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Musculoskeletal Care Management Program
Lumbar and Cervical Spine Surgeries
Frequently Asked Questions

Updated April 2024

General	
Why did HMSA implement a musculoskeletal (MSK) care management program focused on lumbar and cervical spine surgeries? What procedures require prior authorization?	The MSK program is designed to improve quality and manage nonemergent surgeries in outpatient and inpatient settings. • MSK surgeries are a leading driver of health care spending trends. • Variations in patient care exist across all areas of surgery (care prior to surgery, type of surgery, surgical techniques and tools, and post-op care). • Diagnostic imaging advancements have increased diagnoses and surgical intervention aligning with these diagnoses rather than patient symptoms. • Medical device companies are marketing directly to consumers, resulting in patient requests for inappropriate treatments and services. • Surgeries are occurring too soon, leading to additional or revision surgeries. The following procedures require prior authorization: • Lumbar microdiscectomy. • Lumbar decompression (laminotomy, laminectomy, facetectomy, and foraminotomy). • Lumbar spine fusion (arthrodesis) with or without decompression – single and multiple levels. • Cervical anterior decompression with fusion – single and multiple levels. • Cervical posterior decompression with fusion – single and multiple levels. • Cervical posterior decompression (without fusion). • Cervical artificial disc replacement – single and two levels. • Cervical anterior decompression (without fusion). Evolent doesn't manage prior authorization for emergency spine surgery cases admitted through the emergency room or for spine surgery procedures outside of those procedures listed.

Why did HMSA select Evolent to manage its MSK program for lumbar and cervical spine surgeries?	Evolent was selected because its clinically driven program is designed to effectively manage quality and patient safety while ensuring appropriate utilization of resources for HMSA members.
Which HMSA members are covered under this program?	All HMSA members are covered.
Prior Authorization	
When is prior authorization required?	Prior authorization is required for inpatient and outpatient nonemergent lumbar and cervical spine surgeries listed previously. • Facility admissions don't require a separate prior authorization. However, the facility should ensure that prior authorization has been obtained with Evolent before scheduling the surgery.
Who can order an MSK surgery?	MSK surgeries that require medical necessity review are expected to be ordered by: • Orthopedic surgeons. • Neurosurgeons.
Who reviews the surgery requests and medical information provided?	Specialty-matched surgeons and nurses conduct medical necessity reviews and make determinations for MSK surgeries.
Does the prior authorization process change the requirements for facility-related prior authorization?	No, medical necessity review and determination is for the authorization of a surgeon's services and type of surgery.
How does the ordering surgeon obtain prior authorization?	Ordering surgeons can request prior authorization through RadMD.com or by calling 1-866-306-9729.

What information is required for prior authorization?	To expedite the process, have the following information ready before requesting prior authorization:
	• Name and office phone number of ordering surgeon*.
	• Member name and ID number*.
	• Requested surgery type*.
	• CPT codes.
	• Name of facility where the surgery will be performed*.
	• Anticipated date of surgery*.
	• Details justifying the surgical procedure*:
	  ○ Clinical diagnosis*.
	  ○ Date of onset of back pain or symptoms/length of time member has had episode of pain*.
	  ○ Physician exam findings (including findings applicable to the requested services).
	  ○ Diagnostic imaging results.
	  ○ Non-operative treatment modalities completed, date, duration of pain relief, and results (e.g., physical therapy, epidural injections, chiropractic or osteopathic manipulation, hot pads, massage, ice packs and medication).
	
	Be prepared to provide the following information, if requested:
	• Clinical notes outlining type and onset of symptoms.
	• Length of time with pain/symptoms.
	• Nonoperative care modalities to treat pain and amount of pain relief.
	• Physical exam findings.
	• Diagnostic imaging results.
	• Specialist reports/evaluation.
	
	*Required information.

Does the ordering surgeon need separate authorizations for each spine procedure to be performed at the same surgery on the same date?	No. The surgeon must select the most complex, invasive surgery as the primary surgery. **Example: Lumbar fusion** • If the surgeon is planning a single-level lumbar spine fusion with decompression, they'll select single-level fusion. The surgeon doesn't need to request a separate authorization for the decompression procedure as it's part of the lumbar fusion surgery. **Example: Laminectomy** • If the surgeon is planning a laminectomy with a microdiscectomy, they'll select the lumbar decompression. The surgeon doesn't need a separate authorization for microdiscectomy. • If the surgeon is only performing a microdiscectomy (CPT 63030 or 63035), they should select microdiscectomy-only.

Does the ordering surgeon need to enter each CPT procedure code being performed for lumbar and cervical spine surgery?	No. The ordering surgeon must select the primary surgery (i.e., most invasive) to be performed. There's a summary of CPT codes that fall under each procedure category in the HMSA Spine Surgery Utilization Review Matrix.
Are instrumentation (medical device), bone grafts, and bone marrow aspiration included in lumbar or cervical fusion authorizations?	Yes. Instrumentation (medical device), bone grafts, and bone marrow aspiration procedures commonly performed in conjunction with MSK surgeries are included in the authorization; however, the amount of instrumentation must align with the authorized procedure.
What's the response time for a determination?	Generally, a determination will be made in two to three business days after receiving the request with complete clinical documentation. In certain cases, the review process can take longer if additional information is required.
What does the authorization number look like?	The authorization number consists of alphanumeric characters. In some cases, the ordering surgeon may receive a tracking number (not the same as an authorization number) if the surgeon's authorization request isn't approved at the initial contact. Ordering surgeons can use either number to track the status of their request online or through an interactive voice response phone system.
If requesting authorization through RadMD.com and the request pends, what happens next?	You'll receive a tracking number and Evolent will contact you to complete the process.
Can RadMD.com be used to request expedited review authorization requests?	No, expedited review requests must be called in to 1-866-306-9729.
How long is the prior authorization number valid?	The authorization number is valid for 90 days from the date of service.

Is prior authorization necessary for lumbar and cervical surgery if HMSA is NOT the patient's primary insurance?	Yes, prior authorization is required if HMSA is the secondary insurer to another health plan. Exception: If Medicare Part B is the primary insurer, then NO authorization is needed.
Is prior authorization required if HMSA is secondary to another carrier or coverage?	Yes, prior authorization is required if HMSA is the secondary plan to another non-HMSA plan. If the patient has more than one HMSA plan, then only ONE prior authorization is needed under their primary plan. Exception: If Medicare Part B is the primary insurer, NO prior authorization is needed.
If an ordering surgeon obtains a prior authorization number, does that guarantee payment?	No, an authorization number isn't a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility and health plan benefits. Benefits may be subject to limitations and/or qualifications. Medical necessity review and determination is for the authorization of the surgeon's services and type of surgery.
Are retro-authorizations allowed?	Yes. Retrospective review of completed procedures are evaluated for medical necessity and to determine whether there was an urgent or emergent situation that prohibited the provider from obtaining prior authorization. Surgeons performing lumbar and cervical spine surgeries shouldn't schedule or perform these surgeries without prior authorization. Retro-authorization requests must be called in to 1-866-306-9729.
Can an ordering physician verify an authorization number online?	Yes. Ordering physicians can check the status of authorizations at RadMD.com.
Will the authorization number be displayed on the HMSA website?	No.
What if I disagree with Evolent's determination?	If a request for prior authorization or if a claim is denied, surgeons may appeal through HMSA. Surgeons should follow the instructions on their denial letter or explanation of payment notification.

Scheduling Procedures	
Do ordering surgeons have to obtain authorization before they schedule an appointment?	Yes.
Which Surgeons are Affected?	
Which surgeons are impacted by the spine surgery program?	Neurosurgeons and orthopedic surgeons are the key physicians impacted by this program. Procedures performed in any setting are included in this program: • Hospital (inpatient and outpatient) • Ambulatory surgical centers
Claims	
Where do rendering surgeons send claims for outpatient nonemergent MSK services?	Surgeons should continue to send claims to HMSA. Providers are encouraged to use EDI claims submission.
How can I check the status of claims?	Check claims status on the HMSA website at hhinplus.hmsa.com/.
Who should I contact if I want to appeal a prior authorization or claims denial?	Rendering surgeons are asked to follow the appeal instructions on their denial letter or explanation of payment. Surgeons may request a peer-to-peer consultation with an Evolent reviewer regarding a denied prior authorization.
Miscellaneous	
How is medical necessity defined?	Evolent defines medical necessity as services that would: • Meet generally accepted standards of medical practice, be appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient evidence and professionally recognized standards. • Be appropriate to the illness or injury for which it's performed as to type of service and expected outcome. • Be appropriate to the intensity of service and level of setting. • Provide unique, essential, and appropriate information when used for diagnostic purposes. • Be the lowest-cost alternative that effectively addresses and treats the medical problem and rendered for the treatment or diagnosis of an injury or illness. • Not furnished primarily for the convenience of the patient, attending physician, or other surgeon.

Where can an ordering surgeon find Evolent's Guidelines for Clinical Use of MSK Procedures?	Evolent's clinical guidelines can be found at RadMD.com. They're in a PDF format that can easily be printed for future reference. Evolent's guidelines have been developed from practice experiences, literature reviews, specialty criteria sets, and empirical data.
Will the HMSA membership card change with the implementation of this MSK program?	No. The HMSA membership card doesn't contain any Evolent information.
Reconsideration/Re-review/Reopen and Appeals Process	
Is the reconsideration/re-review/reopen process available for the MSK program if a denial is received?	Yes. To initiate the process, the provider's office can upload new or additional information to RadMD.com or fax it (using the case-specific fax cover sheet) to Evolent. A reconsideration/re-review for commercial and QUEST Integration plan members must be initiated within 60 calendar days from the date of denial and prior to submitting a formal appeal. A reopen for HMSA Akamai Advantage® plan members must be initiated within one year of the date of denial. Evolent has a specialized clinical team focused on spine surgery. Peer-to-peer discussions are offered for any request that doesn't meet medical necessity guidelines. The surgeon may call 1-866-306-9729 to initiate the peer-to-peer process. These discussions provide an opportunity to discuss the case and collaborate on the appropriate services for the patient based on the clinical information.
RadMD Access	
If I have access to RadMD.com, do I need to apply for additional access to request authorizations for MSK procedures?	No, if you already have access to RadMD, you can request authorization for any procedure managed by Evolent.
What option should I select to request prior authorizations?	Select Physician's office that orders procedures.

How do I apply for RadMD.com access?	Go to RadMD.com. • Click NEW USER. • Choose Physician's office that orders procedures in the drop-down menu. • Complete the application. • Click Submit. You'll receive an email from our support team within a few hours with an approved username and a temporary passcode. Contact the RadMD support team at 1-800-327-0641 if you don't receive a response within 72 hours.
What is "rendering provider access"?	Rendering provider access allows users to view approved authorizations for their office or facility. Examples of a rendering facility that only needs to view approved authorizations: • Hospital facility. • Billing department. • Offsite location. • Another user who doesn't need to request prior authorizations. To sign up for rendering access, an office must designate an administrator. • Go to RadMD.com. • Select Facility/Office where procedures are performed. • Complete the application. • Click Submit.
Which link on RadMD.com do I select to request prior authorization for MSK procedures?	Click Request Spine Surgery or Orthopedic Surgery.
How can surgeons check the status of an authorization request?	Click View Request Status in RadMD.com's main menu.

How can I confirm what clinical information has been uploaded or faxed to Evolent?	Select the patient's name in View Request Status in the main menu. On the Request Verification Detail page, select the appropriate link for the upload or fax.
Where can providers find their case-specific communication from Evolent?	Click View Request Status.
If I didn't make the initial request for prior authorization, how can I view the status of a case or upload clinical documentation?	Track an Authorization allows users who didn't submit the original request to view the status of an authorization and upload clinical information. This option is also available in the main menu using Search by Tracking Number. A tracking number is required.
Paperless notification: **How can I receive notifications electronically instead of paper?**	Evolent's default communications are electronic. Correspondence for each case is emailed to the person who initially requested prior authorization. Users will be sent an email when determinations are made. • No protected health information (PHI) will be in the email. • The email will contain a link that requires the user to log in to RadMD.com to view PHI. Providers who prefer paper communication will have the option to receive communications via fax.
Contact Information	
Who can I contact at Evolent for more information?	Email HMSAProviderConcerns@evolent.com.
Who can we contact if I need RadMD.com support?	Email RadMDSupport@evolent.com or call 1-800-327-0641. RadMD.com is available 24/7, except when maintenance is performed every third Thursday of the month, 6–9 pm Hawaii time.