



**Frequently Asked Questions
Physical Medicine Program
Pain and Joint Management**

TABLE OF CONTENTS

Pain and Joint Management

PROGRAM OVERVIEW 4

Who is eviCore healthcare? 4

What is the relationship between the Health Plan and eviCore healthcare? 4

When does the program start and which members are included? 5

Which procedures will require pre-authorization?5

Is there paper work for patients to fill out before they are eligible for the pre-authorization program?6

Will new member cards be issued to Plan members? 6

Is pre-authorization required? 6

Does the program include inpatient services? 6

Which places of service require a medical necessity determination? 6

Is a medical necessity determination required if the treatment is administered at a hospital outpatient facility? 7

Are the clinical criteria available for review? 7

HOW TO SUBMIT A REQUEST 7

How can I obtain authorization? 7

Can pre-authorization requests be submitted via fax? 7

What is the best way to submit a pre-authorization? 7

What information will eviCore healthcare require for the pre-authorization process?8

Is registration required at eviCore healthcare’s website? 8

What is the extent of eviCore healthcare’s ability to issue a pre-authorization online? 8

Will I be able to view pre-authorization status? 9

Is there a way to delete a physician after he or she has been added to the Web account? 9

Pain and Joint Management

UTILIZATION REVIEW PROCESS	9
Will urgent requests be accepted?	9
How will I know when a decision has been reached?	9
What length of time is necessary for a case to go through the medical review process?	9
What is the timeline for a peer-to-peer consultation?	10
Is there a way to verify whether an approval number has been assigned to a pre-authorization request?	10
DETERMINATIONS	10
How long does my patient's approval last?	10
Can a medical necessity determination number expire?	10
What is a partial approval notice?	10
Can we file an appeal for cases that have been denied or partially denied?	11
What if a physician does not agree with eviCore healthcare's adverse determination and wants to file an appeal?	11
MODIFICATIONS TO REQUESTS	11
I have already obtained an approval for my patient. Is a new medical necessity determination required if the patient requires additional treatment?	11
If a patient decides to change practices/facilities for a procedure covered by the Pain and Joint Management Program, is a new authorization for payment required?	12
CLAIMS	12
Our system bills on a monthly basis. Is this a problem?	12
Where do I submit claims?	12
Does the authorization number need to be on the claim?	12
What if a claim has been denied?	12

PROGRAM OVERVIEW

Who is eviCore healthcare?

eviCore healthcare (formerly CareCore | MedSolutions) is a medical benefits management company committed to making a positive impact in healthcare. It is our passion, our purpose, and our promise.

We're built with the size and scale to address the complexity of today's healthcare system. Through our exceptional capabilities – and an acute sensitivity to the needs of everyone involved – we harness healthcare's evolving demand and inherent change to better manage and optimize health benefits.

The result is an evidence-based approach that utilizes our proven talent and leading-edge technology to realize better outcomes.

Our experienced professionals – including our clinical staff of doctors and nurses – have the breadth of expertise needed to embrace the perspectives and challenges of our constituents; enabling us to craft and co-create custom solutions and innovative services.

Our technology is a peerless, robust platform that identifies, generates and distributes the precise data, analytics and reports required for quicker, more informed decision-making in each of the millions of cases we handle.

From our unique position at the heart of patient, provider, and payer, we cultivate, connect and integrate the intelligence and insights that prompt more focused actions and improve results.

It's a mindset that proves quality, cost and competence are aligned. One that transcends simply saving resources and time; one that works to improve the system – and ultimately achieves better outcomes.

Asking the right questions leads to delivering the right answers at the right time to the right people – patients, providers, and payers.

What is the relationship between the Health Plan and eviCore healthcare?

The Health Plan has contracted with eviCore healthcare to assist with managing and administering benefits for interventional pain procedures; joint arthroscopies and replacement surgeries; spinal surgeries; physical, occupational, and speech therapy; chiropractic care, acupuncture, and massage therapy.

Please note: This FAQ only addresses Interventional Pain, Arthroscopy, and Joint Replacement.

Pain and Joint Management

When does the program start and which members are included?

The start date is July 1, 2015. Authorization is required for dates of service on or after July 1, 2015, even if the member is receiving continuing treatment. You may obtain a pre-authorization beginning June 15, 2015 for all procedures/surgeries with dates of service of July 1, 2015, and beyond. For information on which members are included, please check the physical medicine section of the Health Plan's website.

Which procedures will require pre-authorization?

For interventional pain the most common procedures are:

- Pain pumps
- Epidural Injections
- Spinal cord stimulators
- Sacroiliac joint injections
- Facet blocks and radiofrequency ablations

Note: Pre-authorization is not required when CPT 62310, 62311, 62318, 62319 used for **post-procedural pain in the inpatient setting with the following diagnoses:**

ICD-9-CM (dates of service through September 30, 2015)

- 338.11 Acute pain due to trauma
- 338.12 Acute post-thoracotomy pain
- 338.18 Other acute postoperative pain
- 338.19 Other acute pain

ICD-10-CM (dates of service on or after October 1, 2015)

- G89.11 Acute pain due to trauma
- G89.12 Acute post-thoracotomy pain
- G89.18 Other acute post procedural pain

Arthroscopy includes procedures involving shoulder, hip, knee, and ankle joints.
Joint replacement includes procedures involving the hip, knee, and shoulder joints.

Each of the CPT codes for the program services will require an authorization to be on file for proper claims payment, including applicable professional, facility and associated claims payment. Pre-authorizations are required for all professional and associated claims. Notification by the facility for inpatient admission is required.

CPT codes requiring pre-service authorization for accurate claims payment will be available in the Pre-authorization and Physical Medicine sections on the Health Plan's website.

Pain and Joint Management

Is there paper work for the patient to fill out before they are eligible for the pre-authorization program?

No. Each in-scope member is automatically enrolled in the program.

Will new member cards be issued to Plan members?

No.

Is pre-authorization required?

Yes. Pre-authorization is required for all codes on the CPT list.

Note: Pre-authorization is not required when CPT 62310, 62311, 62318, 62319 used for **post-procedural pain in the inpatient setting with the following diagnoses:**

ICD-9-CM (dates of service through September 30, 2015)

- 338.11 Acute pain due to trauma
- 338.12 Acute post-thoracotomy pain
- 338.13 Other acute postoperative pain
- 338.19 Other acute pain

ICD-10-CM (dates of service on or after October 1, 2015)

- G89.11 Acute pain due to trauma
- G89.12 Acute post-thoracotomy pain
- G89.18 Other acute post procedural pain

Do facilities need to follow the Health Plan's inpatient notification process for members being admitted for services?

Yes, facilities should continue to follow the Health Plan's documented process.

Does the program include inpatient services?

Yes. The program includes all procedures, regardless of whether they are performed in an inpatient or outpatient setting.

Which places of service require a medical necessity determination?

All professional claims for both inpatient and outpatient interventional pain, joint arthroscopy, and joint replacement surgeries require authorization for claims payment.

Pain and Joint Management

Is a medical necessity determination required if the treatment is administered at a hospital outpatient facility?

Yes. Medical necessity determinations are required for in-scope members for all inpatient and outpatient interventional pain, joint arthroscopy, and joint replacement surgeries.

Are the clinical criteria available for review?

Yes. This document is available online through the eviCore healthcare's provider Web portal at **carecorenational.com**. Hover over *CareCore Solutions* then *Musculoskeletal and Therapy* then click on *Musculoskeletal and Therapy Tools and Criteria*.

HOW TO SUBMIT A REQUEST

How can I obtain authorization?

Pre-authorizations can be obtained 24 hours a day, 7 days a week on the Web at **carecorenational.com**. Pre-authorizations can also be submitted by phone from 7 a.m. to 7 p.m. local time Monday through Friday (excluding holidays) at 1(855) 252-1115.

Can pre-authorization requests be submitted via fax?

Yes. If you choose to fax authorization requests, select the form that best fits the patient's condition. When submitting paper forms, be sure to complete every applicable section. Treatment requests with incomplete sections may result in a request for complete clinical information.

Fax a Pain Treatment Request Clinical Worksheet to (855) 774-1319.

Fax a Joint Arthroscopy of Joint Replacement Treatment Request Clinical Worksheet to (800) 540-2406

What is the best way to submit a pre-authorization?

The fastest way for physicians to achieve a medical necessity determination is by visiting the eviCore healthcare's website at **carecorenational.com** prior to the date of service requiring authorization. If you do not have access to the Internet, you can request a medical necessity determination by calling eviCore healthcare at (855) 252-1115.

Pain and Joint Management

What information will eviCore healthcare require for the pre-authorization process?

To expedite the process, please have the following information ready before logging on to the website or calling in the request:

- Name and office phone number of ordering physician
- Member name and identification (ID) number
- Requested procedure or surgery CPT code(s)
- Name of provider office or facility where the service will be performed
- Anticipated date of service
- Whether procedure/surgery will be performed on an inpatient or outpatient basis
- Details justifying the intended procedure or surgery:
 - ✓ Date of onset of pain or exacerbation
 - ✓ Physical exam findings and patient symptoms (including findings applicable to the requested services)
 - ✓ Clinical diagnosis
 - ✓ Date and results of prior pain management procedures
 - ✓ Diagnostic imaging results
 - ✓ Conservative treatment modalities completed, duration, and results (e.g., physical therapy, chiropractic or osteopathic manipulation, and medication)

Please use the Arthroscopy and Pain Management worksheets, as appropriate, located on the eviCore healthcare Musculoskeletal and Therapy Tools and Criteria website: <https://www.carecorenational.com/benefits-management/musculoskeletal-management/musculoskeletal-and-therapy-tools-and-criteria.aspx>

Please note, starting mid-August 2015, multiple CPT codes can be submitted for pre-authorization for each request.

Is registration required at eviCore healthcare's website?

Yes. A one-time registration is required for each practice or individual. You will be required to log-in prior to obtaining authorizations on the web.

What is the extent of eviCore healthcare's ability to issue a pre-authorization online?

The eviCore healthcare's website will allow physicians to submit pre-authorization requests and obtain an approval online in real time (subject to criteria being met).

Physicians unfamiliar with the website's capabilities can access a Web use training module online from **carecorenational.com** or contact an eviCore healthcare Provider Relations representative at (800) 646-0418 option 3. The provider portal on the eviCore healthcare's website at **carecorenational.com** is the quickest and easiest means of securing pre-authorization.

Pain and Joint Management

Will I be able to view pre-authorization status?

Yes. Providers can view and track all submitted pre-authorizations online at carecorenational.com.

Is there a way to delete a physician after he or she has been added to the Web account?

A user can always delete a physician. There is a "REMOVE" button on the "Manage Account" page where the physicians are listed.

UTILIZATION REVIEW PROCESS

Will urgent requests be accepted?

Yes. Urgent requests will be accepted and a determination expedited if clinically required.

How will I know when a decision has been reached?

When using the online system, immediate authorization will be available when coverage criteria are met. For cases whose decision is reached after clinical review, the provider will be notified with verbal or written communication according to applicable regulation and law.

What length of time is necessary for a case to go through the medical review process?

If coverage criteria are met, the approval is instantaneous. When coverage criteria are not immediately met, clinical review of the request will be completed in the order that the requests are received, but not longer than two business days for most case types. The utilization review timeframes comply with applicable regulation and law.

Cases that meet the definition of an expedited case will be resolved within three hours and a notification will occur within that timeframe.

The turnaround times are dependent upon all necessary information being provided to eviCore healthcare. If there is insufficient information to make a determination, a hold letter will be faxed to the provider's office indicating what information is still required. The surest way to avoid this scenario is to have the requested information prior to submitting for an authorization.

Pain and Joint Management

What is the timeline for a peer-to-peer consultation?

When there is a request for a peer-to-peer consultation, we will make an effort to transfer the call immediately to an available eviCore healthcare medical director. When a medical director is not available, we will offer a scheduled call-back time that is convenient for the practice.

A peer-to-peer consultation is intended to discuss a decision *before* services are performed. A discussion is appropriate prior to services being rendered or on a pre-service basis only. The peer-to-peer consultation must be requested within 14 calendar days of the determination date and before an appeal has been initiated.

A peer-to-peer consultation cannot occur on a pre-authorized request if an appeal is already in process or has been completed. Note: This applies for all lines of business except Medicare Advantage. Medicare Advantage members must first initiate an appeal prior to requesting a peer-to-peer consultation.

Is there a way to verify whether an approval number has been assigned to a pre-authorization request?

Yes. After logging in at **carecorenational.com**, users can click on “Authorization Lookup” to determine the status of a case.

DETERMINATIONS

How long does my patient's approval last?

All authorizations are valid for 60 days. eviCore healthcare communicates the expiration date in the approval notification for each case.

Can a medical necessity determination number expire?

Yes. eviCore healthcare communicates the expiration date in the approval notification provided for each case. Authorization expiration dates are also available at the eviCore healthcare website at **carecorenational.com** after login by clicking on “Authorization Lookup.”

What is a partial approval notice?

A partial approval notice will inform the provider of approved and non-approved services for the submitted pre-authorization request. The partial approval notice will also contain appeal information.

Pain and Joint Management

Can we file an appeal for cases that have been denied or partially denied?

We recommend that you use the reconsideration process before filing a formal appeal. Reconsiderations are completed via telephone, in writing, or through peer-to-peer consultations as applicable. If the initial decision is upheld, then the next step is a first-level appeal. See “What if a physician does not agree with eviCore healthcare’s determination and wants to file an appeal?” below.

Please note: If applicable, Medicare Advantage cases do not allow for reconsiderations. Please refer to the appeal steps on the adverse determination letter.

What if a physician does not agree with eviCore healthcare’s adverse determination and wants to file an appeal?

For denied commercial cases, we recommend that you utilize the reconsideration process before filing a formal appeal. Reconsiderations are completed via telephone, in writing, or through peer-to-peer consultations as applicable. If the initial decision is upheld, then the next step is a first-level appeal. Reconsiderations are not available for Medicare Advantage members. Please refer to the adverse determination letter for detailed appeal steps.

The provider can appeal a clinical decision in writing to:

Fax: (866) 699-8128
Mail: Clinical Appeals
eviCore healthcare
400 Buckwalter Place Blvd
Mail Stop 600
Bluffton, SC 29910

MODIFICATIONS TO REQUESTS

I have already obtained an approval for my patient. Is a new medical necessity determination required if the patient requires additional treatment?

All procedure/surgery codes on the pre-authorization list will require authorization prior to service for accurate claims payment. Minor modifications to a treatment that changes the applicable approved CPT code will require additional medical necessity determination. Please call eviCore healthcare at (855) 252-1115 for steps on how to proceed.

The differences between billed and authorized codes will be accounted for at time of claim payment.

Pain and Joint Management

If a patient decides to change practices/facilities for an arthroscopy or joint replacement surgery procedure, is a new authorization for payment required?

For any modifications to an approved request, please call eviCore healthcare at (855) 252-1115.

CLAIMS

Our system bills on a monthly basis. Is this a problem?

As long as the date of service is within the approved time period, you can bill monthly or weekly.

Where do I submit claims?

Submit claims directly to the Health Plan.

Does the authorization number need to be on the claim?

No. There are no changes for submitting a claim. Please follow the standard Health Plan claims filing process.

What if a claim has been denied?

A claim can be denied for different reasons. Please review the denial reason code and description on the explanation of benefits before calling the Health Plan.

- Failure to obtain pre-authorization or notification for required services will result in claim non-payment and will become a provider liability.
- If you followed the pre-authorization steps and your claim has been denied due to lack of a medical necessity determination, call eviCore healthcare to submit the request. If your request does not demonstrate medical necessity, you will be notified in a manner consistent with your state's requirements. This notice will provide detailed instruction for submitting clinical appeals.