Musculoskeletal Management
Interventional Pain and Joint Surgery

Provider Orientation Presentation for Cigna

Agenda

- Company Overview
- Clinical Approach
- Program Overview
- Submitting Requests
- Prior Authorization Outcomes & Special Considerations
- Reconsideration Options
- Provider Portal Overview
- Additional Provider Portal Features
- Provider Resources
- Q & A

Company Overview

Medical Benefits Management (MBM)

Addressing the complexity of the healthcare system

10 Comprehensive solutions

Evidence-based clinical guidelines

5k+ employees, including **1k+ clinicians**

Advanced, innovative, and intelligent technology

Clinical Approach

Evidence-Based Guidelines

The foundation of our solutions

Dedicated pediatric guidelines

Contributions from a panel of community physicians

Experts associated with academic institutions

Current clinical literature

Aligned with National Societies:

- American College of Cardiology
- American Heart Association
- American Society of Nuclear Cardiology
- Heart Rhythm Society
- American College of Radiology
- American Academy of Neurology
- American College of Chest Physicians
- American College of Rheumatology
- American Academy of Sleep Medicine
- American Urological Association

- National Comprehensive Cancer Network
- American Society for Radiation Oncology
- American Society of Clinical Oncology
- American Academy of Pediatrics
- American Society of Colon and Rectal Surgeons
- American Academy of Orthopedic Surgeons
- North American Spine Society
- American Association of Neurological Surgeons
- American College of Obstetricians and Gynecologists
- The Society of Maternal-Fetal Medicine

Clinical Staffing – Multispecialty Expertise

Dedicated nursing and physician specialty teams for a wide range of solutions

- **Anesthesiology**
- **Cardiology**
- **Chiropractic**
- **Emergency Medicine**
- **Family Medicine**
  - Family Medicine / OMT
  - Public Health & General Preventative Medicine
- **Gastroenterology**
- **Internal Medicine**
  - Cardiovascular Disease
  - Critical Care Medicine
  - Endocrinology, Diabetes & Metabolism
  - Geriatric Medicine
  - Hematology
  - Hospice & Palliative Medicine
  - Medical Oncology
  - Pulmonary Disease
  - Rheumatology
  - Sleep Medicine
  - Sports Medicine

- **Medical Genetics**
- **Nuclear Medicine**
- **OB / GYN**
  - Maternal-Fetal Medicine
- **Oncology / Hematology**
- **Orthopedic Surgery**
- **Otolaryngology**
- **Pain Mgmt. / Interventional Pain**
- **Pathology**
  - Clinical Pathology
- **Pediatric**
  - Pediatric Cardiology
  - Pediatric Hematology-Oncology
- **Physical Medicine & Rehabilitation**
  - Pain Medicine
- **Physical Therapy**
- **Radiation Oncology**
- **Radiology**
  - Diagnostic Radiology
  - Neuroradiology
  - Radiation Oncology
  - Vascular & Interventional Radiology

- **Sleep Medicine**
- **Sports Medicine**
- **Surgery**
  - Cardiac
  - General
  - Neurological
  - Spine
  - Thoracic
  - Vascular
- **Urology**
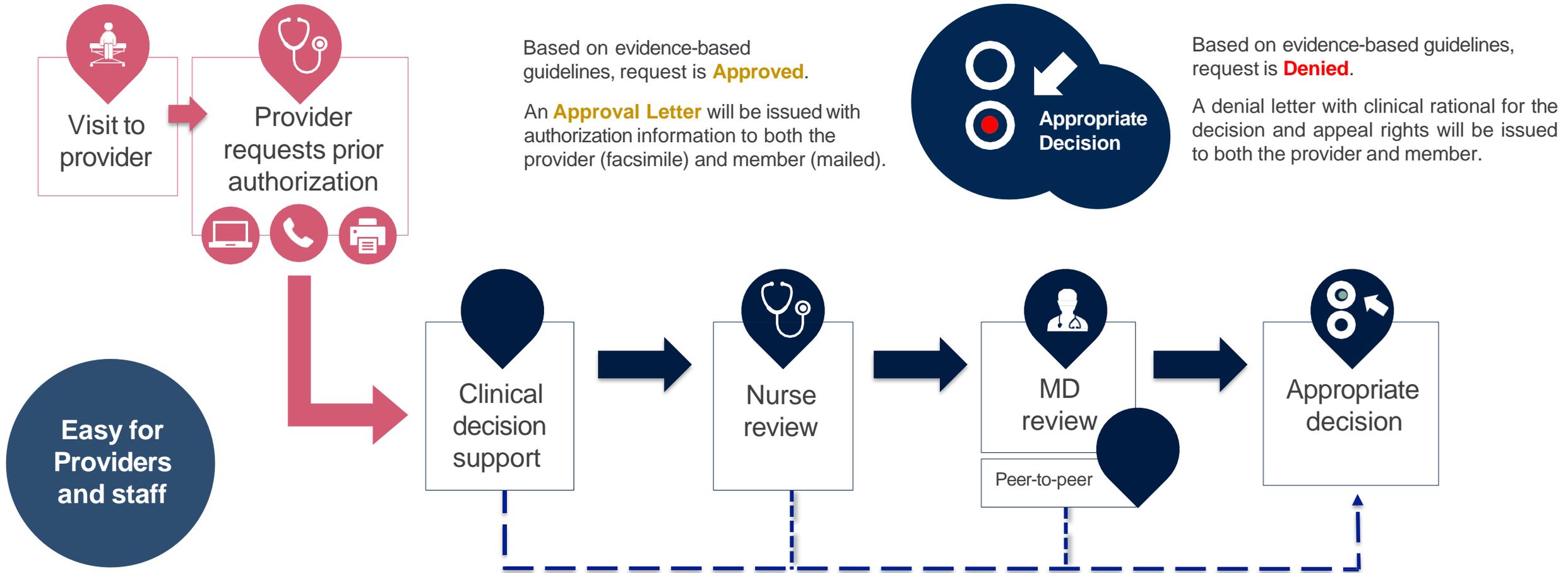
400+ medical directors

Covering **51** specialties

1k+ nurses

Utilization Management – the Prior Authorization Process

Visit to provider

Provider requests prior authorization

Based on evidence-based guidelines, request is **Approved**.

An **Approval Letter** will be issued with authorization information to both the provider (facsimile) and member (mailed).

Appropriate Decision

Based on evidence-based guidelines, request is **Denied**.

A denial letter with clinical rational for the decision and appeal rights will be issued to both the provider and member.

Easy for Providers and staff

Clinical decision support

Nurse review

MD review

Peer-to-peer

Appropriate decision

Program Overview

Cigna Prior Authorization Services

eviCore healthcare (eviCore) will began accepting prior authorization requests for musculoskeletal services on December 15, 2015 for dates of service January 1, 2016 and after.

Prior authorization applies to the following services:	Prior authorization does **NOT** apply to services performed in:
• Outpatient • Inpatient • Elective / Non-emergent	• Emergency Rooms • Observation Services

Providers should verify member eligibility and benefits on the secured provider log-in section at: https://cignaforhcp.cigna.com/

Applicable Memberships

Prior authorization is required for the following membership:

- All Core HMO and PPO/OAP membership
  - PHS members (inpatient)
  - PHS+ members (inpatient/outpatient)
  - Cigna West
- Medicare Advantage (AZ only)
- Global Health (GHB)
- SAR & Payer Solutions (select plans)
- LocalPlus and Individual
- Narrow networks (Surefit, Connect/Focusin)
- Cigna membership in Alliance territories
- Transplant membership

Applicable Memberships

Prior authorization is not required for the following membership:

- Hawaii, Puerto Rico and Guam
- California HMO
- CareLink membership (MA/RI)
- Alliance membership (including HAP and MVP)
- SAR & Payer Solutions (select plans)
- Seton DSA
- Other external vendor manager members (RPO, Kelsey, MH)

Prior Authorization Required:

Interventional Pain:
- Spinal injections
- Spinal implants
  - Spinal cord stimulators
  - Pain pumps

Joint Surgery (Hip, Knee, Shoulder):
- Large joint replacement
- Arthroscopic and open procedures

To find a complete list of Current Procedural Terminology (CPT) codes that require prior authorization through eviCore, please visit:

https://www.evicore.com/resources/healthplan/cigna

Joint Surgery Requirements

Partial Knee and Total Knee Replacement is considered medically necessary when all of the following criteria have been met:

- Function-limiting pain at short distances (e.g. walking less than ¼ mile, limiting activity to two city blocks, the equivalent to walking the length of a shopping mall) for at least 3 months duration.
- Loss of knee function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment.

Radiographic or arthroscopic findings of either of the following:

- Severe unicompartmental (medial, lateral, or patellofemoral) degenerative arthritis evidenced by either Large osteophytes, marked narrowing of joint space, severe sclerosis, and definite deformity of bone contour (i.e., Kellgren-Lawrence Grade IV radiographic findings) or Exposed subchondral bone (i.e., Modified Outerbridge Classification Grade IV arthroscopy findings)
- Avascular necrosis (AVN) of the femoral condyles and/or proximal tibia.
- Intact, stable ligaments, in particular the anterior cruciate ligament
- Knee arc of motion (full extension to full flexion) greater than 90 degrees

Failure of at least 3 months of provider directed non-surgical management.

- For patients with BMI > 40, there must be failure of a least 6 months of provider directed non-surgical management
- Provider directed non-surgical management may be inappropriate. The medical record must clearly document why provider directed non-surgical management is not appropriate.

Total knee replacement is considered medically necessary for a fracture of the distal femur when conservative management or surgical fixation is not considered a reasonable option.

Joint Surgery Requirements

The determination of medical necessity for the performance of shoulder surgery is always made on a case by case basis.

Shoulder arthroscopic or open surgical procedures may be considered medically necessary for individuals when surgery is being performed for fracture, tumor, infection or foreign body that has led to or will likely lead to progressive destruction.

Diagnostic Arthroscopy is considered medically necessary as a separate procedure when all of the following criteria have been met:

Function limiting pain (e.g. loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and /or demands of employment for at least 6 months in duration).

Individual demonstrates any of the following abnormal shoulder physical examination findings as compared to the non involved side.
- Functionally limited range of motion (active or passive)
- Measurable loss in strength
- Positive Neer Impingement Test or Hawkins-Kennedy Impingement Test.
- Failure of provider directed non-surgical management for at least 3 months in duration.
- Advanced diagnostic imaging study (e.g., MRI; CT) is inconclusive for internal derangement/pathology
- Other potential pathological conditions including, but not limited to: fracture, thoracic outlet syndrome, brachial plexus disorders, referred neck pain, and advanced glenohumeral osteoarthritis have been excluded.

Diagnostic arthroscopy is considered not medically necessary for any other indication or condition.

eviCore Musculoskeletal Guidelines for Advanced Procedures:

https://www.evicore.com/provider/clinical-guidelines-details?solution=musculoskeletal%20advanced%20procedures

Interventional Pain Requirements

- Interventional Pain procedures require a separate pre-service authorization request for each date of service. The patients response to prior interventional pain injections will determine if a subsequent injection is appropriate. ***Including the response to the prior interventional pain injection in the office notes will help avoid processing delays.

- For an epidural injection, a patient must have a radiculopathy or radicular pattern confirmed on imaging or EMG/NCS. For a facet procedure, loading of the joint in extension and lateral rotation is needed. For sacroiliac joint injection, a patient must have 3 or 5 positive stress maneuvers of the sacroiliac joint.

- An epidural injection and facet joint injection in the same region is not allowed, except when there is a facet joint cyst compressing the exiting nerve root.

- No more than 1 level interlaminar epidural, 1 nerve root selective nerve root block, 2 level therapeutic transforaminal epidural, 3 level facet/medial branch nerve blocks are indicated in a single session.

- 6 weeks of conservative care is need prior to an epidural steroid injection. 4 weeks of conservative care is needed prior to facet/medial branch nerve blocks and sacroiliac joint injections.

- For cervical and thoracic epidural injections, advanced imaging must be performed within the last 12 months.

- Fluoroscopic or CT scan image guidance is required for all interventional pain injections.

- The limit of diagnostic facet/medial branch nerve blocks is 2 prior to possible radiofrequency ablation. The limit of epidural steroid injections is 3 per episode and 4 per 12 month period.

Interventional Pain Requirements continued

Epidural injections require a 2 week outcome prior to preauthorization of a subsequent epidural. Radiofrequency ablation of the medial branch nerves from C2 – 3 to L5 – S1 require a 6 week interval.

An epidural steroid injection must have a least 2 of the following:

50% or greater relief of radicular pain.
Increased level of function/physical activity.
And or decreased use of medication and/or additional medical services such as Physical Therapy/Chiropractic care.

A diagnostic facet/medial branch nerve block must have at least 80% relief from the anesthetic. 2 facet/medial branch nerve blocks with a least 80% relief are needed for radiofrequency ablation.

A therapeutic sacroiliac joint injection following a diagnostic joint injection must have >75% pain relief.

A repeat therapeutic sacroiliac joint injection must have >75% pain relief and either an increase in level function or reduction in use of pain medication and/or medical services such as PT/Chiropractic care.

Submitting Requests

Methods to Submit Prior Authorization Requests

eviCore Provider Portal (preferred)

The eviCore online portal www.eviCore.com is the quickest, most efficient way to request prior authorization and check authorization status, and it's available 24/7

Phone Number:
888-693-3297
Monday through Friday:
7 am – 8 pm CST

Fax Number:
888-693-3210
PA requests are accepted via fax and can be used to submit additional clinical information

WEB
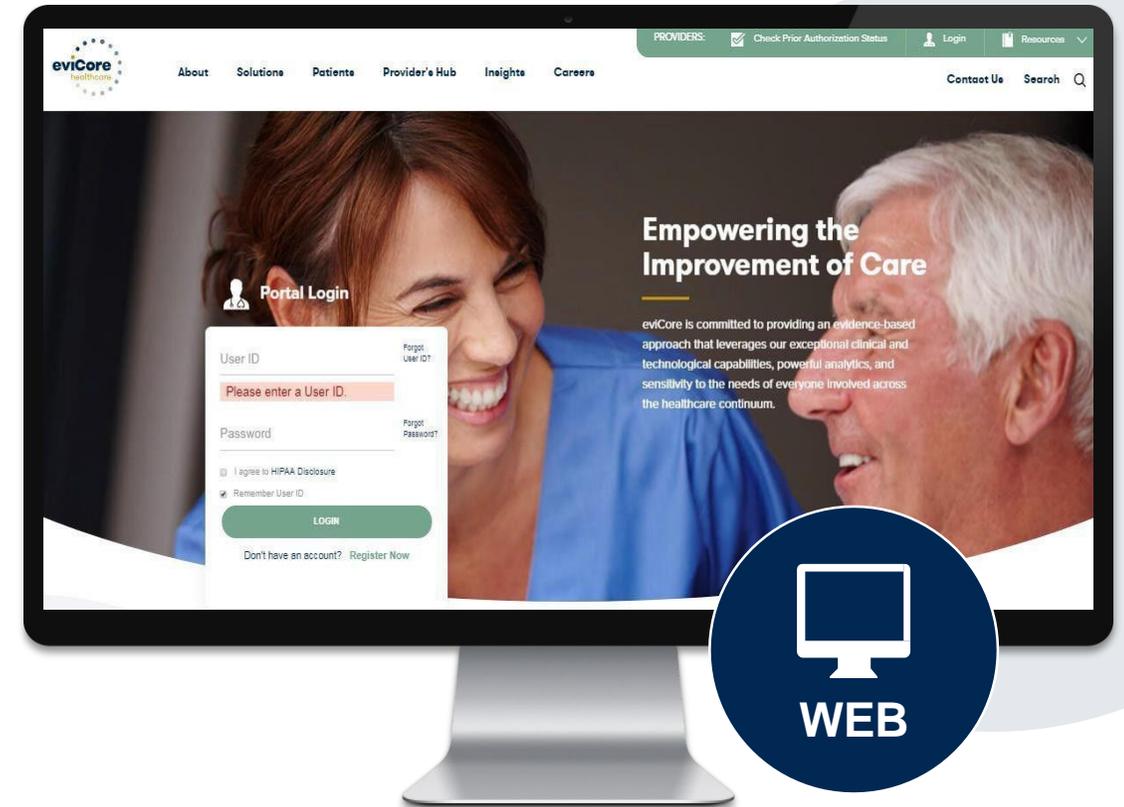
Benefits of Provider Portal

Did you know that most providers are already saving time submitting prior authorization requests online? The provider portal allows you to go from request to approval faster. Following are some benefits & features:

- Saves time: Quicker process than phone authorization requests

- Available 24/7: You can access the portal any time and any day

- Save your progress: If you need to step away, you can save your progress and resume later

- Upload additional clinical information: No need to fax in supporting clinical documentation, it can be uploaded on the portal to support a new request or when additional information is requested

- View and print determination information: Check case status in real-time

- Dashboard: View all recently submitted cases

Keys to Successful Prior Authorizations

To obtain prior authorization on the very first submission, the provider submitting the request will need to gather four categories of information:

1. Member
- ID
- Member name
- Date of birth (DOB)

2. Referring (Ordering) Physician
- Physician name
- National provider identifier (NPI)
- Phone & fax number

Necessary Information

3. Rendering Facility
- Facility name
- Address
- National provider identifier (NPI)
- Tax identification number (TIN)
- Phone & fax number

4. Supporting Clinical
- Pertinent clinical information to substantiate medical necessity for the requested service
- CPT/HCPCS Code(s)
- Diagnosis Code(s)
- Previous test results

Insufficient Clinical – Additional Documentation Needed

Additional Documentation to Support Medical Necessity

If all required pieces of documentation are not received, or are insufficient for eviCore to reach a determination, the following will occur:
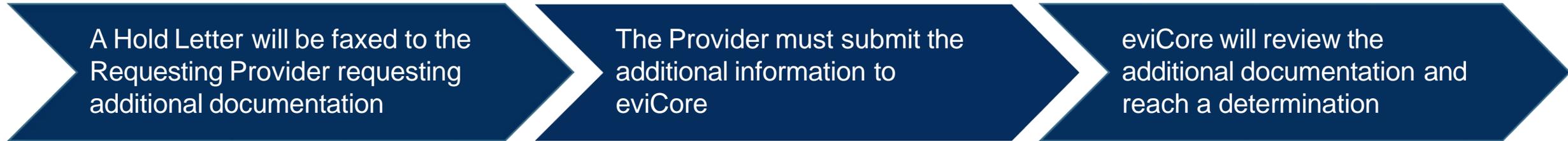
A Hold Letter will be faxed to the Requesting Provider requesting additional documentation	The Provider must submit the additional information to eviCore	eviCore will review the additional documentation and reach a determination
To ensure that a determination is completed within the designated timeframe for each LOB, the case will remain on hold as follows: • Commercial: 45 calendar days	Requested information must be received within the timeframe as specified in the Hold Letter.	Determination will be completed within 2 business days

Appropriate Decision

Prior Authorization Outcomes & Special Considerations

Prior Authorization Approval

Approved Requests

- Standard requests are processed within 2 business days after receipt of all necessary clinical information

- Authorizations are valid for 90 days from the initial request or for the approved inpatient length of stay

- Authorization letters will be faxed to the ordering physician & rendering facility

- When initiating a case on the web you can receive e-notifications when a determination is made

- Members will receive a letter by mail

- Approval information can be printed on demand from the eviCore portal: www.eviCore.com

When a Request is Determined as Inappropriate

Appropriate Decision

Based on evidence-based guidelines, request is determined as **inappropriate**.

A denial letter with the rationale for the decision and the appeal rights will be issued to both the provider and member.

Special Circumstances

Retrospective (Retro) Authorization Requests

- Payer Solutions and SAR membership: Must be submitted within 365 business days from the date of service (all requests beyond 365 day, a claim can be submitted)

- All other Commercial membership: Must be submitted within 15 business days from the date of services (all requests beyond 15 days, a claim can be submitted)

- Reviewed for **clinical urgency** and medical necessity

- Retro requests are processed within 30 business days

- When authorized, the start date will be the submitted date of service

Urgent Prior Authorization Requests

- eviCore uses the NCQA/URAC definition of **urgent**: when a delay in decision-making may seriously jeopardize the life or health of the member

- Can be initiated on provider portal or by phone

- Urgent request will be reviewed within 24 hours

Special Circumstances cont.

Alternative Recommendation

- An alternative recommendation may be offered, based on eviCore's evidence-based clinical guidelines

- The ordering provider can either accept the alternative recommendation or request a reconsideration for the original request

Authorization Update

- If updates are needed on an existing authorization, you can contact eviCore by phone

- If the authorization is not updated and a different facility location or CPT code is submitted on the claim, it may result in a claim denial

Adding Studies and CPT Code Changes

Requests may be submitted by the ordering provider or rendering facility. Requests must meet medical necessity criteria. Timeframes for the requested change vary by setting:

Inpatient

- You may change the date of service to any future date, change the facility or update a CPT code with three exceptions:
  - If the DOS currently on the case is within 1 business day of the current date
  - If the DOS requested is within 1 business day of the current date
  - If the DOS currently on the case is today or has already occurred (i.e. retrospective update)

Outpatient

- Facility change requests may be made at any time
- CPT change requests may be within 15 business days from the date of service

Reconsideration Options

Post-Decision Options

My case has been denied. What's next?

- Providers are often able to utilize post-decision activity to secure case review for overturn consideration

- Your determination letter is the best immediate source of information to assess what options exist on a case that has been denied. You can also call us at 888-693-3297 to speak to an agent who can provide available option(s) and instruction on how to proceed.

Post-Decision Options: Commercial

My case has been denied. What's next?

Clinical Consultation

- Providers can request a Clinical Consultation with an eviCore physician for overturn consideration prior to submission of a formal reconsideration or appeal

Reconsiderations

- Providers and/or staff can request a reconsideration review
- Reconsiderations can be requested in writing or verbally with a Reconsideration nurse

Appeals

- eviCore will process first-level clinical appeals
- All clinical information and the prior authorization request will be reviewed by a physician other than the physician who made the initial determination
- Appeal requests can be submitted in writing through eviCore by:
  - Mail: 730 Cool Springs Blvd, Ste. 800, Franklin, TN 37067
  - Fax: 615-468-4469
  - Email: appealsclaimissues@eviCore.com
- A written notice of the appeal decision will be mailed to the member and faxed to the ordering provider

Provider Portal Overview

Portal Compatibility

The eviCore.com website is compatible with the following web browsers:

- Google Chrome

- Mozilla Firefox

- Microsoft Edge

You may need to disable pop-up blockers to access the site. For information on how to disable pop-up blockers for any of these web browsers, please refer to our Disabling Pop-Up Blockers guide.

eviCore healthcare Website

Visit **www.evicore.com**

Already a user?

If you already have access to eviCore's online portal, simply log-in with your User ID and Password and begin submitting requests in real-time!

Don't have an account?

Click "Register Now" and provide the necessary information to receive access today!
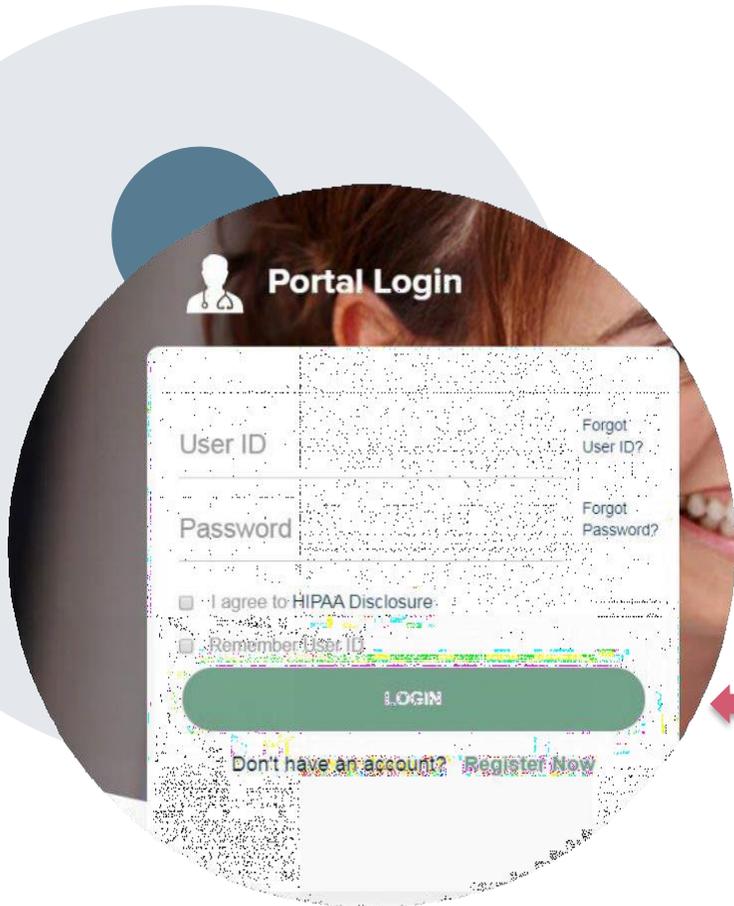
eviCore healthcare website

- Point web browser to evicore.com

- Click on the "Providers" link

- Login or Register

Providers Delivering Medical Solutions That Benefit **Everyone.**

User ID

Password

☐ Remember User ID

For log in problems: please try the email address that you registered with as your user name. If you do not remember your password, please click "Password?".

☐ I Agree to HIPAA Disclosure!

LOGIN

Forgot UserName | Password? | Register

This website is compatible with Internet Explorer 9, 10, 11, Mozilla Firefox and Google Chrome

Creating An Account

Providers Delivering Medical
Solutions That Benefit **Everyone.**

| User ID |
| Password |

☐ Remember User ID

For log in problems: please try the email address that you registered with as your user name. If you do not remember your password, please click "Password?".

☐ I Agree to HIPAA Disclosure!

LOGIN

Forgot UserName | Password? | Register
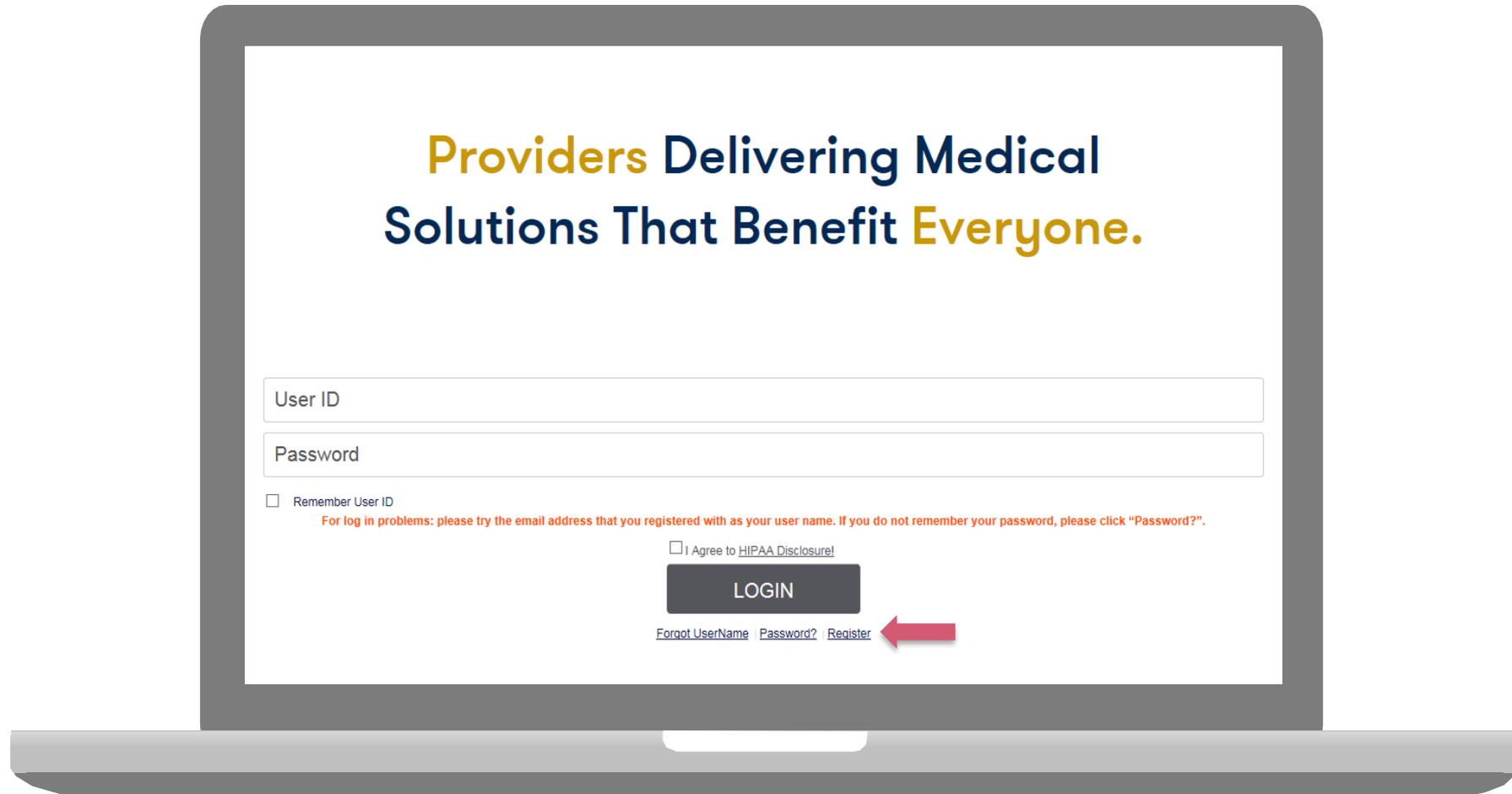
To create a new account, click Register.

Creating An Account

Select a **Default Portal**. Choose the **Account Type**, and complete the registration form. There are (4) account types: Facility, Physician, Billing Office, and Health Plan

Creating An Account

Review information provided, and click "Submit Registration."

User Registration-Continued
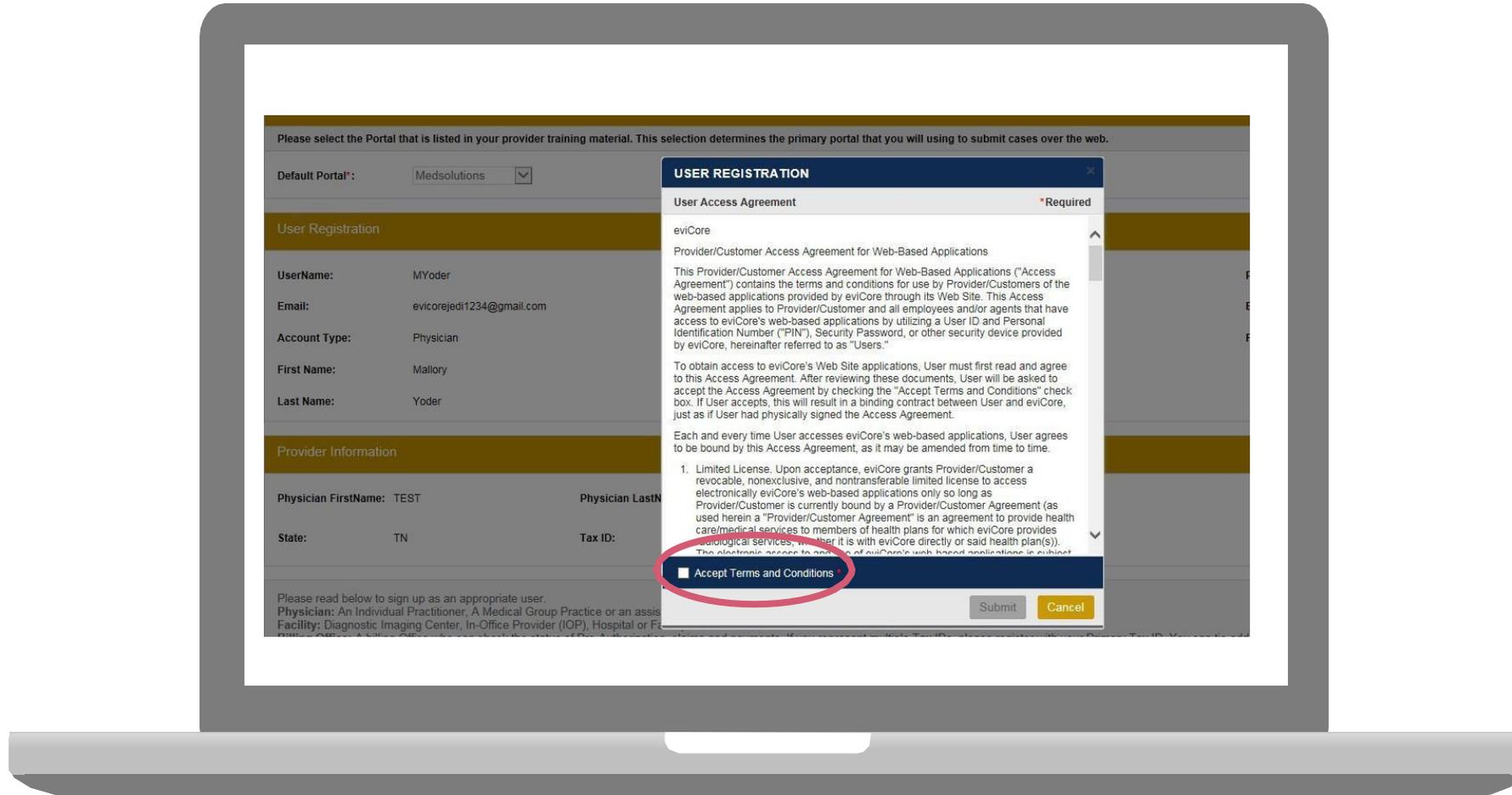
Accept the Terms and Conditions, and click "Submit."

User Registration-Continued

➤ **You will receive a message on the screen confirming your registration is successful. You will be sent an email to create your password.**

Create a Password

Your password must be at least (8) characters long and contain the following:

✓ Uppercase letters

✓ Lowercase letters

✓ Numbers

✓ Characters (e.g., ! ? *)
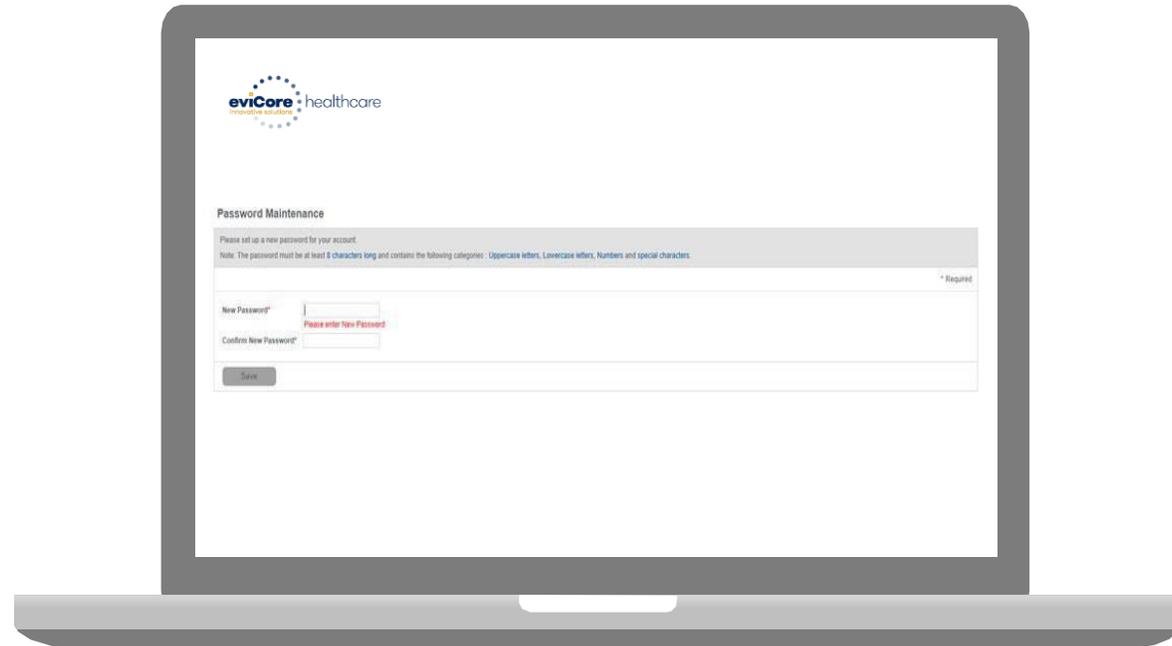
Web Account Overview

Account Log-In

Providers Delivering Medical Solutions That Benefit **Everyone.**

Mallory1897

●●●●●●●●

☐ Remember User ID

For log in problems: please try the email address that you registered with as your user name. If you do not remember your password, please click "Password?".

☑ I Agree to HIPAA Disclosure!

LOGIN

Forgot UserName | Password? | Register
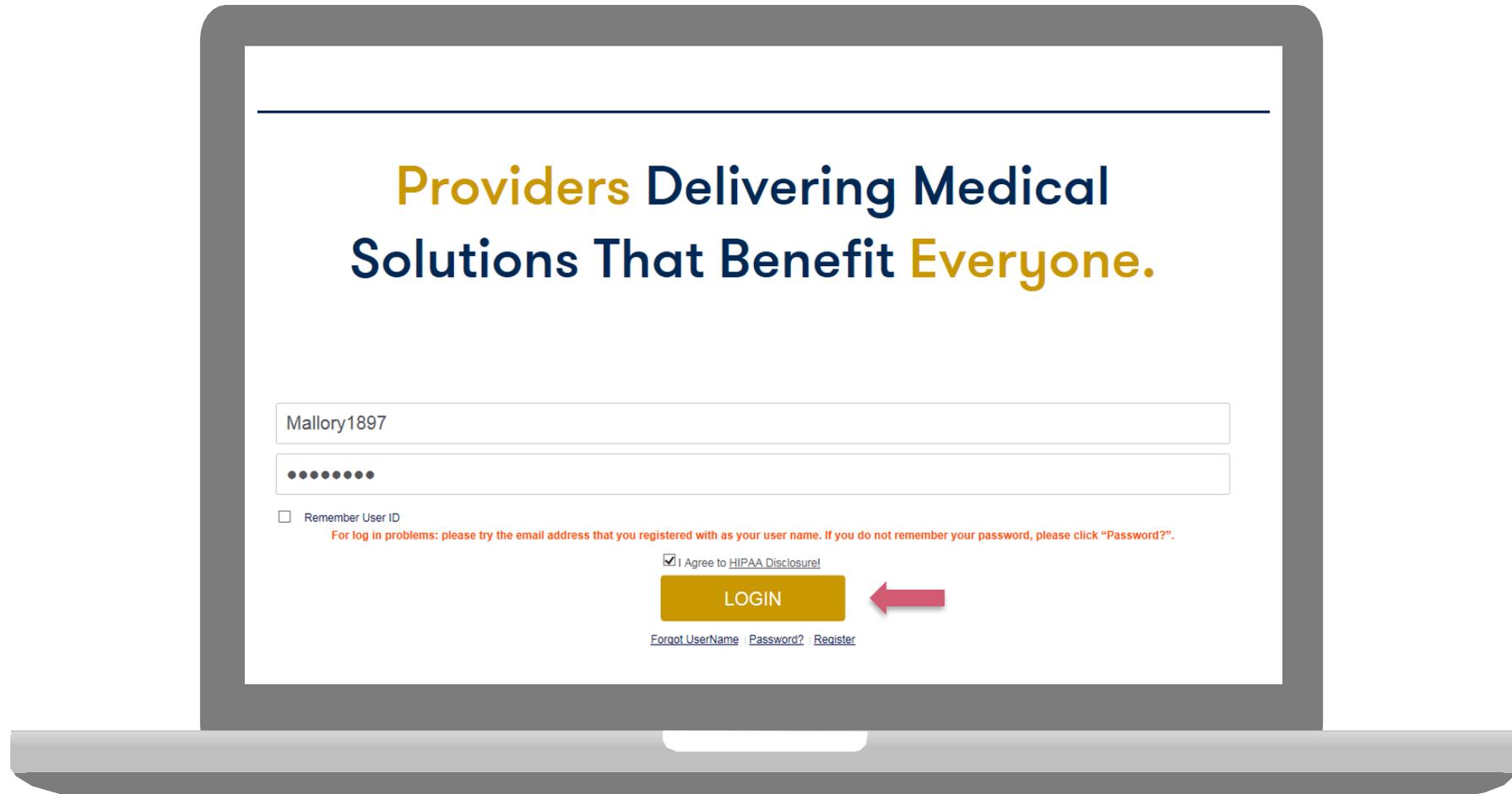
To log-in to your account, enter your **User ID** and **Password**. Agree to the HIPAA Disclosure, and click "**Login.**"

Announcement

Once you have logged in to the site, you will be directed to the main landing page that includes important announcements.

Note: You can access the CareCore National Portal at any time if you are registered. Click the CareCore National Portal button on the top right corner to seamlessly toggle back and forth between the two portals without having to log-in multiple accounts.

Account Settings

The **Options Tool** allows you to access your Account Settings to update information:

- Change password
- Update user account information (address, phone number, etc.)
- Set up preferred Tax ID numbers of Physicians or Facilities

Account Settings

Adding **Preferred Tax ID numbers** will allow you to view the summary of cases submitted for those providers:

- Search for a Tax ID by clicking **Physician** or **Facility**.
- Confirm you are authorized to access PHI by clicking the check box, and hit Save.

Search/Start Case

Home Tab

The Home Page will have <u>two</u> worklists: **My Pending Worklist** and **Recently Submitted Cases**

My Pending Worklist

- Save case information and complete case at a later time
- Submit additional clinical to a pending case after submission without having to fax

Recently Submitted Cases

- Cases that are pending review and/or cases recently approved or denied

To conduct a **Patient Lookup**, first select the appropriate insurance company from the *Insurer* drop down. Next, enter the *Member ID* or *First Name, Last Name* and *Date of Birth* for the result to be returned.

For **Case/Auth Lookup**, you will only need to enter the *Case ID* or *Auth Number* at the bottom of the page and hit **Search**.

Search/Start Case – Member Lookup

Patient Search Result(s)   ?

Member ID	Patient Name	Date Of Birth	Gender	Address	Program	Program Effective Date	Program Term
XYZ00002	HILL, BOBBY	02/01/1974				009	12/31/2999

PLEASE MAKE SURE YOU ARE SELECTING THE COR...   STARTING A NEW REQUEST

> If a partial ID is put in the search box, a list of members will populate. A member can be selected once the member is highlighted blue. Please make sure you select the correct patient by verifying the patient's name and DOB before clicking **Create Case**.

Patient Detail Information

Member ID: XYZ00002	**Gender:** MALE	**Program:** MSI DEMO PROGRAM - PA REQ
Name: HILL, BOBBY	**Address:** 101 MAIN ST, FRANKLIN, TN, 37067	**Program Effective Date:** 01/01/2009
Date of Birth: 02/01/1974	**Insurer:** MEDSOLUTIONS DEMO	**Program Term Date:** 12/31/2999

This is a MEDSOLUTIONS DEMO Program   ...ate Case

> If there are cases associated with the patient, they will populate once the patient is selected. Double click on a case ID in the **Patient History** to open that case.

Patient History - 49 Records found   ?

...resh Data

Case ID ▼	Auth Number	Submit Date	Case Status				
101840634		7/7/2016	Pending	RN Review Process			7
101837513	A31309042	7/7/2016	Approved		07/07/2016	09/05/2016	6
101837334		7/7/2016	Canceled				2
101827785		7/6/2016	Canceled				7
101798766		6/30/2016	Pending	RN Review Process			7

|◀ ◀ **1** 2 3 4 5 6 7 8 9 10 ▶ ▶| 1 - 5 of 49 items

Case Creation – CPT/ICD Codes

- Begin typing the **CPT** and **ICD codes** or descriptions, then click the appropriate option with your cursor. *Please note - the portal allows selection of <u>unlimited</u> CPT and ICD codes.*

- The **Place of Service** option will populate automatically, but it is important to <u>verify the setting of the procedure performed</u>, regardless of CPT code. Please see page 52 for place of service descriptions.

The POS will default to outpatient/inpatient based upon the CPT codes provided. <u>Verify the setting of the procedure performed</u>, and change accordingly, if needed. See page 52

Case Creation – Place of Service

- **Ambulatory**- This should be used when the request will be handled at an ASC (Ambulatory Surgery Center).

- **Office** – This should be used when the request will be requested in the office setting. As an added benefit, this option will also select the 'Procedure to be performed at Requesting Physician's Office' (previously known as the Physician as Facility button on the portal) when the Ordering Physician is a Participating provider.

- **Outpatient** – This should be used if being performed in the Hospital setting and as an Outpatient procedure.

- **Inpatient** – This should be used if being performed in the Hospital setting and as an Inpatient procedure.

Selecting a Product limits which CPTs can be entered into a request. Please be aware that you may have to initiate separate requests for separate Products.
Health Plan or eviCore may contact the patient about this authorization request via call or text.

eviCore healthcare is unable to accept a retrospective or same-day request for an inpatient authorization. If the patient has already been admitted and you cannot change the start date, please contact Cigna directly by using the number on the back of the customer's ID card, and select "urgent" or "emergency" at the appropriate prompt, in order to speak with a Cigna agent (do not select the "pain management or joint surgery" prompt) **Please make sure the correct Place of Service is selected for the procedure being requested before moving forward.**

If you are requesting inpatient services within 2 business days of the admission date, please contact eviCore at 888-693-3297 to initiate the request.

Please select the Date Of Service [   ] 🔟   Place Of Service [Outpatient (2 ⌄]   Initial Service Request ☐

POS Name
Outpatient Hospital | Ambulatory (24)
Inpatient (21)
Office (11)
Outpatient (22)

Save & Next

Case Creation – Ordering Physician

- Select from a default **Physician** or search by **Name**, **Tax ID**, or **NPI** number.
- Once the correct physician displays, select by clicking on the record. Then hit **"Save & Next."**

Case Creation – Facility

- Select from a default **Facility** or search by clicking the **Search Facility** button and entering the **Facility Name**, **Tax ID**, or **NPI** number. For in-office procedure, click the Look-Up IOP button, and choose from the list.

- Once the correct facility displays, select by clicking on the record. Then hit **"Save & Next."**

Case Creation – Review and Submit

- You can edit the CPT/ICD codes, Physician, and Facility information by clicking the "Edit" icons next to the field that needs to be updated.
- Review the case information, then **click Submit.** Case details cannot be changed on the portal once you hit this button. Any changes after submission would need to be made via phone.
- Once you hit Submit, you will receive an automatic approval, or you will be prompted to respond to the clinical questions for additional information.
- We are happy to announce a new feature on this page for status change e-notifications! This allows you to receive an email (e-notification) for any updates to status for this case.

Survey Questions

- After you hit Submit, you may be directed to the **Clinical Survey** questions specific to the procedure being requested.

- As you move through the survey. the previously answered questions will be available in the Review History section at the bottom of the survey.

Survey Questions

- As you move through the survey, the previously answered questions will be available in the Review History section at the bottom of the survey. It is important to complete all questions to receive an immediate notification as to whether the case is approved or if additional clinical information is required.

Survey Questions

- Once you have answered the survey questions, the response history will populate. Hit **Submit** to complete the survey.

Survey Questions

- The survey is now complete and you can click **continue** to close the survey box.
- Based on the information provided, you may receive an automatic approval and be redirected to the approved case summary page or you may be directed to the clinical documentation page.

Providing Clinical Information

Providing Clinical Information

Upload Additional Clinical Documentation   ✕

Additional Documentation   ❓

Warning: Please be sure and review that the attachments or notes apply to this case. Adding clinical information to the wrong case could result in a HIPAA violation.

File Name

Browse

No attachments saved

Clinical Notes

Note Text

Maximum Character limit on each note is 5000.

No notes saved   Save

Apply   Cancel

> You can attach clinical notes or documents by clicking Browse and selecting the correct file(s) located on your computer.

> You can type in free text notes as clinical information. Hit <u>save</u> for any notes entered in the text box.

> Hit Apply to continue or Cancel to add additional information at a later time.

Providing Clinical Information

Once you click **Apply** you will receive a message that your documentation has been accepted, and the case has been sent for medical review.

Case Summary Page – Pending Case

- Once you submit a case for medical review, you will be redirected to the **Pending Case Summary Page** where you'll be able to view case information including case number and current status/activity.

Case Summary Page – Approved Case

- The **Approved Case Summary Page** will provide case information such as the authorization number and effective/end date of the authorization.

Case Summary Page – Denied Case

- The **Denied Case Summary Page** will provide case information as well as the denial rational. Case Summary reports can be accessed/printed at any time.

Provider Resources

Dedicated Call Center

Prior Authorization Call Center – 888.693.3297

Our call centers are open from 7 a.m. to 8 p.m. (local time).

Providers can contact our call center to perform the following:

- Request Prior Authorization
- Check Status of existing authorization requests
- Discuss questions regarding authorizations and case decisions
- Change facility or CPT Code(s) on an existing case
- Request to speak to a clinical reviewer
- Schedule a clinical consultation with an eviCore Medical Director

Online Resources
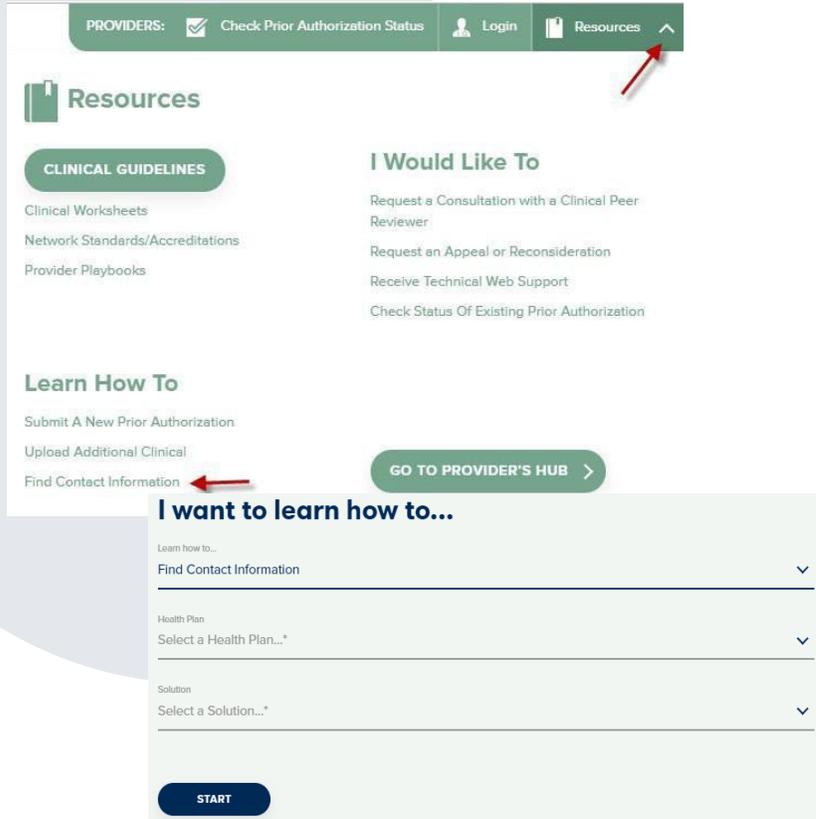
Web-Based Services and Online Resources

- You can access important tools, health plan-specific contact information, and resources at www.evicore.com

- Select the Resources to view Clinical Guidelines, Online Forms, and more.

- Provider's Hub section includes many resources

- Provider forums and portal training are offered weekly, you can find a session on www.eviCore.WebEx.com, select WebEx Training, and search upcoming for a "eviCore Portal Training" or "Provider Resource Review Forum"

- The quickest, most efficient way to request prior authorization is through our provider portal. Our dedicated **Web Support** team can assist providers in navigating the portal and addressing any web-related issues during the online submission process.

- To speak with a Web Specialist, call (800) 646-0418 (Option #2) or email portal.support@evicore.com

Client & Provider Operations Team

Client and Provider Services

Dedicated team to address provider-related requests and concerns including:

- Questions regarding Accuracy Assessment, Accreditation, and/or Credentialing

- Requests for an authorization to be resent to the health plan

- Consumer Engagement Inquiries

- Eligibility issues (member, rendering facility, and/or ordering physician)

- Issues experienced during case creation

- Reports of system issues

How to Contact our Client and Provider Services team

Email: ClientServices@evicore.com (preferred)

Phone: 1 (800) 646 - 0418 (option 4)

For prompt service, please have all pertinent information available. When emailing, make sure to include the health plan in the subject line with a description of the issue, with member/provider/case details when applicable.

Provider Engagement Team

Provider Engagement team

Regional team that on-boards providers for new solutions and provides continued support to the provider community. How can the provider engagement team help?

- Partner with the health plan to create a market-readiness strategy for a new and/or existing program

- Conduct onsite and WebEx provider-orientation sessions

- Provide education to supporting staff to improve overall experience and efficiency

- Create training materials

- Monitor and review metrics and overall activity

- Conduct provider-outreach activities when opportunities for improvement have been identified

- Generate and review provider profile reports specific to a TIN or NPI

- Facilitate clinical discussions with ordering providers and eviCore medical directors

How to contact the Provider Engagement team?

You can find a list of Regional Provider Engagement Managers at evicore.com → Provider's Hub → Training Resources

Provider Resource Website

Provider Resource Pages

eviCore's Provider Experience team maintains provider resource pages that contain client- and solution-specific educational materials to assist providers and their staff on a daily basis. The provider resource page will include, but is not limited to, the following educational materials:

- Frequently Asked Questions
- Quick Reference Guides
- Provider Training

- CPT code list

To access these helpful resources, please visit:

https://www.evicore.com/healthplan/cigna

Provider Newsletter

Stay Updated With Our Free Provider Newsletter

eviCore's provider newsletter is sent out to the provider community with important updates and tips. If you are interested in staying current, feel free to subscribe:

- Go to eviCore.com

- Scroll down and add a valid email to subscribe

- You will begin receiving email provider newsletters with updates

Provider Resource Review Forums

The eviCore website contains multiple tools and resources to assist providers and their staff during the prior authorization process.

We invite you to attend a Provider Resource Review Forum, to navigate www.eviCore.com and understand all the resources available on the Provider's Hub. Learn how to access:

- eviCore's evidence-based clinical guidelines

- Clinical worksheets

- Check-status function of existing prior authorization

- Search for contact information

- Podcasts & Insights

- Training resources

How to register for a Provider Resource Review Forum?

You can find a list of scheduled **Provider Resource Review Forums** on www.eviCore.com → Provider's Hub → Scroll down to eviCore Provider Orientation Session Registrations → Upcoming

Thank You!