Frequently Asked Questions

Who is eviCore healthcare?

eviCore healthcare, an Evernorth Health Services business, is a specialty medical benefits management company that partners with health plans to provide certain utilization management services.

Which members will eviCore healthcare manage for AmeriHealth Caritas Family of Companies?

eviCore will manage prior authorization of certain services for members who are enrolled in the following AmeriHealth Caritas Family of Companies health plans:

- AmeriHealth Caritas Pennsylvania
- AmeriHealth Caritas District of Columbia
- AmeriHealth Caritas Florida
- AmeriHealth Caritas Louisiana
- AmeriHealth Caritas New Hampshire
- AmeriHealth Caritas North Carolina
- AmeriHealth Caritas Delaware
- AmeriHealth Caritas VIP Care (DE, FL)
- AmeriHealth Caritas VIP Care Plus (MI)
- AmeriHealth Caritas Community Health Choices
- First Choice by Select Health of South Carolina Inc
- First Choice VIP Care Plus
- First Choice VIP Care
- Blue Cross Complete of Michigan
- Keystone First
- Keystone First VIP Choice
- Keystone First Community Health Choices

What services will require prior authorization from eviCore healthcare? (Click on the program name for additional information specific to that program)

Medical Oncology*	Radiation Oncology
Genetic Testing***	Outpatient Physical & Occupational Therapy
Pain Management	Joint and Spine Procedures
DME**	Diagnostic Sleep Testing and Sleep DME**

Please refer to the list of CPT/HCPCS codes that require prior authorization from eviCore healthcare at the following link: www.evicore.com/resources/healthplan/amerihealth-caritas-family-of-companies

- *Find the Health Plan > Select Solution Resources> Select a Solution > Select CPT Code List*

Note: Services performed within an observation stay, inpatient stay, or emergency room visit do not require authorization from eviCore healthcare.

Medical Oncology is not in scope for Blue Cross Complete, AmeriHealth Caritas VIP Care Plus, and AmeriHealth Caritas North Carolina; Pharmacy medications are out of scope for AmeriHealth Caritas Louisiana.

****DME and Sleep DME are not in scope for AmeriHealth Caritas Florida, AmeriHealth Caritas VIP Care, and Blue Cross Complete of Michigan.***

*****Genetic Testing is out of scope for Keystone First Community Health Choices.***

How do I check the eligibility and benefits of a member?

Member eligibility and benefits should be verified **with the health plan** before requesting prior authorization through eviCore.

- *Providers should verify member eligibility and benefits the Plan's secured provider log-in section at: www.navinet.net or call Provider Services at:*

State	Plan Name	Provider Services
DE	AmeriHealth Caritas Delaware	Provider Services 1-855-707-5818
DE	AmeriHealth Caritas Delaware LTSS	Provider Services1-855-707- 5818 ; TTY: 1-855-362-5769
DE	AmeriHealth Caritas VIP Care (DSNP)	Provider Services 1-833-433-2177
DC	AmeriHealth Caritas District of Columbia	Provider Services 1-202-408-2237, or 1-888-656-2383
FL	AmeriHealth Caritas Florida	IVR/provider Services 1-800-617-5727
FL	AmeriHealth Caritas VIP Care	Provider Services 1-833-350-3477
LA	AmeriHealth Caritas Louisiana	Louisiana Medicaid REVS Telephone Line: 1-800-776-6323 or AmeriHealth Caritas Louisiana's Automated Eligibility Hotline 24 hours/7 days a week, 1-888-922-0007
MI	Blue Cross Complete	Provider Service 1-888-312-5713
MI	AmeriHealth Caritas VIP Care Plus	Provider Services 1-888-667-0318
NH	AmeriHealth Caritas New Hampshire	Provider Services 1-888-599-1479
NC	AmeriHealth Caritas North Carolina	Provider Services 1-888-738-0004
OH	AmeriHealth Caritas Ohio	Provider Services 1-833-644-6001 ALSO: Providers can submit eligibility inquiries through ODM's Provider Network Management system: https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing
PA	AmeriHealth Caritas VIP Care (DSNP)	Provider Services 1-800-521-6007
PA	AmeriHealth Caritas Pennsylvania Community Health Choices	Provider Services 1-800-521-6007
PA	AmeriHealth Caritas Pennsylvania	Provider Services 1-800-521-6007, or https://tinyurl.com/DHSPromise
PA	Keystone VIP Choice	Provider Services at 1-800-521-6007
PA	Keystone Health Plan East	Provider Services 1-800-521-6007
PA	Keystone First Community HealthChoices	Provider Services 1-800-521-6007
SC	First Choice by Select Health SC	Provider Services is 1-800-741-6605
SC	First Choice VIP Care (DSNP)	Provider Services 1-888-978-0151
SC	First Choice VIP Care Plus (MMP)	Provider Services 1-888-978-0862

If you need assistance finding a member in the eviCore portal, contact Client Services at **clientservices@evicore.com**

Who needs to request prior authorization through eviCore?

All physicians, or their staff, are required to obtain a prior authorization for services prior to the service being rendered in an office or outpatient setting. It is the responsibility of the performing facility to confirm that the ordering physician completed the prior authorization process for tests or services.

How do I request a prior authorization through eviCore healthcare?

Web Portal

The eviCore portal is the preferred method to initiate a request. It is the quickest, most efficient way to request prior authorization and is available 24/7. Providers can request authorization by visiting www.evicore.com. If you need information about creating a user account, refer to the provider orientation training material. If you have an eviCore user account and need technical assistance, reach out to Web Support at **portal.support@evicore.com.**

Call Center

eviCore's call center is open from 7 a.m. to 7 p.m. local time. Providers and/or staff can request prior authorization and/or make changes to existing cases by calling **1-877-506-5193**.

What are the benefits of using eviCore healthcare's Web Portal?

Our web portal provides 24/7 access to submit or check on the status of your request. The portal also offers additional benefits for your convenience:

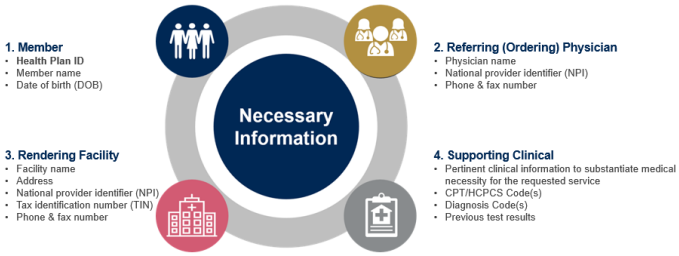
- Speed – Requests submitted online require half the time (or less) than those taken telephonically. A real-time approval is often available.
- Efficiency – Upload medical documentation to the case upon initial submission, reducing the need for follow-up calls and consultation.
- Real-Time Access – Web users are able to see real-time status of a request.
- Member History – Web users are able to see both existing and previous requests for a member.
- Providers are able to self-schedule post-decision options such as clinical consultations and appeals.

Where can I access eviCore healthcare's clinical guidelines?

eviCore's clinical guidelines are available online 24/7 and can be found by visiting the following link: www.evicore.com/provider/clinical-guidelines

What information is required when requesting prior authorization?

When requesting prior authorization, please ensure the clinical information pertaining to the member and the requested service is readily available.



For a checklist of information needed to align with medical necessity criteria, please follow this link: https://www.evicore.com/-/media/files/evicore/provider/training-resources/required-medical-information-check-list.pdf

Note: *not all programs on this list are delegated to eviCore healthcare for management for AmeriHealth Caritas Family of Companies at this time.*

How can I submit additional clinical information?

Through the **provider portal** at www.eviCore.com - log in and then select "Authorization Lookup," and click on the box that indicates "upload additional clinical."

You can also **fax** clinical information to eviCore healthcare; reference the case # and member ID and DOB on each page.

Fax Pain/Joint/Spine	1-800-540-2406
Fax Med Oncology and Radiation Oncology	1-800-540-2406
Fax Genetic Testing	1-844-545-9213
Fax Sleep and Sleep DME	1-866-999-3510
Fax PT/OT	1-855-774-1319
Fax DME	1-866-663-7740

What is the most effective way to get authorization for urgent (expedited) requests?

Urgent requests are defined as a condition that is a risk to the patient's health, ability to regain maximum function and/or the patient is experiencing severe pain that require a medically urgent procedure. Urgent requests may be initiated on our web portal at www.evicore.com or by telephoning our contact center at **1-877-506-5193**. Urgent requests will be processed within 24 hours from the receipt of the request.

Note: Please select urgent for those cases that truly are urgent and not simply for a "quicker" review.
If a request is selected as urgent but does not meet guidelines to be considered urgent, the case may be reassigned as a routine case.

After I submit my request, when and how will I receive the determination?

After all clinical information is received, for normal (non- urgent) requests, a decision is made within 2-3 business days. For urgent requests, a decision is made within 24 hours (Medicare/Medicaid) and 72 hours (Commercial). The provider will be notified by e-notification or fax.

How long is the authorization valid?

Authorization timeframes can vary. Please refer to the approval letter, or authorization information on the web portal for the specific date range. If the service is not performed within *the specified timeframe* on the authorization, please contact eviCore healthcare at **1-877-506-5193.**

What are my options if I receive and adverse determination?

The referring and rendering provider will receive a denial letter that contains the reason for denial as well as post-decision options. The denial letter has the best information regarding potential next steps.

Does eviCore review cases retrospectively if no authorization was obtained?

- Retrospective requests for **Medicare** cases need to be made within 180 days from the date of service.
  - Determination letters will be sent to the member, and ordering provider, within 30 days of receipt of request.
- Retrospective requests for **Medicaid** cases need to be made within 180 days from the date of service.
  - Note: AmeriHealth Caritas New Hampshire requires retrospective requests to be made within 120 days from the date of service.
  - AmeriHealth Caritas Louisiana allows 12 months from the date of service.

All retrospective authorization requests will be reviewed for clinical urgency and medical necessity.

Retrospective Determination letters will be sent to the member and provider within 30 days of receipt; requests made by AmeriHealth Caritas District of Columbia will receive a determination letter within 14 calendar days; requests made for AmeriHealth Caritas of Pennsylvania will receive a determination letter within 15 calendar days of decision or 30 days of receipt of the request.

How do I make changes to an authorization that has been performed? How do I make changes to authorization that has not been performed?

The requesting provider or member should contact eviCore with any change to the authorization, whether or not the procedure has already been performed. It is very important to update eviCore healthcare of any changes to the authorization in order for claims to be correctly processed.

What information about the prior authorization will be visible on the eviCore healthcare website?

The Authorization Lookup function on the website will provide the following information:

- Prior Authorization Number/Case Number
- Patient Name and DOB
- Status of Request
- Service Code
- Site Name and Location
- Prior Authorization Date and Expiration Date
- Upload Clinical
- Post Decision Options

How do I determine if a provider is in network?

Participation status can be verified by calling the health plan number on the back of the member's insurance card. Providers may also contact eviCore healthcare at **1-877-506-5193**. eviCore receives a provider file from the contracted health plan with all independently contracted participating and non-participating providers.

Where do I submit my claims?

All claims will continue to be submitted directly to the health plan.

Where do I submit questions or concerns regarding this program?

For program related questions or concerns, please email: clientservices@evicore.com
Common Items to Send to Client Services include:

- Questions regarding Accuracy Assessment, Accreditation, and/or Credentialing
- Requests for an authorization to be resent to the health plan
- Consumer Engagement Inquiries
- Complaints and Grievances
- Eligibility issues (member, rendering facility, and/or ordering physician)
- Issues experienced during case creation
- Reports of system issues

Who do I contact for online support/questions?

Web portal inquiries can be emailed to portal.support@evicore.com or call 1-800-646-0418 (Option 2).

Where can I find additional educational materials?

For more information and reference documents, please visit our resource page at:
www.evicore.com/resources/healthplan/amerihealth-caritas-family-of-companies

Medical Oncology Program

Medical Oncology is not in scope for Blue Cross Complete, AmeriHealth Caritas VIP Care Plus, and AmeriHealth Caritas North Carolina; Pharmacy medications are out of scope for AmeriHealth Caritas Louisiana.

What is eviCore healthcare's Medical Oncology program?

eviCore's Medical Oncology Review Program consist of Prior Authorization Medical Necessity Determinations for all primary injectable and oral chemotherapeutic agents used in the treatment of cancer as well as select supportive agents in combination with the chemotherapy. The program also includes newly approved chemotherapy agents that are used for the treatment of cancer.

Which Medical Oncology treatments/medications require prior authorization for AmeriHealth Caritas Family of Companies?

- Primary Injectable and Oral Chemotherapy – Part B medications **only** [MEDICARE SPECIFIC]
- Supportive Medications given with Chemotherapy
- The list of affected drugs can be viewed on www.evicore.com/resources/healthplan/amerihealth-caritas-family-of-companies
  - *Find the Health Plan > Select Solution Resources> Select Medical Oncology > Select CPT Code List*
- Additionally, drugs covered under this program, but are being used to treat non-cancer conditions may still require prior authorization through AmeriHealth Caritas Family of Companies. Contact the number on the ID card to confirm requirements.

What is covered in my authorization?

- All drugs that are included in the treatment regimen – there are no partial approvals
- The HCPC codes associated with the approved drugs
- The time period indicated on the authorization (8-14 months)

How often do I need to update my authorization?

- When the authorization time has expired
- When there is a change in treatment including new or different drugs.
- An update is not need if an approved drug is no longer being administered as a part of the approved regimen

Radiation Oncology Program

Which Radiation Oncology treatments require prior authorization for AmeriHealth Caritas Family of Companies?

eviCore healthcare relies on information about the patient's unique presentation and physician's intended treatment plan to authorize all services from the initial simulation through the delivery of the last fraction of radiation. Such techniques include:

- Conventional Isodose Planning, Complex
- 3D Conformal
- Intensity-Modulated Radiation Therapy (IMRT)
- Image-Guided Radiation Therapy (IGRT)
- Stereotactic Radiosurgery (SRS)
- Stereotactic Body Radiation Therapy (SBRT)
- Brachytherapy
- Radiopharmaceuticals - ***out of scope for AmeriHealth Caritas North Carolina***
- Hyperthermia
- Proton Beam Therapy - ***not a covered benefit for adults 21 years and older for AmeriHealth Caritas North Carolina***
- Neutron Beam Therapy

The list of codes managed by the eviCore Radiation Oncology program can be viewed on the provider resource website at www.evicore.com/resources/healthplan/amerihealth-caritas-family-of-companies

- *Find the Health Plan > Select Solution Resources> Select Radiation Oncology > Select CPT Code List*

What clinical information is required when requesting prior authorization?

- Diagnosis/ICD-10
- Start date of treatment
  - Do not enter the simulation date nor the date on which authorization became required through eviCore
  - When asked, enter the FIRST treatment delivery date for the patient's course of treatment
- Cancer type to be treated*
- Completed physician worksheet and/or request form as applicable

***The requester will be asked to select the cancer type as part of the case build process**

- If a non-cancerous diagnosis is being treated then specify "non-cancerous" indication during case build
- If eviCore does not have a cancer or non-cancerous selection that fits the diagnosis, then please specify "Other" cancer type during case build.
- Individual CPT and HCPCS codes are not specifically requested for review as part of the Radiation Oncology prior authorization process.

Note:

- The intended treatment plan is reviewed against the evidence-based guidelines developed by the eviCore Medical Advisory Board. LCDs and NCDs are followed for Medicare cases. In some states, there may be an existing state policy that will first be applied to the case review before application of the eviCore guidelines.
- eviCore healthcare will review all lesions to be treated as a single episode of care. If there is uncertainty regarding synchronous cancers or treatment of multiple lesions please call and request to speak to a clinical reviewer.

Do I need a separate pre-service authorization number for each service code requested?

eviCore healthcare will assign one authorization number per treatment plan with a decision for medical necessity. Radiation Oncology authorizations are not built by individual CPT code, but instead by cancer type. The requester will be redirected to choose the appropriate cancer type or site of treatment (ex: Breast Cancer) if attempting to select a CPT Code and HCPCS code.

What is included in a Radiation Oncology Prior Authorization Request?

- The pre-service authorization written notifications will communicate approved and denied services, which include the treatment technique, number of phases, number of fractions and approval, or denial, of Image Guided Radiation Therapy (IGRT). *Example: 10 fractions of 3D conformal treatment to treat Breast Cancer.*

- If Image Guidance Radiation Therapy (IGRT) is requested it may or may not be approved, separate from the primary treatment technique; this will be communicated in the case notifications. The eviCore IGRT Policy is included in our guidelines on www.eviCore.com

How long is an authorization valid?

Radiation Oncology authorizations are valid for varying periods of time. The authorization timespan is dependent on the cancer type and treatment plan. The timespan will be communicated by eviCore on the authorization letter. **It is critical the provider contact eviCore healthcare if the services are not performed within the provided timeframe for the authorization.** eviCore should be contacted prior to billing for the services that will fall outside of the timespan of the authorization.

All eviCore authorization effective dates are determined based on the start date of Radiation Oncology treatment. The date is set to be 14 calendar days from whichever of the following dates falls earlier in time: treatment start date or episode date (case initiation date). This 14-day window is to allow for simulation and planning procedures prior to the initiation of radiation treatment.

If the simulation and/or planning occurred, but the treatment begins after the required date for authorizations through eviCore, will it need authorization?

Yes, an authorization is required if any of the relevant dates of service fall after the date on which authorization become required through eviCore.

Genetic Testing Program

Genetic Testing is out of scope for Keystone First Community Health Choices

Which Genetic Testing services require prior authorization for AmeriHealth Caritas Family of Companies?

- Hereditary Cancer Syndromes
- Carrier Screening Tests
- Tumor Marker / Molecular Profiling
- Hereditary Cardiac Disorders
- Cardiovascular Disease and Thrombosis Risk Variant Testing
- Pharmacogenomics Testing
- Neurologic Disorders
- Mitochondrial Disease Testing
- Intellectual Disability / Developmental Disorders

What clinical information is required for a prior authorization request for a genetic test?

- Details about the test being performed (test name, description and/or unique identifier)
- All information required by applicable policy
- Test indication, including any applicable signs and symptoms or other reasons for testing
- Any applicable test results (laboratory, imaging, pathology, etc.)
- Any applicable family history
- How test results will impact patient care

Outpatient Physical and Occupational Therapy Program

Which Musculoskeletal Outpatient Therapy services require prior authorization for AmeriHealth Caritas Family of Companies?

- Occupational Therapy
- Physical Therapy

Am I required to wait for pre-authorization before treating my patient?

You can perform the initial evaluation and provide treatment on the initial date of service without the need for prior authorization. For any treatment after this, prior authorization is required through eviCore. If treatment is initiated on a different date than the initial evaluation date, you will need to obtain prior authorization before the initial treatment visit occurs.

When should a pre-service authorization request be submitted for therapy services?

When submitting your initial request for authorization, the clinical information obtained from the initial evaluation will help you create your authorization request. If additional therapy is required after the initial request, requests for ongoing care can be submitted as early as seven (7) days prior to the requested start date. The current findings date on your pre-service

authorization request should be within 14 days of your requested start date. Delays may occur if the request is made too far in advance and/or if the clinical information is incomplete or too old.

How many visits and units will eviCore approve when I submit a pre-service authorization request?

The number of visits and units approved will vary based on the condition/complexity/response to care. When the requested care is medically necessary, eviCore will approve a number of visits/units to be used over a specific period to treat the patient's condition, demonstrate progress, and allow for a meaningful evaluation of the need to continue care beyond what has already been approved.

- For **Blue Cross Complete of Michigan** members, prior authorization for outpatient OT and PT, and home health OT and PT is required **after** the member has had 24 visits per calendar year.

- For **AmeriHealth Caritas North Carolina** members, there is a maximum of 27 visits combined for members 21 years old and older for outpatient OT and PT per calendar year; there is no limit for members under 21.

***Requests for Speech Therapy should be submitted to the health plan; eviCore is not delegated to manage speech therapy for AmeriHealth Caritas Family of Companies.**

Musculoskeletal Pain Management, Joint and Spine Procedures Program

Which Pain Management and Joint/Spine procedures require prior authorization for AmeriHealth Caritas Family of Companies?

Interventional Pain

- Spinal injections (Includes Sacroiliac Joint, Epidural steroid injections, Facet Joint injections, Regional Sympathetic Blocks)
- Chemodenervation – Botulinum Toxin Injections
- Radiofrequency Joint Ablation Denervation
- Spinal implants
    - Spinal cord stimulators
    - Pain pumps (implantable intrathecal drug delivery system)

Joint Surgery

- Large joint replacement (includes Hip, Knee, and Shoulder
- Arthroscopic and open procedures (includes Hip, Knee, and Shoulder)

Spine Surgery

- Spinal Implants
    - Electrical bone growth stimulators
    - Pain Pumps (implantable intrathecal drug delivery system)
    - Graft (implant – Allograft/Autograft)
- Cervical/ Lumbar
    - Decompressions
    - Fusions
    - Total Disc Arthroplasty (Cervical/Lumbar)
    - Vertebroplasty/Kyphoplasty
    - Microdiscectomy (Cervical/Lumbar)

Will eviCore manage authorization requests for inpatient stays for joint and spine surgeries?

Yes. eviCore will review Spine and Joint surgery requests for medical necessity and make a determination based on the clinical information provided. Additionally, eviCore will collect the requested place of service. If an inpatient stay is deemed medically necessary, eviCore will communicate the appropriate length of the inpatient stay in the determination letter.

Does eviCore manage concurrent bed days for inpatient admissions?

No. eviCore does not provide concurrent bed day management for inpatient admissions. All modifications/extensions to the approved length of stay are managed by the health plan using their existing concurrent review process.

The list of codes managed by the eviCore MSK program can be viewed on the provider resource website at www.evicore.com/resources/healthplan/amerihealth-caritas-family-of-companies

- *Find the Health Plan > Select Solution Resources> Select Musculoskeletal Advanced Procedures > Select CPT Code List*

eviCore's clinical guidelines are available online 24/7 and can be found by visiting the following link: www.evicore.com/provider/clinical-guidelines

Durable Medical Equipment Program

****DME is not in scope for* AmeriHealth Caritas Florida, AmeriHealth Caritas VIP Care Florida, or Blue Cross Complete of Michigan.**

Which Durable Medical Equipment services require prior authorization for AmeriHealth Caritas Family of Companies?

Precertification applies to the following DME Requests:

- Home based
- Medically necessary
- Active rentals for HCPCS codes that currently do not have a pre-certification through the health plan but require pre-certification
- DME HCPCS code list is subject to change so please refer to our Provider Newsletter, provider resources site or Durable Medical Equipment announcements that are sent out

For any hospital discharges contingent upon DME precertification approvals, the DME supplier should either:

- Fax supporting clinical documentation and indicate "**Pending Discharge**" on the fax cover sheet or precertification form
- Call eviCore at **1-877-506-5193**
- Indicate, **"Hospital discharge is pending DME precertification"** during the clinical intake discussion - eviCore will offer prompt nurse review to help support customer discharge goals

The list of codes managed by the eviCore DME program can be viewed on the provider resource website at www.evicore.com/resources/healthplan/amerihealth-caritas-family-of-companies

- *Find the Health Plan > Select Solution Resources> Select DME > Select CPT Code List*

Sleet Diagnostic Testing Program

**** eviCore healthcare is not delegated to manage prior authorization requests for Sleep DME for AmeriHealth Caritas Florida, AmeriHealth Caritas VIP Care Florida, or Blue Cross Complete of Michigan.**

Which Sleep services require prior authorization for AmeriHealth Caritas Family of Companies?

- Polysomnography
- PAP Titration
- Split-Night Studies
- Home Sleep Testing

- Home APAP Titration
- PAP Therapy Devices and Supplies*
- Oral Appliances*

After initial PAP therapy has been authorized, is a second authorization needed for rental to purchase of the PAP device?
Yes. If the member's use of their PAP therapy during the initial 90 day period meets usage criteria, DME providers will need to fax the usage data to eviCore. eviCore will review the data and if the usage meets criteria, an authorization for continued rental to purchase will be provided.

The list of codes managed by the eviCore Sleep DME program can be viewed on the provider resource website at www.evicore.com/resources/healthplan/amerihealth-caritas-family-of-companies

- *Find the Health Plan > Select Solution Resources> Select Sleep > Select CPT Code List*