Musculoskeletal Program – Newport Mesa Unified FAQ

What's happening?

- Beginning January 1, 2016, eviCore healthcare (eviCore) (formerly CareCore | MedSolutions) will provide utilization management, including precertification and clinical appeals, for musculoskeletal (MSK) services for customers.
- Primary MSK services include interventional pain management and major joint surgery (i.e. hip, knee and shoulder joint surgery). This could include procedures performed in either an outpatient or inpatient place of service, depending on the procedure being performed.
- This is an expansion of our existing relationship with eviCore, who currently manages our high-technology radiology, diagnostic cardiology, and radiation therapy programs.
- For California Network (HMO) customers, utilization management will continue to be managed via the Provider Medical Group (for customers who have elected Primary Care Physicians in a capitated model) or via Cigna (for customers who have elected Primary Care Physicians not in a capitated model).

What does this mean for customers?

- This program helps ensure that the MSK services that customers receive are medically necessary; are based on evidence-based, industry standard medical practices; and are received from quality, cost-effective providers.
- If precertification is not requested for the affected services, the services may be denied for failure to obtain precertification.

Program Overview

1. **What are musculoskeletal services?**
   Musculoskeletal services are those that help treat pain and discomfort in muscles, bones, and joints, and can affect all major areas of the body.

2. **How do musculoskeletal services differ from chiropractic services?**
   Medical necessity review is already in place for chiropractic services which include a separate defined list of CPT codes. Musculoskeletal services will be identified with an explicit list of CPT codes that are aligned with industry standards.

3. **What musculoskeletal services are included in this program?**
   Our Program includes 383 CPT codes in the following pain management and surgical procedures:

   Pain Management:
   - Epidural steroid injections
   - Facet injections
   - Epidural adhesiolysis
   - Spinal cord stimulators
   - Pain pumps
   - Radiofrequency ablation (RFA)

   Surgical procedures:
   - Shoulder
   - Hips
   - Knees

4. **What will be managed under this precertification program?**
   For OAP & PPO
   As part of this agreement, eviCore will coordinate the utilization management and precertification of interventional pain management procedures (e.g., implantable fusion pumps / spine injection), as well as precertification of major joint surgeries (e.g. hip, knee, shoulder) for services in an inpatient and outpatient setting.

   For Network (HMO)
   Either the customer's elected Provider Medical Group or Cigna will coordinate the utilization management and precertification of interventional pain management procedures (e.g., implantable fusion pumps / spine

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injection), as well as precertification of major joint surgeries (e.g. hip, knee, shoulder) for services in an inpatient and outpatient setting.

5. **Why is Cigna expanding the precertification requirement to include MSK?**
This precertification program is designed to improve adherence to evidence-based guidelines, promote patient safety and efficient patient care and, as a result, reduce claim costs. Utilization management impacts medical cost by preventing medically inappropriate and unnecessary visits and services. .

6. **Do other national carriers have a precertification program for MSK services?**
BCBS, United Healthcare, and Aetna all have similar MSK precertification management programs

7. **Will there be an impact to providers as a result of expanding the Precertification Program to include MSK services?**
For OAP & PPO
Providers will need to contact eviCore to request precertification of MSK services for OAP & PPO customers.
For Network (HMO)
Providers will need to work through their medical group utilization review process or contact Cigna to request precertification of MSK services for Network customers.

8. **Is precertification required for services performed by out-of-network providers?**
Yes. Precertification is required regardless of whether the provider participates in our network or not.

   However, it is the customer's responsibility to confirm that out of network providers obtain precertification.

   Note that only the OAP and PPO plans have Out of Network coverage. This is not applicable to the California Network (HMO) customers as coverage is In Network only.

9. **How can providers request precertification for these MSK services?**
Starting December 15, 2015 for dates of service beginning January 1, 2016, providers should request precertification directly from the appropriate channel (eviCore for OAP & PPO customers, the Medical Group or Cigna for California Network customers)

10. **Can Cigna customers be billed by a provider for covered services that have been denied for payment due to no precertification?**
In-network doctors aren't allowed to bill customers for services that weren't approved in advance. Cigna's provider agreements contain a member hold harmless provision that prohibits contracted providers from billing patients for covered services that are administratively denied due to failure to obtain precertification.

    Out-of-network doctors may bill customers for services that weren't approved in advance.

11. **Does this change affect customers who are currently in a course of musculoskeletal treatment?**
The program will only review requests for new MSK services beginning January 1, 2016 and later.

12. **What if a customer already has a treatment that was scheduled prior to January 1, 2016 with an actual treatment date after January 1, 2016?**
In Network (contracted) providers have received proactive mailings from Cigna to ensure that they are aware of the change and will conduct appropriate review for any services after January 1, 2016.

    For customers seeking care with Out of Network providers, they will be responsible for ensuring that appropriate medical necessity review and approval was received prior to receiving services. If an out-of-network claim comes in for a customer who ***did not*** receive approval for the services, a retro-active medical necessity review will be completed. If the service is deemed to meet medical necessity requirements it will be paid. If the service is deemed to not be medically necessary, the claim would be denied. Customers would have appeal rights as laid out in their plan documents.

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