claim review program questions and answers

Purpose

Amerigroup Community Care participates in a number of OrthoNet, LLC programs. This document provides important questions and answers specific to the focused claim review (FCR) program performed by OrthoNet.

Overview

Who is OrthoNet?

For the FCR program, 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?

Our claims experience shows that we receive 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.

When will the FCR program begin?

This will vary by market, but any eligible claim received after that market's go-live date can be reviewed by OrthoNet, regardless of the date of service. Providers have been advised of a program start date of [June 1, 2015].

Review process

What is OrthoNet's role in the review process?

OrthoNet will review selected musculoskeletal claims and compare the claim submitted with the services documented as rendered according to the operative report or office notes. 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?

Since this is a coding review, the operative report or office notes for the service will be required for OrthoNet review. If you do not send the operative report or office notes with the claim, OrthoNet will request these records be provided to them directly (within 13 days) prior to claim payment. Note: If the operative report or office notes are not submitted by the provider, the service will be denied.

Impacted members and providers

Which members are impacted in this program?

Government Business Division (GBD) in scope:

- Specialty Products Group (SPG) and Medicare Advantage – all states, group and individual

- Medicaid – FL, GA, IN, KY, LA, MD, NJ, NV, NY, SC, TN, TX, VA, WA, WI and WV

Which providers are included in this program?
This program includes but is not limited to the following provider specialties: orthopedic surgery, neurosurgery, podiatry, hand surgery, neurology, pain management, sports medicine, plastic surgery, general surgery, physiatry/physical medicine and rehabilitation, dermatology, cardiology, urology and ear, nose and throat.

Note: This program only applies to professional (CMS 1500) claims. Facility (UB04) claims are excluded from this review.

Out-of network providers
If a member receives musculoskeletal services from a provider who is not directly contracted with Amerigroup, 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 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 medical records. If the service was rendered by a nonparticipating provider, OrthoNet will contact the nonparticipating provider in order 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?
If the provider submits the operative report or office notes with the claim, the information will be received by Orthonet. It will then be reviewed and a determination will be made and communicated. If the required operative report or office notes are not received with the claim, Orthonet will contact the provider directly and request the required information be sent within 13 days.

Will operative reports or office notes be accepted after a claim has been denied as records not received?
Yes. Medical records can be submitted post-denial directly to OrthoNet for review. OrthoNet will provide their determination on the claim and an Amerigroup claims examiner will adjust the claim accordingly.

What happens if the medical records submitted have missing information?
OrthoNet will contact the provider to request the additional information.

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 payment will be sent to the provider advising

them of the coding review determination. The explanation of payment codes associated with the Orthonet review are: OR2, OR3, OR4, OR5, OR6 and OR7.

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 FCR program may 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, 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. OrthoNet will contact you to request the operative report or office notes and provide instructions for submission as needed. Submit these records directly to OrthoNet upon their request.

Communications

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

Providers were 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.

Questions not addressed above

If a provider has a question that is not addressed above, reassure them that they will get additional information by fax and website prior to state notification requirements. At this point, there is no change in any review system, so there is nothing additional required.

Appeal Rights: Refer to the state's Provider Manual and/or the Amerigroup Provider Manual.