carelon

Carelon Medical Benefits Management Musculoskeletal Program

Frequently Asked Questions

Program Overview and Administration

1. Who is Carelon? How will the program be administered?

Carelon is a leading specialty benefits management company with more than 25 years of experience and a growing presence in the management of radiology, cardiology, genetic testing, oncology, musculoskeletal, sleep management, surgical, and rehabilitation. Our mission is to help ensure health care services are more clinically appropriate, safer, and more affordable. We promote the most appropriate use of specialty care services through the application of widely accepted clinical guidelines delivered via an innovative platform of technologies and services. This program will be administered by Carelon.

2. What is the Musculoskeletal Program?

The Musculoskeletal Program is a utilization management program that requires providers to request prior authorization for spine and joint surgeries and interventional pain management procedures. The requests are evaluated against evidence-based, Carelon Clinical Guidelines.

3. How does it benefit my practice and patients?

The Carelon Musculoskeletal Program is here to support you in helping your patients receive the care that is appropriate, safe, and affordable. Through impactful communication and education about the program, we are poised to engage you and your office support staff in the management of the complexities associated with spinal surgeries, joint surgeries, and interventional pain management procedures. We have developed an approach that works with you to:

- Promote standard of care through the consistent use of evidence-based criteria
- Direct care to the most clinically appropriate setting

Your patients' health plan is implementing the program to help you in your efforts to ensure your patients receive care that is appropriate, safe, and affordable – and delivers improved results for your practice too.

4. What is the relationship between Carelon and the health plan?

The health plan has contracted with Carelon to work directly with you to assist your efforts in patient care. We help you manage interventional pain management procedures, spinal surgeries, and joint surgeries (including all associated revision surgeries).

5. How does Carelon work with health plans?

Carelon collaborates with health plans to help improve health care quality and manage costs for some of today's complex tests and treatments, working with physicians like you to promote patient care that's appropriate, safe, and affordable. In part- nership with health plans, we are fully committed to achieving their goals – and yours – to improve health outcomes and reduce costs. Our powerful specialty benefits platform powers evidence-based clinical solutions that span the specialized clinical categories where a health plan has chosen to focus. Our robust medical necessity review process is fully compliant with regulatory and accrediting organizations, while offering a superior experience for you and the health plan's providers and members.

About the Musculoskeletal Program

1. How does the Musculoskeletal Program work?

Through our program, we are here to assist you and other participating providers. You contact Carelon to request a review of certain surgeries and interventional pain management treatments. We review complex surgeries and interventions in the inpatient and outpatient settings against evidence-based clinical guidelines to ensure care is medically necessary according to medical evidence. We also assist you in reviewing the site of care you request to make sure that it is appropriate for your patient's procedure based on their specific clinical circumstances.

When the care requested does not meet clinical criteria, our established staff of spinal surgeons, anesthesiologists, orthopedic surgeons, neurosurgeons, and pain management physicians provide peer-to-peer consultation.

2. What is included in the Spine, Joint, and Pain Management Program?

- Spinal surgery – Cervical, thoracic, lumbar, sacral, and sacroiliac joint fusion
- Joint surgery
- Interventional pain management

Acute fractures or trauma and neurological conditions that present in the emergency room do not require preauthorization.

Note: Preauthorization is required for notification purposes only (medical necessity review is not required) when CPT 62320 and 62322 are used for post-procedural pain with any of the following ICD-10-CM diagnoses: G89.11 (acute pain due to trauma), G89.12 (acute post-thoracotomy pain) or G89.18 (other acute post-procedural pain).

ICD-10-CM

G89.11 Acute pain due to trauma

G89.12 Acute post-thoracotomy pain

G89.18 Other acute post procedural pain

Contact Carelon to obtain a pre-service review for the following non-emergency modalities:
Note: Review requirements and modalities may vary by health plan. Please verify or check with the patient's health plan if you have any questions.

Spine surgery – Cervical, thoracic, lumbar, sacral, and sacroiliac joint fusion

- Automated percutaneous and endoscopic discectomy
- Bone grafts
- Bone growth stimulators
- Cervical/lumbar spinal fusions
- Cervical/lumbar spinal laminectomy
- Cervical/lumbar spinal discectomy
- Cervical/lumbar spinal disc arthroplasty (replacement)
- Sacroiliac joint fusion
- Spinal deformity (scoliosis/kyphosis)
- Vertebroplasty/kyphoplasty

Joint surgery (including all associated revision surgeries)

- Hip arthroplasty

- Knee arthroplasty
- Shoulder arthroplasty
- Hip arthroscopy
- Knee arthroscopy
- Shoulder arthroscopy
- Treatment of osteochondral defects
- Meniscal allograft transplantation

Small Joint Surgery (including all associated revision surgeries)

- Total ankle replacement
- Hammertoe correction
- Bunionectomy
- Hallus rigidus
- 1st toe arthrodesis

Interventional pain management

- Epidural adhesiolysis
- Epidural injections (interlaminar/caudal and transforaminal)
- Facet joint injections/ medial branch blocks
- Facet joint radiofrequency nerve ablation
- Implanted spinal cord stimulators
- Regional sympathetic blocks
- Sacroiliac joint injections
- Thermal intradiscal procedures

3. Does the program include inpatient services?

Yes, the program includes all procedures regardless if they are performed on an inpatient or outpatient basis. Carelon will review the case for the medical necessity of the procedure. In some instances Carelon will also be performing the medical necessity for inpatient admission. Using evidence-based Level of Care clinical guidelines, we will determine if the procedure and member conditions meet the criteria for inpatient admission.

4. How is the initial goal length of stay determined?

Carelon will either determine the initial goal length of stay of an inpatient admission based on a default elected by the Health Plan or utilizing Truven goal length of stay values.

5. Are your clinical criteria available for review?

Yes, the Carelon Clinical Guidelines are easily accessible online. See Clinical Guidelines. You can also find these within the Carelon ***Provider****Portal*℠ when clinical review requests are initiated.

6. What kind of cases are reviewed for clinical site of care review process?

We review complex surgeries and interventional pain management in the inpatient and outpatient settings against evidence-based clinical guidelines to help reduce inappropriate care, overtreatment, and excessive costs, while helping to ensure appropriate, safe, and affordable care. Our established staff of spinal surgeons, anesthesiologists, orthopedic surgeons, neurosurgeons, and pain management physicians provide peer-to-peer engagement.

About the Carelon Clinical Review Process

1. How do I participate in the Musculoskeletal Program through Carelon?

The best way to submit a review request is to use the ***Provider****Portal*.

Provider*Portal* allows you to open a new order, update an existing order, and retrieve your order summary.
As an online application, ***Provider****Portal* is available 24 hours a day, 7 days a week. Your first step is to register your practice in ***Provider****Portal* if you are not already registered. Go to www.providerportal.com to register.

If you have previously registered for other services managed by Carelon (diagnostic imaging, radiation therapy), there is no need to register again.

2. Is registration required on Carelon ***Provider****Portal*?

Each member of your staff who enters review requests will need to register. Here is how to do it:

- Step one: Go to www.providerportal.com and select "Register Now" to launch the registration wizard
- Step two: Enter user details and select user role as "ordering provider"
- Step three: Create username and password
- Step four: Enter the tax ID numbers for your providers
- Step five: Check your inbox for an email from Carelon. Click on the link to confirm email address

The ***Provider****Portal* support team will then contact the user to finalize the registration process.

3. What do I need to register?

- Your email address
- The tax ID number for the providers whose orders you will be entering
- Your phone and fax number

4. What does the ***Provider****Portal* allow me to do:

- Submit a new order request
- Update an existing order request
- Retrieve your order summary

5. Will members be able to contact Carelon?

Members should contact the health plan directly if they have any questions

6. Who can submit review requests?

Only ordering physicians and their staff members may submit review requests. Servicing/rendering providers cannot submit requests, but are encouraged to verify that prior authorization has been obtained before performing a test for the member. Servicing/rendering provider can verify prior authorization using ***Provider****Portal*.

7. How does a physician office staff member obtain an order number from Carelon and request clinical appropriateness review?

There are two ways providers can contact Carelon to request review and obtain an order number:

Online

- Get fast, convenient online service via the ***Provider****Portal* (registration required). ***Provider****Portal* is available 24 hrs/day, 7 days/week. Go to www.providerportal.com to begin. Select the health plan code from drop-down menu.

By phone

- Contact the Carelon contact center

8. When should providers contact Carelon to request clinical appropriateness review?

Providers should contact Carelon to request clinical appropriateness review and obtain an order number before scheduling or performing any spine and joint procedures and interventional pain management services.

9. What information will Carelon require in order to evaluate a request?

Our simple checklists show exactly what information you will need.

10. What should I enter as the date of service for the procedure?

The date of service is the actual date the procedure(s) are likely to take place.

11. Can we request an urgent authorization?

If you have an urgent request, please contact Carelon contact center to initiate an urgent authorization request.

12. How can providers determine whether an order number has been obtained for a member?

Providers can contact Carelon to determine whether an order number has been obtained for a member covered under the programs.

13. What happens if I do not call Carelon or enter information through the ***Provider****Portal*?

You are encouraged to request prior authorization before performing procedures. Retrospective requests may be initiated up to 2 business days after performing services. Failure to contact Carelon for spine and joint surgeries and interventional pain management procedure prior authorization may result in claim denial.

About Determinations

1. Once I have submitted a request, how long will it take to receive a response from Carelon?

Requests that meet medical necessity criteria:
Requests that meet criteria receive a response immediately in the ***Provider****Portal* or on the phone with the Carelon contact center.

Requests that do not meet medical necessity criteria:
When an order request cannot be approved immediately, the request is transferred to a registered nurse (RN) or a physical therapist for further review. If they are not able to approve the request, it will be transferred to a physician reviewer. The physician reviewer can approve the case based on a review of information collected or through their discussion with the surgeon/physician (peer-to-peer). In the event that the Carelon physician reviewer cannot approve the case based on the information previously collected, is unable to reach you to discuss the case, or is unable to approve the case based on the information supplied by you during the peer-to-peer discussion, the physician reviewer will issue a denial for the request. No adverse determination is made until the case has been reviewed by a physician reviewer at Carelon.

2. How will we know when a peer-to-peer is needed?

When a case pends for review, it will go to an "In Progress" status. Carelon will call the ordering physician requesting a call-back for peer-to-peer review, should it be required.

3. How long does my patient's approval last?

Unless otherwise required by state law, outpatient spine and joint surgeries are valid for 60 calendar days. Inpatient spine and joint surgeries are valid for the date of service + initial length of stay. Pain management approvals are valid for 10 business days. Carelon communicates the expiration date in the approval notification for each case.

4. Can an authorization number for a medical necessity determination expire?

Yes, Carelon communicates the expiration date in the approval notification provided for each case.

5. What are my options if a review request does not meet clinical criteria?

Your office can contact Carelon to request a peer-to-peer discussion at any time before or after the determination. When there is a request for a peer-to-peer consultation, we will make an effort to transfer the call immediately to an available Carelon physician reviewer for interventional pain management procedures, for joint and spine surgeries, we do schedule peer-to-peer consultations, this is done by contacting the Carelon peer-to-peer phone number provided.

After you receive notice of a denial, the provider has two options for further review at Carelon. One is to ask for a reconsideration of the decision within 10 days of the denial. This gives the provider an opportunity to provide additional information to one of our physician reviewers who will have the authority to overturn the denial. If you choose not to pursue a reconsideration, the other option is to submit documentation in support of your request through the document upload feature on the ***Provider****Portal*.

6. How do I enter a request on the *ProviderPortal*?

For step-by-step instructions for submitting a case, go to the Reference Desk in the ***Provider****Portal.*

7. Why is a Duplicate Order notification displayed on my Order Request?

This notification will appear when a similar request is on file or the dates from one order to another order overlap.

8. Why is the provider showing as Out-of-Network?

When the facility and/or provider is Out-of-Network the benefits may not apply or may be paid at a lower rate. If you believe your provider is in-network, check with your Network Provider representative with the health plan to see that your provider is entered into the system as in-network.

9. Why is my provider not available for selection in the *ProviderPortal*?

If your provider is not available for selection, contact ***Provider****Portal* support at 800-252-2021.

10. What do the Case Status notifications indicate?

Case Status indicates the overall determination on the request submitted for Carelon review.

- In Progress – case is pending Carelon clinical review. The request will be reviewed by an Carelon RN, physical therapist (and Carelon MD, if necessary), to clarify/collect additional clinical information via phone call to the provider's office. Peer-to-peer may be offered to gather additional clinical information to evaluate the request against medical necessity criteria.
- Completed – case has been reviewed by Carelon and an order ID number has been given.
- Authorized – case requiring Carelon approval has been authorized.
- Non-Authorized – cases requiring Carelon approval does not meet medical necessity criteria and has not been authorized. The entire case is denied.
- Multiple Decisions Rendered – (partial approval, mixed outcome, etc.) Some of the procedures requested have been approved, some procedures have been denied.
- Voluntarily Cancelled – the provider's office canceled/withdrew the case, following submission.
- Not Reviewed/Error Entry – the case was withdrawn (i.e. accidentally entered, duplicate case entry).
- Other Impact - the case was identified as a duplicate due to it be previously submitted.

11. What if I can't find the procedure I'm searching for?

Only procedures managed by Carelon as part of the program can be submitted for review. If you are unable to find the diagnosis in the system, you may call Carelon Customer Service at 800-252-2021 or contact the health plan.

More Information

1. Where can I access additional information?

For more information: Our dedicated musculoskeletal provider website offers you all the tools and information you need.
To access go here.

For assistance using the ***Provider****Portal* contact us by email or at 800-252- 2021.