Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

TurningPoint

# Musculoskeletal procedure authorizations

## Frequently asked questions for providers

**For Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠**

Revised April 2024

*In this document*

## General information

Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with TurningPoint Healthcare Solutions LLC for some musculoskeletal services. TurningPoint works with physicians and facilities to reduce surgical treatment variability, to promote safety and quality-of-care improvements and to provide support for your patients.

As part of this program, Blue Cross and BCN have delegated utilization management functions to TurningPoint for surgical procedures related to musculoskeletal conditions, including joint replacement surgeries and other related arthroscopic procedures, pain management procedures, and spinal procedures.

Utilization management requirements apply to the following groups and members:

- Blue Cross commercial
  - All fully insured groups except MESSA
  - Select self-funded groups

    Note: This includes UAW Retiree Medical Benefits Trust non-Medicare members
  - All members with individual coverage

  To determine which Blue Cross commercial members require prior authorization, see the document titled Determining prior authorization requirements for members.
- Medicare Plus Blue members
- BCN commercial members
- BCN Advantage members

For more information, see "Which procedures require prior authorization through TurningPoint?" on page 4.

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## Frequently asked questions for providers

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## What is TurningPoint?

TurningPoint provides an innovative musculoskeletal surgical quality and safety management program through which patients, payers and providers collaborate to improve the quality and affordability of health care services.

TurningPoint's comprehensive solution integrates evidence-based utilization management guidelines with clinical best practices, site-of-care optimization for select procedures, specialized peer-to-peer engagement, device and recall management, innovative quality programs and advanced reporting and analytics to promote the overall health management of each member.

## Which providers are affected by this agreement?

All musculoskeletal (orthopedic, spine, neurosurgical and pain management) providers whose patients fall under the enrolled plans are affected.

## Which procedures require prior authorization through TurningPoint?

For members with the plans specified earlier in this document, TurningPoint manages prior authorizations for:

| Type of procedure | Details | |
|---|---|---|
| Orthopedic surgical procedures | *Including all associated partial, total and revision surgeries* | |
| | • Knee arthroplasty<br>• Unicompartmental/bicompartmental knee replacement<br>• Hip arthroplasty<br>• Shoulder arthroplasty<br>• Elbow arthroplasty<br>• Ankle arthroplasty<br>• Wrist arthroplasty<br>• Acromioplasty and rotator cuff repair | • Anterior cruciate ligament repair<br>• Knee arthroscopy<br>• Hip resurfacing<br>• Meniscal repair<br>• Hip arthroscopy<br>• Femoroacetabular arthroscopy<br>• Ankle fusion<br>• Shoulder fusion<br>• Wrist fusion<br>• Osteochondral defect repair |
| Pain management procedures | • Epidural steroid injections<br>• Selective nerve root blocks<br>• Facet joint injections | • Sacroiliac (SI) injections<br>• Spinal neurotomy/ablations<br>• Implantable pain pumps |

| Type of procedure | Details | |
|---|---|---|
| Spinal surgical procedures | *Including all associated partial, total and revision surgeries* | |
| | • Spinal fusion surgeries<br>  ○ Cervical<br>  ○ Lumbar<br>  ○ Thoracic<br>  ○ Sacral<br>  ○ Scoliosis<br>• Disc replacement | • Laminectomy/discectomy<br>• Kyphoplasty/vertebroplasty<br>• Sacroiliac joint fusion<br>• Implantable pain pumps<br>• Spinal cord neurostimulator<br>• Spinal decompression |

To view the procedure codes for which TurningPoint manages prior authorizations, see the Musculoskeletal procedure codes that require authorization by TurningPoint document.

Notes:

- The codes in this document require prior authorization only for musculoskeletal procedures; when performed for non-musculoskeletal procedures, you don't need to request prior authorization through TurningPoint.
- This procedure code list is updated from time to time and is subject to members' benefits, to medical policy changes and to updates to American Medical Association coding guidelines.

## Are experimental and investigational procedures payable?

See the table below for information by line of business.

| Line of business | Are E&I procedures payable? |
|---|---|
| Blue Cross commercial and BCN commercial | E&I procedures are nonpayable. |
| Medicare Plus Blue and BCN Advantage | E&I procedures are payable when they're performed as part of a clinical study and follow Medicare national coverage determinations (if available) or Medicare local coverage determinations (in the absence of national coverage determinations). |

## What are TurningPoint's hours and days of operation?

TurningPoint staff are available by phone from 8 a.m. to 8 p.m. Eastern time Monday through Friday, excluding holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day).

You can contact TurningPoint toll-free at 1-833-217-9670 or locally at 313-908-6040.

If a provider needs to request a prior authorization after hours or on weekends or holidays, TurningPoint medical professionals are on-call 24 hours a day, 7 days a week.

### How do I register for direct access to the TurningPoint Provider Portal?

If you have access to Blue Cross and BCN's provider portal (availity.com**), you can access the TurningPoint Provider Portal through Availity® Essentials. You don't need to register with TurningPoint. See "How do I submit prior authorization requests to TurningPoint?" on page 7 for more information.

To access the TurningPoint Provider Portal through the TurningPoint website, you must register with TurningPoint. To register:

1. Go to myturningpoint-healthcare.com.**
2. Click *Register for access* under the Login Now button.
3. Fill out a validation form and submit the form to TurningPoint.

If you have questions or need assistance, email TurningPoint at portalregistration@turningpoint-healthcare.com.

### How do I access the TurningPoint Provider Portal?

See "How do I submit prior authorization requests to TurningPoint?" on page 7.

### Whom do I contact with questions regarding the program?

For questions regarding TurningPoint's surgical quality and safety management program or to set up an in-service with your practice, call TurningPoint at 313-908-6041. You'll be directed to a provider engagement specialist.

## Prior authorizations

### Who is responsible for requesting prior authorization?

The physician or provider office that will perform the procedure is responsible for requesting prior authorization.

TurningPoint prior authorizations cover both the procedure and the place of service.

We recommend that the ordering physician or provider office secure the prior authorization and provide the authorization number to the facility or providers when they schedule the procedure.

Note: For musculoskeletal surgeries that are authorized by TurningPoint, facilities don't need to request separate prior authorizations. For more information, see "If TurningPoint authorized a member for an outpatient procedure but the member has a medical reason for an extended stay, how should the facility submit the prior authorization request?" on page 21.

# Musculoskeletal procedure authorizations

## Frequently asked questions for providers

**For Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠**

Revised April 2024

## Should I submit prior authorization requests directly to TurningPoint?

Yes. Submit prior authorization requests for musculoskeletal surgeries and related procedures to TurningPoint.

## How do I submit prior authorization requests to TurningPoint?

Submit prior authorization requests to TurningPoint as follows:

- For commercial members, Michigan's prior authorization law** requires health care providers to submit prior authorization requests electronically. Alternate submission methods (fax or phone) are allowed in the case of temporary technological problems, such as power or internet outages.
- For Medicare Advantage members, submit requests using any of the methods outlined in this section.

| Method of submission | Details |
|---|---|
| Through our provider portal — for **Michigan** providers | Access the TurningPoint Provider Portal through our provider portal. To do this:<br>1. Log in to our provider portal (availity.com**).<br>2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.<br>3. Click the *TurningPoint Provider Portal* tile in the Applications tab.<br>4. Choose a provider from the Select a Provider drop-down list.<br>5. Choose a provider type from the Select a Provider Type drop-down list.<br>6. Click *Submit*.<br>If you're having trouble accessing the TurningPoint Provider Portal using this process, contact Availity Client Services at 1-800-AVAILITY (282-4548).<br>If you're having trouble while working in the TurningPoint Provider Portal, contact TurningPoint Customer Service toll-free at 1-833-217-9670 or locally at 313-908-6040. |
| Through our provider portal — for **non-Michigan** providers who **are** registered with Availity | Access the TurningPoint provider portal by:<br>1. Logging in to our provider portal (availity.com**).<br>2. Entering the member's contract number from their ID card. Be sure to include the alpha prefix.<br>Availity determines the member's plan and takes you to the Pre-Service Review for Out-of-Area and Local Members screen.<br>3. Clicking the *TurningPoint Provider Portal* link.<br>4. If prompted, completing a one-time registration process with TurningPoint.<br>Note: To determine whether prior authorization is required, click the *Inpatient Authorization* link or the *Outpatient Authorization* link in the Pre-Service Review for Out-of-Area and Local Members screen and follow the prompts. |

| Method of submission | Details |
|---|---|
| Through our provider portal — for **non-Michigan** providers who **aren't** registered with Availity | Access the TurningPoint provider portal by:<br>1. Logging in to your local plan's website.<br>2. Selecting an ID card prefix for Michigan.<br>The Pre-Service Review for Out-of-Area and Local Members screen opens.<br>3. Clicking the *Inpatient Authorization* link or the *Outpatient Authorization* link, as appropriate.<br>4. If prompted, completing a one-time registration process with TurningPoint. |
| Through the TurningPoint website | Access the TurningPoint Provider Portal at myturningpoint-healthcare.com.**<br>If you're having trouble accessing the TurningPoint Provider Portal using this process, contact the TurningPoint Technical Support team at 313-908-6041.<br>If you're having trouble while working in the TurningPoint Provider Portal, contact TurningPoint Customer Service toll-free at 1-833-217-9670 or locally at 313-908-6040.<br>You must register with TurningPoint before you can log in through the TurningPoint website. See "How do I register for direct access to the TurningPoint Provider Portal?" on page 6 for information about registering. |
| By fax | Fax the appropriate prior authorization request form to TurningPoint as follows:<br>• Fax the *Joint and spine procedures authorization request form* to 313-879-5509.<br>• Fax pain management prior authorization request forms to 313-483-7323.<br>To determine which form to use, see "Which form should I use to fax a prior authorization request to TurningPoint?" on page 8. |
| By phone | Call TurningPoint toll-free at 1-833-217-9670 or locally at 313-908-6040. |

## Which form should I use to fax a prior authorization request to TurningPoint?

The most efficient way to submit prior authorization requests is through the TurningPoint Provider Portal.

If you need to fax a prior authorization request to TurningPoint, complete the appropriate form and fax it to the number on the form. Click a link below to open a form:

- Joint and spine procedures authorization request form
- Pain management: Epidural steroid injections authorization request form
- Pain management: Facet joint injections authorization request form

- Pain management: Neuroablation procedures authorization request form
- Pain management: Sacroiliac joint injections authorization request form

To determine which pain management form you should submit, see the "Pain management" section of the Musculoskeletal procedure codes that require authorization by TurningPoint document. This document specifies which procedure codes fall within each pain management category.

You can also find these forms on the following pages of the **ereferrals.bcbsm.com** website:

- Blue Cross Musculoskeletal Services
- Blue Cross Pain Management Services
- BCN Musculoskeletal Services
- BCN Pain Management Services

## How do I know if I need to request prior authorization from TurningPoint for members who have coverage through Blue Cross commercial plans?

See the document titled Determining prior authorization requirements for members. Follow the step-by-step instructions in that document to determine whether prior authorization is required.

## When do I need to include device and manufacturer information in prior authorization requests?

To view a list of procedures for which you need to submit device and manufacturer information, see the "Appendix: Device and manufacturer information" on page 25.

## For Blue Cross commercial members, is prior authorization required for musculoskeletal procedures that aren't managed by TurningPoint?

Not all Blue Cross commercial self-funded groups participate in TurningPoint's musculoskeletal surgical quality and safety management program.

Here's what you need to know about Blue Cross commercial members who have coverage through self-funded groups that don't participate in the program:

- **For outpatient musculoskeletal procedures:** You don't need to obtain prior authorization.
- **For inpatient musculoskeletal procedures:** You need to obtain prior authorization for the inpatient admission, even though you aren't required to obtain prior authorization for the musculoskeletal procedures. For these requests:

  1. In the e-referral system, submit a prior authorization request for procedure code *99222 as outlined in the "Submit an inpatient authorization" section of the e-referral User Guide.
  2. When submitting this request, do not submit the musculoskeletal procedure codes. Instead, attach clinical information or insert notes that specify the procedures that will be performed to the prior authorization request for procedure code *99222.

  **Important!** Do not submit a prior authorization request for the musculoskeletal procedure codes.

To determine whether a Blue Cross member requires prior authorization from TurningPoint, see the document titled Determining prior authorization requirements for members.

## Are there site-of-care requirements for any musculoskeletal procedures?

There are site-of-care requirements for select hip and knee surgeries, as outlined below:

- For Medicare Plus Blue, BCN commercial and BCN Advantage members, for dates of service on or after Jan. 3, 2022
- For Blue Cross commercial members, for dates of service on or after Jan. 2, 2023

Based on medical necessity review, TurningPoint may approve prior authorization requests for select hip and knee surgeries only when scheduled in an outpatient setting.

If TurningPoint approves a prior authorization for a hip or knee surgery in an outpatient setting and the member experiences a change in condition that requires an inpatient admission, see “If TurningPoint authorized a member for an outpatient procedure but the member has a medical reason for an extended stay, how should the facility submit the prior authorization request?” on page 21 to learn what you need to do.

Performing select hip and knee surgeries in outpatient settings is supported by both evidence-based guidelines and the Centers for Medicare & Medicaid Services.

## What are the requirements for pain management procedures?

The following table outlines the requirements for pain management procedures.

| Procedure | Requirements |
|---|---|
| All pain management procedures | When conservative treatment is required, TurningPoint requires six weeks of conservative therapy with three specific modalities.<br>You can view conservative treatment requirements in the medical policies, which are available in the TurningPoint Provider Portal. |
| Epidural steroid injections | TurningPoint requires imaging confirmation to support radiculopathy. |
| | TurningPoint has exclusions for the presence of health conditions that could be worsened by steroids.<br>You can view the full list of exclusions in the medical policy, which you can view in the TurningPoint Provider Portal. |
| Facet joint injections | TurningPoint allows the treatment of two levels per session for diagnostic facet joint injections. |
| Sacroiliac joint injections | In keeping with North American Spine Society guidelines, TurningPoint has stringent criteria for the diagnosis of sacroiliac joint pain and requires two diagnostic injections to confirm. |
| Neuroablation | TurningPoint doesn’t allow neuroablation at any prior fused spinal levels. |

## Will TurningPoint approve contradicting procedure codes?

No. TurningPoint will review each code for medical necessity. If the surgical plan or pathology doesn't warrant an extensive additional procedure, TurningPoint will approve the primary code and deny additional coding, per the Medicare National Correct Coding Initiative, or NCCI, edit.

TurningPoint follows NCCI edit guidelines. For more information about NCCI edits, see https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.**

In keeping with NCCI edit guidelines, TurningPoint approves codes based on the clinical documentation and surgical plan submitted for a member.

TurningPoint will issue partial approvals as follows:

- TurningPoint will approve only the codes that are supported by the clinical documentation.
- TurningPoint won't approve contradicting procedure codes.

Example: If a provider submits a prior authorization request for both a total knee arthroplasty and a partial knee arthroplasty, TurningPoint will approve the procedure codes that are supported by the clinical documentation and deny the remaining procedure codes.

If the surgical plan changes intraoperatively, providers can update the authorized codes. For more information, see "What if the procedure that was performed doesn't match the procedure code TurningPoint authorized?" on page 19.

## Do I have to fill out questionnaires when I submit prior authorization requests?

You'll need to fill out questionnaires when you submit prior authorization requests for pain management procedures through the TurningPoint Provider Portal.

When you submit prior authorization requests for pain management procedures via fax, the fax forms include the questions you need to answer.

Whether you submit your request online or by fax, TurningPoint will reach out to you if additional information is needed before they can make a determination.

## Can I request multiple primary procedure codes for pain management services on a single prior authorization?

For pain management injections, TurningPoint will authorize one injection session on a date of service. The injection session should include only injections of the same type that are done at one or multiple levels. (Varies by medical policy. You can view medical policies in the TurningPoint Provider Portal.)

TurningPoint doesn't authorize injection series. As a result, providers have to submit a prior authorization request for each subsequent injection session. This allows TurningPoint to evaluate the

medical necessity of each subsequent injection after considering the member's response to the previous injection.

## How many prior authorizations are needed for multi-stage procedures?

When procedures with two or more stages are planned for different dates of service, you must submit a prior authorization request for each date of service. Each request must include clinical information.

When submitting requests for the following procedures, clinical information must include the outcome of the procedure performed in the previous stage:

| Procedure | TurningPoint policy number |
|---|---|
| Autologous chondrocyte implantation | OR-1014 |
| Spinal cord stimulator | OR-1015 |
| Implantable pain pump | OR-1034 |
| Epidural steroid injection | PM-1001 |
| Neuroablation | PM-1002 |
| Sacroiliac joint injection | PM-1003 |
| Facet joint injection | PM-1004 |

Note: You can view the full medical policies within the TurningPoint Provider Portal.

For multi-stage procedures not listed above, you should also include clinical information and provide information about the outcome of the procedure performed in the previous stage.

This allows TurningPoint to evaluate the medical necessity of each prior authorization request after considering the member's pathology and the procedure codes requested.

## If a patient needs a pain management injection within the duration of an existing pain management prior authorization, do I need to submit a new prior authorization request?

Yes. Providers must submit a prior authorization request and receive approval from TurningPoint for each subsequent injection session.

## Do add-on codes require prior authorization?

For most services, only primary procedure codes require prior authorization. However, add-on codes require prior authorization for pain management services.

## How long does the prior authorization process take?

Turnaround times won't exceed the time frames listed below.

| Type of request | Medicare Plus Blue and BCN Advantage | Blue Cross commercial and BCN commercial |
|---|---|---|
| Standard (non-urgent) requests for orthopedic and spine procedures[1] | 5 calendar days after TurningPoint receives complete information[2] | 5 calendar days after TurningPoint receives complete information[3] |
| Standard (non-urgent) requests for pain management procedures[1,6] | 3 calendar days after TurningPoint receives complete information[4] | 3 calendar days after TurningPoint receives complete information[5] |
| Expedited (urgent) requests[1] | 72 hours | 72 hours |
| Retroactive requests[1] | 14 calendar days from the date on which TurningPoint received the retroactive authorization request | 15 calendar days from the date on which TurningPoint received the retroactive authorization request |

(1)If you don't submit complete information, TurningPoint will make at least three attempts to contact you to obtain the missing information.

(2)If you don't submit complete information, there may be delays in processing your request. For Medicare Advantage members, providers will have an additional 9 calendar days during which they can submit missing information; TurningPoint will make a determination based on the information they've received after a total of 14 calendar days. For additional information, see "What steps does TurningPoint take before denying a prior authorization request?" on page 17.

(3)If you don't submit complete information, there may be delays in processing your request. For commercial members, providers will have an additional 10 calendar days during which they can submit missing information; TurningPoint will make a determination based on the information they've received after a total of 15 calendar days. For additional information, see "What steps does TurningPoint take before denying a prior authorization request?" on page 17.

(4)If you don't submit complete information, there may be delays in processing your request. For Medicare Advantage members, providers will have an additional 11 calendar days during which they can submit missing information; TurningPoint will make a determination based on the information they've received after a total of 14 calendar days. For additional information, see "What steps does TurningPoint take before denying a prior authorization request?" on page 17.

(5)If you don't submit complete information, there may be delays in processing your request. For commercial members, providers will have an additional 12 calendar days during which they can submit missing information; TurningPoint will make a determination based on the information they've received after a total of 15 calendar days. For additional information, see "What steps does TurningPoint take before denying a prior authorization request?" on page 17.

[6]If TurningPoint requests additional clinical information for a prior authorization request for a pain management procedure and the additional information is due on a weekend or holiday, TurningPoint may extend the due date to the next business day.

## What happens if I submit a request to TurningPoint when I should have submitted it to Blue Cross or BCN, or vice versa?

When TurningPoint receives a request for prior authorization, they validate the procedure and medical codes against the scope of services agreed upon between TurningPoint and Blue Cross or BCN. If TurningPoint determines that the request is out of scope, they will forward the request to Blue Cross or BCN and notify the provider that they have forwarded the request.

Likewise, if you contact Blue Cross or BCN about procedures that are managed by TurningPoint, you'll be redirected to TurningPoint.

Note: TurningPoint will be actively engaged in the education of each provider practice to ensure they have the appropriate contact information to limit the number of redirections that need to take place.

## Do musculoskeletal procedures that are performed during an inpatient admission require prior authorization from TurningPoint?

Musculoskeletal surgeries don't require prior authorization from TurningPoint when they're performed emergently during an inpatient admission or as the result of a direct or urgent admission.

However, you do need to request prior authorization for the inpatient admission, whether it originated in the ED or elsewhere. For these requests, submit procedure code *99222 as outlined in the e-referral User Guide; see the "Submitting an emergency or urgent admission (includes Blue Cross member submissions)" subsection within the "Submit an inpatient authorization" section for more information.

Note: Surgeries that are scheduled in advance and aren't related to an emergency event require prior authorization.

See "How do I submit a claim for a musculoskeletal procedure that was performed emergently during an inpatient admission?" on page 22 for information about submitting claims.

## What documentation should I submit with a prior authorization request?

You'll need to provide the following minimum information when you submit a prior authorization request:

- Provider information
- Facility information and anticipated surgery date
- Health plan information
- Member information
- Requested procedures/diagnosis

- Clinical information should include:
  - History of present illness
  - Radiological imaging reports
  - Attempted conversation therapies
  - Documented surgical plan

  For more information about the clinical documentation that's required, see the pertinent medical policy within the TurningPoint Provider Portal.
- Device manufacturer and product type information (if known)

For information about the methods by which you can submit prior authorization requests, see "How do I submit prior authorization requests to TurningPoint?" on page 7.

## What criteria does TurningPoint use to make determinations on prior authorization requests?

TurningPoint uses the following criteria:

| Plan type | Criteria for making determinations |
|---|---|
| Commercial — Blue Cross commercial and BCN commercial | TurningPoint applies medical policy guidelines for musculoskeletal and pain management procedures that Blue Cross Blue Shield of Michigan, BCN and TurningPoint agreed on. |
| Medicare Advantage — Medicare Plus Blue and BCN Advantage | TurningPoint applies the Medicare national coverage determinations / Medicare local coverage determinations.<br>If there is no Medicare NCD / LCD, TurningPoint applies medical policy guidelines for musculoskeletal and pain management procedures that Blue Cross Blue Shield of Michigan, BCN and TurningPoint agreed on. |

You can view the medical policies in the TurningPoint Provider Portal.

## Where can I view the medical policies for this program?

You can view the medical policies that are related to musculoskeletal procedures and related services by accessing the TurningPoint Provider Portal and clicking *Help* in the menu at the top of the screen.

## What qualifications do TurningPoint physicians have to review prior authorization requests?

TurningPoint employs orthopedic and spine physicians who have held positions within the largest associations related to their specialties:

- Six former presidents of the American Academy of Orthopaedic Surgeons

- The past president and current board member of the North American Spine Society
- Former presidents of the American Board of Orthopaedic Surgery
- The past president of the Pediatric Orthopedic Society of North America
- Two of the AAOS's former board representatives to CMS for all musculoskeletal-related billing and coding changes
- Multiple past regional and state orthopaedic association presidents, including the former presidents of the California, New York, Texas and New Jersey orthopaedic associations, as well as multiple AAOS board members

## Whom should I call with follow-up questions after I submit a prior authorization request?

After you submit a prior authorization request to TurningPoint, you can submit questions through the TurningPoint Provider Portal, which you can access through our provider portal (availity.com**) or at myturningpoint-healthcare.com.**

You can also direct follow-up questions to TurningPoint during normal business hours by calling 1-833-217-9670 (toll-free) or 313-908-6040 (local).

Normal business hours are 8 a.m. to 8 p.m. Eastern time Monday through Friday, excluding holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day).

## How are providers and members notified of the outcome of prior authorization requests?

TurningPoint will make a courtesy call to notify providers of the outcome of each prior authorization request.

The provider and member will receive a determination letter regarding the status of the prior authorization request, along with supporting information.

## How long will the prior authorization approval be valid?

Prior authorization requests approved on or after Jan. 1, 2022, are valid for six months from the planned date of service for all outpatient musculoskeletal procedures, including pain management procedures.

For example, if TurningPoint approves a prior authorization request for a service planned for June 1, the approval will be valid from June 1 through November 30. If the surgery is performed during that time period, the authorization will match the claim without any changes to the authorization.

## What steps does TurningPoint take before denying a prior authorization request?

TurningPoint does the following prior to denying a prior authorization request.

**Important:** If you don't respond to TurningPoint's outreaches, they'll move forward based on the information you provided when you submitted the prior authorization request.

| TurningPoint | During the outreach… |
|---|---|
| Requests additional clinical information | TurningPoint will make two attempts to reach you by phone and one attempt by fax, with at least 24 hours between each attempt.<br>During this outreach, they'll communicate the time frame for submitting additional clinical information:<br>• **For commercial members:** 15 calendar days<br>• **For Medicare Advantage members:** 14 calendar days |
| Places an intent to deny call | TurningPoint will make this call two days prior to the due date for submitting additional clinical documentation.<br>During the call:<br>• **For commercial members:** TurningPoint will offer a peer-to-peer review. You'll need to provide three dates and times when you're available to meet.<br>This conversation can take place before or after TurningPoint makes a determination on the prior authorization request. However, it must take place before you file an appeal.<br>• **For Medicare Advantage members:** Per CMS guidelines:<br>○ You can request a peer-to-peer review. You'll need to provide three dates and times when you're available to meet.<br>○ TurningPoint can consider information obtained during a peer-to-peer review only when the conversation takes place prior to making a determination on the prior authorization request.<br>Note: If the peer-to-peer review takes place after TurningPoint issues an adverse determination, TurningPoint can't reverse the denial. In such cases, the peer-to-peer review is for informational purposes only. |

For commercial members, you can request a reconsideration after TurningPoint has issued an adverse determination. To learn more, see "What is the reconsideration process for denied prior authorization requests for commercial members?" on page 18.

For Medicare Plus Blue and BCN Advantage members, there isn't a reconsideration process. However, you can file an appeal. For information about appeals, see "What is the grievance and appeals process for denied prior authorization requests?" on page 20.

## What types of providers can request peer-to-peer reviews?

TurningPoint schedules peer-to-peer reviews with physicians and with advanced practice providers, or APPs (physician assistants and nurse practitioners).

Reviews are conducted by providers of the same type. For example:

- If the requesting provider is an M.D., the review discussion will be scheduled with an M.D. at TurningPoint.
- If the requesting provider is a physician assistant, the review discussion will be scheduled with a physician assistant at TurningPoint.

Note: APPs can participate in peer-to-peer reviews related to routine prior authorization denials specific to coding, medical policy and documentation requirements for knee, ankle, shoulder, hip, elbow, wrist, spine and pain management procedures. If you have questions about which cases are eligible for APP peer-to-peer reviews, contact the TurningPoint Provider Relations team at providersupport@turningpoint-healthcare.com.

For more information, see the following documents, which are available on Musculoskeletal Services pages and the Pain Management pages on **ereferrals.bcbsm.com**:

- TurningPoint Peer to Peer Quick Reference Guide
- TurningPoint Advance Practice Practitioner (APP) Peer-to-Peer Process

Note: The documents linked above are also available through the TurningPoint Provider Portal.

## What is the reconsideration process for denied prior authorization requests for commercial members?

For denied prior authorization requests for Blue Cross commercial and BCN commercial members, you can request that TurningPoint reconsider their decision.

You have two options to request a reconsideration of a decision:

- You can ask TurningPoint to review additional clinical documentation, you can provide clarifying details that are pertinent to the request or both. Submit the documentation, details or both in one of these ways:
  - Through the TurningPoint Provider Portal
  - By fax. Include a cover sheet that identifies the patient and send the fax to 313-879-5509 for joint and spine procedures or to 313-483-7323 for pain management procedures.
- You can request a peer-to-peer review to review the case with a physician. To do this, call 1-833-217-9670. You'll need to provide three dates when you're available to meet. TurningPoint will schedule the conversation based on the dates you request.

You can request a reconsideration or a peer-to-peer review any time before providing services or filing an appeal with the health plan.

If you completed a reconsideration or peer-to-peer review and are dissatisfied with the decision, you may file an appeal.

Note: For Medicare Plus Blue and BCN Advantage members, there isn't a reconsideration process. However, you can file an appeal. For information about appeals, see "What is the grievance and appeals process for denied prior authorization requests?" on page 20.

## How do I update the date of service or the facility on a prior authorization?

If there's a change to the date of service or to the facility, call TurningPoint to update the prior authorization.

## How do I update procedure codes on a prior authorization before the date of service?

If a change was made to the procedure that was originally authorized, call TurningPoint to update the coding. If medical necessity review is required for the new coding, you may have to submit additional clinical documentation.

## What if the procedure that was performed doesn't match the procedure code TurningPoint authorized?

In some situations, you may not know which orthopedic or spinal procedure will be required in advance of a surgery or the surgical plan may change intraoperatively. As a result, the procedure code TurningPoint authorized may not represent the procedure that was actually performed.

You'll need to determine whether you can substitute the code for the procedure that was actually performed for the code TurningPoint authorized. If you can substitute the code, you won't need to contact TurningPoint to update the procedure coding.

To learn how to determine if the approved code allows substitutions and to view all codes that allow substitutions, see the Musculoskeletal procedure code substitutions for orthopedic and spinal surgeries document.

If you file a claim using a substitute procedure code, Blue Cross or BCN will process the claim based on the code for the procedure that was performed.

If you can't substitute the code for the procedure that was performed, you need to submit a postservice change request to TurningPoint by doing one of the following:

- Completing the Postservice change request form and faxing it to TurningPoint. To find the form, go to the **ereferrals.bcbsm.com** website, click *Blue Cross* or *BCN*, and then click the *Musculoskeletal Services* link.

Note: If you already submitted a claim, you'll need to click Yes for the question "Have you submitted a claim to Blue Cross or BCN?" in the *Postservice change request* form.

- Calling TurningPoint toll-free at 1-833-217-9670 or locally at 313-908-6040.

### Can I submit a retroactive authorization request?

Yes. You can submit retroactive authorization requests for up to 90 days after the procedure is performed.

To submit a retroactive authorization request to TurningPoint, follow the instructions in "How do I submit prior authorization requests to TurningPoint?" on page 7.

### Do I need to submit a form when submitting an appeal to Blue Cross or BCN?

Yes. When appealing on behalf of a member, submit the following form:

- For Blue Cross commercial members, submit an Authorized Representative form.
- For BCN commercial members, submit an Appointment of Representative form.

Providers who submit the necessary form can follow the member appeal process, which is outlined in the denial letter. The denial letter also includes the form you must submit to appeal on behalf of a member.

### What is the grievance and appeals process for denied prior authorization requests?

There are no changes to the grievance and appeals process. For information about the process of requesting an appeal, refer to the denial letter.

## Facilities

### How do I get an authorization updated to reflect an inpatient setting prior to surgery?

To update the setting, the ordering provider needs to contact TurningPoint.

### If an authorization shows an outpatient setting for a procedure that's on the CMS list of inpatient-only procedures, what should I do?

Contact TurningPoint toll-free at 1-833-217-9670 or locally at 313-908-6040. TurningPoint will update the setting on the authorization.

## If TurningPoint authorized a member for an outpatient procedure but the member has a medical reason for an extended stay, how should the facility submit the prior authorization request?

Because this is a medical admission, submit the prior authorization request through the e-referral system. Blue Cross or BCN will use the inpatient admission criteria to review the request.

When submitting the request, select inpatient as the place of service, select "Direct" as the admission type and enter CPT code *99222. Be sure to attach clinical notes that support the medical reason for admission.

## Are there any changes to how facilities report patient discharge dates to Blue Cross or BCN?

If you've been reporting discharge information to Blue Cross and BCN, please continue to do so.

We also rely on admission, discharge, and transfer data we receive from the Michigan Health Information Network, or MiHIN, systems to update discharge information.

## How can I tell how many days TurningPoint approved for an inpatient prior authorization?

You can determine the number of days TurningPoint approved for an inpatient prior authorization by doing one of the following:

- Calling TurningPoint toll-free at 1-833-217-9670 or locally at 313-908-6040
- Accessing the e-referral system. Note that:
    - The status of prior authorization requests is available in the e-referral system 24 hours after TurningPoint makes a determination
    - You need to search for the member, not for the TurningPoint authorization number
- Accessing the TurningPoint Provider Portal. Facilities can view prior authorizations for all procedures that have been requested to take place in their facility.

## How do I request additional days for an inpatient stay?

You can request additional days for an inpatient stay through the e-referral system.

In the e-referral system, you'll need to search for the member, not for the TurningPoint authorization number.

# Claims

## Does prior authorization guarantee payment?

Authorization is not a guarantee of payment. Claims submitted for these services will also be subject, but not limited to, the following:

- Member eligibility at the time services were provided
- Benefit limitations and/or exclusions
- Appropriateness of codes billed
- Medical necessity review, if prior authorization wasn't obtained before services were provided

## Does TurningPoint process claims for Blue Cross and BCN?

No, Blue Cross and BCN process claims.

If you submit a claim for a service for which you didn't receive prior authorization, Blue Cross or BCN may deny the claim.

## How do I submit a claim for a musculoskeletal procedure that was performed emergently during an inpatient admission?

Once you've obtained prior authorization for the inpatient admission (as discussed in "Do musculoskeletal procedures that are performed during an inpatient admission require prior authorization from TurningPoint?" on page 14), follow the normal claims submission process for inpatient admissions.

For information about submitting claims, see the following resources:

| Plan | Resource |
|---|---|
| Blue Cross commercial | The Claims chapter in the *Blue Cross PPO Provider Manual*<br>To access this chapter:<br>1. Log in to our provider portal (availity.com**).<br>2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.<br>3. Click the *Resources* tab.<br>4. Click *Secure Provider Resources (Blue Cross and BCN)*.<br>5. Click the *Provider Manuals* link in the Easy Access tile.<br>6. Click *Blue Cross commercial.*<br>7. Click the *Claims* link, which is listed under "Billing." |

| Plan | Resource |
|---|---|
| Medicare Plus Blue | See the following sections of the Medicare Plus Blue PPO Provider Manual:<br>• Utilization management — Look for the subsection titled "Prior authorization of musculoskeletal surgical procedures, including orthopedic, pain management and spinal procedures – TurningPoint"<br>• Claim filing |
| • BCN commercial<br>• BCN Advantage | The Claims chapter in the *BCN Provider Manual*<br>To access this chapter:<br>1. Log in to our provider portal (availity.com**).<br>2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.<br>3. Click the *Resources* tab.<br>4. Click *Secure Provider Resources (Blue Cross and BCN)*.<br>5. Click the *Provider Manuals* link in the Easy Access tile.<br>6. Click *BCN commercial and BCN Advantage*.<br>7. Click the *Claims (Billing)* link. |

For Provider Inquiry contact information, see "Whom should I call if I have questions about musculoskeletal claims that aren't answered in this document?" on page 24.

## What is the audit and recovery process for claims?

On inpatient professional claims, include only the musculoskeletal procedure codes that TurningPoint authorized.

On a quarterly basis, Blue Cross and BCN will review paid inpatient claims from professional providers to ensure that the procedure codes on the claims match the procedure codes TurningPoint authorized. If we find overpayments because the claim included codes that TurningPoint didn't authorize, we'll pursue payment recoveries as necessary.

You can request that TurningPoint add procedures codes to an authorization, but you must make this request prior to submitting a claim. For information about how to do this, see the following questions:

- "How do I update procedure codes on a prior authorization before the date of service?" on page 19
- "What if the procedure that was performed doesn't match the procedure code TurningPoint authorized?" on page 19

## What will happen if I submit a claim with a procedure code that doesn't match the code TurningPoint approved?

Blue Cross and BCN will deny any codes other than those authorized by TurningPoint.

For information about what to do when there's a change to the procedure code or site of care, see the following questions:

- "How do I update procedure codes on a prior authorization before the date of service?" on page 19
- "What if the procedure that was performed doesn't match the procedure code TurningPoint authorized?" on page 19
- "How do I update the date of service or the facility on a prior authorization?" on page 19
- "If TurningPoint authorized a member for an outpatient procedure but the member has a medical reason for an extended stay, how should the facility submit the prior authorization request?" on page 21.

## Whom should I call if I have questions about musculoskeletal claims that aren't answered in this document?

If you have questions about a claim, call the appropriate number below.

- Blue Cross commercial, BCN commercial and BCN Advantage members:
  - Professional providers: Call Provider Inquiry at 1-800-344-8525.
  - Facility providers: Call Provider Inquiry at 1-800-249-5103.
- Medicare Plus Blue members: Call 1-866-309-1719.

# Appendix: Device and manufacturer information

Include device and manufacturer information with prior authorization requests as follows:

| TurningPoint policy number | TurningPoint policy name | Implant data | Information to submit |
|---|---|---|---|
| OR-1001 | Total hip replacement | Not required | • Implant manufacturer<br>• Product name |
| OR-1002 | Total knee replacement | Not required | • Implant manufacturer<br>• Product name |
| OR-1003 | Lumbar disc replacement | Required | • Device manufacturer<br>• Product name |
| OR-1004 | Lumbar fusion | Required | • Graft<br>• Cage<br>• Instrumentation manufacturer<br>• Product name |
| OR-1005 | Bone morphogenetic protein | Required | Graft info (submitted with spinal fusion request) |
| OR-1006 | Cervical disc replacement | Required | • Device manufacturer<br>• Product name |
| OR-1007 | Cervical decompression | Required, if planned | • Device manufacturer<br>• Product name |
| OR-1008 | Lumbar decompression | Required, if planned | • Device manufacturer<br>• Product name |
| OR-1009 | SI joint fusion | Required | • Implant manufacturer<br>• Product name |
| OR-1010 | Thoracic decompression | Required, if planned | • Device manufacturer<br>• Product name |
| OR-1011 | Thoracic fusion | Required | • Graft<br>• Cage<br>• Instrumentation manufacturer<br>• Product name |

| TurningPoint policy number | TurningPoint policy name | Implant data | Information to submit |
|---|---|---|---|
| OR-1012 | Cervical fusion | Required | • Graft<br>• Cage<br>• Instrumentation manufacturer<br>• Product name |
| OR-1013 | ACL repair | Not required | • Graft (auto vs. allograft)<br>• Implant information |
| OR-1014 | Osteochondral defects | Required | • Graft (auto vs. allograft)<br>• Implant information |
| OR-1015 | Spinal cord stimulator | Required | • Device manufacturer<br>• Product name |
| OR-1016 | Total hip revision | Not required | • Implant manufacturer<br>• Product name |
| OR-1017 | Total knee revision | Not required | • Implant manufacturer<br>• Product name |
| OR-1018 | Acromioplasty and rotator cuff repair | Not required | • Graft (auto vs. allograft)<br>• Implant information |
| OR-1019 | Shoulder fusion | Not required | • Implant manufacturer<br>• Product name |
| OR-1020 | Spinal deformity fusion | Required | • Graft<br>• Cage<br>• Instrumentation manufacturer<br>• Product name |
| OR-1021 | Ankle replacement | Not required | • Implant manufacturer<br>• Product name |
| OR-1022 | Elbow replacement | Not required | • Implant manufacturer<br>• Product name |
| OR-1023 | Shoulder replacement | Not required | • Implant manufacturer<br>• Product name |

| TurningPoint policy number | TurningPoint policy name | Implant data | Information to submit |
|---|---|---|---|
| OR-1024 | Vertebral augmentation | Not required | • Device manufacturer<br>• Product name |
| OR-1025 | Femoroacetabular arthroscopy | Not required | • Implant manufacturer<br>• Product name |
| OR-1026 | Hip resurfacing | Not required | • Implant manufacturer<br>• Product name |
| OR-1027 | Meniscal transplantation | Required | • Graft (auto vs. allograft)<br>• Implant information |
| OR-1028 | Partial knee replacement | Not required | • Implant manufacturer<br>• Product name |
| OR-1029 | Knee arthroscopy | Not required | • Implant manufacturer<br>• Product name |
| OR-1030 | Ankle fusion | Not required | • Implant manufacturer<br>• Product name |
| OR-1031 | Hip arthroscopy | Not required | • Implant manufacturer<br>• Product name |
| OR-1032 | Wrist fusion | Not required | • Implant manufacturer<br>• Product name |
| OR-1033 | Wrist replacement | Not required | • Implant manufacturer<br>• Product name |
| OR-1034 | Implantable infusion pump | Required | • Device manufacturer<br>• Product name |
| OR-1035 | Computer assisted navigation | Not applicable | Not applicable |
| OR-1036 | Shoulder procedures | Not required | • Implant manufacturer<br>• Product name |
| OR-1037 | Spinal devices | Required | • Device manufacturer<br>• Product name |

| TurningPoint policy number | TurningPoint policy name | Implant data | Information to submit |
|---|---|---|---|
| OR-1038 | Sacral decompression | Required, if planned | • Device manufacturer<br>• Product name |
| OR-1039 | Thermal intradiscal procedures | Not applicable | Not applicable |
| OR-1040 | Manipulation under anesthesia | Not applicable | Not applicable |
| OR-1042 | Hip osteotomy | Not required | • Implant manufacturer<br>• Product info |
| OR-1043 | MPFL reconstruction | Not required | • Graft (auto vs. allograft)<br>• Implant information |
| OR-1044 | Pubic symphysis fusion | Not required | • Implant manufacturer<br>• Product info |
| OR-1045 | Spinal osteotomies | Not applicable | Not applicable |
| PM-1001 | Epidural steroid injections | Not required | Injectate |
| PM-1002 | Neuroablation | Not required | Injectate |
| PM-1003 | SI joint injections | Not required | Injectate |
| PM-1004 | Facet joint injections | Not required | Injectate |

Note that you can view the full medical policies in the TurningPoint Provider Portal.



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