Musculoskeletal Prior Authorization for Excellus BlueCross BlueShield

Provider Orientation 2019

eviCore healthcare
innovative solutions

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Company Highlights

4K employees
including 1K clinicians

Headquartered in Bluffton, SC
Offices across the US including:

- Lexington, MA
- Colorado Springs, CO
- Franklin, TN
- Greenwich, CT
- Melbourne, FL
- Plainville, CT
- Sacramento, CA

SHARING A VISION AT THE CORE OF CHANGE.

100M members
managed nationwide

NCQA Certification – Utilization Management

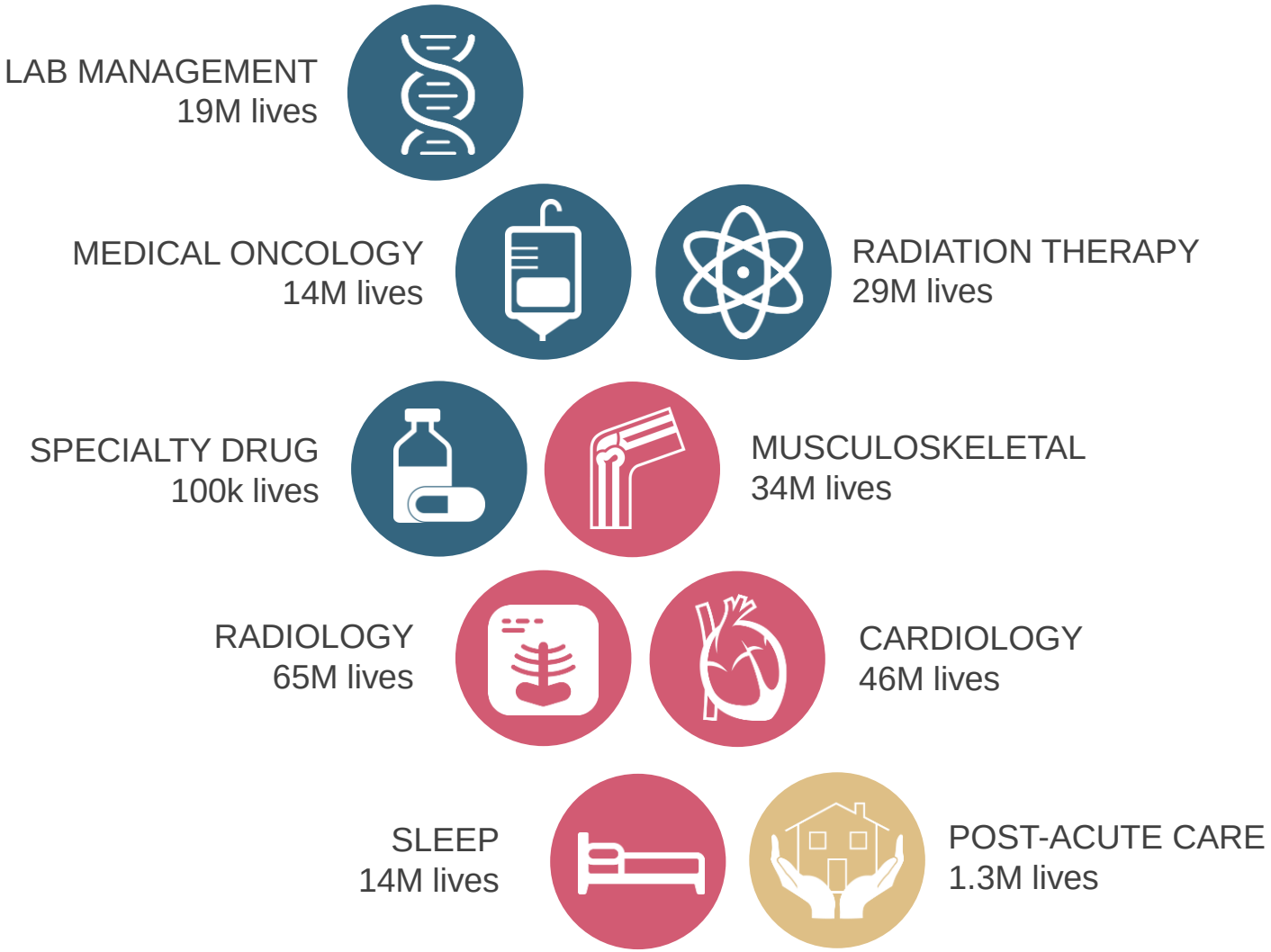
URAC – Accredited Health Utilization Management

Six Sigma

12M claims
processed annually

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Integrated Solutions



Musculoskeletal Solution Experience

- Since 2008
- 30+ regional and national clients
- 34M total membership
  - 25.5M Commercial membership
  - 2M Medicare membership
  - 6.5M Medicaid membership
- 3,120 average cases built per day

NCQA Certification Utilization Management

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT

Musculoskeletal by the Numbers

44

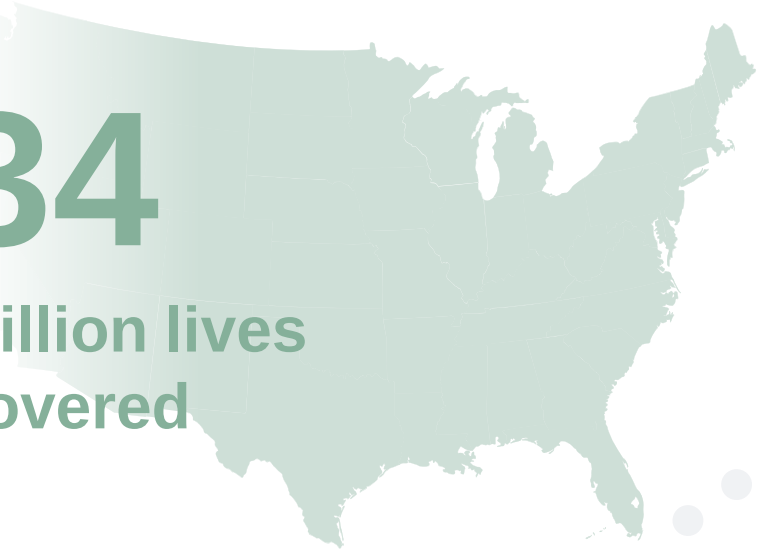
Musculoskeletal physicians on staff

66

Musculoskeletal-trained nurses on staff

34

Million lives covered



Our Clinical Approach

Clinical Platform

Multi-Specialty Expertise

- Family Medicine
- Internal Medicine
- Pediatrics
- Sports Medicine
- OB/GYN
- Cardiology
- Nuclear Medicine
- Anesthesiology
- Radiation Oncology
- Sleep Medicine
- Oncology/Hematology
- Musculoskeletal
  - Orthopedic Surgery
  - Spine Surgery
  - Interventional Pain
- Radiology
  - Nuclear Medicine
  - Musculoskeletal
  - Neuroradiology

- **190+ board-certified medical directors**
- **Diverse representation of medical specialties**
- **450 nurses with diverse specialties and experience**
- **Dedicated nursing and physician teams by specialty for Cardiology, Oncology, OB-GYN, Spine/Orthopedics, Neurology, and Medical/Surgical**

Evidence-Based Guidelines

The foundation of our musculoskeletal solution:

Dedicated pediatric guidelines

Medicare LCDs & NCDs

Academic institutional experts and community physician panels

Current clinical literature

Aligned with National Societies

- American Academy of Neurology
- American College of Rheumatology
- American Association of Neurological Surgeons
- American Academy of Orthopedic Surgeons
- American Society of Interventional Pain Physicians
- North American Spine Society
- American College of Occupational and Environmental Medicine
- American Academy of Physical Medicine and Rehabilitation
- American Association of Hip and Knee Surgeons
- American Pain Society
- Official Disability Guidelines
- Medicare Guidelines
- Spine Intervention Society
- American Academy of Orthopedic Surgeons
- The American Orthopedic Society for Sports Medicine
- Cochrane Reviews
- American Physical Therapy Association
- American Chiropractic Association
- American Occupational Therapy Association
- American Speech Language Hearing Association
- American Society of Anesthesiologists

Service Model

Client Provider Operations

The Client Provider Operations team is responsible for high-level service delivery to our health plan clients as well as ordering and rendering providers nationwide

Client Provider Representatives

Client Provider Representatives are cross-trained to investigate escalated provider and health plan issues.

Client Experience Managers

Client Experience Managers lead resolution of complex service issues and coordinate with partners for continuous improvement.

Regional Provider Engagement Managers

Regional Provider Engagement Managers are on-the-ground resources who serve as the voice of eviCore to the provider community.

Why Our Service Delivery Model Works

One centralized intake point allows for timely identification, tracking, trending, and reporting of all issues. It also enables eviCore to quickly identify and respond to systemic issues impacting multiple providers.

Complex issues are escalated to resources who are the subject matter experts and can quickly coordinate with matrix partners to address issues at a root-cause level.

Routine issues are handled by a team of representatives who are cross trained to respond to a variety of issues. There is no reliance on a single individual to respond to your needs.

Musculoskeletal Prior Authorization Program for Excellus BCBS

Program Overview

eviCore will begin accepting requests on January 21, 2019 for dates of service February 1, 2019 and beyond

Prior authorization applies to services that are:

- Outpatient
- Inpatient
- Elective / Non-emergent
- 23-hour observation

Prior authorization does not apply to services that are performed in:

- Emergency room

It is the responsibility of the rendering provider to request prior authorization approval for services.

Applicable Membership

Authorization is required for Excellus BCBS members enrolled in the following programs:

- **Commercial Fully Insured***
- **Medicare Advantage Products**

*Membership should be validated with the Health Plan to determine fully insured vs. self-insured Commercial products

Prior Authorization Required:

Joint Surgery
- Large joint replacement
- Arthroscopic and open procedures

Spine Surgery
- Spinal Implants
  - Spinal cord stimulators
  - Pain Pumps
- Cervical/Thoracic/Lumbar
  - Decompressions
  - Fusions

Interventional Pain
- Spinal injections
- Spinal implants
  - Spinal cord stimulators
  - Pain pumps

To find a list of CPT (Current Procedural Terminology) codes that require prior authorization through eviCore, please visit:

www.ExcellusBCBS.com

Prior Authorization Requests

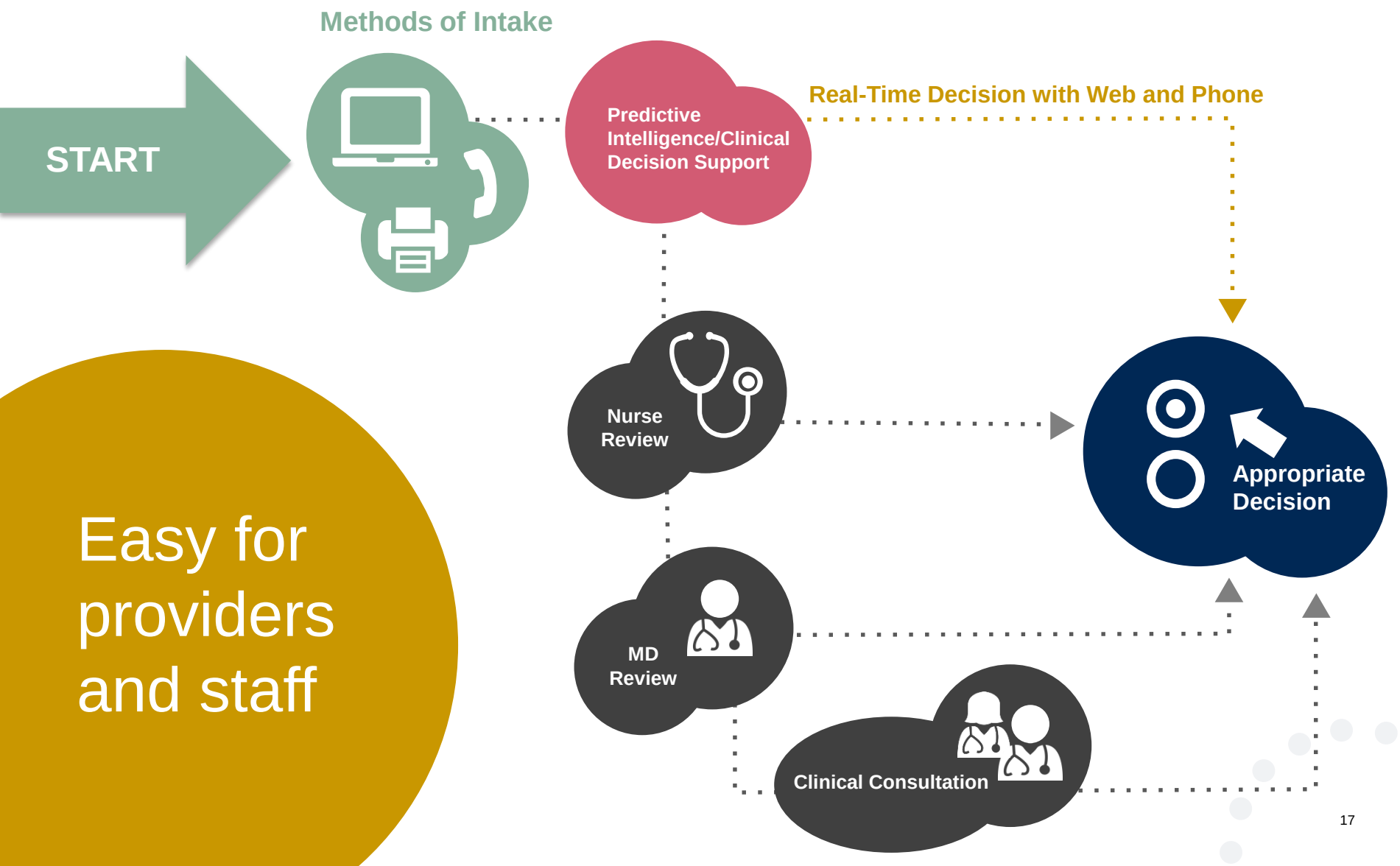
How to request prior authorization:

www.ExcellusBCBS.com
Available 24/7 and the **quickest** way to create prior authorizations and check existing case status

Or by phone:
1-866-889-8056
7 a.m. to 7 p.m. (EST)
Monday - Friday

Fax option: 1-866.466.6964 Fax forms available at www.evicore.com

Clinical Review Process



Easy for providers and staff

Needed Information

Member
Member ID
Member name
Date of birth (DOB)

Facility
Facility name
National provider identifier (NPI)
Street address

Referring Physician
Physician name
National provider identifier (NPI)
Tax identification number (TIN)
Fax number

Requests
CPT code(s) for requested procedure

The appropriate diagnosis code for the working of differential diagnosis

If clinical information is needed, please be able to supply:

- Imaging studies and prior test results related to the diagnosis
- Office notes related to the current diagnosis
- Therapy notes related to the current diagnosis

Prior Authorization Outcomes

Approved Requests:

- All requests are processed within **two business days** after receipt of all necessary clinical information.
- Authorizations are typically good for **90 calendar days** from the date of determination.

Delivery:

- Outbound call will be made to the ordering provider and member
- Faxed to ordering provider and rendering facility,
- Mailed to the member.
- Information can be printed on demand from the eviCore healthcare Web Portal.

Denied Requests:

- Communication of denial determination
- Communication of the rationale for the denial
- How to request a Peer Review

Delivery:

- Outbound call will be made to the ordering provider and member
- Faxed to the ordering provider and rendering facility
- Mailed to the member

Prior Authorization Outcomes – Commercial

Reconsiderations

- Additional clinical information can be provided without the need for a physician to participate
- Must be requested on or before the anticipated date of service
- Commercial members only

Peer-to-Peer Review:

- If a request is denied and requires further clinical discussion for approval, we welcome requests for clinical determination discussions from referring physicians. In certain instances, additional information provided during the consultation is sufficient to satisfy the medical necessity criteria for approval.
- **Peer-to-Peer reviews** can be scheduled at a time convenient to your physician.

Pre-Decision Consultation – Medicare / Medicare Advantage

Pre-Decision Consultation

- If your case requires further clinical discussion for approval, we welcome requests for clinical determination discussions from referring physicians prior to a decision being rendered.
- In certain instances, additional information provided during the pre-decision consultation is sufficient to satisfy the medical necessity criteria for approval.

Special Circumstances

Appeals

- eviCore will not process first level appeals.
- Please follow the process currently in place with Excellus BCBS.

Retrospective Reviews

- eviCore will not process retrospective requests.
- Please follow the process currently in place with Excellus BCBS.

Outpatient Urgent Procedures

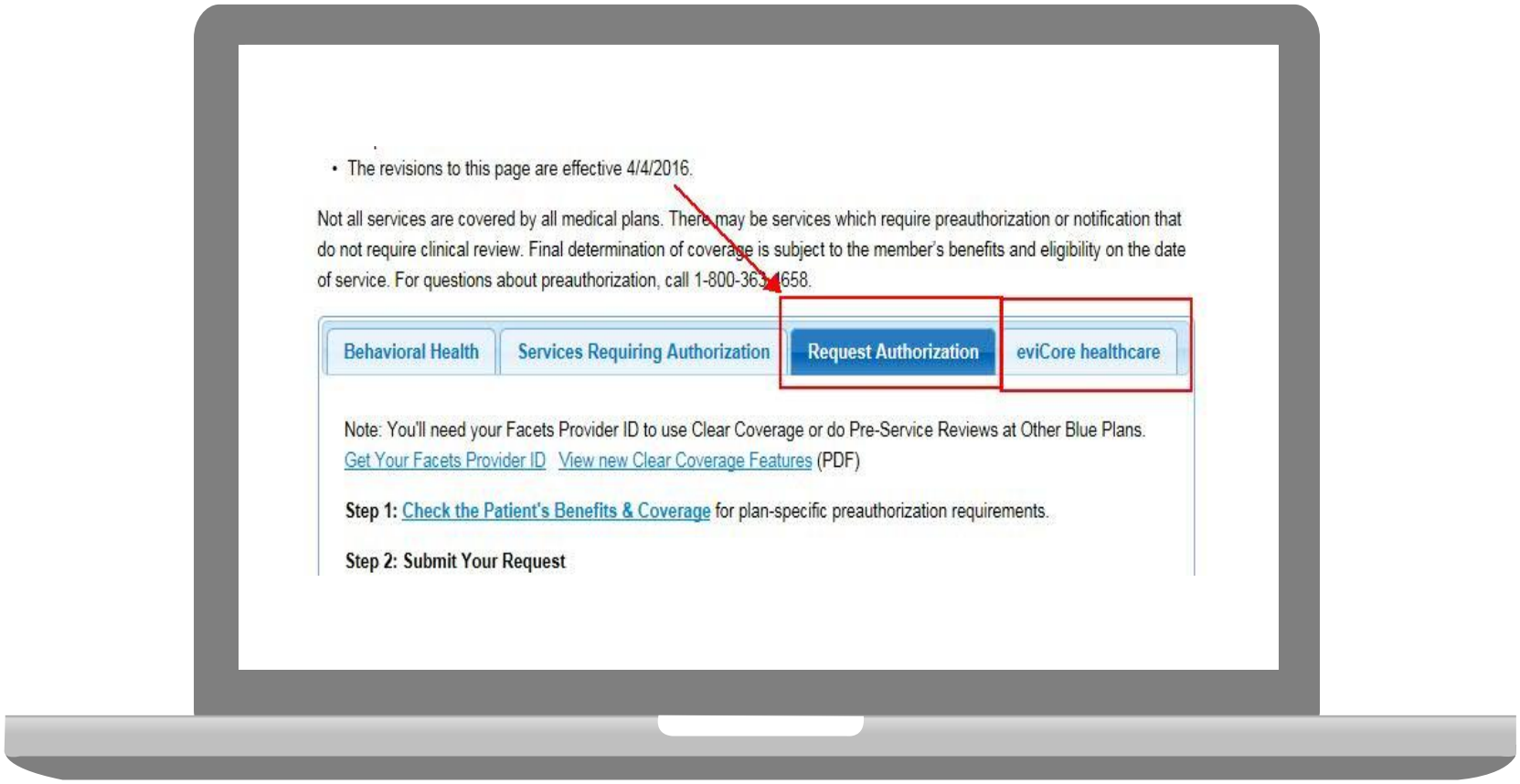
- Urgent requests may be submitted on the portal or by phone.
- In order to submit an urgent request online, providers must upload all supporting clinical documentation during case initiation.
- If submitting by phone, request an expedited outpatient prior authorization review and provide clinical information.
- Requests will be reviewed for clinical urgency and medical necessity.
- Urgent Cases will be reviewed within **24 hours not to exceed 72 hours** of the request.

Web Portal Services

Single-Sign On for Excellus BCBS Providers

Sign in under Provider and select Referrals and Auths
****Sign in must be MD or linked directly to an MD**

Single-Sign On for Excellus BCBS Providers

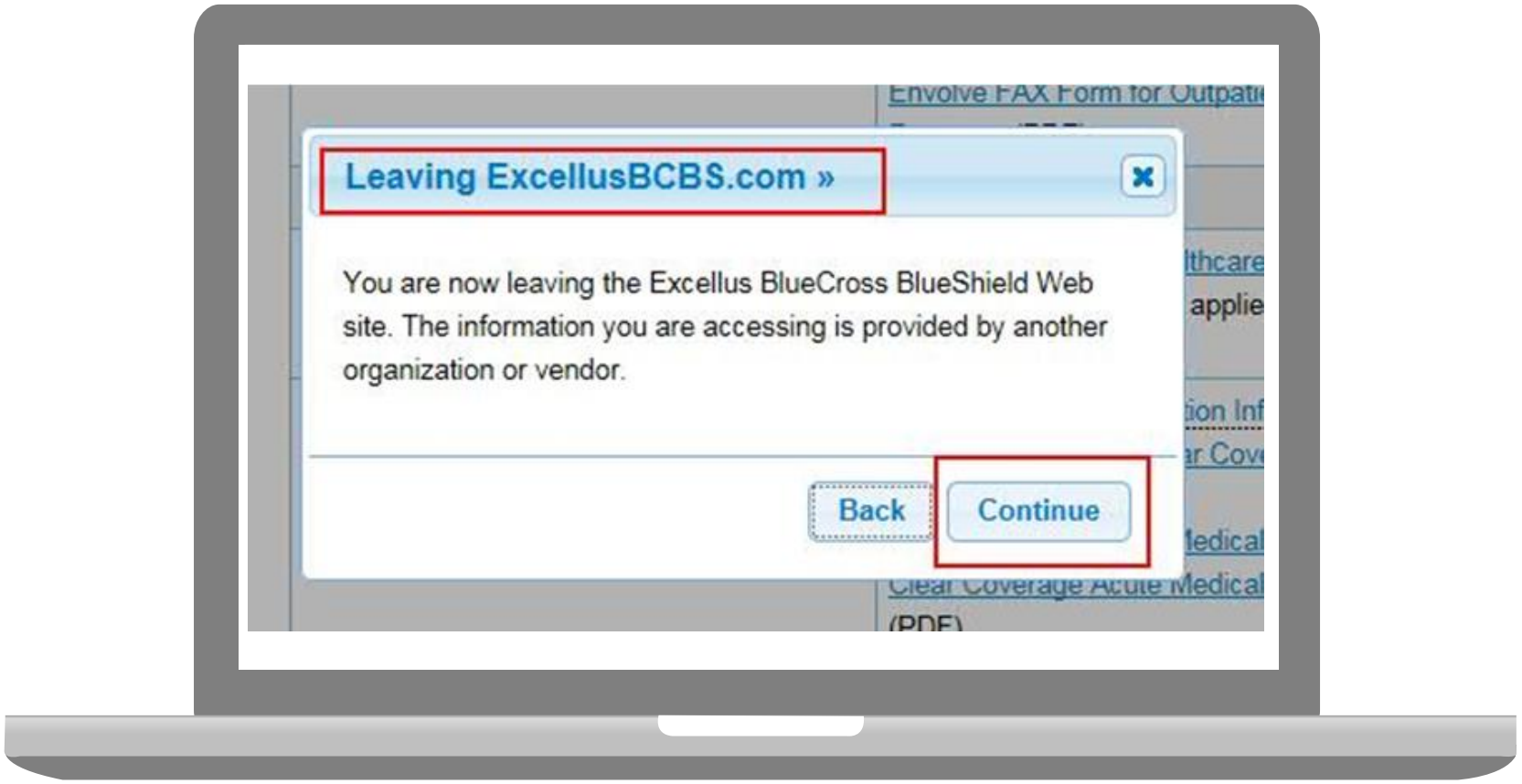


Select the **Request Authorization**

Single-Sign On for Excellus BCBS Providers

Go to **B. Requests for Commercial and Medicare** and select **Online with eviCore healthcare**

Leaving ExcellusBCBS.com

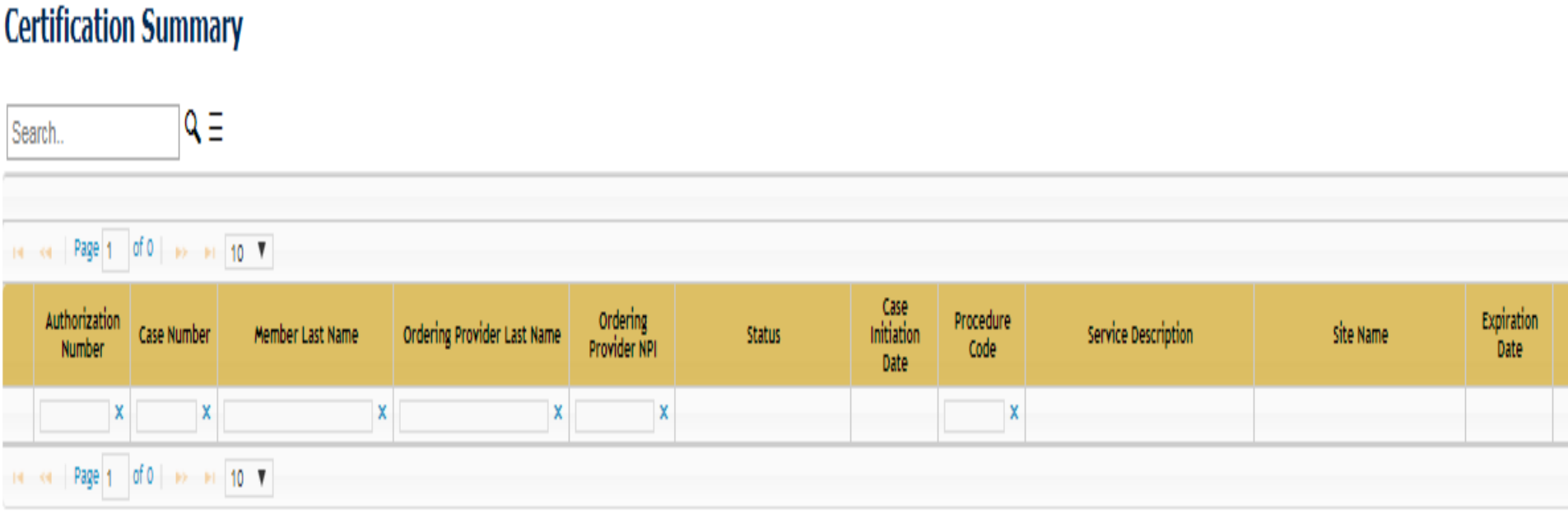


You will receive notification that you are leaving ExcellusBCBS.com and accessing the eviCore web portal. Please select Continue.

Select Program

Select the **Program** for your certification.

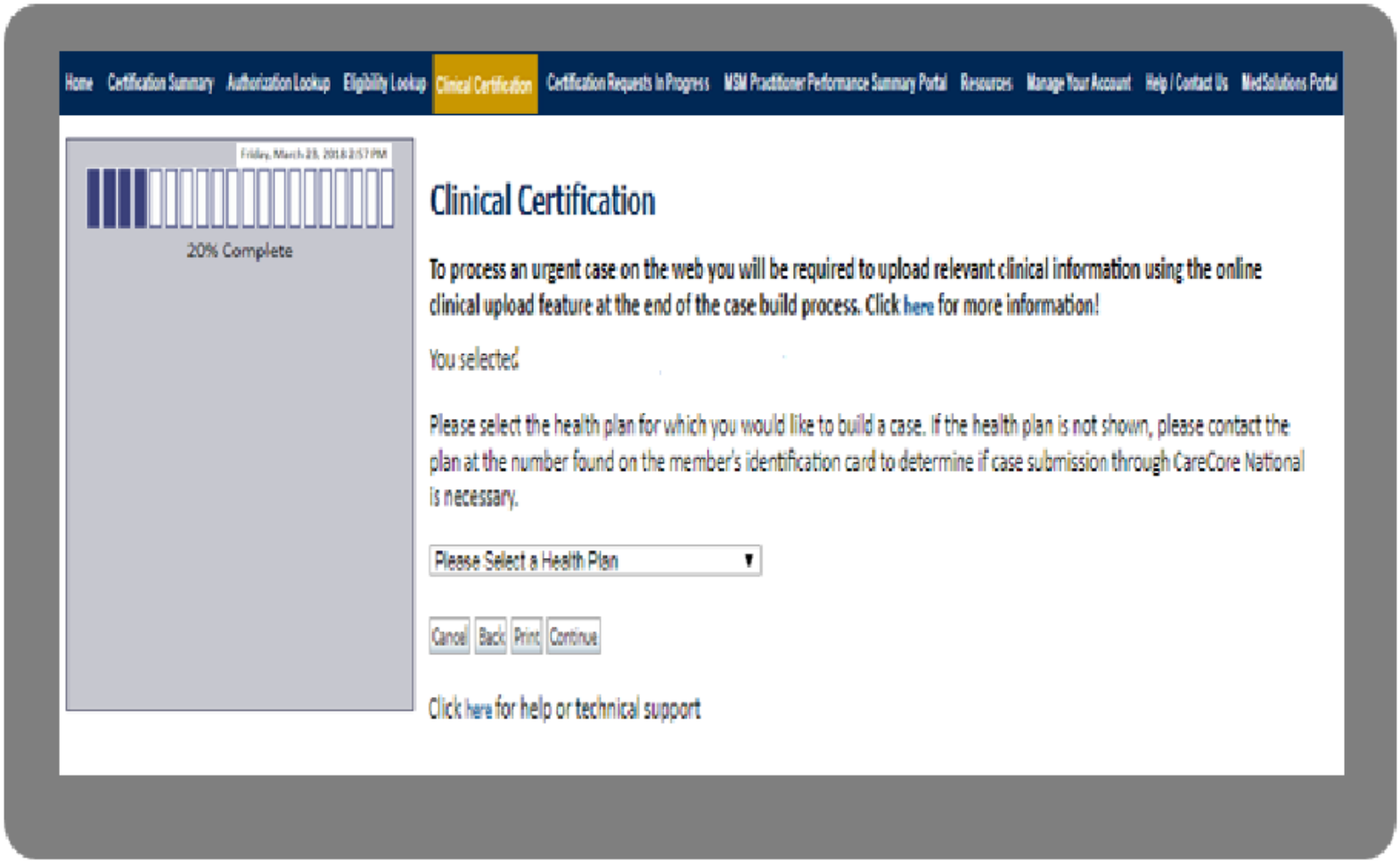
Certification Summary Dashboard



Select Provider

Select the **Practitioner/Group** for whom you want to build a case.

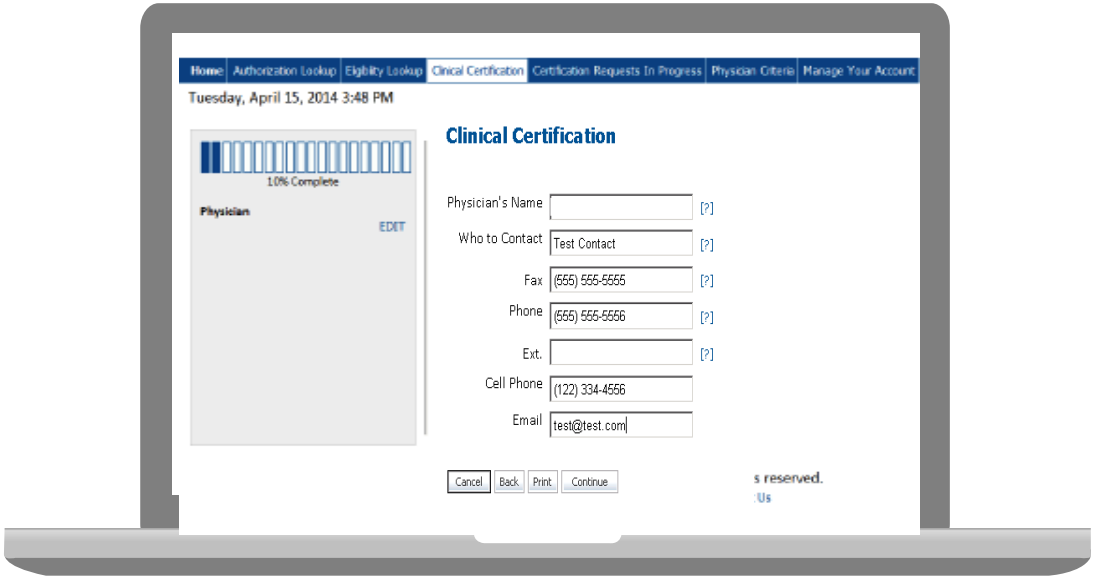
Select Health Plan



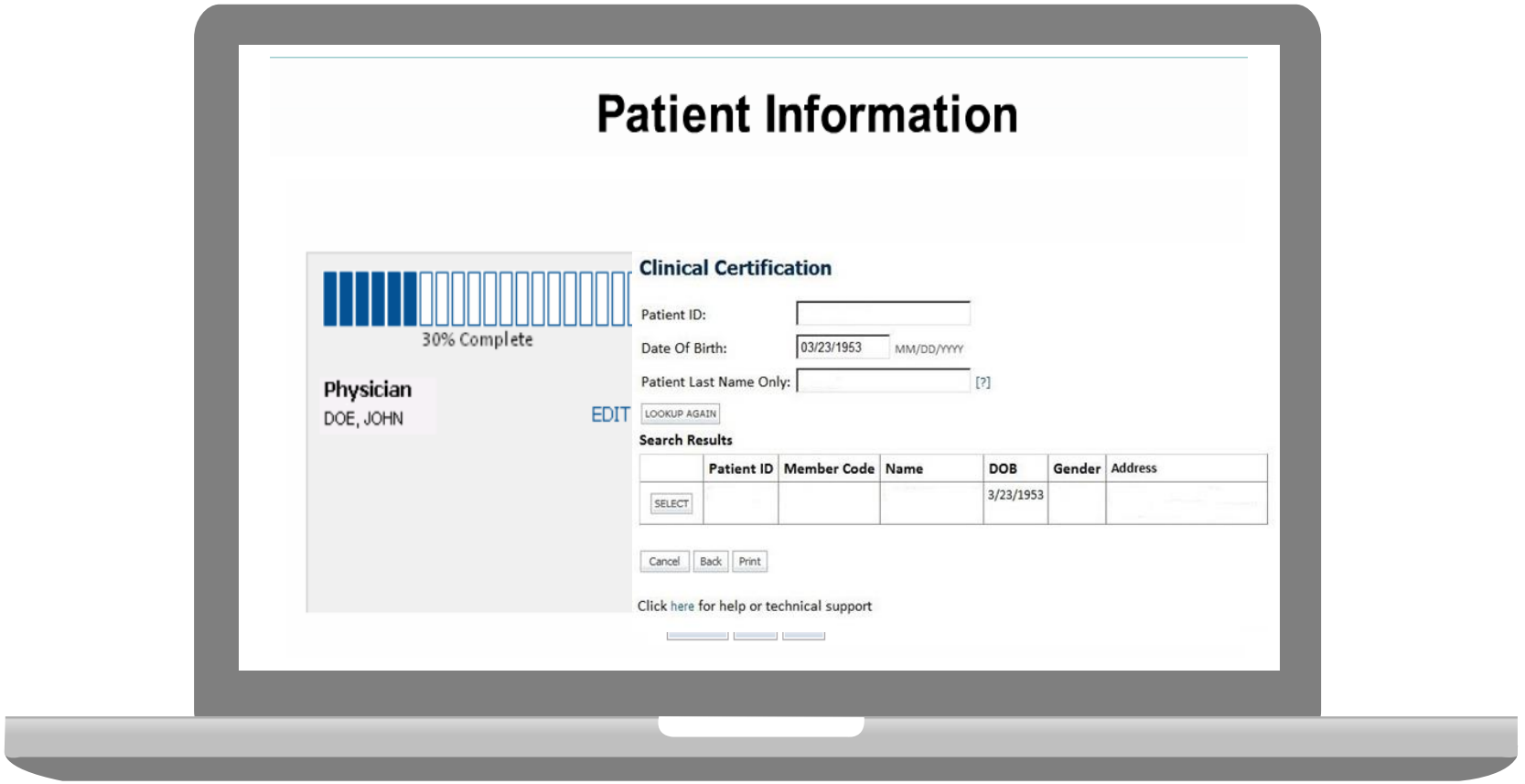
Choose the appropriate Health Plan for the case request. If the health plan does not populate, please contact the plan at the number found on the member's identification card. Once the plan is chosen, please select the provider address in the next drop down box.

Contact Information

Enter the **Provider's name** and appropriate information for the point of contact individual.

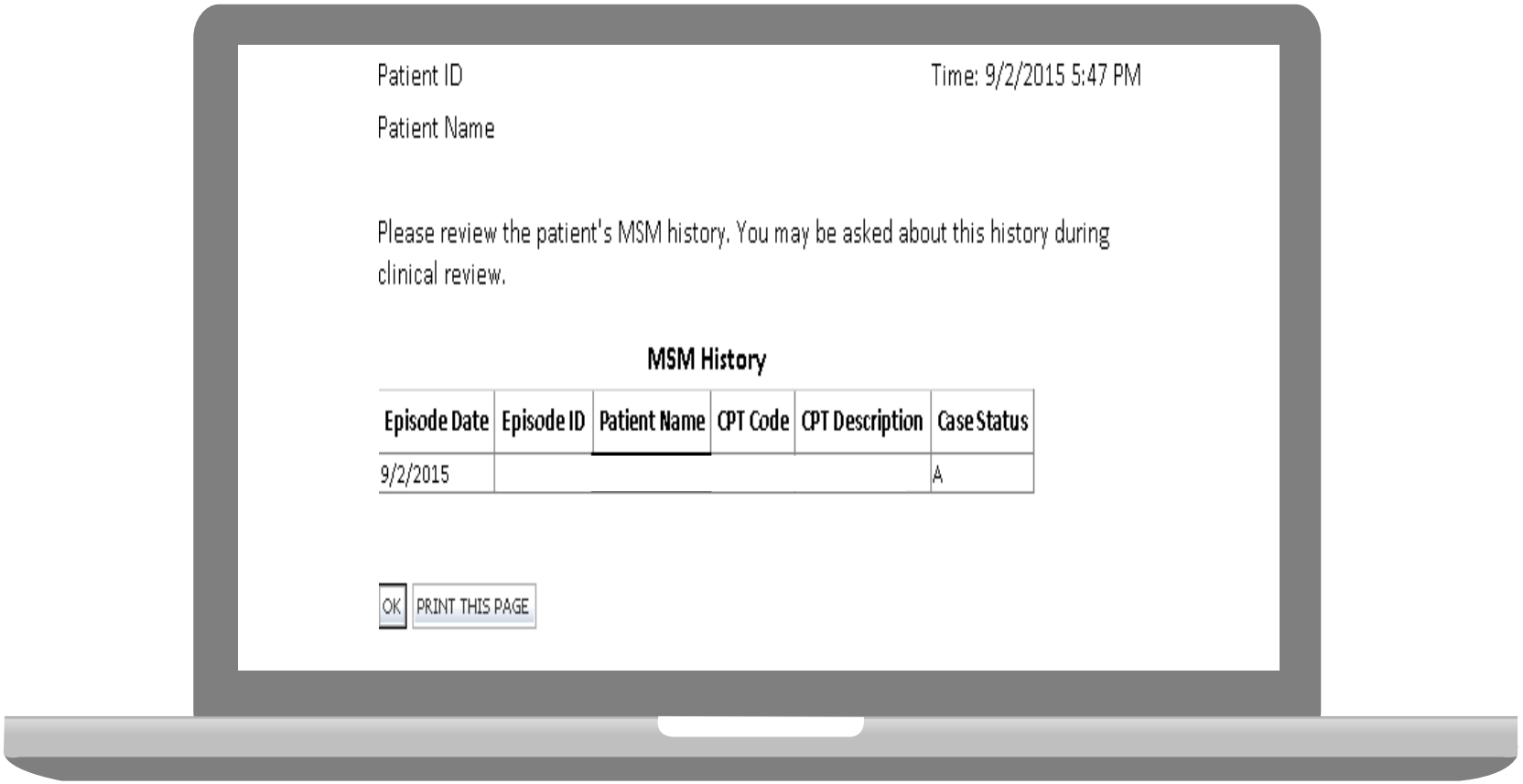


Member Information

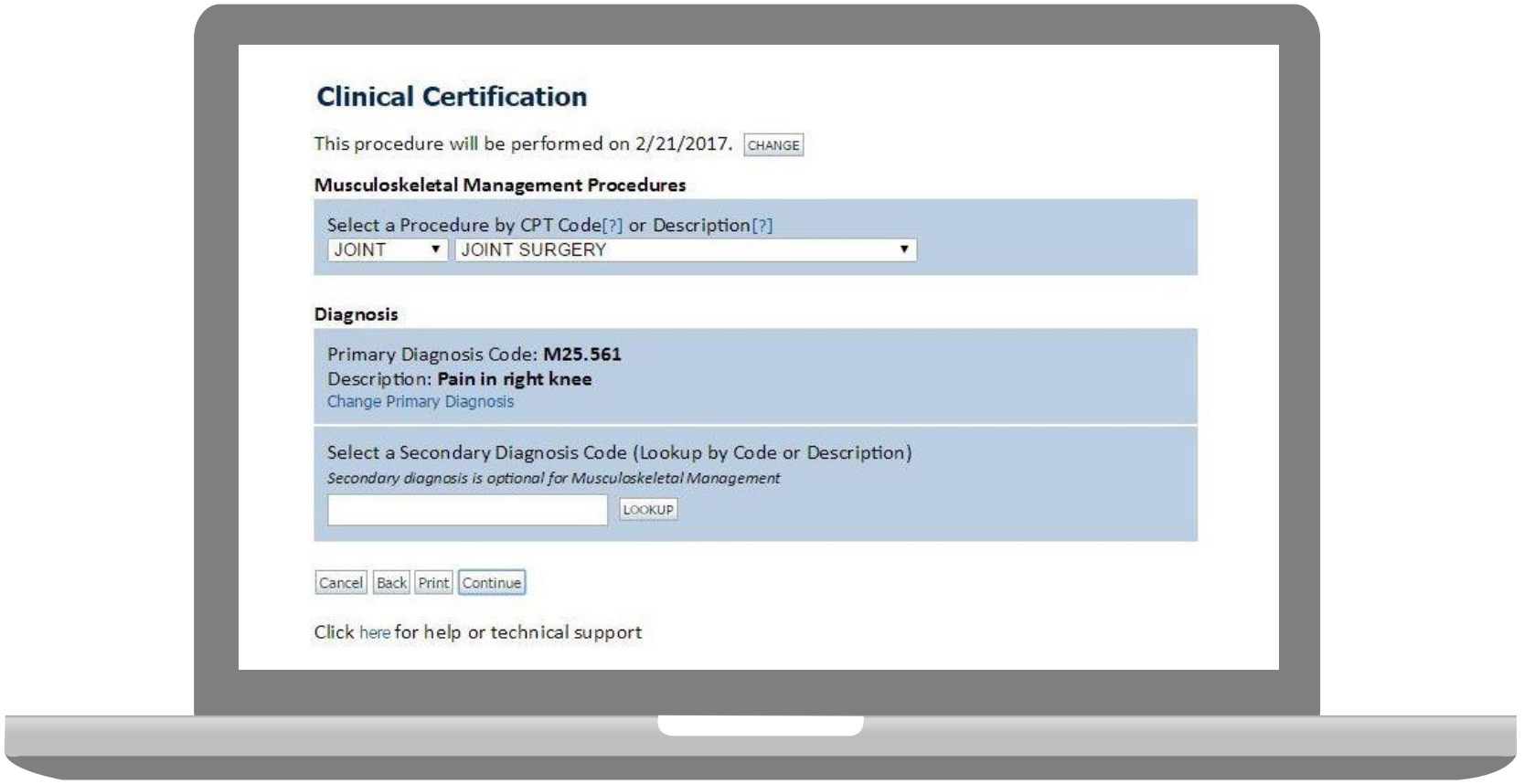


Enter the **member information** including the Patient ID number, date of birth, and patient's last name. Click **"Eligibility Lookup."**

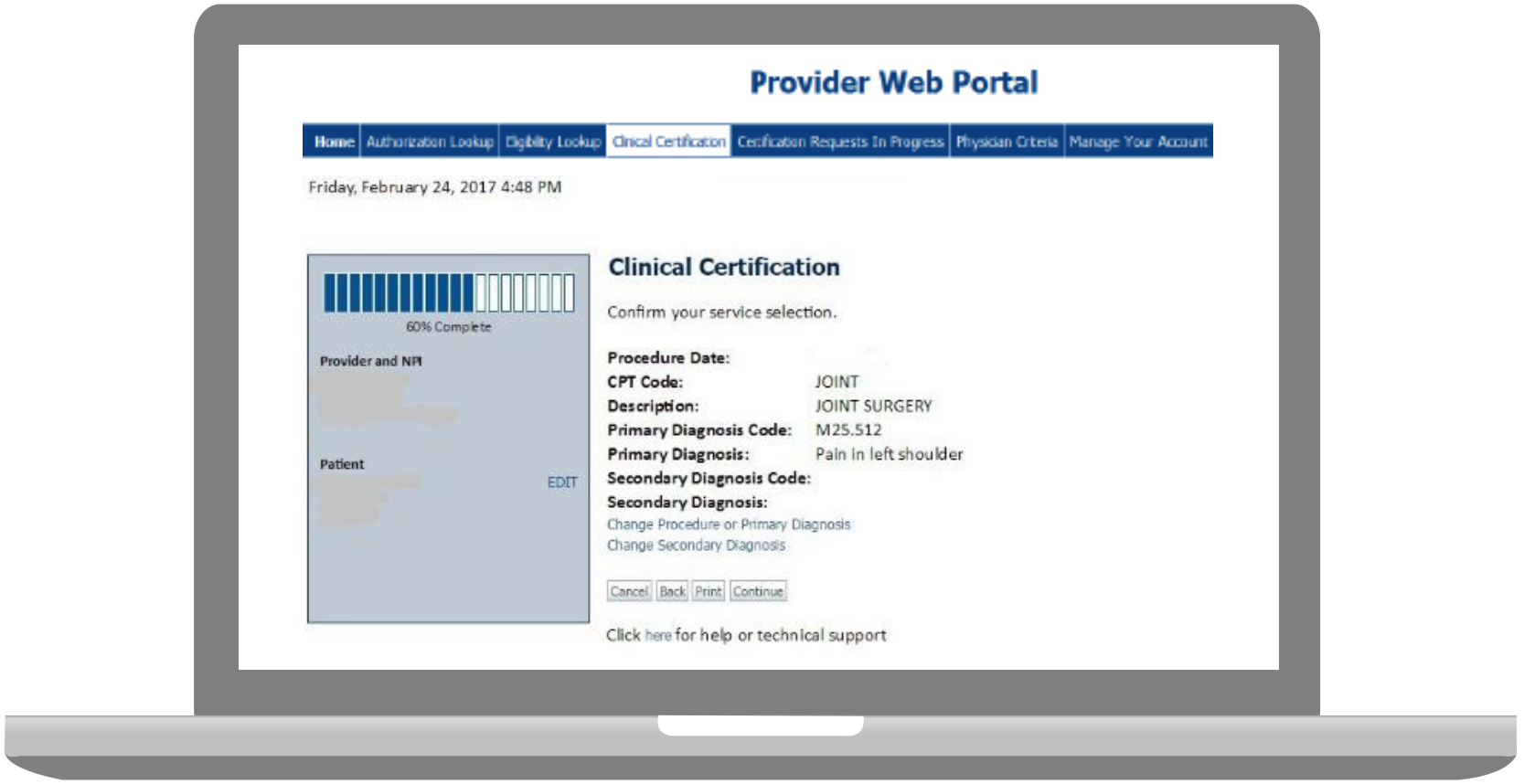
Member History



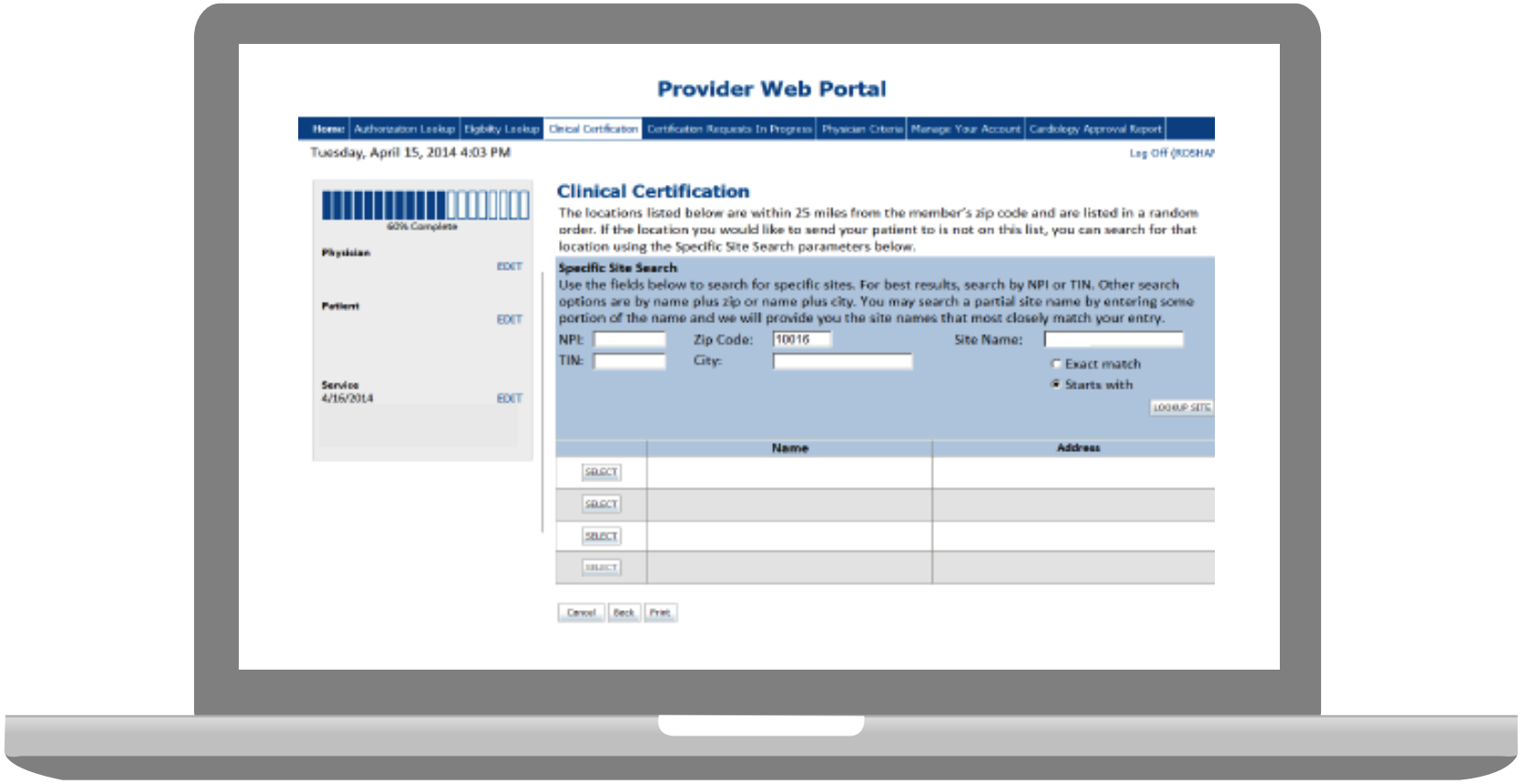
Clinical Details



Verify Service Selection



Site Selection

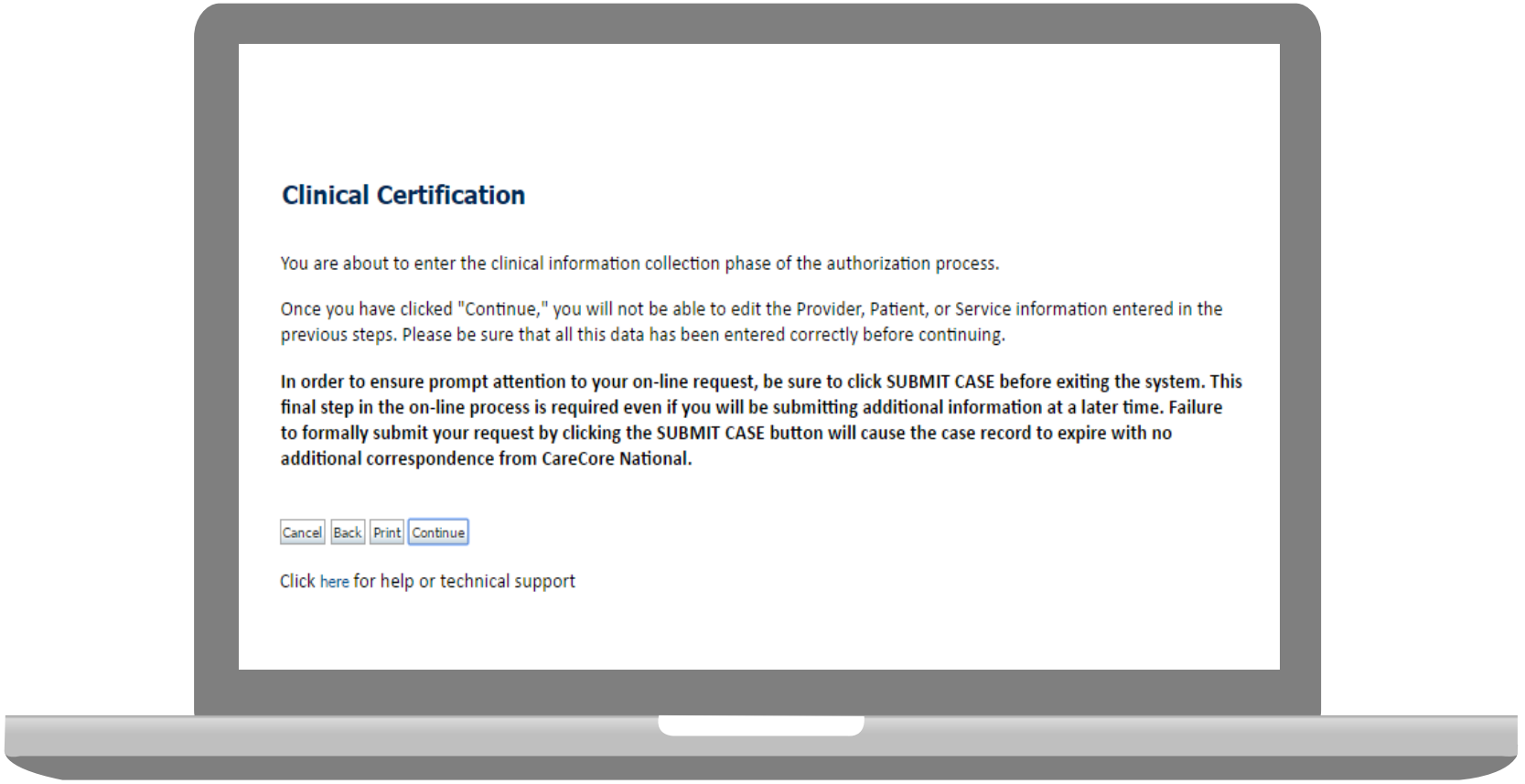


Select the appropriate site for the request.

Site Selection

Confirm the site selection.

Clinical Certification



- Verify all information entered and make any needed changes prior to moving into the clinical collection phase of the prior authorization process.
- You will not have the opportunity to make changes after that point.

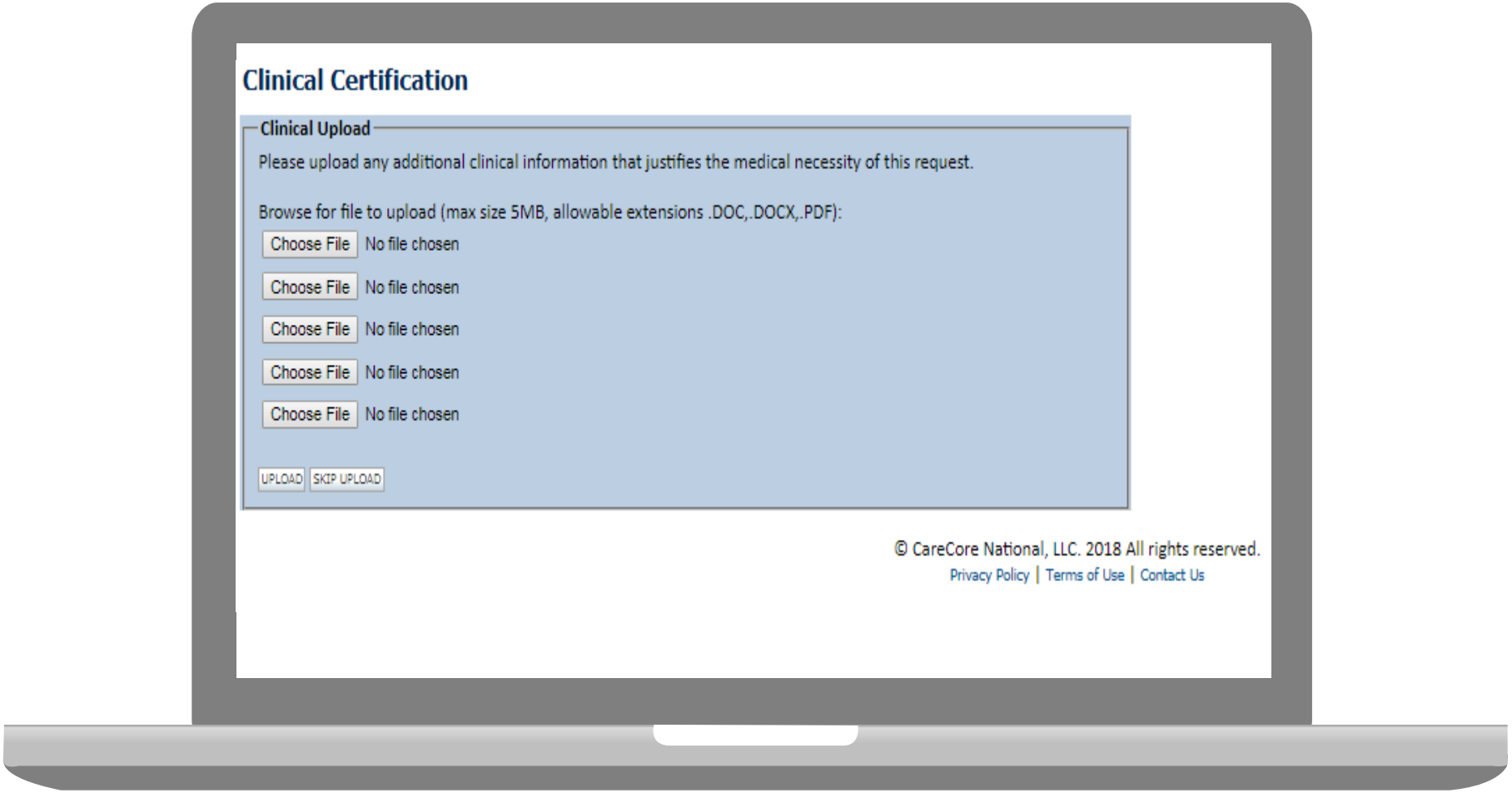
Contact Information

Select an Urgency Indicator and Upload your patient's relevant medical records that support your request.

If your request is urgent select No, if the case is standard select Yes.

You can upload up to **FIVE documents** in .doc, .docx, or .pdf format. Your case will only be considered Urgent if there is a successful upload.

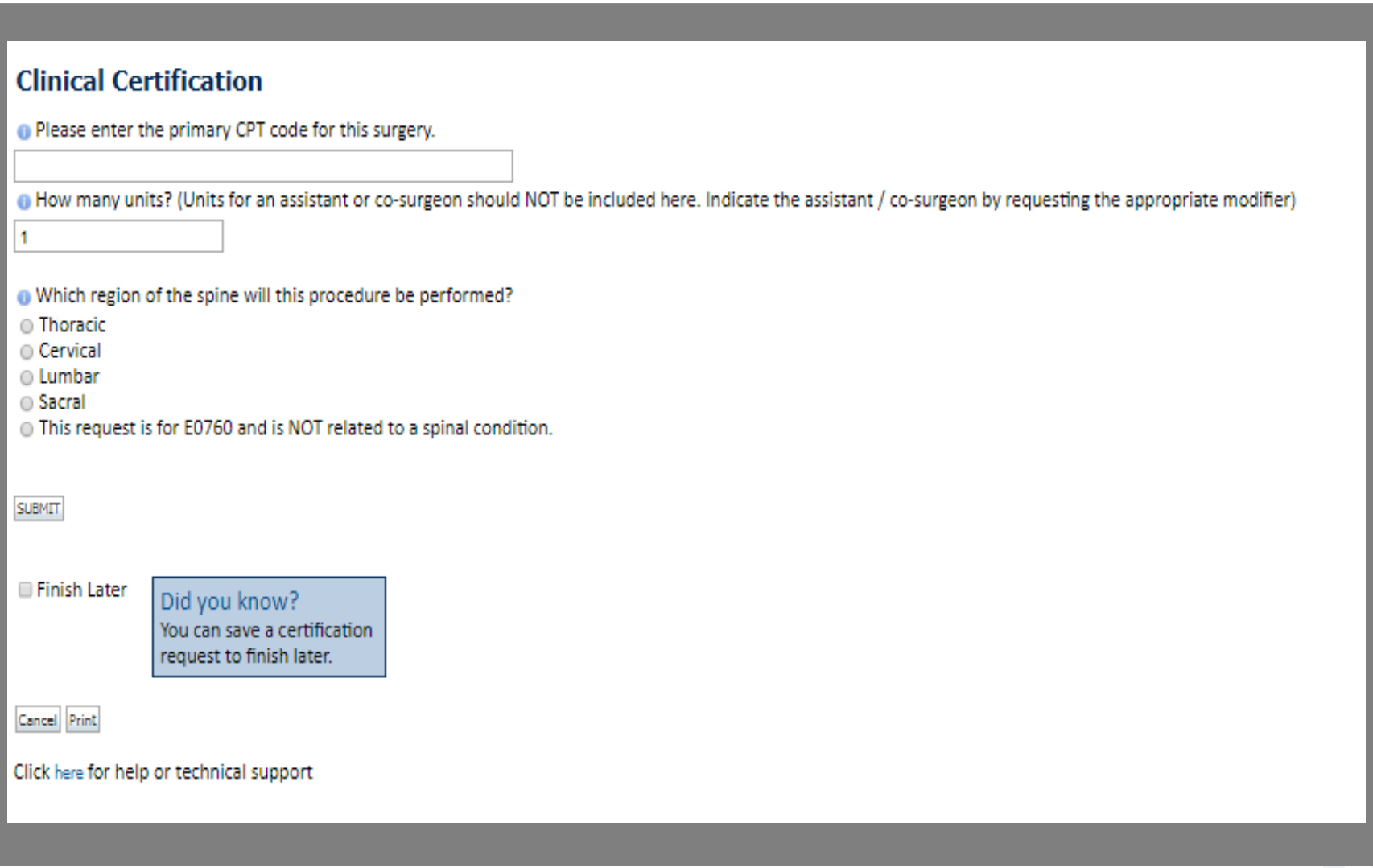
Medical Review



If additional information is required, you will have the option to either free hand text in the additional information box, or you can mark Yes to additional info and click submit to bring you to the upload documentation page.

Providing clinical information via the web is the quickest, most efficient method.

Pause/Save Option



Once you have entered the clinical collection phase of the case process, you can save the information and return within two business days to complete.

Clinical Certification Pathway

Clinical Certification

Lumbar Discectomy - LEVEL / SIDE

Please indicate the levels involved in this procedure: (Choose all that apply)

- ☐ L1 - L2
- ☐ L2 - L3
- ☐ L3 - L4
- ☐ L4 - L5
- ☐ L5 - S1
- ☐ Unknown

Please indicate the side this procedure will be performed:

- ○ Left
- ○ Right
- ○ Bilateral

PREVIOUS SURGERY

Is this the first lumbar disk surgery at this level and side?

- ○ Yes
- ○ No

Please indicate the reason for the requested procedure:

[▼]

SUBMIT

☐ Finish Later

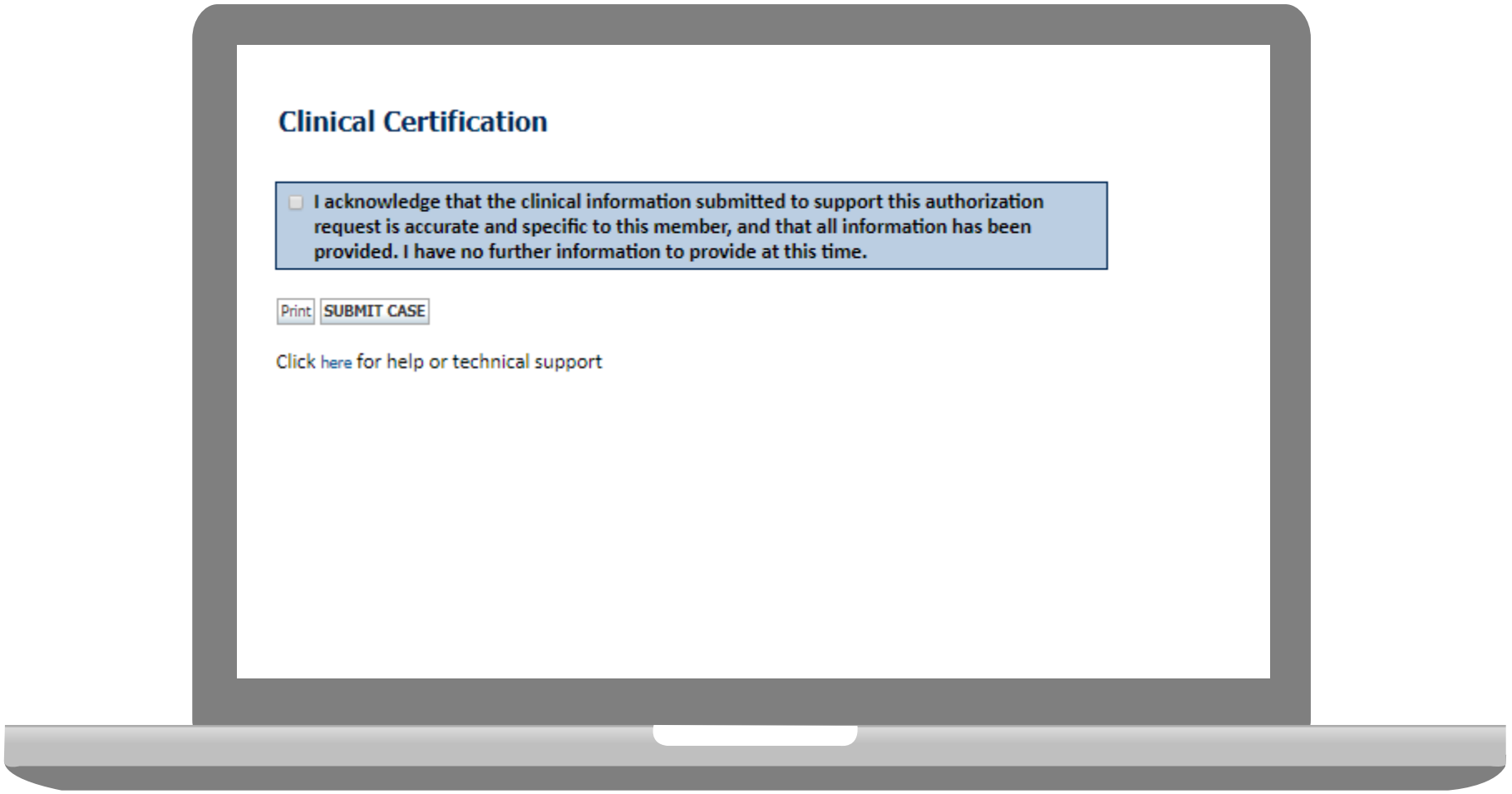
Did you know?
You can save a certification request to finish later.

Cancel Print

Click here for help or technical support

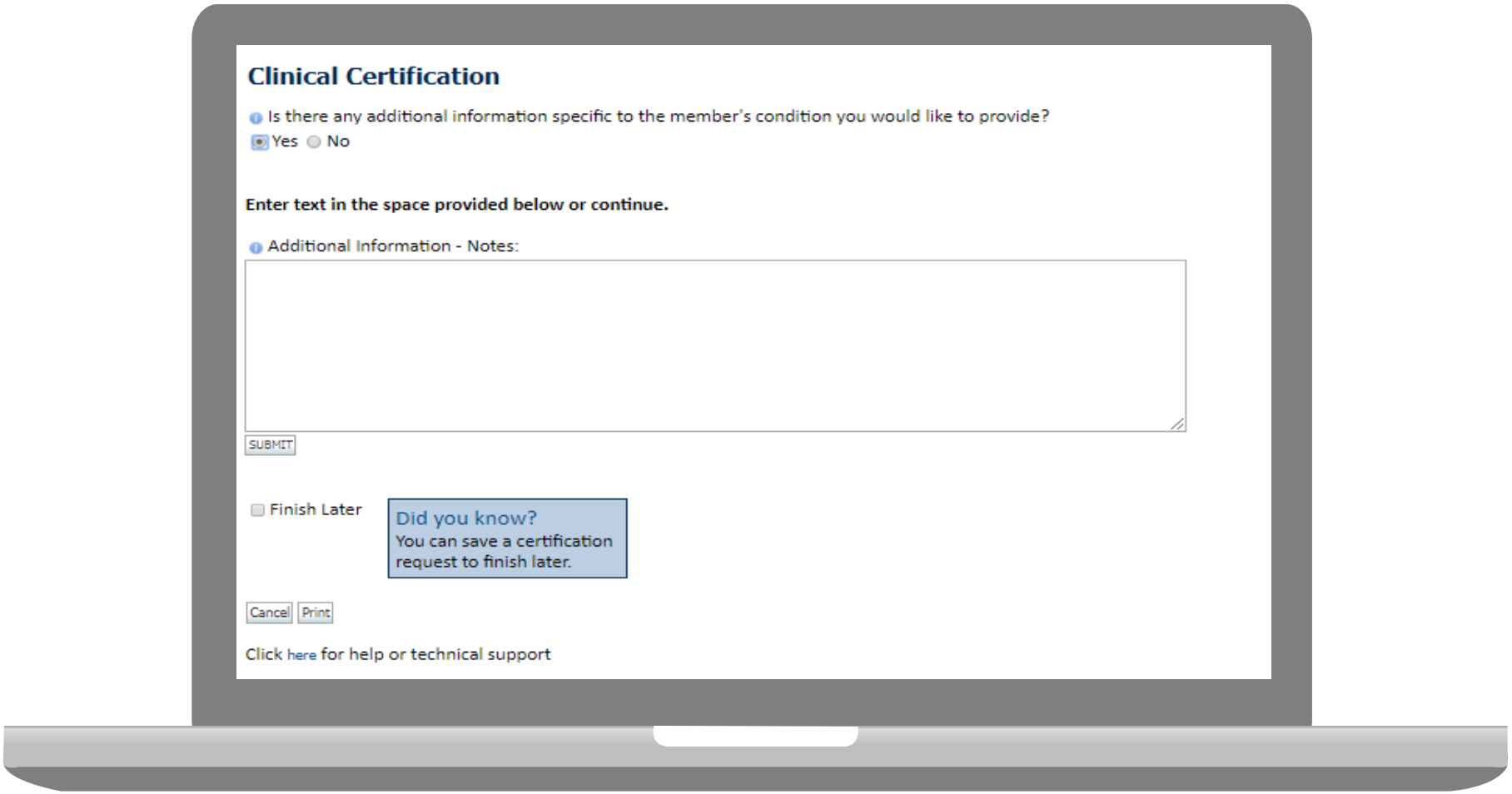
Clinical Certification Pathway Continued

Medical Review



Acknowledge the Clinical Certification statements, and hit "**Submit Case**."

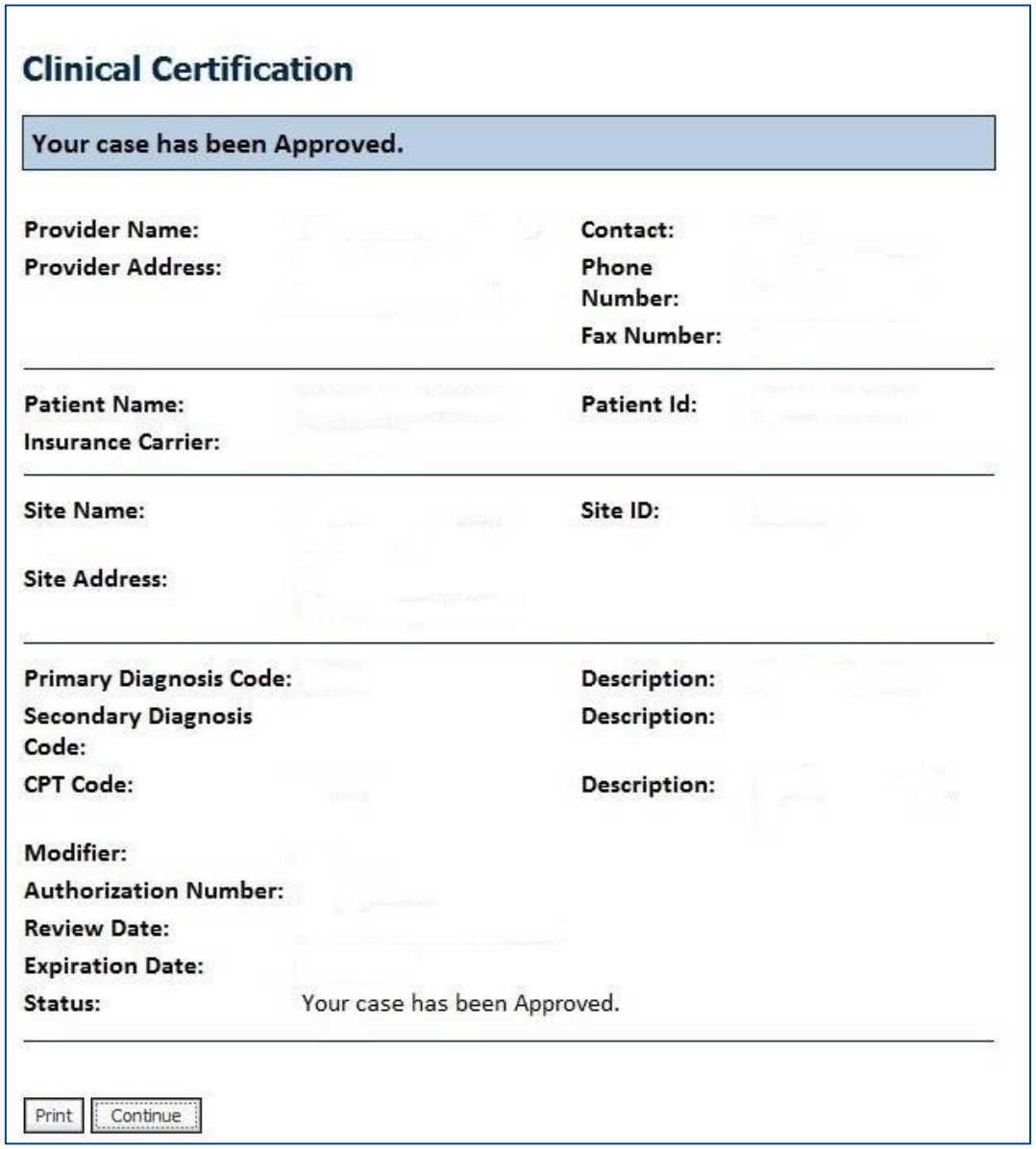
Medical Review



If additional information is required, you will have the option to either free hand text in the additional information box, or you can mark Yes to additional info and click submit to bring you to the upload documentation page.

Providing clinical information via the web is the quickest, most efficient method.

Approval



Clinical Certification

Your case has been Approved.

Provider Name: **Contact:**
Provider Address: **Phone Number:**
Fax Number:

Patient Name: **Patient Id:**
Insurance Carrier:

Site Name: **Site ID:**
Site Address:

Primary Diagnosis Code: **Description:**
Secondary Diagnosis Code: **Description:**
CPT Code: **Description:**

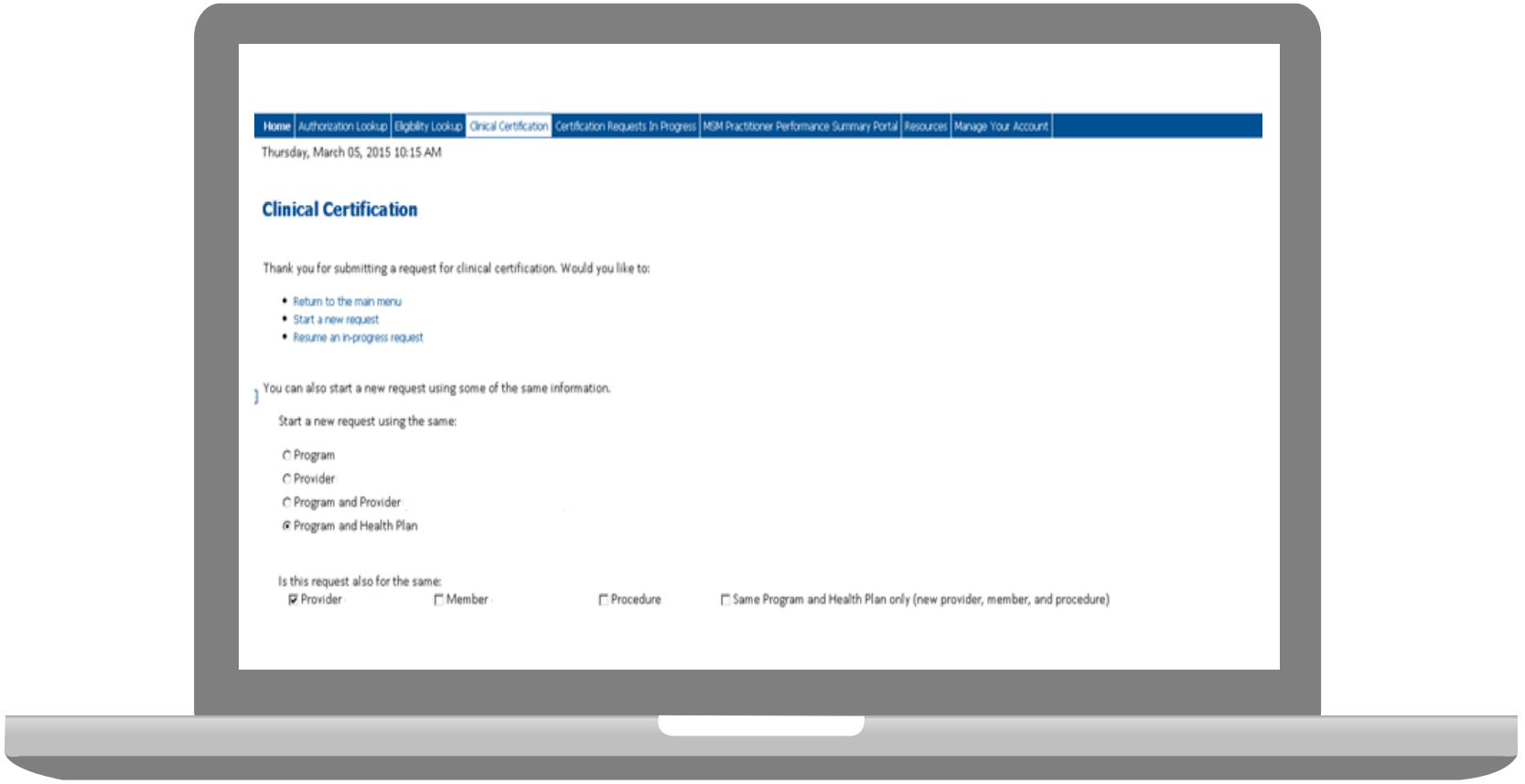
Modifier:
Authorization Number:
Review Date:
Expiration Date:
Status: Your case has been Approved.

Print Continue

Once the clinical pathway questions are completed and the answers have met the clinical criteria, an approval will be issued.

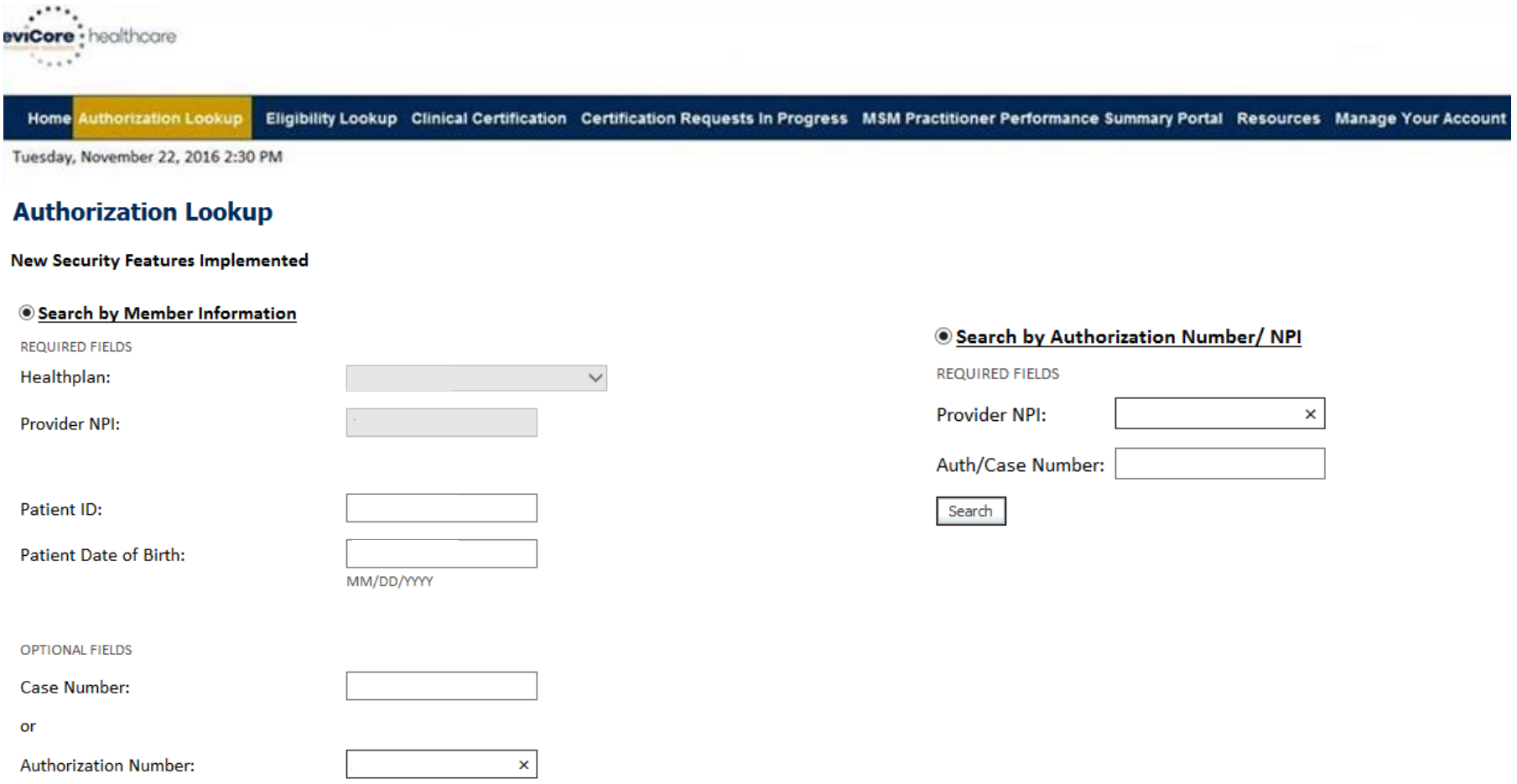
Print the screen and store in the patient's file.

Building Additional Cases



Once a case has been submitted for clinical certification, you can return to the Main Menu, resume an in-progress request, or start a new request. You can indicate if any of the previous case information will be needed for the new request.

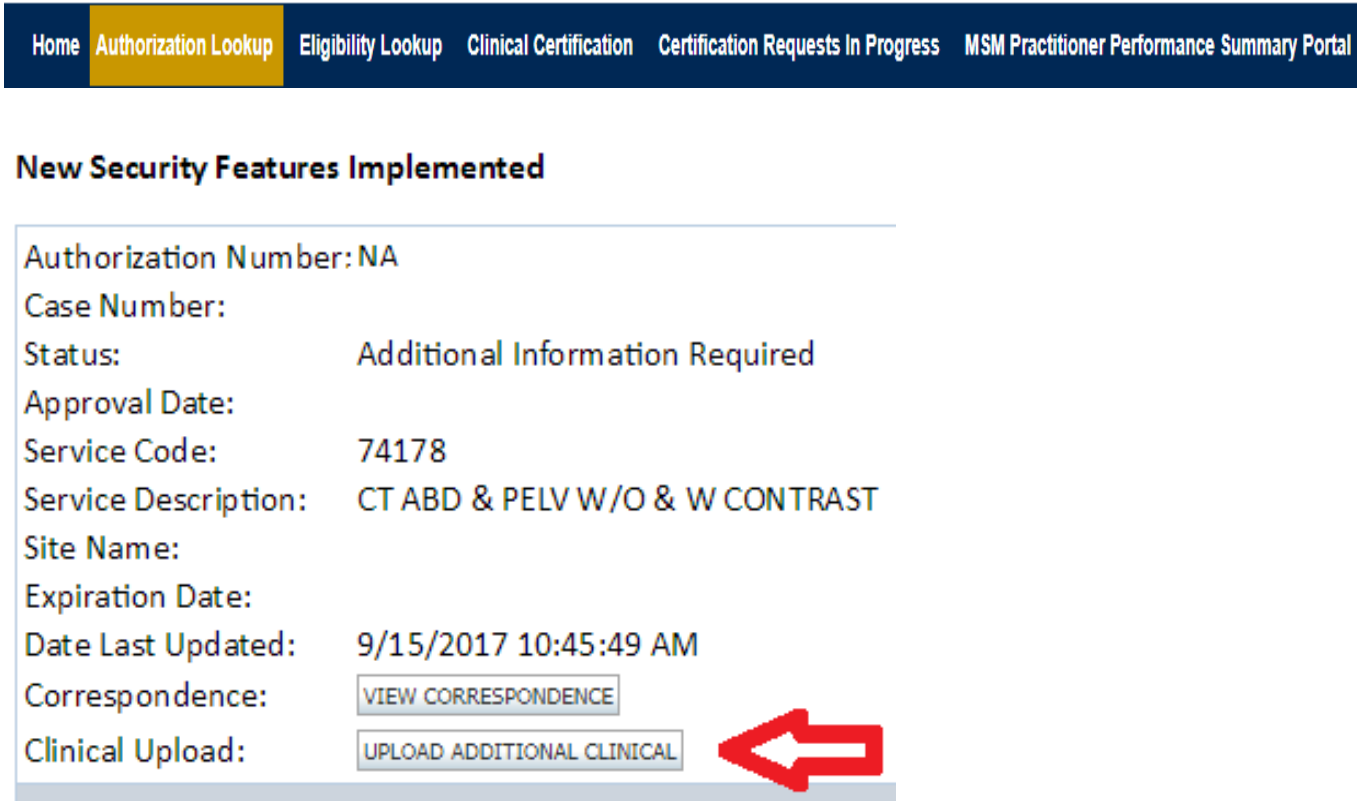
Authorization look up



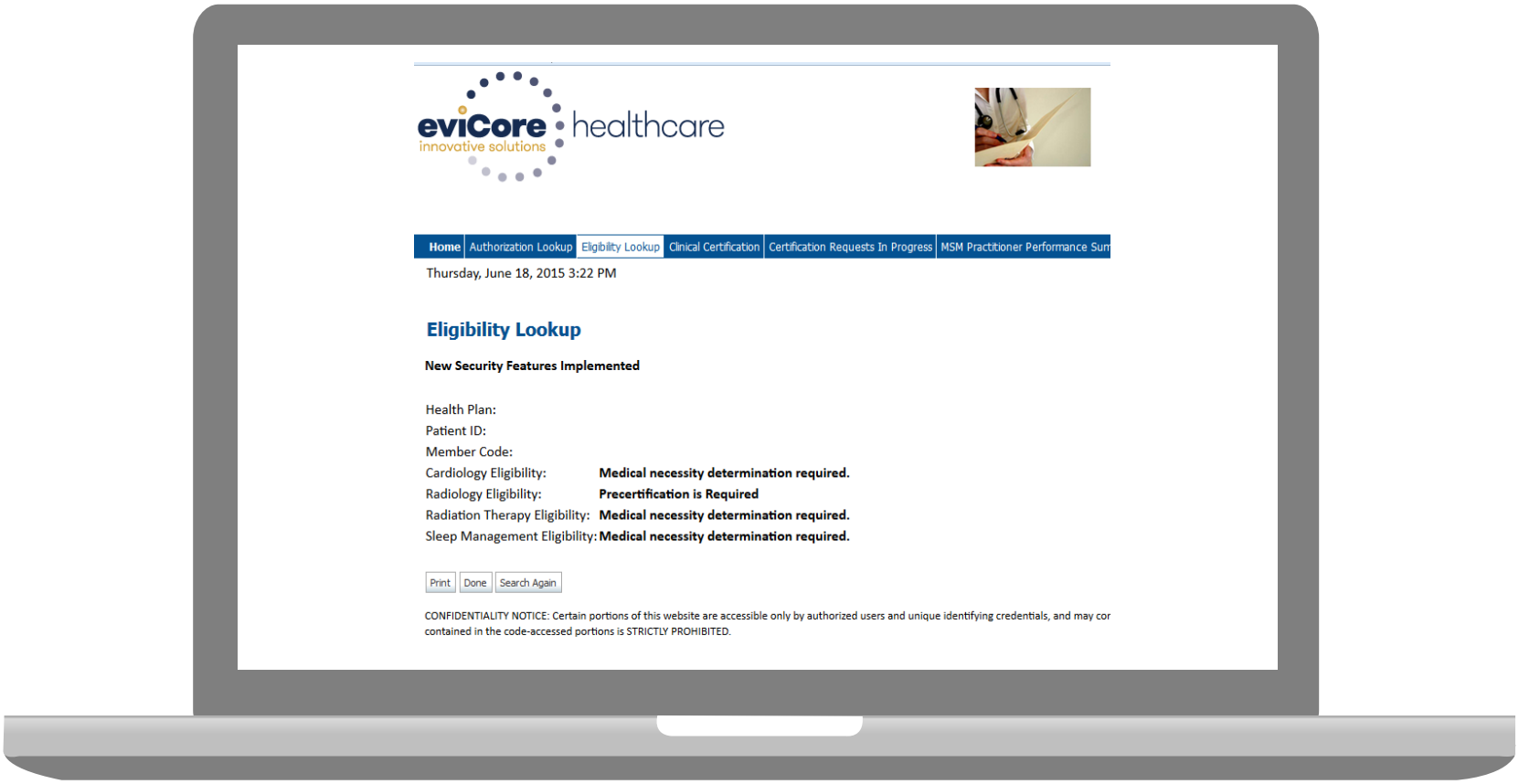
Select Search by **Authorization Number/NPI**. Enter the provider's NPI and authorization or case number. Select **Search**.

You can also search for an authorization by **Member Information**, and enter the health plan, Provider NPI, patient's ID number, and patient's date of birth.

Electronic Clinical Upload



Eligibility Look Up

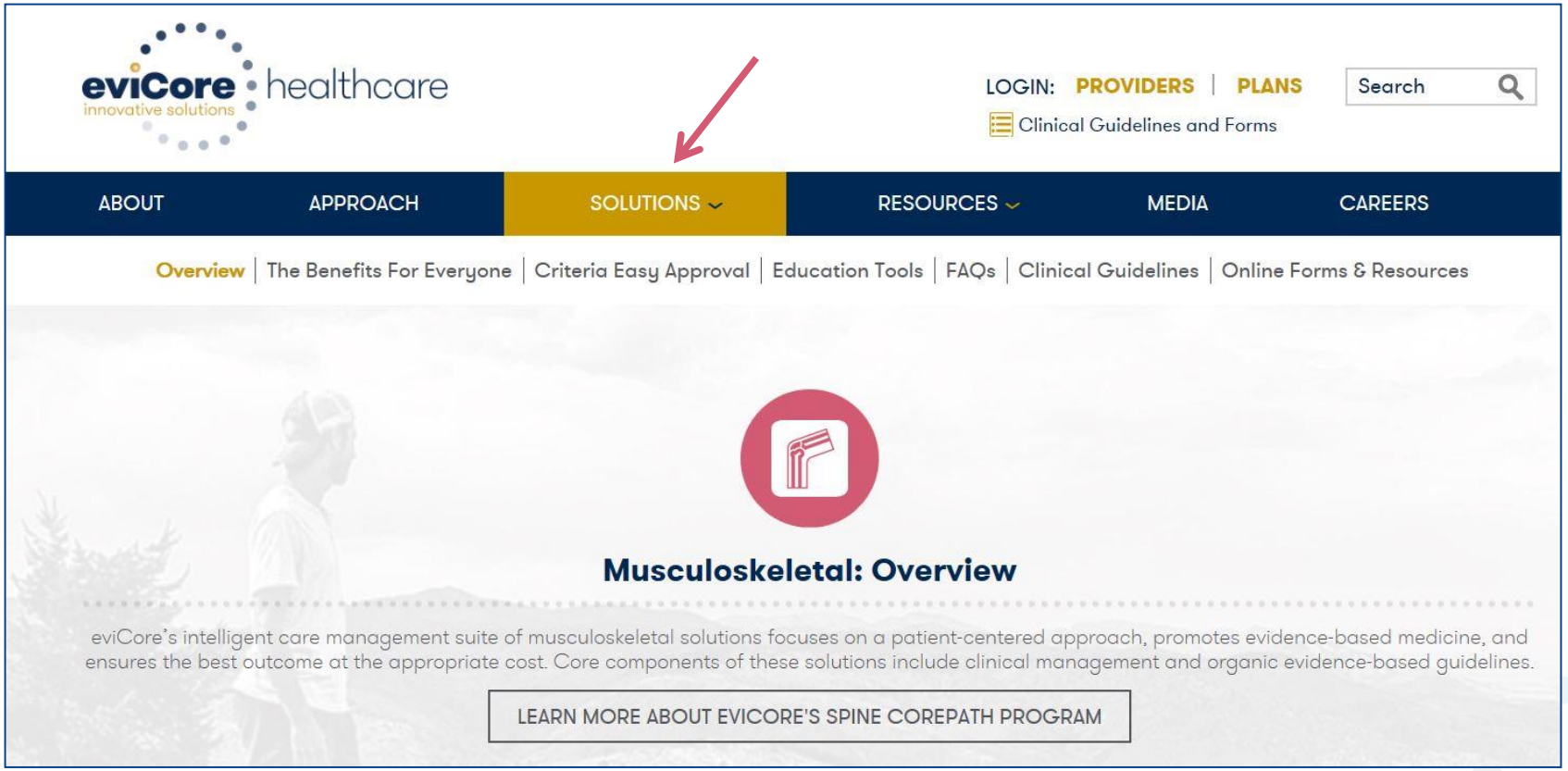


Provider Resources

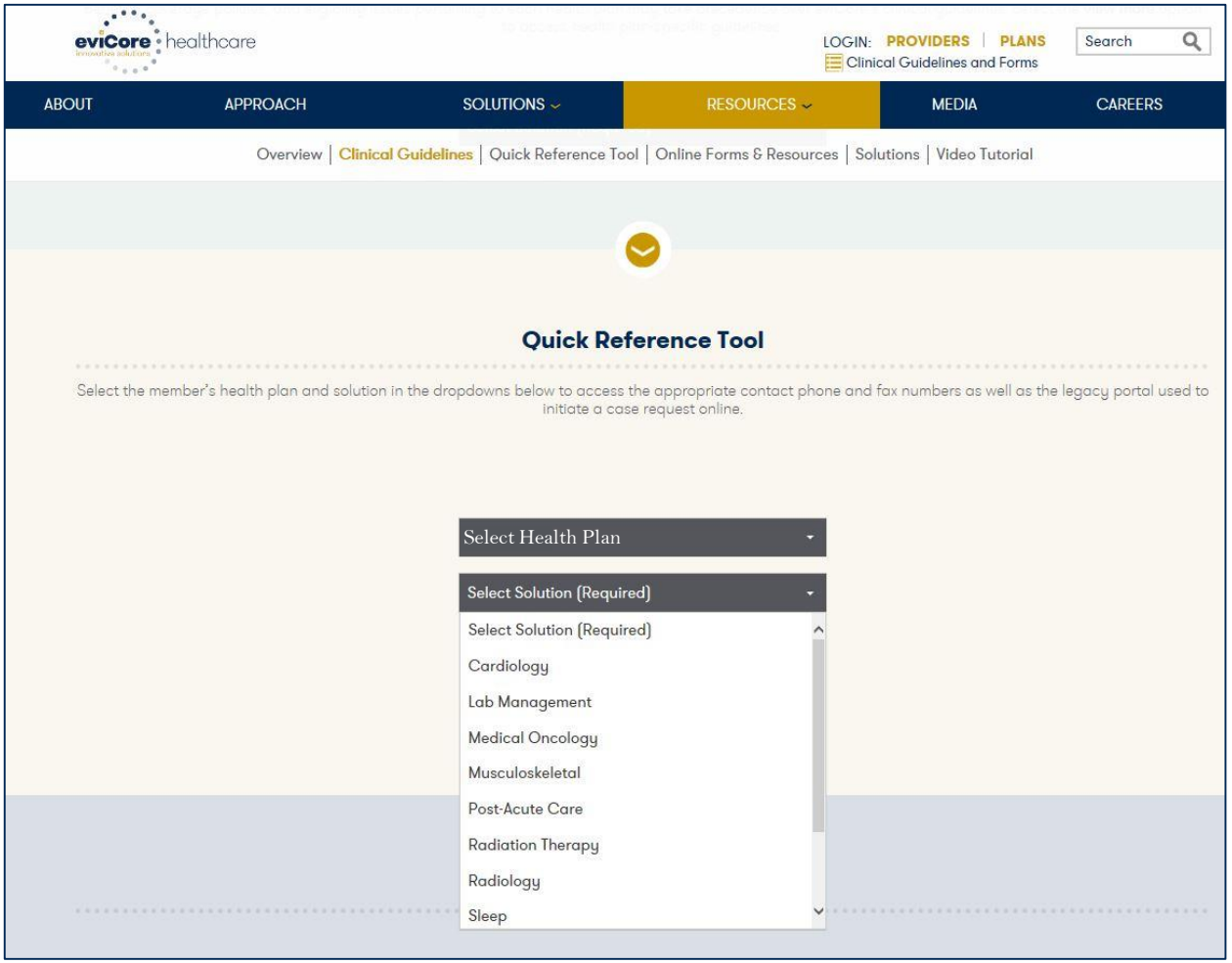



Musculoskeletal Online Resources

Clinical Guidelines, FAQs, Online Forms, and other important resources can be accessed at www.evicore.com. Click "Solutions" from the menu bar, and select the specific program needed.



Quick Reference Tool



Access the Quick Reference Tool at www.evicore.com under the "Clinical Guidelines and Forms" section.

Provider Resources: Prior Authorization Call Center

Prior Authorization Call Center

Web-Based Services

Documents

7 a.m. - 7 p.m. (Eastern Standard Time): 1-866-889-8056

- Obtain prior authorization or check the status of an existing case
- Discuss questions regarding authorizations and case decisions
- Change facility or CPT Code(s) on an existing case

eviCore fax number: 1-866-466-6964

Provider Resources: Web-Based Services

Prior Authorization Call Center

Web-Based Services

Documents

Email portal.support@evicore.com

Call a Web Support Specialist at (800)646-0418 (Option 2)

Connect with us via Live Chat

Provider Resources: Implementation Document

Prior Authorization Call Center

Web-Based Services

Documents

Excellus BCBS Implementation site - includes all implementation documents:

https://www.evicore.com/healthplan/excellusbcbs

- Provider Orientation Presentation
- CPT code list of the procedures that require prior authorization
- Quick Reference Guide
- eviCore clinical guidelines
- FAQ documents and announcement letters

You can obtain a copy of this presentation on the implementation site listed above.

Thank You!