

Summary: Aetna has delegated the administration of chiropractic benefits to Triad Healthcare, Inc. for their HMO-based members (including Medicare Advantage plans) in New Jersey. This program will take effect on July 15, 2010. This delegation includes network contracting, utilization management and claims payment and is an extension of the services currently provided by Triad to Aetna members in Northern New Jersey.

EFFECTIVE DATE: July 15, 2010

Which Aetna members are included? Members with an HMO plan (including Medicare Advantage plans) who reside or have selected a primary care physician in New Jersey.

How do I verify patient eligibility? Office staff may contact Triad at 1-800-409-9081 to verify member eligibility and inclusion in this program.

Does Triad's program require a PCP referral? Triad's program does not require a PCP referral for chiropractic care; however any Aetna plans that currently require a PCP referral will continue to do so.

What are determinations of medical necessity? As per all Aetna certificates of coverage, coverage is limited to medically necessary healthcare services not otherwise excluded from its benefit plans. Triad has been delegated the responsibility to review chiropractic services to determine medical necessity. In general, chiropractic care is considered medically necessary for the treatment of a wide scope of neuromusculoskeletal (NMS) conditions, the most common being spinal subluxation. After an initial trial, ongoing chiropractic care for these conditions is considered medically necessary during a period of time in which measurable clinical improvement of the patient is documented. Aetna's current benefits do not provide coverage for chiropractic maintenance care, wellness care or supportive care.

How do I find out if a certain procedure is covered? Coverage for each member may vary; therefore it is important to verify coverage for certain procedures by reviewing Aetna's Clinical Policy Bulletins (CPBS) located on the Aetna website (http://www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html) or by calling Aetna directly using the number listed on the back of the member's insurance card.

How can I access Triad's Medical Policies? All of Triad's medical policies are accessible –on Triad's website (www.triadhealthcareinc.com/providers/policies.aspx). Changes to medical policy occur from time to time as new information and/or evidence becomes available. These changes are noted on the website and published thirty (30) days prior to implementation.

Who performs determinations of medical necessity? Determinations of medical necessity are performed by New Jersey licensed chiropractors.

How are determinations of medical necessity performed? Determinations are performed in one of two ways.

- 1. Post-Service.** Upon receipt of a claim, Triad's clinical staff will review the claim to determine medical necessity of the billed services. If additional information is needed to make this determination, the necessary information and/or substantiating documentation will be requested. This process is applied to chiropractic claims received from both participating and non-participating providers. A determination of medical necessity will be rendered upon receipt of the information.
- 2. Pre-Service.** This is preferred by most participating providers. Providers may submit a plan of care and receive a determination of medical necessity in advance of services being rendered to the patient. Pre-Service review is not available to non-participating providers. **Please note: Certain Medicare plans may require a pre service plan of care. Please contact Triad prior to rendering services to your Medicare patients.**

How does the Pre Service process work? The Pre-Service process requires the use of a standardized data collection form – Triad Initial Care Plan and Triad Extension of Care Plan. The forms include provider and patient demographics, patient-centered clinical information and the proposed treatment plan.

- 1. Initial Care Plan (ICP).** After the patient's initial visit and before that patient returns for a second visit an ICP can be submitted. The ICP should include the services provided during the initial visit, in addition to the services you are planning to render. You may elect to submit additional information (i.e., SOAP notes) to Triad for review. Additional information can be written in the comment section at the end of the care plan, attached to the care plan, or faxed separately to 1-866-225-1033.
 - a. An ICP should be submitted before the second visit or within fourteen (14) business days of a patient's initial date of entry, whichever occurs first.
 - b. An ICP should be submitted for patients returning to care after an interruption of greater than ninety (90) days or for patients in a current course of care who develop a new condition that requires a change in their existing treatment plan.
- 2. Extension of Care (EOC).** If you determine that ongoing care is necessary after you have completed the ICP, you may submit an EOC. The purpose of the EOC is to document measurable clinical improvement of the patient during the initial plan of care.
 - a. The EOC form should be submitted as soon as possible following the end of initial care or as close to the first day your patient returns to care after an interruption.

Which form do I submit for existing patients, an ICP or EOC? If you elect to submit a request for pre service review, an ICP should be submitted for new patients as well as existing patients being treated for the first time under the new program.

Where can I obtain an ICP or EOC form? Forms and instructions can be found on our website (www.triadhealthcareinc.com/providers/forms.aspx.) Forms can also be emailed or mailed directly to your office by calling 1-800-409-9081.

Where do I submit medical records and care plans? Fax your completed care plan and/or medical records to 1-866-225-1033. You may also mail completed care plan and/or medical records to Triad Healthcare, Inc., 80 Spring Lane, Plainville, CT 06062.

How will I receive notification of a medical necessity determination? Triad will return all medical necessity determinations by fax or mail depending on the method of submission by the provider. Triad makes every effort to provide determinations within two (2) business days.

Does Triad require or administer any pre authorization requirements? No

Where do I submit claims? Participating providers will need to submit all claims for dates of service from July 15, 2010 forward for Aetna HMO-based members (including Medicare Advantage plans) in New Jersey directly to Triad. Participating provider claims submitted directly to Aetna for HMO members will be denied by Aetna and will have to be re-submitted to Triad. **Non-participating providers** will need to submit all claims for dates of service from July 15, 2010 forward for Aetna HMO-based members (including Medicare Advantage plans) in New Jersey directly to Aetna.

1. Paper claims can be submitted directly to Triad at: Triad Healthcare, Inc. Attn: Claims, 80 Spring Lane, Plainville, CT 06062
2. Electronic Submission – Triad Healthcare, Inc. has partnered with MD On-Line for electronic claim submission. Claims can be individually entered free of charge. To access this benefit, log on to www.triadhealthcareinc.com/providers/onsolution.aspx and click the “Submit” button under *Online Solutions*. This will route you to MD On-Line’s portal for Triad Providers. Please include Triad’s address (see above) and electronic payer ID #39181. To learn more about MD On-Line’s products for submitting Triad claims electronically FREE OF CHARGE, please call: 1-888-499-5465.

How long do I have to submit a claim? All claims should be submitted within 180 days from the date of rendered services to be considered for payment.

I am already contracted with an EDI vendor for claims submission. Can I continue to submit claims through my current vendor? You will need to contact your current vendor to determine if they will continue to accept electronic claims and convert them to paper in order to submit to Triad Healthcare, Inc. Triad’s only electronic connection is MD On-line.

How am I reimbursed for services? For dates of service beginning July 15, 2010, Triad participating providers (Triad/Aetna participating) will be reimbursed for covered services according to the Triad fee schedule. A copy of the Triad fee schedule can be provided by calling 1-800-409-9081. Non-participating providers will continue to be reimbursed in accordance with Aetna’s usual and customary prevailing fee schedules.

Do I have to contract with Triad to remain in network with Aetna? Participation with Triad is necessary to provide chiropractic services to Aetna members. Therefore, if you wish to continue to provide in-network services to our members, please contract with Triad.

How do I contract with Triad? If you have not contracted with Triad, you may do so now by calling Triad Provider Service at 1- 888-584-8742. All the necessary information will be provided to you at that time.

Where can I get a copy of the provider manual? Participating providers can obtain a copy of the provider manual at Triad's website (www.com.com/providers/manual.aspx). You can view the manual or print a copy for your records.

If I have a change in business information (business name, address or Tax Identification Number) what do I need to do to get it updated with Triad and Aetna? If you have a business name change or address change you will need to submit the changes in writing including the effective date of the change. Please fax all changes to 888-844-6645. If you have a Tax Identification Number (TIN) change you will need to contact Triad's customer service to obtain the appropriate documentation for your TIN change.

Who do I notify if I add a provider to my practice? All providers that will be billing under your Tax Identification Number will need to become participating in the Triad network. Please contact Triad's customer service department to obtain an enrollment packet.

Am I participating under all locations and Tax Identification Numbers? Yes, under your contract with Triad Healthcare you are considered participating under all practice locations and Tax Identification Numbers that you submit on a claim.

Can I appeal a clinical decision made by Triad? Yes. If you find that you are in disagreement with a determination of medical necessity that cannot be resolved verbally with Triad, you can appeal this decision. Please submit all clinical appeals to Aetna. Triad does not perform clinical appeals for Aetna. Please refer to the appeal rights attached to your determination letter in order to determine where your appeal should be submitted.

Can I appeal a claim determination made by Triad? Yes. Triad shall include an attached explanation of the relevant appeals process with all claim denials sent both to the member and provider. All written comments, documents, records and other information submitted with the appeal will be reviewed and considered without regard to whether those documents or materials were considered in making the initial denial. Appeals must be submitted in writing and must be received by Triad within ninety (90) days of receipt of the adverse determination. Providers must use the New Jersey Department of Banking & Insurance "Health Care Provider Application to Appeal a Claim Determination" form, which is available on Triad's website.

(www.com.com/providers/forms.aspx).

How can I contact or provide feedback to Triad? Complete a survey. To provide the highest quality of service and measure our effectiveness, we have made surveys available to our provider community. Periodically we will notify you of survey opportunities. Please take the time to complete these surveys as this is one of the ways Triad enhances its service to the provider community.



Frequently Asked Questions for Aetna/Triad New Jersey

General Questions: if you would like to speak with someone at Triad, contact Triad's Call Center at 1-800-409-9081. A representative will answer your questions or schedule a call with a Clinical Coach. All providers are encouraged to speak directly to a Clinical Coach regarding clinical determinations for which there is a question or concern.