Frequently Asked Questions
Listed below are Frequently Asked Questions (FAQs) regarding the clinical policies and procedures for providers providing therapy services to Anthem members.

Why is Anthem implementing this Utilization Management (UM) program?
Anthem claims experience shows that the number of members receiving PT/OT and number of visits rendered per case exceed the regional benchmark. Anthem wants to be sure that members are receiving physical and occupational therapy care when they need it and that the care is focused on producing the results the members need.

What is the effective date for the program?
The effective date of this program is November 1, 2015

What impact, if any, will this have on providers?
This program does not eliminate any current provider from the Anthem network. The program is designed to provide a uniform, outcome-based set of criteria for the provision of rehabilitation services.

What services does this include?
All outpatient and office based physical and occupational services are included.

What services are not included?
This management program does not include inpatient rehabilitation, speech therapy, home health, DME requests (e.g. splints), services performed by a chiropractor, cardiac or pulmonary rehabilitation.

What members are included or excluded from this program?

Members included
Use the table below to determine the plans included in the program.

<table>
<thead>
<tr>
<th>Markets</th>
<th>Products in scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All Markets</td>
<td>• Individual</td>
</tr>
<tr>
<td>• West: California, Colorado, Nevada</td>
<td>• Traditional (grandfathered and grandmothered plans)</td>
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<tr>
<td>• Central: Indiana, Kentucky, Ohio,</td>
<td>• Small Group</td>
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<tr>
<td>Missouri and Wisconsin</td>
<td>• Large Group</td>
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<tr>
<td></td>
<td>• ACA (HIX)</td>
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<td></td>
<td>• Private Exchange (PEX)</td>
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<td></td>
<td>• Local Fully-Insured</td>
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<tr>
<td></td>
<td>• PPO</td>
</tr>
<tr>
<td>All Markets except California</td>
<td>• HMO</td>
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<tr>
<td></td>
<td>• POS</td>
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<td></td>
<td>• ASO (as a buy-up option)</td>
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</tbody>
</table>

Members excluded
The members and plans listed below are excluded from the program.

• Medicare
• Anthem National Accounts FI (WGS, CS90, NASCO)
• FEP
• Medicaid
• Medicare Advantage
• Medicare Supplement
• HOST (Not our member)
What providers and/or settings are excluded from the program?

Providers excluded
The following providers are excluded from participation in this program.

- Chiropractors
- Acupuncturists
- Massage Therapists
- Home Health Centers or Agencies
- Inpatient Skilled Nursing Facilities

Settings excluded
The following settings are excluded from participating in this program.

- Services rendered as part of an emergency room service.
- Services rendered in a hospital inpatient setting.
- Services rendered in an urgent care setting.
- Services rendered as part of an observation room services
- Home based services

What is OrthoNet’s role in the authorization process?
Anthem has delegated utilization management responsibilities for outpatient and office based physical and occupational therapy services to OrthoNet effective November 1, 2015. OrthoNet’s scope of responsibility includes the management of the prior-authorization process for these outpatient and office based services in accordance with Coverage Determination documents and Anthem’s medical polices and clinical utilization management guidelines. This will be for new cases only for dates of service on or after November 1, 2015

Does this change any Anthem member’s benefit limits for outpatient rehabilitation?
No, this does not affect any current benefits. Benefit information for Anthem members is available by calling the number on the member’s card or by viewing the member's benefits in Availity.

Where will providers submit their claims for physical and occupational therapy services?
Providers should continue to bill Anthem for services as they do today. There is no change to the claims submission process. Claims for these services will be paid according to the provider’s existing Anthem agreement.

How do I obtain an authorization from OrthoNet?
Providers will receive information from the plan explaining the authorization process. Additional information is available either online at www.orthonet-online.com or by calling OrthoNet’s Provider Services. Providers in California should call 844-691-4062.

*Please note: An authorization is not a guarantee of payment and it is contingent upon the member's benefits, contract limitations and eligibility at the time of service.*
How do I submit a request for prior authorization of therapy visits?

A. Complete the THERAPY Fax Request Form (available online at www.orthonet-online.com, in the provider section, select the appropriate health plan).
   In the Therapy Provider Information section provide either the facility name or treating provider name with their corresponding provider identification number (tax ID and/or NPI). Also, to identify offices with multiple locations, please complete the address, city, state, zip code fields and the fax number of the location where the member is to be treated and where return authorization notification is to be sent. In the Patient Information section, fill in the member’s name, date of birth and the member’s Anthem 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 and diagnosis. Please complete this form with all the required information. This will ensure that your request will be processed timely upon receipt.

B. Submit the Fax Request Form.
   Please fax the completed form along with a copy of a completed PT/OT/ST Initial Report Form or its equivalent, to OrthoNet’s Medical Management Fax Server. California providers should fax the form to 844-349-7496. Please submit only Fax Request Forms and any associated documents to this number. If you do not have Fax Request Forms, they may be obtained by accessing our website at www.orthonet-online.com, in the provider section, select the appropriate health plan; or by calling OrthoNet’s Provider Services Department and a package will be mailed to you.

   Providers in California should call 844-691-4062.

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 two business days following the receipt of all necessary information. Providers will be notified via fax of the approval status and the number of visits approved.

What will OrthoNet need to render a decision on my request?
In order for OrthoNet to promptly respond to your request, please provide current, objective clinical data (i.e., strength, active and passive ranges of motion, functional capabilities and limitations, etc.) that address both the Member’s response to treatment and the progress made towards outlined goals. It is also important to submit baseline scoring and subsequent results of any functional testing performed during the treatment period. This information may be supplied on OrthoNet’s report forms, Functional Progress Chart, or by using your own forms or clinical notes that would supply the same information. If the member is currently in treatment, be sure to include the initial evaluation and most recent re-evaluation so that progress can be measured throughout the course of care.

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, chiropractic, physiatry, neurology, pediatrics, podiatry and sports medicine.

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, render a determination within two (2) business days following the receipt of all necessary information.

How will I find out about the decision?
OrthoNet will fax all decision notifications to providers after a decision has been made. These notifications will be faxed to the fax number that is on file with Anthem 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 and to complete the fax number section of the form.

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 important 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 cannot be processed.

**Do I have to use OrthoNet’s clinical documentation templates?**
No, information may be supplied on OrthoNet’s report forms, Functional Progress Chart, or by using your own forms or clinical notes that would supply the same information. It is important that all objective information be provided in order for the request to be processed in a timely manner.

**Does the initial evaluation need to be authorized?**
Initial evaluation treatment visits do not require prior authorization. However, subsequent visits do require authorization from OrthoNet prior to the patient being treated. Please follow the procedures outlined above for requesting pre-certification of additional visits. Please make sure that you use the appropriate OrthoNet-Anthem Fax Request Form for all treatment visit requests.

**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 to inquire about the status of a member’s authorization request.

**Where do we send claim appeals?**
There is no change to the claims appeal process. Providers should continue to submit claim appeals to Anthem in the usual manner. Questions regarding claims and appeals should be directed to Anthem.

**What about patients currently undergoing a course of treatment?**
Any IN, WI, OH, KY, or MO member who is already in an active course of treatment on or after November 1, 2015 will need those services authorized through OrthoNet.

Any CA, CO, or NV member already in an active course of treatment prior to November 1, 2015 will not need those services authorized through OrthoNet until dates of service on or after December 1, 2015.

**What if I have a question that is not answered above?**
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 or you may contact your Anthem Provider Relations Representative.

Providers in California should call 844-691-4062.