LICENSING ORTHONET CLINICAL CRITERIA

OrthoNet of the Mid-Atlantic, Inc. ("ODS") is licensed by the State of New Jersey as an Organized Delivery System, under which license ODS provides its New Jersey health-plan customers with utilization management of physical and occupational therapy ("PT/OT"), as well as other management services. In providing utilization management of PT/OT, ODS uses the clinical guidelines (the "OrthoNet^{SM} Clinical Criteria"), which have been developed over many years by OrthoNet LLC ("OrthoNet"), a New York limited liability company. The OrthoNet Clinical Criteria are comprised of a series of evidenced-based criteria which, for each standard episode of PT/OT care, describe the clinical factors that may be applied by professional care managers and qualified medical directors to determine if additional skilled PT/OT services are medically necessary.

Interested parties may license the OrthoNet Clinical Criteria directly from OrthoNet. Most customers, however, elect OrthoNet's turnkey PT/OT program, in which OrthoNet fully implements the OrthoNet Clinical Criteria for the health plan, either for a stated management fee or on a risk-capitation basis.

For further information on licensing the OrthoNet Methods for your organization, please write to Product Licensing, OrthoNet LLC, 1311 Mamaroneck Avenue, White Plains, New York 10605, or email at LicensedCriteria@orthonet-online.com.

ORTHONET CLAIMS PROCESSING & PAYMENT INFORMATION

The following information describes ODS' the documentation that must be submitted with claims by New Jersey providers:

Claims Submission

Services must be billed on Form HCFA-1500 (physicians) or Form UB-92 (facilities), in a HIPAA compliant electronic format. Claim forms must be complete and submitted with all information requested by the member's carrier. This includes, but is not limited to, the billing of services using up-to-date ICD-9 (Provider & Diagnostic Codes) and CPT (Current Procedural Terminology) Codes.

Unless otherwise stipulated in the provider's participating provider contract (with OrthoNet or the carrier, as the case may be), claims must be submitted within 90 days of the date of service.

Additional documentation requirements

OrthoNet requires additional documentation under the following circumstances:

OrthoNet is not the member's primary carrier
In this case, OrthoNet requires that the member's primary insurance carrier be billed first. After final disposition of the claim by the primary carrier, the claim should be submitted to OrthoNet along with the primary insurance carriers Explanation of Payment (EOP).

Possible Third Party Liability
If the claim is the result of an accident, OrthoNet may find it necessary to request details of the accident prior to adjudication of the claim.

Services that require the review of the treatment notes
In certain circumstances, claims of designated providers may be subject to "focused claims review," in which case the designated provider will be required to submit supporting clinical notes with their claims. Providers whose claims are subject to focused review will be notified by either OrthoNet or the respective carrier of this in advance, which notice will provide greater specificity on how and what to submit. Similarly, in certain circumstances OrthoNet or the carrier may designate certain procedures that will not be paid unless supporting clinical notes are submitted. Providers will be notified by either OrthoNet or the respective carrier of this in advance, which notice will provide greater specificity on how and what to submit.

Claims submitted without required documentation will not be paid and a request for the additional documentation will be sent to the provider via explanation of benefit (EOB).

Reduction of payment for duplicate/subsequent services.

For physical and occupational therapy claims services for Aetna, CIGNA, Health Net and US Family Health, for which network and claims services have been contractually delegated to OrthoNet, providers contracted with OrthoNet are reimbursed at a per visit rate and are not subject to the standard payment reductions that apply in fee-for-service reimbursement structure.

Providers contracted directly with Oxford Health Plan remain subject to their respective health plans claims payment policies and procedures, even where OrthoNet provides claims services. Please refer to Oxford's website for payment reduction guidelines.

Claims Appeals.

Providers may file a claim appeal when appropriate for claims in which the determination was made to deny or reduce payment. To file a claim appeal, providers must complete and submit the attached New Jersey Department of Banking and Insurance *"Health Care Provider Application to Appeal a Claims Determination"* Form for the applicable Health Plan for which services were performed. ***(Please refer to the appropriate NJ Claim Appeal Form which can be found under the applicable Health Plan in the "Health Plan Contracts" section of this website.)***

Claim Appeal Information:

You have the right to appeal claims determination(s) on claims you submitted to OrthoNet. You also have the right to appeal an apparent lack of activity on a claim you submitted.

DO NOT submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- OrthoNet's determination indicates that we considered the health care services for which the claim was submitted not to be medically necessary, to be experimental or

investigational, to be cosmetic rather than medically necessary or dental rather than medical. INSTEAD, you may submit a request for a Stage 1 UM Appeal Review. To do so, follow the instructions to initiate a Stage 1 UM Appeal Review described in the non-certification letter received. For more information, contact the OrthoNet Medical Management Appeals Department at 914-681-8800.

- OrthoNet's determination indicates that we considered the person to whom health care services for which the claim was submitted to be ineligible for coverage because the health care services are not covered under the terms of the relevant health benefits plan, or because the person is not a Health Plan member. INSTEAD, you may submit a complaint. For more information, contact the Provider Services or Member Services Department of the applicable Health Plan to confirm the information provided.
- OrthoNet has provided you with notice that we are investigating this claim (and related ones, as appropriate) for possible fraud.

You MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF OrthoNet's determination:

- Resulted in the claim not being paid at all for reasons other than a UM determination or a determination of ineligibility, coordination of benefits or fraud investigation
- Resulted in the claim being paid at a rate you did not expect based upon the payment agreement between you and OrthoNet
- Resulted in the claim being paid at a rate you did not expect because of differences in our treatment of the codes in the claim from what you believe is appropriate
- Indicated that OrthoNet requires additional substantiating documentation to support the claim and you believe that the required information is inconsistent with OrthoNet's stated claims handling policies and procedures, or is not relevant to the claim

You also MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- You believe OrthoNet has failed to adjudicate the claim, or an uncontested portion of a claim, in a timely manner consistent with law, and the terms of the contract between you and OrthoNet, if any
- OrthoNet's determination indicates we will not pay because of lack of appropriate authorization, but you believe you obtained appropriate authorization from OrthoNet or another carrier for the services
- You believe OrthoNet has failed to appropriately pay interest on the claim
- You believe OrthoNet's statement that we overpaid you on one or more claims is erroneous, or that the amount OrthoNet has calculated as overpaid is erroneous
- You believe OrthoNet has attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims (essentially, that we have under-priced the current claim)