Post-Acute Care and Home Health Care
Cigna Medicare Advantage

Frequently Asked Questions

Who is eviCore healthcare?
eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides Post-Acute Care (PAC) and Home Health Care (HHC) utilization management services for Cigna Medicare Advantage Customers.

Which customers will eviCore manage for PAC and HHC?
Beginning May 27, 2022, eviCore will accept PAC and HHC precertification requests for Cigna customers with Medicare Advantage coverage for dates of service June 1, 2022 and beyond.

IMPORTANT: The PAC program excludes both initial and concurrent skilled nursing facility reviews performed by NaviHealth in Delaware, Maryland, New Jersey, Pennsylvania, and Washington D.C. The Home Health Care program excludes Arizona Medicare customers. This program does not apply to Cigna commercial customers.

Which PAC and HHC services require precertification?
Services requiring prior authorization are:

- Skilled nursing facility (SNF) admissions
- Inpatient rehabilitation facility (IRF) admissions
- Long-term acute care (LTAC) admissions
- Home Healthcare (HHC) services

How does a provider check the eligibility and benefits of a customer?
Providers should verify customer eligibility and benefits on the secured provider log in section on the Cigna HSConnect provider portal https://www.hsconnectonline.com/login.aspx or by calling Cigna Medicare Advantage Provider Service at 800.230.6138.

Eligibility may also be verified at evicore.com/ep360 during the precertification process.

How does a provider initiate a precertification request?
Providers may request precertification in one of the following ways:

- **eviCore Provider Portal (preferred)**
  The eviCore online portal evicore.com/ep360 is the quickest, most efficient way to request precertification and check status.
- **Fax**
  Precertification requests are accepted via fax and can be used to submit additional clinical information.
  - PAC: 800.575.4429
  - HHC: 855.826.3724
- **Phone**
  Providers may request PAC and HHC precertification by calling 800.298.4806

Where can a provider find PAC and HHC precertification request forms?
PAC and HHC precertification forms are available on the eviCore provider resource website https://www.evicore.com/resources/healthplan/cigna-medicare

How does a provider check the precertification status for a customer?
Precertification status can be viewed on demand via the eviCore portal at evicore.com/ep360 or by calling eviCore at 800.298.4806.

What are the hours of operation?
eviCore hours of operation are:

- Monday – Friday 8 a.m. to 8 p.m. CST
- Saturday 8 a.m. to 4 p.m. CST
- Sunday 8 a.m. to 1 p.m. CST
- Holidays 8 a.m. to 1 p.m. CST
- 24 hour on call coverage

Who is responsible for submitting the initial PAC precertification requests?

- Hospitals are responsible for submitting the initial inpatient precertification for SNF, IRF or LTAC admissions for customers discharging from an acute care facility.
- PAC Facilities (SNF, IRF and LTAC) are responsible for submitting the initial precertification requests for customers admitting from the community, emergency department, or outpatient setting, and to submit precertifications for concurrent review requests.
- IRF and LTAC facilities are responsible for submitting the initial precertification for customers transitioning to a lower level of care, such as a SNF.

NOTE: If a patient is transferred to the hospital directly from a PAC facility and stays >24 hours, a new precertification is required and should be requested by the hospital prior to discharge.

Who is responsible for submitting the initial HHC precertification requests?

- HHC agencies are responsible to submit the initial precertification requests for HHC services for members discharging from the hospital or for members with a new community referral from a physician or treating practitioner.
- The initial HHC precertification requests for patients discharging from a Post-Acute Care (PAC) facility (Skilled Nursing, Inpatient Rehab and Long Term Acute Care) should be submitted by the admitting HHC Agency.
- HHC agencies should submit all concurrent review requests to eviCore.

What medical necessity criteria does eviCore healthcare utilize for precertification?
eviCore may utilize a number of resources in reviewing precertification requests, including, but not limited to:

Post-Acute Care Criteria
MCG™ evidence-based care guidelines®, Medicare Benefit Policy Manuals
Home Health Criteria
MCG™ evidence-based care guidelines®, Medicare Benefit Policy Manual, Other Evidence-Based Tools

What information is required when requesting an Initial precertification for PAC?

- Admission Details
  - Facility type being requested
  - Accepting facility demographics (if known)
  - Patient demographics
  - Anticipated date of hospital, LTAC, or IRF discharge (if applicable)
- Clinical Information
  - Hospital admitting diagnosis
  - History and physical
  - Progress notes, i.e., attending physician, consults and surgical (if applicable)
  - Medication list
  - Wound or Incision/location and stage (if applicable)
- Mobility and Functional Status
  - Prior and current level of functioning
  - Therapy evaluations: PT/OT/ST
  - Therapy progress notes, including level of participation

What information is required when requesting date extensions for PAC?

- Precertification Details
  - Facility type and demographics
  - Patient demographics
  - Number of days and dates requested
- Clinical Information
  - Hospital admitting diagnosis and ICD-10 code
  - Clinical progress notes
  - Medication list
  - Wound or Incision/location and stage (if applicable)
- Mobility and Functional Status
  - Prior and current level of functioning
  - Focused therapy goals: PT/OT/ST
  - Therapy progress notes, including level of participation
  - Discharge plans (include discharge barriers, if applicable)

What information is required when requesting a precertification for HHC?

- Precertification Details
  - Site of Care demographics
  - Patient demographics
  - Services requested
  - Home Health ordering physician demographics (including phone and fax)
  - Anticipated date of discharge
- Clinical Information
  - ICD10 code
  - Clinical progress notes
  - Medication list
  - Wound or incision/location and stage (if applicable)
  - Discharge summary (when available)
- Mobility and Functional Status
  - Prior and current level of functioning
  - Focused therapy goals: PT/OT
  - Therapy progress notes including level of participation
  - Discharge plans (include discharge barriers, if applicable)

To ensure the precertification process is completed as quickly and efficiently as possible, it is highly recommended that you submit pertinent clinical information to substantiate medical necessity for the type of service being requested.

The requirements are outlined on the eviCore precertification request form
https://www.evicore.com/resources/healthplan/cigna-medicare

When will a provider receive the precertification determination from eviCore?
Once all information is submitted to eviCore, outreach will be made to providers with a determination within two (2) business days.

How will precertification determinations be communicated to the providers?
eviCore will communicate the determination utilizing the following methods:

- Verbal notification is made to requesting provider
- Written notification will be faxed to the requesting PAC and HHC provider
- Customers will receive a precertification determination letter by mail
- Precertification status can be printed on demand from the eviCore portal at www.evicore.com/ep360

When does the initial precertification approval expire?

- PAC: The initial precertification will expire 10 days from the date of issue.
- HHC: The initial precertification will expire 14 days from the date of issue.

What is the process eviCore is unable to approve the request for a PAC service?

- If eviCore is unable to approve the request based on the information provided, notification is made to the requesting provider.
- The provider is given the option to either send additional information to support medical necessity criteria or schedule a clinical consultation.
- When a request does not meet criteria, it goes to second level MD review.
- If the MD if unable to approve, an alternate recommendation may be offered. The requesting provider can either accept or reject the alternative recommendation or schedule a clinical consultation.

Important: If one of these options is not utilized by the requesting provider within one business day, an adverse determination is made and the request is denied.

What is the process eviCore is unable to approve the request for a HHC service?

- If eviCore is unable to approve the request based on the information provided, notification is made to the requesting provider.
- The provider is given the option to either send additional information to support medical necessity criteria or schedule a clinical consultation.
- When a request does not meet criteria during nurse review, it goes to second level MD review.
- If the MD if unable to approve, the requesting provider must either send additional information to support medical necessity criteria or schedule a clinical consultation within one business day or an adverse determination is made and the request is denied.

What is the process if a PAC and HHC service does not meet clinical criteria?

When a request does not meet medical necessity based on evidence based guidelines, an adverse determination is made and the request is denied. In those cases, a denial letter with the rationale for the decision, reconsideration options, and appeal rights will be issued to the provider and customer by eviCore.

In the event of an adverse determination, what post-denial processes are available?

Appeal Process

- Cigna will process first-level appeals. Delegation of second level appeals may vary by state regulations
- The timeframe to submit an appeal request will be outlined on the determination letter and is typically within 180 days of the adverse decision*
- Appeal requests can be submitted to Cigna in writing via US Mail or by fax. The Cigna appeal address and fax number will be provided on the determination letter
- Customers or providers with appeal questions may call the number indicated on the customer's ID card
- The appeal determination will be communicated by Cigna to the ordering provider and customer
- Appeal turnaround times:*
    - Expedited 72 hours
    - Standard provider 30 days

* May vary by state regulations

Medicare Advantage customers requesting an appeal of the denial for continued PAC and HHC services should follow the process outlined on their denial letter.

Does eviCore review cases retrospectively if no authorization was obtained?

Retrospective reviews are not allowed, with the exception of special circumstances. Please contact Cigna directly for consideration.

What if a precertification is issued and revisions need to be made to an existing precertification request?
The servicing provider should contact eviCore with any changes for customers who are still in the PAC facility or receiving ongoing HHC services. Any change(s) requested after the customer is discharged must be submitted to Cigna.

Note: Notification of any changes to the original post-acute care facility, HHC agency or diagnosis code(s) is important in order for claims to be correctly processed for the servicing provider.

How does a requesting provider determine if a servicing provider is in network?
To find a participating provider, go to Cigna.com > Find a Doctor, Dentist or Facility, or call eviCore at 866.686.4452.

Where do providers submit claims?
All claims will continue to be filed directly with Cigna. Check the customer ID card for the claims address.

What is Cigna's payor ID number?
Electronic claims may be submitted through:

- Change Healthcare/Availity (Payor ID: 63092 or 52192)
- SSIGroup/Proxymed/Medassets/Zirmed/OfficeAlly/GatewayEDI (Payor ID: 63092)
- Relay Health (Professional claims CPID: 2795 or 3839, Institutional claims CPID: 1556 or 1978)

Are servicing providers required to enroll in Electronic Funds Transfer?
Providers are required to enroll in Electronic Fund Transfer (EFT) with Cigna in order to receive electronic payment for services rendered.

Where do providers submit inquiries regarding Cigna claims submissions?
If the available self-service tools do not provide claim resolution, providers should contact Cigna Medicare Advantage Provider Customer Service at 1.800.230.6138. All inquiries regarding Cigna claims submissions should be directed to Cigna.

How do providers submit a program-related question or concern?
For program-related questions or concerns, please email clientservices@evicore.com or call 800.575.4517 (option 4).

Whom should providers contact for eviCore portal support/questions?
To speak with a portal specialist, please call 800.646.0418 (Option 2) or email portal.support@evicore.com
Our dedicated Portal Support team can assist providers in navigating the portal and addressing any portal related issues during the online submission process.

Where can providers find additional information?
For more information and reference documents, please visit eviCore's provider resources site for this program:
https://www.evicore.com/resources/healthplan/cigna-medicare