PROVIDER GUIDE

TurningPoint authorizations

Learn how to submit authorization requests for cardiac and musculoskeletal (MSK) surgical procedures.

Priority Health | TurningPoint

What's inside this guide

This guide includes an overview of the scope, features and operational process of the cardiac and musculoskeletal (MSK) managed care programs.

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Background

Priority Health has partnered with TurningPoint Healthcare Solutions, LLC ("TurningPoint") to manage cardiac and musculoskeletal (MSK) surgical care for our members.

Through this partnership, we seek to:

- ✓ **Optimize health outcomes** for our members
- ✓ **Work more closely with you**, our provider partners, to ensure our members receive evidence-based, value-driven care

About TurningPoint

TurningPoint is an independent specialty condition management company with 120+ clinical experts focused on sub-specialties in high-complexity, high-cost categories. Their process aligns with our clinical approach by reviewing requested care and using evidence-based guidelines to support care plan decisions.

Program highlights

1. **Efficient, user-friendly request process** for obtaining authorizations
2. **Peer-to-peer engagement** with a TurningPoint cardiac or MSK specialist
3. **Clinical support tools** to assist in the tracking and monitoring of patient outcomes
4. **Reporting and analytics** that give physicians and practice administrators greater visibility and transparency into their performance
5. **FDA recall tracking** and monitoring to facilitate timely and consistent notification when a member has received or needs a revision surgery due to a Class I or II FDA device recall

TurningPoint contacts

Your contacts for questions about the portal and submitting authorization requests:

myturningpoint-healthcare.com
313.221.5553 | *providersupport@tpshealth.com*

Portal support
Submit a ticket online or email *portalsupport@tpshealth.com*

Priority Health contacts

Your contacts for questions about this authorization program, billing, appeals and more:

Accountable Care Networks
Contact your Provider Network Management Specialist.

Practitioners & provider groups
Contact our Provider Helpline
800.942.4765 | Mon.-Thurs. 7:30-5; Fri. 9-5

Program overview

These programs start with an authorization process that uses nationally recognized, evidence-based criteria to guide decisions on high-cost cardiac and MSK services.

You'll submit authorization requests to TurningPoint for a select set of procedures. Our provider portal, **prism**, will automatically redirect you to TurningPoint for the appropriate procedures.

Once your request is submitted, TurningPoint's team will review and determine whether the procedure is approved, partially approved or denied. You'll receive a determination letter with details on the decision and any available next steps, including peer-to-peer discussions and appeals, as appropriate.

Device recall & safety management

Because of the volume and complexity of cardiac and MSK implant recalls, we use a consistent safety management process, across all providers and specialties, to help ensure patient safety.

1. **Providers submit member-specific device information** post-procedure to TurningPoint to support a device recall database. This is done via the TurningPoint provider portal, by uploading implant records with procedure notes.
2. **TurningPoint monitors the FDA website daily**, updating the device recall database in real time.
3. **TurningPoint analyzes device recalls weekly**, issuing reports to Priority Health on any members who may need revisions due to device recall.

Customer service & ongoing support

TurningPoint's provider relations and utilization management teams are dedicated to your staff's continued support. TurningPoint offers:

1. **Clinical discussions** regarding evidence-based treatment plans. These discussions include key medical directors from both Priority Health and TurningPoint's clinical teams to engage with the identified key clinical representatives from each physician group.

   The goal: Offer transparency into the criteria and the opportunity for physicians to give clinical input regarding best practices.

2. **Ongoing provider staff training and support** including frequent and regular communication from TurningPoint's provider relations team – over the phone and on-site, if desired.

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The goal: Continue to help you with any additional training needs or specific issues (technical or otherwise) that need to be resolved.

Schedule a training, in-person or virtual, by contacting TurningPoint's provider relations team at *providersupport@tpshealth.com*.

3. **Language assistance programs** are available to providers (and members) upon request. To arrange for oral or written translation services, contact TurningPoint at 313.221.5553 or 855.511.0840.

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Operational guide

Follow the steps below to submit an authorization request to TurningPoint.

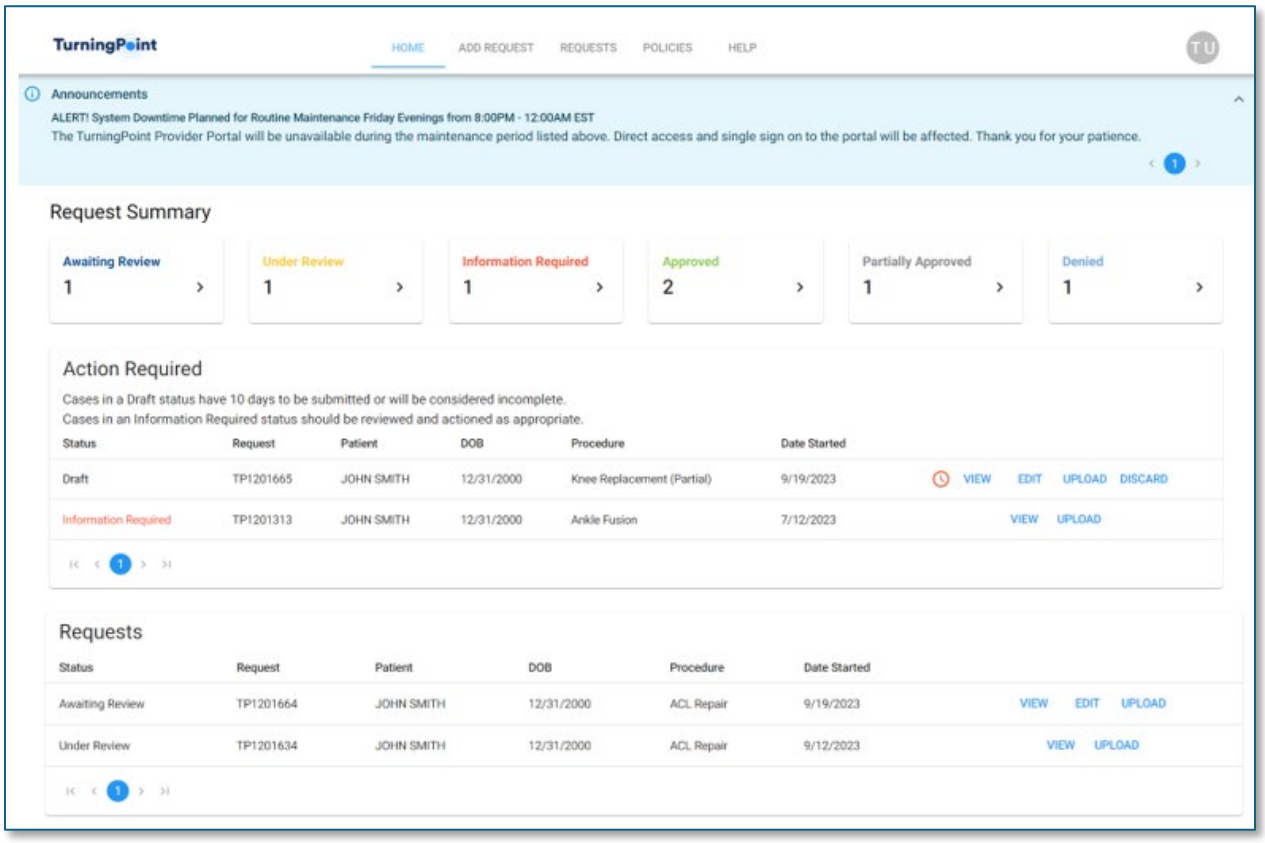
You don't need to create an account with TurningPoint to submit authorization requests. You'll be able to initiate requests and access the TurningPoint portal through your existing Priority Health **prism** provider account.

Submit an authorization request

Step 1: Enter basic details into prism

1. Log into your **prism** account.
2. Click **Authorizations** in the main menu, then **Request an Authorization**.
3. Enter the **Requesting provider**, **Primary procedure** and **Facility information** required.
4. Click the **Go to TurningPoint** button that appears.

Step 2: Familiarize yourself with TurningPoint's provider portal homepage.

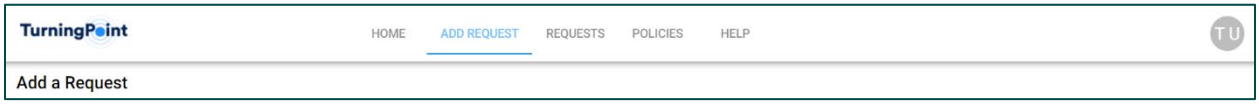


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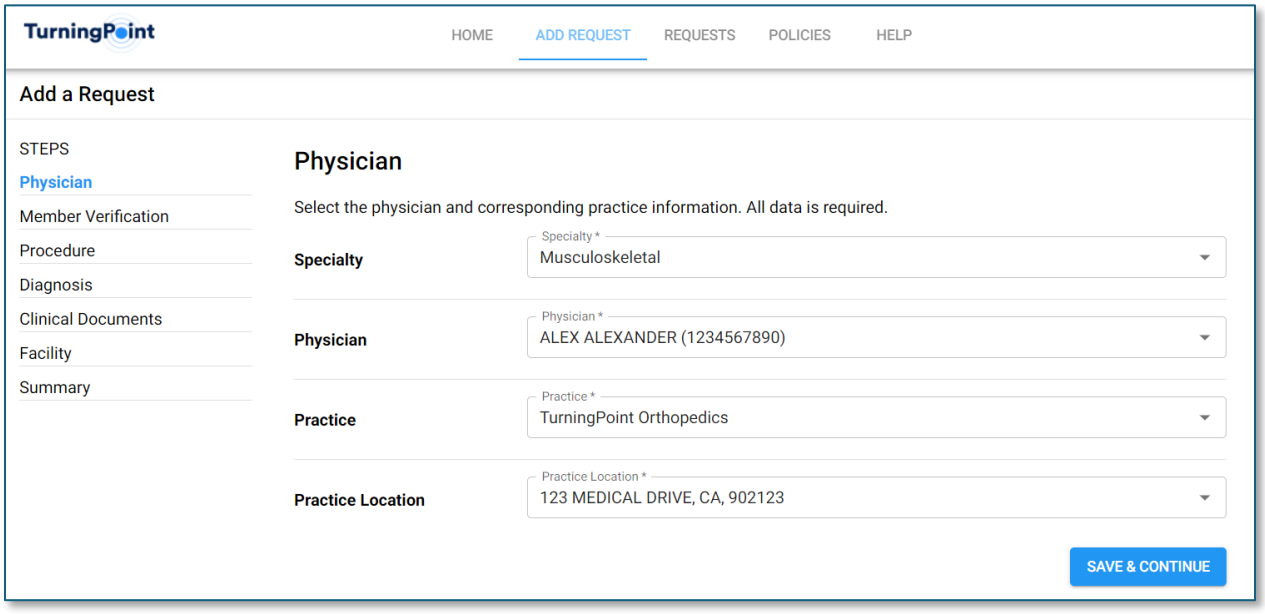
1. **Menu navigation bar**: Helps you navigate to the different pages within the provider portal.
2. **Your login information**: Allows you to change your password, select the portal's display language and log out.
3. **Announcements**: Shows important information regarding upcoming engagement opportunities, system maintenance and any updates for your provider group.
4. **Request summary**: Shows a snapshot of all requests related to your group. These tiles are also shortcuts to the Requests page and will automatically set a view filter to show only those requests counted within that tile.
5. **Action required**: Shows all items requiring action, specific to your provider group, and can include incomplete drafts and any additional information requests.
6. **Requests**: Allows you to see all requests related to your provider group.

Step 3: Submit a request for authorization.

1. Click **Add Request** in the top menu to open the submission form.



2. **Add physician information**:
   - Enter the **Specialty**, **Provider** and **Practice** information.
   - Click **Save & Continue**.

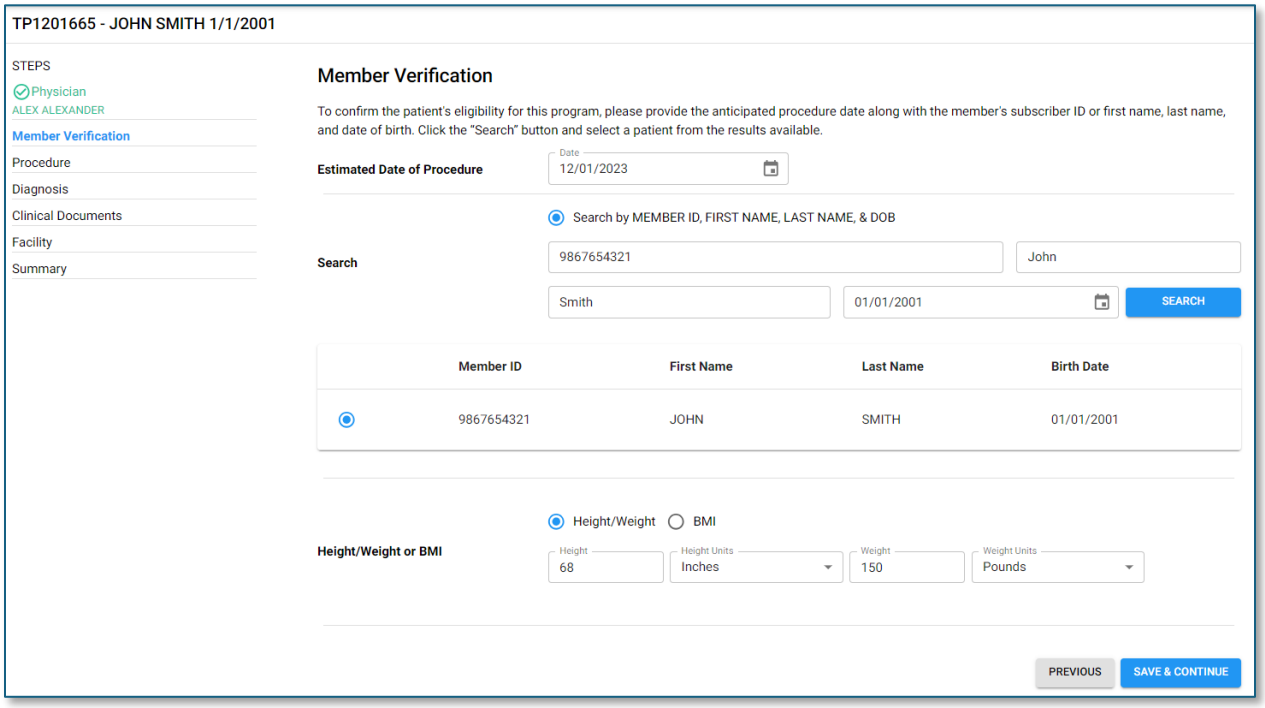


Note: The Steps menu on the left side of the screen shows all steps in the authorization request process and highlights which step is active.

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3. **Add member verification information**:

- Enter the **Estimated Date of Procedure.**
- **Search** for the member using their Priority Health member ID number or their name and date of birth. Click **Search** after entering details.
- **Select** the blue circular button to the left of the appropriate member.
- Enter the member's **Height** and **Weight** or select the BMI radio button to enter the BMI instead.



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4. **Add procedure information**:

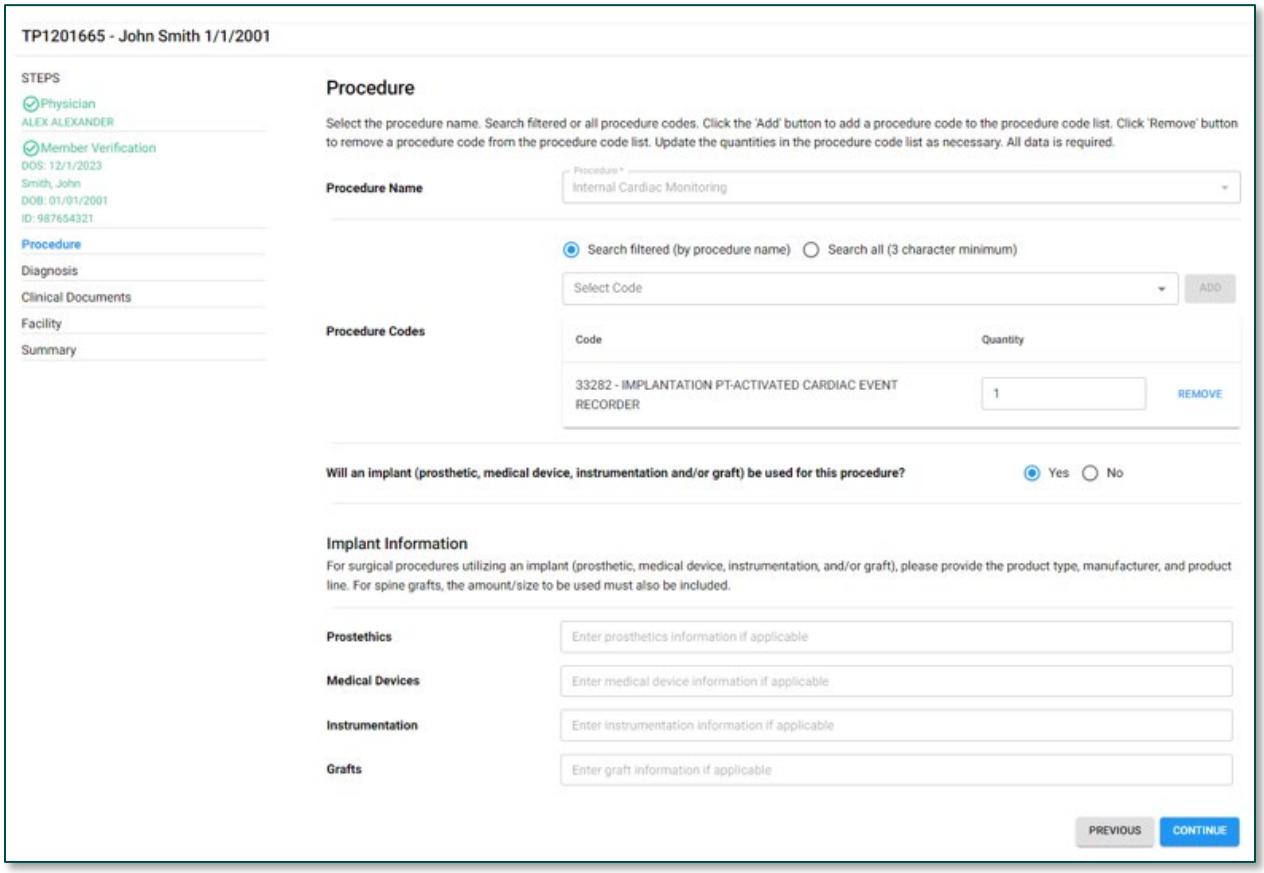
- Enter the **Procedure Name** by typing in the search bar in plain language (i.e., pacemaker or hip arthroscopy) and selecting the appropriate procedure from the dropdown menu.

- Search for and select the appropriate **Procedure Codes** (CPT® codes) associated with the procedure. Your search can be filtered by the previously entered procedure name or select the **Search all** circular button to work with an unfiltered list. Select the appropriate code(s) from the dropdown menu and enter the quantity in the text box.

- Select **Yes or No** to answer the following question: Will an implant (prosthetic, medical device, instrumentation and/or graft) be used for this procedure?

- Enter applicable **Implant Information** if you selected Yes to the above question. This section won't appear if you selected No.

- Click **Continue**.

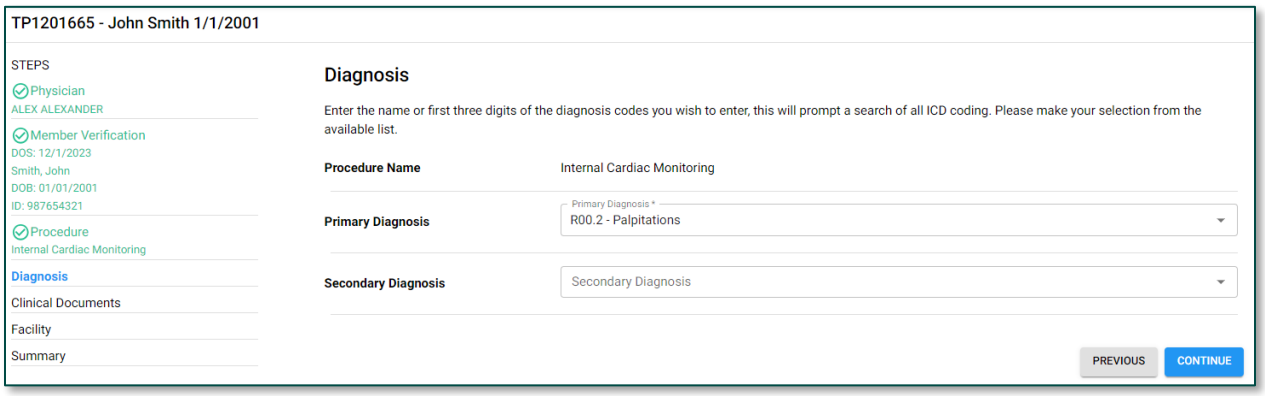


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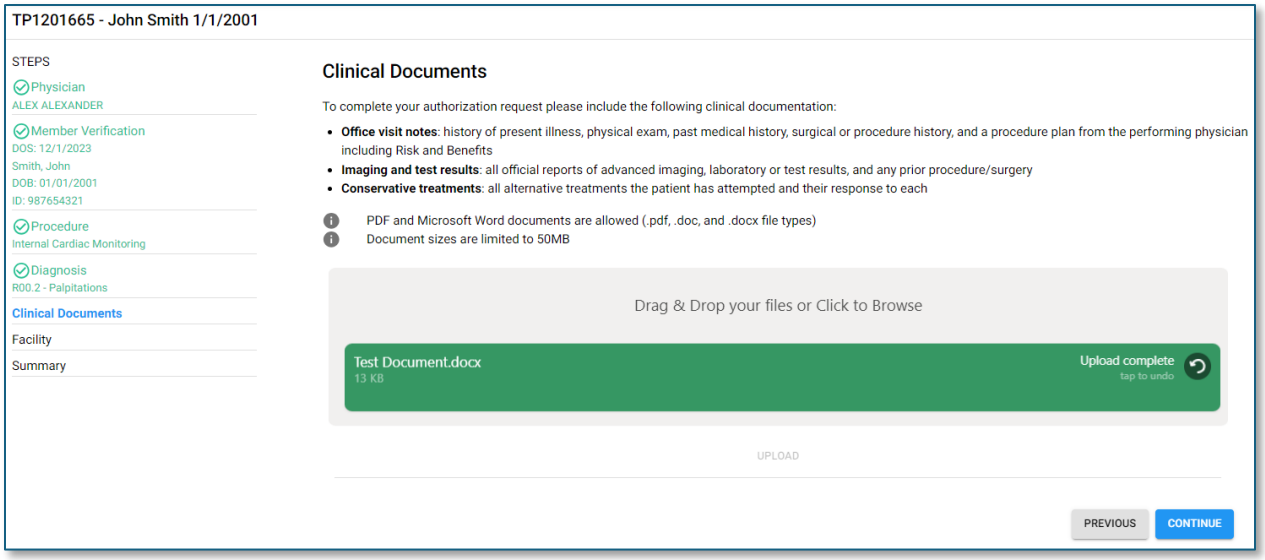
5. **Add diagnosis information**:

   - Search for the **Primary Diagnosis**. Enter the procedure code in the text box to generate a list of options to select from. If applicable, do the same for a **Secondary Diagnosis**.

   - Click **Continue**.



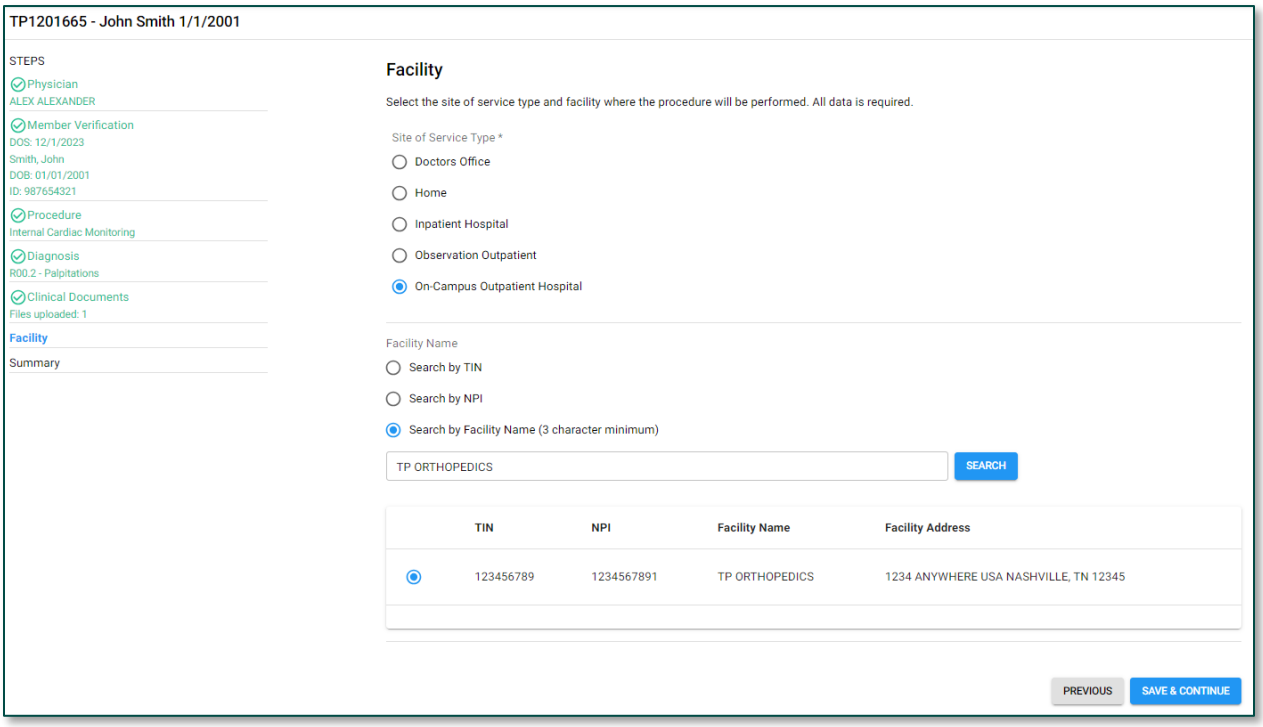
6. Drag and drop or click to upload **Clinical Documents** supporting your authorization request. Click **Continue**.



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7. **Select the facility**:

    - Select the **Site of Service Type**, **Network Affiliation** and **Facility Name** search parameters.
    - Type the facility search information in the search bar and click **Search**.
    - Select the button to the left of the appropriate facility.
    - Click **Save & Continue**.

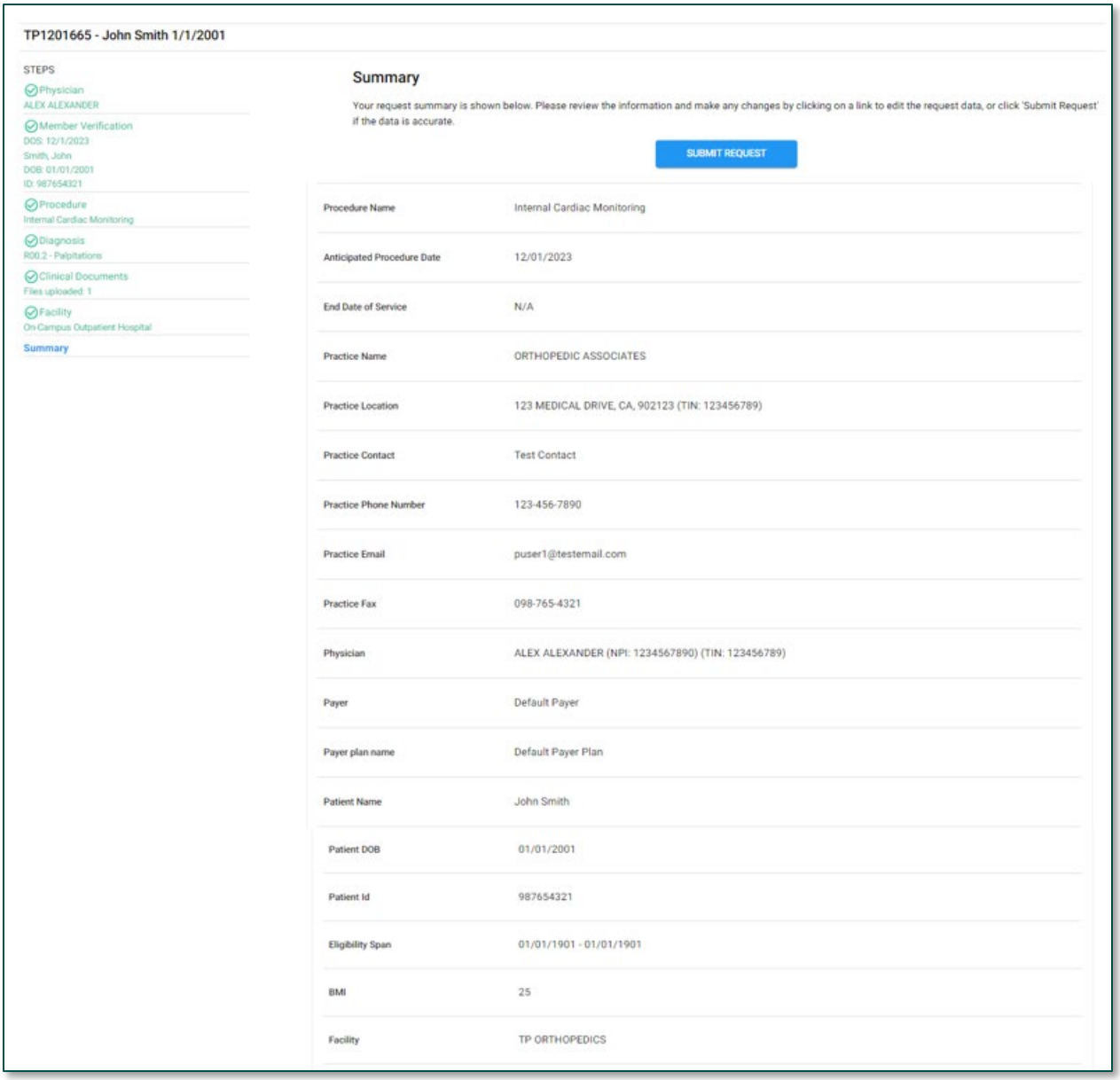


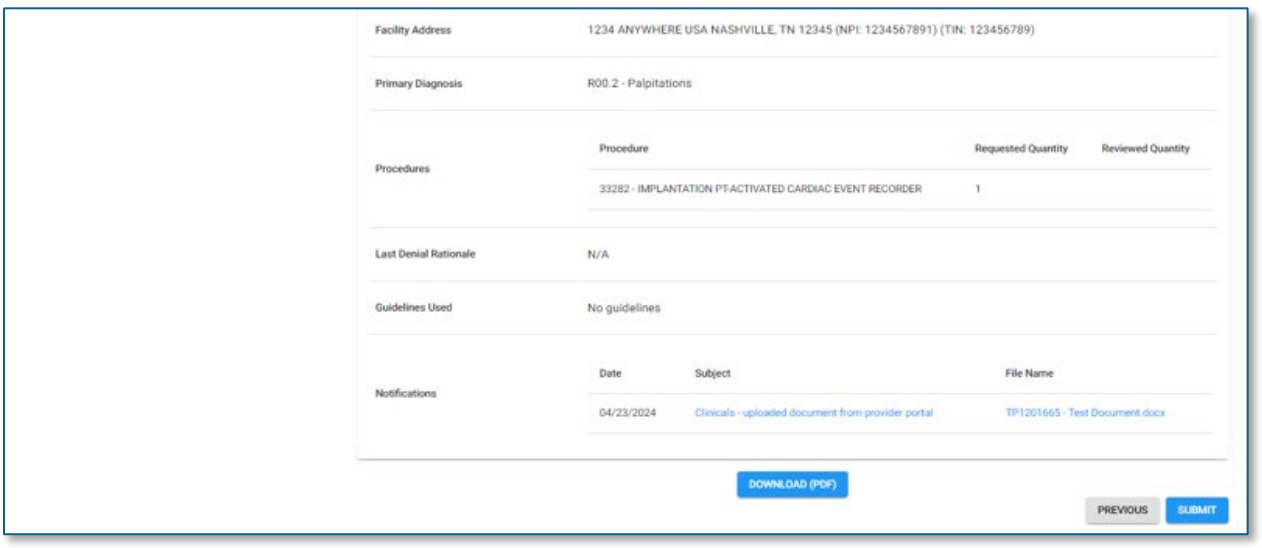
8. **Review & submit your request**

    - Review the summary of your request details on the page that populates. Here you may click:
        - **Submit Request** or **Submit** to submit it to TurningPoint for review
        - **Download (PDF)** to download the summary
        - **Previous** to review or edit request details

To manually submit an authorization, fill out and submit the Authorization Request Form (found under the Help tab in TurningPoint's portal). Please allow additional time if submitting outside the portal.

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Procedure codes & updates to procedure codes

Initial prior authorization submission

When you're submitting for prior authorization, make sure your surgical plan matches the codes you're requesting.

Pre-service changes

Before the date of service, call TurningPoint at 313.221.5553 or 855.511.0840. If medical necessity review is required for the new coding, a new request will be created, and you may need to submit additional clinical documentation.

Post-service change requests (pre-claim)

If a change was made to the procedure that was originally authorized and the procedure has already taken place, fax the Post Service Change Review form (found under the Help tab in TurningPoint's portal) to TurningPoint at 313.261.7199 or 833.374.0036 to update the authorization **before submitting the claim to Priority Health**. Procedure notes will be required, and supplemental supporting clinical documentation may also be necessary.

See authorization status

1. Log into your **prism** account.
2. Under the **Authorizations** menu, click **Authorization Inquiry**.
3. Click the **TurningPoint link**. This will take you directly into the TurningPoint portal.
4. In the TurningPoint portal, click **Requests** in the menu.
5. Filter by Request ID, Patient, Physician or Status.
6. Review the **Status column** for the request in question.

Additional helpful tips

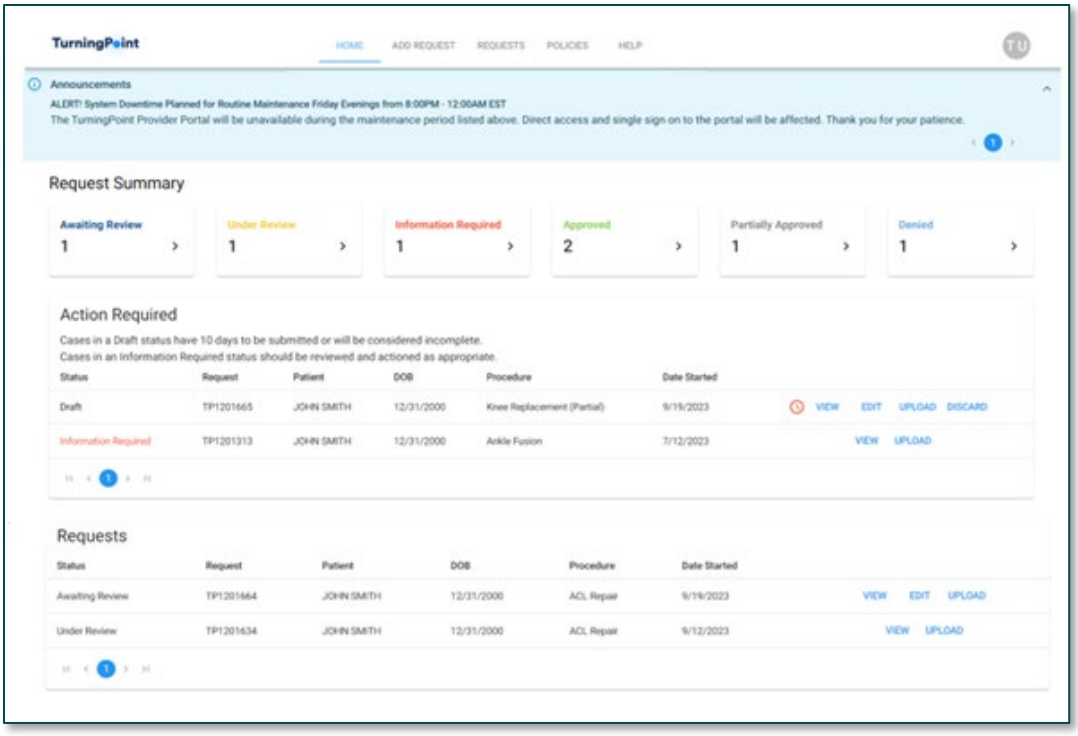
Below are helpful tips on navigating the rest of the TurningPoint provider portal.

Home tab

On the Home tab, you'll be able to see:

- **Announcements**, including any TurningPoint system alerts
- **Request summary**, which organizes your organization's requests into categories: awaiting review, under review, with information required, approved, partially approved and denied
- **Actions required** on your part regarding current requests

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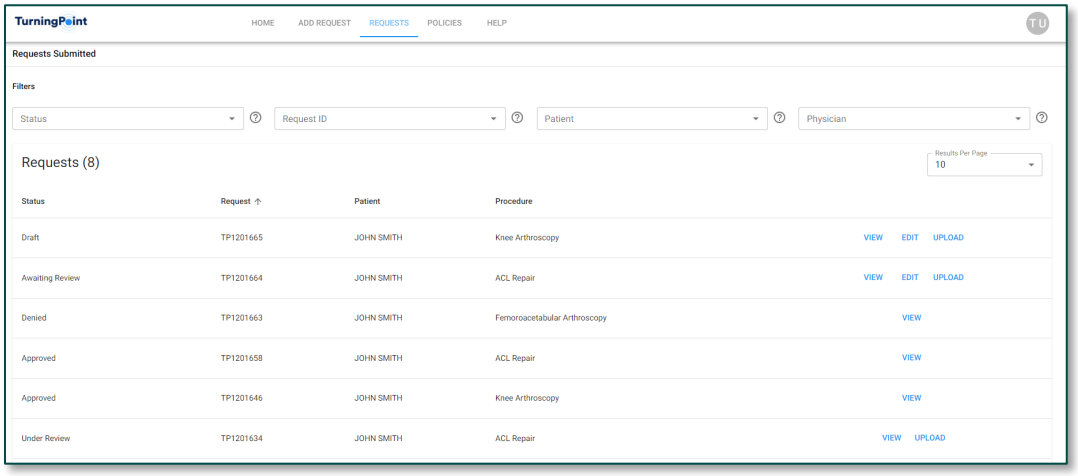


Requests tab

In the **Requests** tab, you'll see all requests related to your provider group, including those submitted by other users affiliated with your group's TIN.

There you can use the **Filters** section to search these requests by status, request ID, patient name or ID and physician name or NPI. Along the right side of each request, you'll see a set of possible actions. These will allow you to view, edit or upload a request, depending on the request's status.

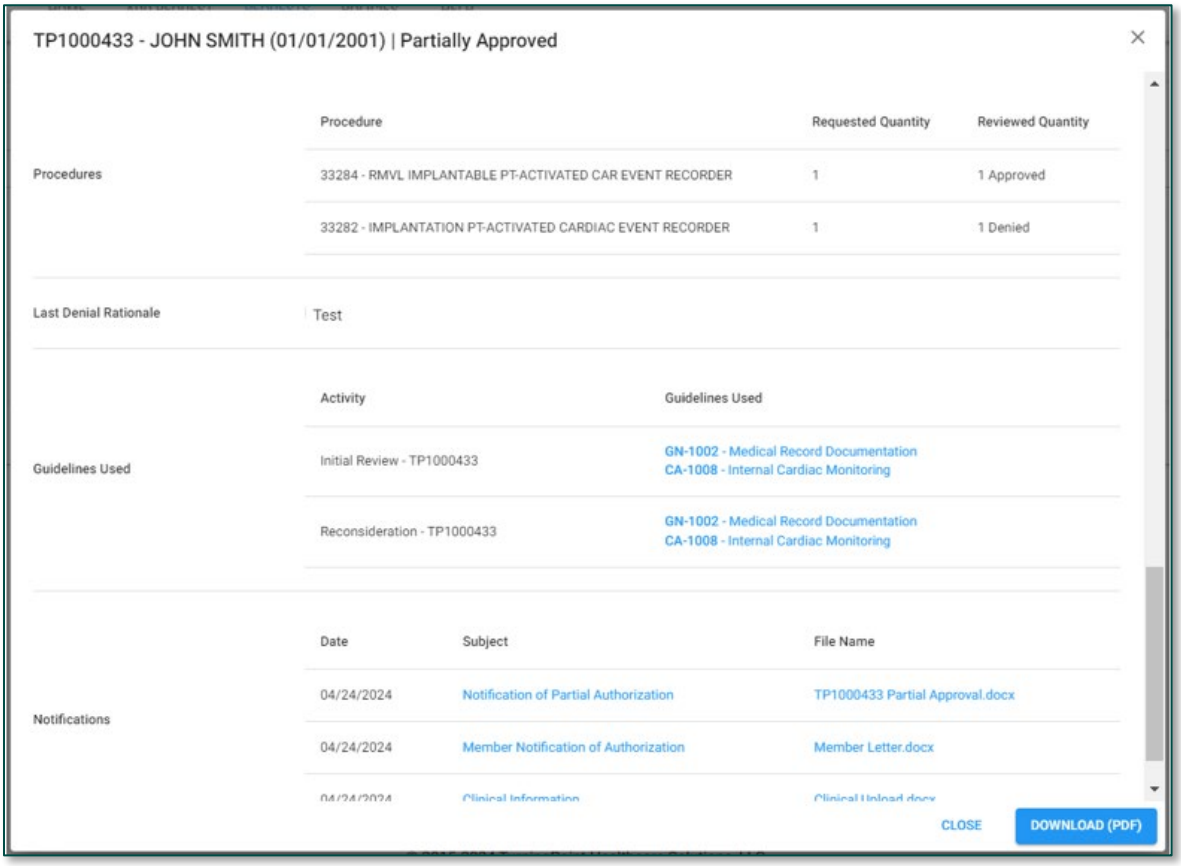
Request status	Possible actions
Draft or Awaiting Review	View, edit or upload clinical documents
Under Review	View or upload clinical documents
Determined (approved, partially approved or denied)	View only



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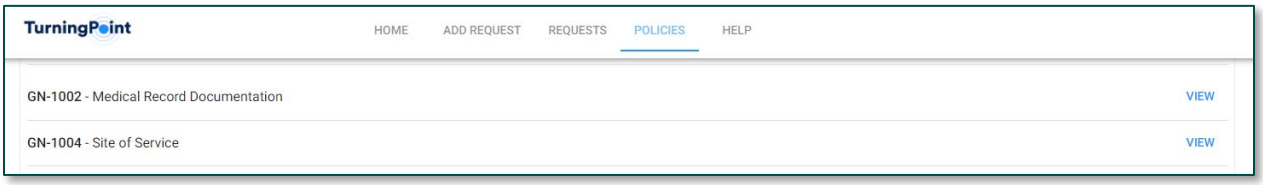
When viewing a request, you can review the request summary, including the following information:

- **Procedure codes**: Quantity approved / denied
- **Guidelines used**: Medical policies and clinical guidelines used to review the request
- **Documents**: Clinical documents uploaded for the request and the determination letters sent to the provider and member



Policies tab

The Policies section allows you to select and review all medical policies and clinical guidelines relevant to this authorization program.

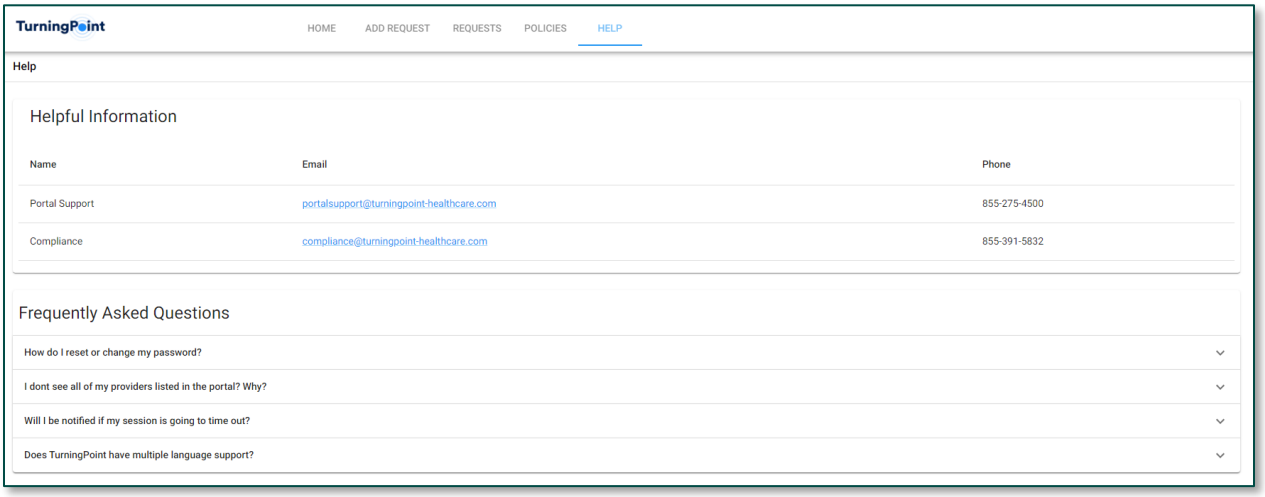


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Help tab

The Help section offers the TurningPoint team's provider support contact information. Reach out if you need support or to resolve any issues.

This section may also include helpful articles and information (i.e., training information, FAQs, Priority Health website links) to support your practice. Directions for oral and written translations are also found here.



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Authorization decision timelines

Request type	Medicare	Medicaid	Commercial
Standard (non-urgent) requests	**7 days**	**7 days**	**7 days**
Expedited (urgent) requests	**72 hours**	**72 hours**	**72 hours**
Retrospective requests	**7 days**	**30 days**	**30 days**

Note: due to medical necessity documentation, the preferred workflow is for the following procedures to always be submitted retrospectively: Non-coronary Angioplasty/Stenting, Coronary Angioplasty/Stenting and Peripheral Revascularization.

Appeal turnaround times

Request type	Medicare (Handled by Priority Health)	Medicaid (Handled by TurningPoint)	Commercial (Handled by TurningPoint)
Level 1 pre-service (UM) clinical appeals	See the process in our Provider Manual.	**Appeal submission**: 65 days from the denial date **Decision notification**: 30 days from the appeal submission	**Appeal submission**: 65 days from the denial date **Decision notification**: 30 days from the appeal submission
Level 1 pre-service (UM) expedited appeals	See the process in our Provider Manual.	**Appeal submission**: 65 days from the denial date **Decision notification**: 72 hours from the appeal submission	**Appeal submission**: 65 days from the denial date **Decision notification**: 72 hours from the appeal submission
Level 1 post-service (UM) clinical appeals	See the process in our Provider Manual.	**Appeal submission**: 65 days from the denial date **Decision notification**: 60 days from the appeal submission	**Appeal submission**: 65 days from the denial date **Decision notification**: 60 days from the appeal submission

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Additional information requests

If additional information is required to make a determination on your authorization request, TurningPoint will conduct the following outreach:

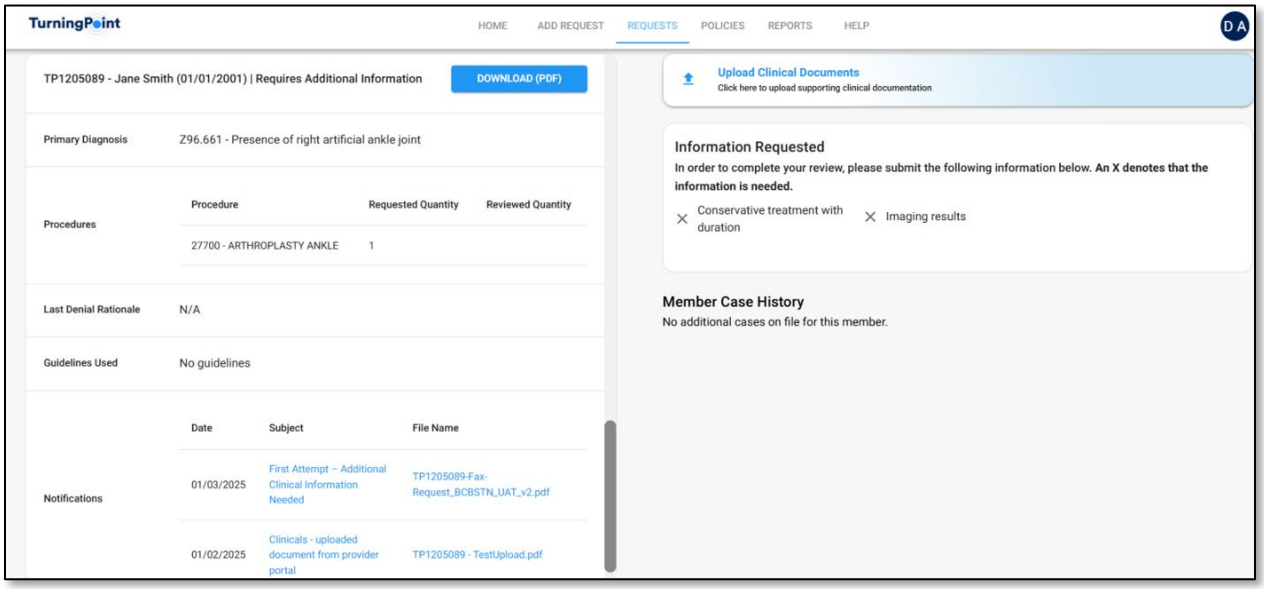
Commercial & Medicaid plans	Medicare plans
• Up to 3 attempts for additional information	• Up to 3 attempts for additional information • 1 Intent to Deny (ITD) call

Attempts for additional information

TurningPoint sends up to three requests for additional information, via a combination of phone and fax outreach.

Additionally, in the TurningPoint portal, navigate to the **Home tab** to view any actions required for your current requests. Under the **Status column**, you'll see Information Required noted in red if additional information is needed.

Download a copy of the faxed request, including a list of the information required and instructions to submit it, in the Requests tab of the TurningPoint portal:



Medicare Intent to Deny (ITD) calls

Once an authorization request for a Medicare case has been denied, there isn't an option for a reconsideration or a peer-to-peer review that could overturn the denial (see below) – appeal is the only avenue. Because of this, TurningPoint makes an Intent to Deny (ITD) ahead of a potential denial for Medicare cases.

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ITD calls are an extra step to give providers the opportunity to prevent an adverse determination by letting the contact your practice's designated contact know that additional medical information is required to make a determination on a case.

During the ITD call, TurningPoint will help the practice take appropriate action to avoid an adverse decision by sharing:

- Rationale for the potential adverse determination
- Information about the option to schedule a peer-to-peer discussion **before** the final determination
- When the case is set to deny if additional information isn't received, or a pre-denial peer-to-peer isn't scheduled

Note: We're unable to keep a case open beyond the Medicare authorization request turnaround times. In the event requested information isn't received or the case isn't resolved through a pre-denial peer-to-peer by the deadline, the case will move through the final determination process.

Denials management

Reconsideration process

For commercial and Medicaid cases that have been denied – partially or fully – you may request a reconsideration before filing an appeal. Reconsiderations take additional information / documentation into account, **return a decision within 5 calendar days** and may result in a revised determination without the need to proceed to an appeal.

A peer-to-peer (P2P) isn't required for a reconsideration but can be a helpful step following a post-denial peer-to-peer review (P2P) for commercial and Medicaid plans.

Requirements for a case to be eligible for a reconsideration:

- Member's primary health plan is commercial or Medicaid*
- Adverse determination (partial or full) on the case in question has been issued
- Procedure hasn't occurred
- No claims have been submitted for payment by the provider / facility for the procedure
- Request with necessary documentation is submitted by the requesting provider **within 15 business days** of the initial adverse determination
- A reconsideration has been requested either via the portal, fax or phone

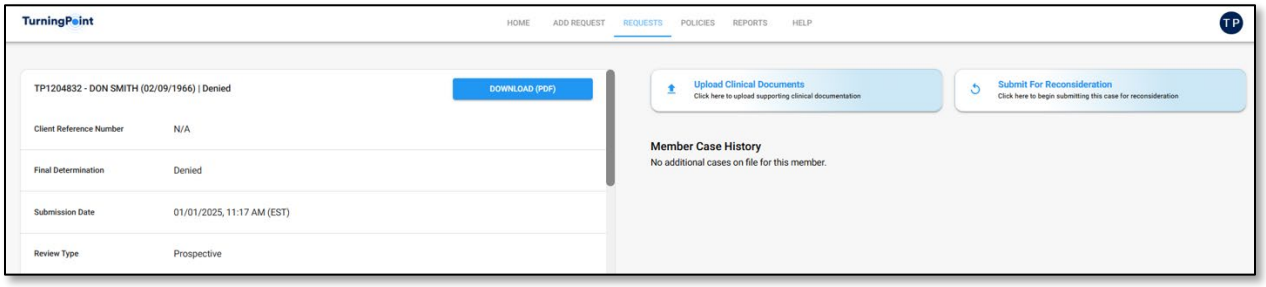
Note: A P2P isn't required to submit a reconsideration request, and reconsiderations don't always result in an approval.

**If the member has Medicare as their primary coverage, TurningPoint can only complete an educational peer-to-peer for authorizations post-determination. This educational peer-to-peer won't change the outcome of the authorization – only an appeal can do that.*

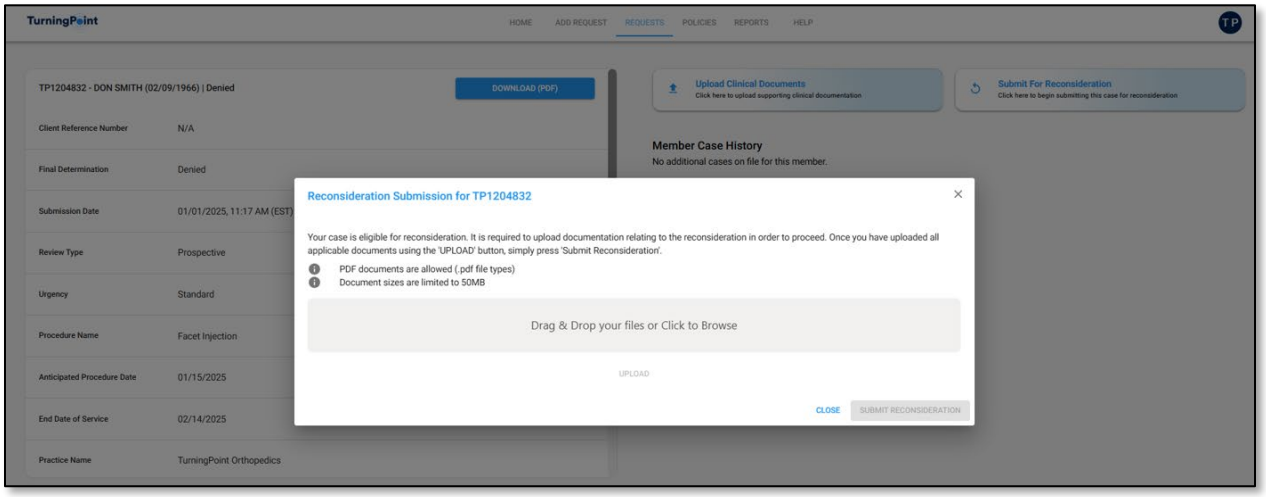
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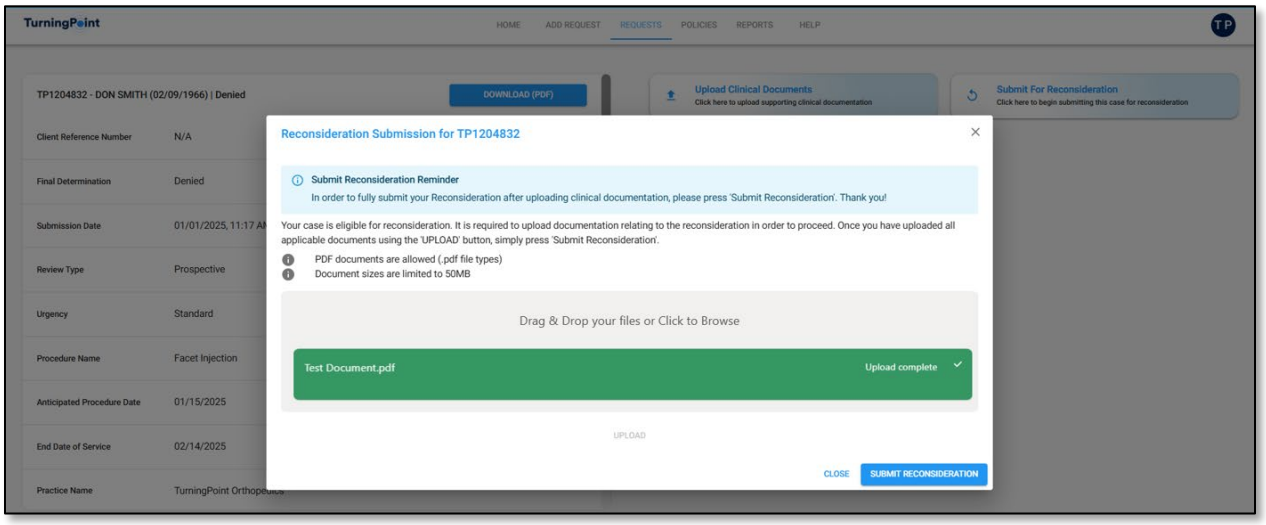
How to submit a reconsideration request

If a case is eligible for a reconsideration (per the requirements listed above), you'll see the following button on the Case Details page:



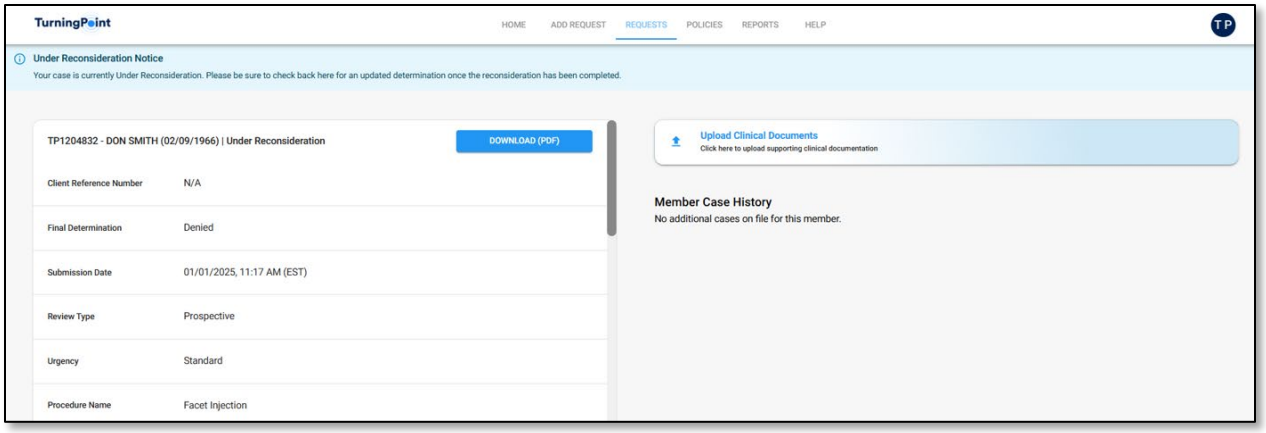
Click the **Submit For Reconsideration** button. Upload the necessary documentation showing additional information, codes or clarifications, then click **Submit Reconsideration**.





Once submitted, the case will be automatically updated to "Under Reconsideration."

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Peer-to-peer process

Peer-to-peer reviews are unique in that they are conducted by specialized physicians in accordance with the procedure. TurningPoint offers peer-to-peers during denial notification, however provider offices may also request them. TurningPoint will request three dates and times for scheduling to help navigate physician schedules.

Requesting a peer-to-peer

Call TurningPoint at 800.581.3920 to submit your request.

Once your request is submitted, the TurningPoint peer-to-peer coordination team will request three separate dates with at least a 2-hour timeframe that the requesting physician will be available. This availability is then matched to a TurningPoint Medical Director of the same specialty.

A peer-to-peer coordinator will contact the provider's office to confirm the exact date and time that the call will take place. TurningPoint will make a confirmation call to the provider's office to finalize the scheduled date and time. On the date and time of the scheduled peer-to-peer call, the coordinator will contact the requesting provider and connect them with the TurningPoint Medical Director.

Commercial and Medicaid members

Providers have 15 calendar days to request a peer-to-peer. Information obtained in a pre- or post-denial peer-to-peer may impact the determination of an authorization case.

The peer-to-peer must take place before an appeal is submitted.

Medicare Advantage members

- **Pre-denial peer-to-peer**: Information obtained in a pre-denial peer-to-peer may impact the determination of an authorization case

- **Post-denial peer-to-peer**: TurningPoint cannot reverse the denial if the peer-to-peer review occurs post-denial. In such cases, an appeal is required to change the decision, and the post-denial peer-to-peer review is for educational purposes only.

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Medical necessity appeals

Commercial & Medicaid members

- **Level 1 appeal**: To initiate a level 1 appeal for **Medicaid** and **commercial** programs, submit the request to TurningPoint via fax to 313.261.7199 or over the phone at 313.221.5553. If requesting an appeal by phone, you may need to submit additional clinical documentation.

- **Level 2 appeal**: For level 2 appeals, refer to the Priority Health appeal process.

Medicare Advantage members
To initiate a medical necessity appeal for **Medicare** programs, refer to the Priority Health Medicare appeals process. There's only one level of pre-service appeal for Medicare plans.

Medicare Advantage members

To initiate a medical necessity appeal for **Medicare** programs, refer to the Priority Health Medicare appeals process. There's only one level of pre-service appeal for Medicare plans.

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