Evolent Musculoskeletal Care Management (MSK) Solutions Program Frequently Asked Questions (FAQ's) For Buckeye Health Plan Physicians/Surgeons	
Question	**Answer**
GENERAL	
Why is Buckeye Health Plan implementing Evolent's Musculoskeletal Care Management (MSK) Solutions Program focused on inpatient and outpatient hip, knee, shoulder, and spine surgeries?	Evolent was selected as a partner for Buckeye Health Plan due to their clinically driven programs designed to ensure appropriate care, improve quality, and effectively manage the increasing utilization of resources. Additional reasons for implementing the MSK Solution Program include: • Musculoskeletal surgeries are a leading cost of health care spending trends. • Variations in member 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 member symptoms. • Medical device companies marketing directly to consumers. Surgeries are occurring too soon leading to the need for additional or revision surgeries.
Which procedures are included in the program?	**<u>Outpatient and Inpatient Hip Surgeries: *</u>** • Total Hip Arthroplasty/Resurfacing • Revision/Conversion Hip Arthroplasty • Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincer & labral repair) • Hip Surgery – Other (includes synovectomy, chondroplasty, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy) **<u>Outpatient and Inpatient Knee Surgeries: *</u>** • Total Knee Arthroplasty (TKA) • Revision Knee Arthroplasty • Partial-Unicompartmental Knee Arthroplasty (UKA) • Knee Manipulation under Anesthesia (MUA) • Knee Ligament Reconstruction/Repair • Knee Meniscectomy/Meniscal Repair/Meniscal Transplant

	• Knee Surgery – Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement, chondroplasty, lateral release/patellar realignment, articular cartilage restoration) **<u>Outpatient and Inpatient Shoulder Surgeries: *</u>** • Total/Reverse Arthroplasty or Resurfacing • Revision Shoulder Arthroplasty • Partial Shoulder Arthroplasty/Hemiarthroplasty • Shoulder Rotator Cuff Repair • Shoulder Labral Repair • Frozen Shoulder Repair/Adhesive Capsulitis • Shoulder Surgery – Other (includes debridement, manipulation, subacromial decompression, biceps tenotomy/tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy, distal clavicle excision, acromioplasty) **<u>Outpatient and Inpatient Spine Surgeries:</u>** • Lumbar Microdiscectomy • Lumbar Decompression (include laminotomy, laminectomy, facetectomy, foraminotomy) • Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single & Multiple Levels • Lumbar Artificial Disc Replacement • Cervical Anterior Decompression with Fusion (ADCF) – Single & Multiple Levels • Cervical Posterior Decompression with Fusion – Single & Multiple Levels • Cervical Anterior Decompression (without fusion) • Cervical Posterior Decompression (without fusion) • Cervical Artificial Disc Replacement – Single & Two Levels • Sacroiliac Joint Fusion *Provider must submit separate authorization requests for each hip, knee, and shoulder, even if bilateral joint surgery is to be performed on the same date.
What Buckeye Health Plan members will be covered?	The program applies to members undergoing inpatient or outpatient hip, knee, shoulder, and spine surgeries.

What providers are impacted by program?	Neurosurgeons and Orthopedic Surgeons are the key physicians impacted by the MSK surgery program. Surgeries performed in the following settings are included in this program: • Hospital (Inpatient & Outpatient Settings) • Ambulatory Surgical Centers
What day will the program start?	The program will start on January 1, 2024.
PRIOR AUTHORIZATION	
How do providers submit prior authorization requests?	Providers can submit prior authorization requests via the Evolent website (RadMD.com) or by contacting Evolent at 1-800-642-6551.
Is an authorization required for the facility admission?	Buckeye Health Plan prior authorization requirements for the facility admissions do not require a separate prior authorization. However, the facility should ensure that an Evolent prior authorization has been obtained prior to scheduling the surgery/procedure.
Who will be reviewing the surgery requests and medical information provided?	As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee, and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

What information is required to submit an authorization request for surgery?	To expedite the prior authorization process, please have the following information ready before submitting:
	Required information:
	• Name and office phone number of ordering physician
	• Member name and ID number
	• Requested surgery type
	• CPT Codes (not required)
	• 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) • Specialist reports/evaluation
How do I send required clinical information to Evolent?	The most efficient way to send required clinical information is to upload your documents to RadMD.com. The upload feature allows clinical information to be uploaded directly after completing an authorization request. Utilizing the upload feature expedites your request since it is automatically attached and forwarded to our clinicians for review. You may also fax required clinical information to 1-800-784-6864. To ensure prompt receipt of your information: • Use the Evolent fax coversheet as the first page of your clinical fax submission. *Please do not use your own fax coversheet, since it will not contain the case specific information needed to process the case • Make sure the tracking number on the fax coversheet matches the tracking number for your request • Send each case separate with its own fax coversheet • Providers may print the fax coversheet from RadMD.com. • Evolent will fax this coversheet to providers during authorization intake or during the review process. **Using an incorrect fax coversheet may delay a response to an authorization request.*
Do providers need a separate request for all spine surgeries performed on the same date of service?	No. Evolent will provide a list of surgery categories to choose from and the provider must select the most complex and invasive surgery being performed as the primary surgery. **Example: Lumbar Fusion** If the surgeon is planning a single level Lumbar Spine Fusion with decompression, the surgeon will select the single level fusion procedure. The surgeon does not need to request a separate authorization for the decompression procedure being performed as part of the Lumbar Fusion Surgery. This is included in the Lumbar Fusion request. **Example: Laminectomy** If the surgeon is planning a Laminectomy with a Microdiscectomy, the surgeon will select the Lumbar decompression procedure. The surgeon does not need to

	request a separate authorization for the Microdiscectomy procedure. If the surgeon is only performing a Microdiscectomy (CPT 63030 or 63035), the surgeon should select the Microdiscectomy only procedure.
Will providers need to enter each CPT procedure code being performed for a hip, knee, shoulder, or spine surgery?	The intake process is designed to guide ordering providers to the correct primary surgery as additional CPT codes are entered. We recommend entering multiple codes (if applicable) to ensure the correct procedure type is selected.
Is instrumentation (medical device), bone grafts, and bone marrow aspiration included as part of the spine or joint fusion authorizations?	Yes. The instrumentation (medical device), bone grafts, and bone marrow aspiration procedures commonly performed in conjunction with musculoskeletal surgeries are included in the authorization; however, the amount of instrumentation must align with the procedure authorized.
What is the response time for a prior authorization request?	Turnaround times meet all applicable regulations contingent upon receipt of sufficient clinical documentation.
What does an Evolent authorization number/request ID look like?	The Evolent authorization number/request ID consists of alpha-numeric characters. In some cases, an Evolent tracking number (not the same as an authorization number) will be provided prior to a determination being made on a request. Example of authorization number/request ID: 24327ABC123 Example of tracking number: 160000000000 Providers can use either of these numbers to track the status of their request online or through an Interactive Voice Response (IVR) telephone system.
If requesting authorization through RadMD and the request pends, what happens next?	When an authorization request is submitted and it pends for additional clinical information, RadMD users should upload clinical information to assist with the determination process.
How do I submit retrospective or expedited authorization requests?	To submit retrospective or expedited prior authorization requests, contact Evolent at 1-800-642-6551.

How long is the prior authorization number valid?	The authorization number is valid for 30 days from the date of request.
Is prior authorization required if Buckeye Health Plan is NOT the member's primary insurance?	No.
If the provider obtains a prior authorization number does that guarantee payment?	An authorization number is not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Evolent's medical necessity review and determination is for the authorization of the surgeon's professional services and type of surgery being performed. We encourage providers to check member eligibility at the time an appointment is made and at the time of check-in.
Does Evolent allow retro-authorizations?	It is important that physicians and office staff are familiar with prior authorization requirements. Claims for procedures above that have not been properly authorized will not be reimbursed. Providers **should not** schedule or perform these procedures without prior authorization.
Can providers verify an authorization number online?	Yes. Providers can check the status of authorization requests quickly and easily by going to the Evolent website at RadMD.com.
Is the Evolent authorization number displayed on the Buckeye Health Plan website?	No.
What if I disagree with Evolent's determination?	In the event of a prior authorization or claims payment denial, providers may appeal the decision through Buckeye Health Plan. Providers should follow the instructions on their non-authorization letter or Explanation of Payment (EOP) notification.

SCHEDULING PROCEDURES	
Do providers have to obtain an authorization before they call to schedule an appointment?	Providers should obtain prior authorization before scheduling the member.
CLAIMS RELATED	
Where do rendering providers/surgeons send their claims for MSK surgeries?	Providers should continue to send claims to Buckeye Health Plan and are encouraged to submit electronic claims.
How can claims status be checked?	Providers can check claims status via the Buckeye Health Plan website buckeyehealthplan.com.
Who should a provider contact if they want to appeal a prior authorization or claims payment denial?	Providers are asked to follow the appeal instructions on their non-authorization letter or Explanation of Benefits (EOB) notification.
MISCELLANEOUS	
How is medical necessity defined?	Evolent defines medical necessity as services that: • Meets 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 is 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; and • Not furnished primarily for the convenience of the member, the attending physician, or other surgeon.
Where can a provider find Evolent's Guidelines for Clinical Use of MSK Procedures?	Clinical guidelines can be found on the Evolent website at RadMD.com. They are presented in a PDF file format that can easily be printed for future reference. Evolent's clinical guidelines have been developed from practice experiences, literature reviews, specialty criteria sets and empirical data.
Will member ID cards change with the implementation of this program?	No. The Buckeye Health Plan member ID cards will not change with the implementation of this program.

RE-REVIEW AND APPEALS PROCESS	
Is the re-review process available if a denial is received?	Once a denial determination has been made, if the provider has new or additional information to share, a re-review can be initiated by uploading via RadMD or faxing (using the case-specific fax coversheet) additional clinical information to support the request. A re-review must be initiated within 5 business days from notification of denial and prior to submitting a formal appeal Providers can request a peer-to-peer discussion for any request that does not meet medical necessity guidelines. Providers can call Evolent at 1-800-642-6551 to initiate the peer-to-peer process.
RADMD ACCESS	
If I currently have RadMD access, will I need to apply for additional access?	If the user already has access to RadMD, RadMD will allow you to submit an authorization request for any procedure managed by Evolent.
What option should I select to initiate authorization requests?	Selecting "**Physician's office that orders procedures**" will allow you to initiate authorization requests for MSK procedures.
How do I apply for RadMD access?	Prospective users should go to RadMD.com. • Click "**New User**". • Choose "**Physician's office that orders procedures**" from the drop-down box. • Complete application with required information. • Click "**Submit**" When a RadMD application is successfully submitted, users receive an email with a link to create a password. Please contact the RadMD Support Team at 1-800-327-0641 if you do not receive a response within 72 hours.
What is rendering provider access?	Rendering provider access allows users to view all approved authorizations for their office or facility. If an office is interested in signing up for rendering access, you will need to designate an account administrator. • Prospective users should go to RadMD.com • Select "**Facility/Office where procedures are performed**" from the drop-down box. • Complete application with required information • Click "**Submit**" Examples of a rendering providers that only need to view approved authorizations:

	• Hospital facilities • Billing departments • Offsite locations
What link on RadMD will I select to initiate an authorization request for an MSK surgery?	Clicking the "**Request Spine Surgery or Orthopedic Surgery**" link will allow the user to submit a request for an MSK surgery.
How can providers check the status of an authorization request?	Providers can check on the status of an authorization by using the "**View Request Status**" link on the RadMD main menu.
How can I confirm what clinical information has been uploaded or faxed to Evolent?	Clinical Information that has been received via upload or fax can be viewed by selecting the member on the View Request Status link from the main menu. On the bottom of the "**Request Verification Detail**" page, select the appropriate link for the upload or fax.
Where can providers find their case-specific communication from Evolent?	Links to case-specific communication to include requests for additional information and determination letters can be found via the "**View Request Status**" link.
If I did not submit the authorization request, how can I view the status of a case or upload clinical documentation?	The "**Track an Authorization**" feature allows users who did not submit the original request to view the status of an authorization, as well as upload clinical information. This option is also available as a part of your main menu options using the "**Search by Tracking Number**" feature. A tracking number is required with this feature.
Paperless Notification: How can I receive notifications electronically instead of on paper?	Evolent defaults communications including final authorization determinations to paperless/electronic. Correspondence for each case is sent to the email address of the individual who submitted the authorization request. Users will be sent an email when determinations are made. • No PHI will be contained in the email. • The email will contain a link that requires the user to log into RadMD to view PHI. Providers who prefer paper communication will be given the option to opt out and receive communications via fax.
CONTACT INFORMATION	
Who can providers contact for RadMD support?	For RadMD assistance, please contact RadMDSupport@Evolent.com or call 1-800-327-0641.

Who can a provider contact at Evolent for more information?	Providers can contact: Mara Grimm Provider Relations Manager 804-548-0584 mara.grimm@Evolent.com.