Evolent Musculoskeletal Care Management (MSK) Program Frequently Asked Questions (FAQ's) For CountyCare Physicians/Surgeons	
Question	**Answer**
GENERAL	
Why is CountyCare implementing a Musculoskeletal Care (MSK) program focused on outpatient Interventional Pain Management (IPM) and inpatient and outpatient spine surgeries?	The MSK program is designed to improve quality and manage the utilization of IPM procedures and musculoskeletal surgeries. • 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. **Outpatient IPM:** A separate prior authorization number is required for each procedure ordered. A series of injections will not be approved. • Spinal Epidural Injections • Paravertebral Facet Joint Injections or Blocks • Paravertebral Facet Joint Denervation (Radiofrequency (RF) Neurolysis) • Sacroiliac Joint Injections **Outpatient and Inpatient Spine Surgeries:** • Lumbar Microdiscectomy • Lumbar Decompression (include laminotomy, laminectomy, facetectomy, foraminotomy) • Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single & Multiple Levels • 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 Evolent (formerly National Imaging Associates, Inc.) does not manage prior authorization for emergency MSK surgery cases that are admitted through the emergency room or for MSK surgery procedures outside of those listed above.
Why did CountyCare select Evolent to manage its MSK program?	Evolent was selected to partner with us because of its clinically driven program designed to effectively manage quality and member safety, while ensuring appropriate utilization of resources for CountyCare membership.
Which CountyCare members will be covered under this relationship and what networks will be used?	The MSK program applies to CountyCare's Medicaid members and is managed through CountyCare's contractual relationships.
IMPLEMENTATION	
What is the implementation date for this MSK program?	Implementation is March 1, 2025.
PRIOR AUTHORIZATION	
When is prior authorization required?	Prior authorization is required through Evolent for the IPM procedures and MSK surgeries above. CountyCare's prior authorization requirements for the facility or hospital admission must be obtained separately and only initiated after the surgery has met Evolent's medical necessity criteria. Once an authorization has been obtained for the procedure/surgery, CountyCare will reach out to the rendering provider to authorize the facility in which the procedure will be performed.
Is prior authorization required for members who already have a procedure scheduled?	Procedures performed on or after March 1, 2025 require prior authorization through Evolent.
Are pain management procedures included in this program?	Yes. All non-emergent outpatient Interventional Pain Management (IPM) procedures are required to be prior authorized through Evolent.
Who will be reviewing the surgery requests	As a part of the Evolent clinical review process, actively practicing neurosurgeons (spine) will conduct the medical

and medical information provided?	necessity reviews and determinations of musculoskeletal surgery cases.
Does the Evolent prior authorization process change the requirements for facility-related prior authorizations?	Evolent's medical necessity review and determination process is only for the authorization of the surgeon's professional services and type of surgery being performed.
How do providers submit prior authorization requests?	Providers submit prior authorization requests via the Evolent website (RadMD.com) or by calling Evolent at 1-800-424-1732.

What information is required to submit an authorization request?	To expedite the process, please have the following information ready before logging on to the Evolent website or calling the call center:
	(*denotes required information)
	• Name and office phone number of ordering physician*
	• 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)
	
	Please be prepared to provide the following information, if requested:
	• Clinical notes outlining type and onset of symptoms.
	• Length of time with pain/symptoms
	• Non-operative care modalities to treat pain and amount of pain relief.
	• Physical exam findings
	• Diagnostic Imaging results
	• Specialist reports/evaluation

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 CountyCare provider must select the most complex and invasive surgery being performed as the primary surgery. **Example: Lumbar Fusion** If the CountyCare 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 CountyCare 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 CountyCare surgeon is only performing a Microdiscectomy (CPT 63030 or 63035), the surgeon should select the Microdiscectomy only procedure.
Will the provider 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 kind of response time should be expected?	Please have the following information available when initiating an authorization request: • 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) • Pain/Member Symptoms • 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) Generally, within 2 to 3 business days after receipt of request with full clinical documentation, a determination will be made. In certain cases, the review process can take longer if additional clinical information is required to make a determination.
What does an Evolent authorization number look like?	The Evolent authorization number consists of alpha-numeric characters. In some cases, the provider may instead receive an Evolent tracking number (not the same as an authorization number) if the authorization request is not approved at the time of initial contact. 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?	You will receive a tracking number and Evolent will contact you to complete the process.
Can RadMD be used for retrospective or expedited authorization requests?	No, those requests will need to be called into Evolent's call center for processing at 1-800-424-1732.
How long is the prior authorization number valid?	The authorization number is valid for 60 calendar days from the date of request.
Is prior authorization necessary if CountyCare 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.
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.
What happens if I have a service scheduled for March 1, 2025?	An authorization can be obtained beginning March 1, 2025 for dates of service March 1, 2025 and beyond. Evolent and CountyCare work with the provider community on an ongoing basis to continue to educate providers.
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 CountyCare 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 CountyCare. 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?	Evolent asks where the surgery is being performed and the anticipated date of service. Providers should obtain prior authorization before scheduling the member and the facility or hospital admission.
WHICH SURGEONS ARE AFFECTED?	
Which surgeons are impacted by the MSK Program?	Neurosurgeons and Orthopedic Surgeons are the key physicians impacted by this program. Procedures performed in the following settings are included in this program: • Hospital (Inpatient & Outpatient Settings) • Ambulatory Surgical Centers • In Office
CLAIMS RELATED	
Where do rendering providers/surgeons send their claims for outpatient, non-emergent MSK services?	CountyCare rendering providers/surgeons continue to send claims directly to CountyCare. Rendering providers/surgeons are encouraged to use EDI claims submission.

How can claims status be checked?	Rendering providers/surgeons should check claims status via the https://countycare.valence.care website or by calling 312-864-8200.
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.
How do providers know who Evolent is?	CountyCare and Evolent share training and education materials with physicians and surgeons prior to the implementation. CountyCare and Evolent also coordinate outreach and orientation for providers.
Will training be offered prior to the implementation date?	Yes. Evolent will conduct provider training sessions during February of 2025.
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 the CountyCare member ID card change with the	No. The CountyCare member ID card does not contain any Evolent information on it and the member ID card will not change with the implementation of this MSK Program.

implementation of this MSK Program?	
RE-REVIEW AND APPEALS PROCESS	
Is the re-review process available for the MSK program 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 cover sheet) additional clinical information to support the request. A re-review must be initiated within **5 business days** from the date of denial and prior to submitting a formal appeal. Evolent has a specialized clinical team focused on the MSK program. Peer-to-peer discussions are offered for any request that does not meet medical necessity guidelines. Providers can call 1-800-424-1732 to initiate the peer-to-peer process. These discussions provide an opportunity to discuss the case and collaborate on the appropriate services for the member based on the clinical information provided.
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
Which 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. RadMD is available 24/7, except when maintenance is performed every third Thursday of the month from 9 pm – midnight PST.
Who can a provider contact at Evolent for more information?	Providers can contact: Sharee Adams Provider Solutions Manager 314-387-5761 or SAdams@evolent.com.