healthfirst®
Health Insurance for New Yorkers

Frequently Asked Questions

OrthoNet – Prior Authorization Review for Peripheral Vascular Surgery Procedures

Why is Healthfirst implementing this program?

Healthfirst is dedicated to the well-being and highest level of care for its members; that's why this program has been implemented. The program was implemented to help ensure patients receive appropriate care for their vascular conditions or care that is covered under their benefit plan.

The program's effective date is June 1, 2018.

OrthoNet will begin accepting prior authorization requests on May 21, 2018 for procedures performed on or after June 1, 2018.

What impact, if any, will this have on providers?

Providers will now contact OrthoNet instead of Healthfirst for all authorizations. This program is designed to provide a uniform, outcome-based set of criteria for the provision of selected peripheral vascular procedures.

The program provides the ability to discuss proposed cases that cannot be preauthorized under the criteria (MCG edition 20th edition) with a medical director at OrthoNet who has relevant training and experience in these conditions and procedures.

What products/line of business does this change impact?

This change impacts all Healthfirst PHSP and MHI products, including our Leaf Plans.

What services do these include?

Vascular procedures for lower extremities, including endovascular revascularizations, balloon angioplasties, vascular embolizations, stent placement angioplasties, intravascular ultrasounds, transcatheter therapies, and arterial/venous mechanical thrombectomies.

What services are not included?

Cardiac and cardiovascular, vascular neurology, pulmonary vascular, and gastrointestinal vascular procedures are not included in this program. In addition, this program does not include any office visits/consultations, X-rays, CTs, MRIs, laboratory testing, or pharmacy.

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What is the Healthfirst Clinical Appeals process?

There is no change to the current Healthfirst Clinical Appeals process. You may review the current clinical appeals process in the Healthfirst Provider Manual at **www.hfprovidermanual.org/Results/NY/appeals and www.hfprovidermanual.org/Results/NY/claim%20appeals**.

What is OrthoNet's role in the authorization process?

Healthfirst has delegated utilization management responsibilities for peripheral vascular surgical procedures to OrthoNet effective June 1, 2018. OrthoNet's scope of responsibility includes the management of the prior-authorization process for these services in accordance with Coverage Determination documents and Healthfirst's medical polices and clinical utilization management guidelines.

Where should providers submit claims for services rendered?

Providers should continue to submit claims to Healthfirst for services, as they do today. There is no change to the claims-submission process. Claims for these services will be paid according to their existing Healthfirst agreement. A list of services where authorizations are required through OrthoNet is posted in the Claims and Billing section of our website at **www.healthfirst.org/providers/claims-billing/**.

How do I obtain an authorization request from OrthoNet?

Information is available either online at **www.orthoNet-online.com/provider.html**, or by calling OrthoNet's Provider Services at **1-844-504-8091**, Monday to Friday, 9am–5pm.

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 prior authorization request?

A. Complete a Vascular Prior Authorization Request Form for the corresponding service

Select the corresponding Request Form for the service you are providing. The aforementioned request forms may be obtained by going to **www.orthoNet-online.com/provider.html** and selecting the Healthfirst page in the left menu. You may also call OrthoNet's Provider Services Department at **1-844-504-8091**, Monday to Friday, 9am–5pm.

Provider Information Section:

In the Provider Information section, list the facility name and/or the treating provider name, along with the corresponding Healthfirst provider identification number (NPI) and tax ID (TIN). Also, to identify offices with multiple locations, please complete the address, city, state, and 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.

Patient Information Section:

Completely fill in the member's name, date of birth, and Healthfirst identification number. Complete the fields from left to right.

Request Information Section:
Darken the appropriate selections to complete the Request Type, Service Type, and the appropriate Diagnosis Code. ***Please also answer the remaining clinical questions. A response to your request may be delayed if fields are left blank.***

B. Submit the Fax Request Form

Please fax the completed fax form(s), along with any supporting medical documentation ***relative to the date of service***, to OrthoNet's Medical Management Fax Server, as listed below:

Pain Management/Spinal Surgery/Podiatry/Vascular Fax Submission line:
1-844-478-8250.

Please submit only Fax Request Forms and medical notes to this number.

C. Receive the Authorization Response

It is OrthoNet's goal to review the request and supporting clinical data, verify eligibility/benefits, render a determination, and (if approved) assign an authorization number within one to two business days following the receipt of all required information. Providers will be notified via fax of the approval status.

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

As with all precertification requests for surgical procedures:

- All relevant patient history, including documentation of all applicable testing (with copies of the actual reports)
- An assessment of the patient's current functional status and any significant comorbidities.
- A record of all conservative and surgical care received by the patient and documentation of response/outcomes
- A statement of proposed care plan with details of the proposed interventions

Who will be reviewing my request?

The requests are reviewed by a dedicated team of nurses (who have relevant clinical experience in this area) and medical directors (surgeons with expertise in peripheral vascular surgery).

When will the decision be made?

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

Why do I have to use OrthoNet's authorization forms?

Due to the high volume of requests and updates received daily at OrthoNet, it is imperative that all faxed submissions be accompanied by the OrthoNet Vascular Prior Authorization Request Form. This enables OrthoNet to efficiently identify, route, track, and review all submissions promptly and efficiently.

Submissions without the form or with incomplete request forms cannot be processed, so it is vital that these are reviewed for accuracy and completion before submission.

Can I treat members prior to receiving an authorization for services?

If you treat a patient prior to OrthoNet's authorization determination, please be advised that authorization(s) may not be granted and that service provided may not be eligible for payment. Should you need to, you may call OrthoNet's Provider Service Department at **1-844-504-8091**, Monday to Friday, 9am–5pm, to inquire about the status of an authorization request.

Where should claims appeals be sent?

There is no change to the claims appeal process. Providers should continue to submit claim appeals to Healthfirst in the usual manner. Questions regarding claims and appeals should be directed to Healthfirst Provider Services at **1-888-801-1660**, Monday to Friday, 9am–5pm, or directly to your Healthfirst Network Account Manager.

Corrected Claims: Corrected claims must be marked "corrected" and should be submitted within 180 days of the date of service. All corrected claims must include the original Healthfirst claim number that is being corrected. For electronic corrected claim submission, the claim frequency type code must be a 7.

These requests may be submitted electronically through your clearinghouse or mailed to:

Healthfirst Correspondence Unit
P.O. Box 958438
Lake Mary, FL 32795-8438

Reviews and Reconsiderations:
Requests must be made in writing, with supporting documentation:

- Request within 90 days from the paid date on Explanation of Payment (EOP)
- Requests are accepted through the Healthfirst secure Provider Portal or may be mailed to:

  Healthfirst Correspondence Unit
  P.O. Box 958438
  Lake Mary, FL 32795-8438

- Appeal the outcome of a review and reconsideration in writing, with supporting documentation, within 60 days from the date listed on the reconsideration letter and send to:

  Provider Claims Appeals
  P.O. Box 958431
  Lake Mary, FL 32795-8431

What other resources are available?
For additional information regarding this program, you may visit the OrthoNet website at **www.OrthoNet-online.com** or contact OrthoNet's Provider Services Department at **1-844-504-8091**, Monday to Friday, 9am–5pm. For further assistance, you may also visit the Provider Resources page on the Healthfirst website at **www.healthfirst.org/providers** or contact your Healthfirst Network Account Manager.