Gastroenterology Solution

Frequently Asked Questions

Who is eviCore healthcare?

eviCore healthcare (eviCore) is a specialty medical benefits management company that provides utilization management services for Prominence Health Plan.

What is eviCore healthcare's Gastroenterology Prior Authorization Program?

eviCore's Prior Authorization Gastroenterology Program helps ensure that certain gastroenterology tests and procedures are medically necessary according to evidence-based guidelines. eviCore works with Prominence Health Plan to administer precertification for the gastroenterology procedures listed below.

- Esophagogastroduodenoscopies (EGD)
- Capsule endoscopies
- Colonoscopies, high risk screening (G0105) and non-screening

Which members will require prior authorization for Gastroenterology services?

On November 14, 2022, eviCore will begin accepting prior authorization requests for the following Prominence Health Plan membership:

- **Medicare Advantage**

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

Member eligibility and benefits should be verified with Prominence Health Plan before requesting prior authorization through eviCore.

What procedures will require prior authorization through eviCore?

Esophagogastroduodenoscopies (EGD), capsule endoscopies, and colonoscopies as described below will require authorization through eviCore. Providers and staff can refer to a detailed list of CPT codes that require prior authorization by visiting https://www.evicore.com/resources/healthplan/prominence.

What are the methods of requesting prior authorization through eviCore?

The quickest, most efficient way to obtain prior authorization for Prominence Health Plan gastroenterology procedures is through eviCore's 24/7 self-service web portal at www.evicore.com using the CareCore National portal.

While we encourage requests to be submitted through the portal, prior authorization can also be obtained by contacting our call center via 844.303.8454 or by fax 800.540.2406

What are the hours of operation for the contact call center?

eviCore healthcare's prior authorization call center is available from 7:00 a.m. to 7:00 p.m., Monday through Friday local time. The web is available 24/7.

What non-clinical information will be required to obtain a prior authorization?

- Member Name, Date of Birth, Address, and Member ID
- Requested Procedure(s): Esophagogastroduodenoscopy (EGD) and/or Capsule Endoscopy and/or Colonoscopy
- CPT Code(s) relevant to the requested procedure(s). See below regarding submitting general diagnostic or multiple CPT codes for EGD and/or colonoscopy procedure(s)
- Referring Provider's National Provider Identifier (NPI), telephone number, and fax number
- Rendering Facility NPI, telephone number, and fax number

What clinical information will be required when requesting prior authorization?

If clinical information is needed, providers must be able to supply the following information:

- Relevant history and physical examination
- Relevant summary of the patient's clinical condition
- Imaging and/or pathology and/or laboratory reports, as indicated, relevant to the requested procedure
- Comorbidities, if applicable
- Indication for the specified procedure
- Prior treatment regimens
- Results of prior endoscopic procedures, if relevant
- Genetic testing results, if applicable

Where are eviCore healthcare's clinical guidelines located?

Providers and/or staff can easily access eviCore's clinical guidelines at the following link:

www.evicore.com

On the top right of the page click on Resources >>> Under Resources choose Clinical Guidelines >>> Click on the Gastroenterology icon >>>> Choose the Health Plan in the search bar

What is the most effective way to request authorization for urgent requests?

The quickest, most efficient way to obtain authorization for medically urgent requests is through www.eviCore.com. Urgent requests can be submitted online by indicating that the procedure is **not** routine/standard. Urgent requests can also be submitted by calling 844.303.8454 and by clearly indicating that the treatment is for medically urgent care.

Note: Medically urgent outpatient procedures must meet the **National Committee for Quality Assurance's (**NCQA**)** definition of medical urgency. To be considered urgent, the patient must have conditions that are a risk to their life, health, or ability to regain maximum function, or have severe pain that requires a medically urgent procedure.

Can a request for authorization be submitted after a procedure has been performed?

Retro requests, or those submitted after the procedure has been performed, are not in scope for Prominence Medicare Advantage members and will be administratively denied.

Once prior authorization has been requested, how long will it take for eviCore to make the determination?

Decisions for non-urgent prior authorization requests are typically made within two 2-3 business days of receipt of all necessary clinical information, but will not take longer than 14 calendar days. When gastroenterology services are required due to a medically urgent condition, eviCore healthcare will usually give a decision within 72 hours of receiving all necessary demographic and clinical information. Please state that the authorization is for medically urgent care when appropriate.

Note: Medically urgent outpatient procedures must meet the National Committee for Quality Assurance's (NCQA) definition of medical urgency. To be considered urgent, the patient must have conditions that are a risk to their life, health, or ability to regain maximum function, or have severe pain that requires a medically urgent procedure.

Who can request a prior authorization?

A representative of the ordering provider's staff can ask for prior authorization. This could be someone from clinical, front office, or billing staff acting on behalf of the ordering provider. Alternatively, the rendering facility can also request the prior authorization, however only one request should be made. Note: Our system is NPI number driven so both NPI numbers for the rendering facility and the ordering provider are needed.

Once a determination has been made, how is notification provided?

Based on evidence-based guidelines, if a request is determined as not medically necessary, a notification with the rationale for the decision and post decision/appeal rights will be issued. Denial letters will be faxed to the ordering provider and rendering facility. Members will receive a letter by mail.

Providers can also validate the status of a request using the eviCore portal at www.evicore.com or by calling eviCore at 844.303.8454.

If a prior authorization request is denied, what follow-up information will be provided?

The referring provider will receive an adverse determination via fax that outlies the reason for the denial as well as reconsideration and appeal rights. Providers can request a Clinical Consultation with an eviCore physician to better understand the reason for denial. Once a denial decision has been made, however, the decision cannot be overturned via Clinical Consultation.

What information about the prior authorization request can be found on the eviCore healthcare Web Portal?

The authorization status function on the portal provides the following information:

- Prior Authorization Number/Case Number
- Status of Request
- Site Name and Location
- Prior Authorization Date
- Expiration Date

What if a provider doesn't know the specific EGD or colonoscopy CPT code(s) they plan to perform at the time prior authorization is requested?

eviCore recognizes that providers may not know beforehand what procedures may be performed during the course of the planned endoscopy. Therefore, eviCore does not require the specific EGD or colonoscopy CPT code(s) at the time precertification is requested. Providers can choose a general diagnostic EGD (CPT 43235) or colonoscopy code (CPT 45378), or another code that might more closely resemble the anticipated procedure. Providers may submit billing for any of the EGD or colonoscopy CPT codes included on the Prominence Health Plan Provider Resource site managed by eviCore. Providers do not have to contact eviCore if the procedure ultimately performed is different than the one initially approved, as approval received for one EGD or colonoscopy procedure code represents approval for any respective EGD or colonoscopy codes within the billable code list performed on the same date of service.

What if, during the course of the EGD or colonoscopy, more than one type of therapeutic or diagnostic maneuver is carried out? Can I submit billing for multiple EGD or colonoscopy CPT codes that reflect the nature of the procedure performed?

Yes, as long as the EGD or colonoscopy procedures performed are included on the Prominence Health Plan Provider Resource site's list of EGD or colonoscopy CPT codes managed by eviCore. We recognize that multiple maneuvers (e.g., polypectomy of one lesion, and then destruction of a different lesion by electrocautery, etc.) may occur during the course of a planned EGD or colonoscopy. The additional codes can be submitted and will be reimbursed based on Providence Health Plan policy for payment in this circumstance. Providers do not have to contact eviCore if they need to perform multiple delegated EGD or colonoscopy procedure(s) different from the one requested, as approval received for one EGD or colonoscopy procedure code represents approval for any respective EGD or colonoscopy codes within the billable code list performed on the same date of service.

Note: Endoscopic retrograde cholangiopancreatography and endoscopic ultrasound do not require precertification through eviCore at this time.

If the specific procedure needs to be changed during case build, should the case build be canceled?

The following provides information about changes to a case build:

- If a provider requested an EGD and a different EGD is needed, the provider does not need to submit a new case or submit a request to cancel the case build.
- If a provider requested a colonoscopy and a different colonoscopy is needed, the provider does not need to submit a new case or submit a request to cancel the case build.
- If a provider requested an EGD or colonoscopy and needs to change to a Capsule Endoscopy (or vice versa), the provider will have to request to cancel case build and start over with the correct procedure.
- If a provider requested a Capsule Endoscopy and a different Capsule Endoscopy code is needed, the provider will need to submit a request to cancel case build and start over with the correct procedure.

How do I submit a claim for monitored anesthesia or moderate sedation in conjunction with the EGD or Colonoscopy?

If an EGD or colonoscopy request has been approved, providers can submit monitored anesthesia or moderate sedation codes in the same claim and Prominence Health Plan will reimburse per normal processes. However, if the EGD or colonoscopy procedure is denied, Prominence Health Plan will not reimburse for the anesthesia or sedation codes.

Can a claim for monitored anesthesia and/or moderate sedation be submitted in conjunction with an approved capsule endoscopy?

No, it is generally not medically necessary to administer anesthesia or moderate sedation in conjunction with capsule endoscopies unless an EGD is considered medically necessary to place the capsule directly into the stomach or duodenum, in which case the request for sedation would be paid in conjunction with the EGD. Otherwise, Prominence Health Plan will not reimburse for these codes.

If the provider performs two capsule endoscopies (e.g., 91110 and 91111) but only has an authorization for one of these codes, will Prominence Health Plan pay for both?

No. Unlike the EGD or colonoscopy procedures, the capsule endoscopy procedures are not substitutable for one another. As a result, Prominence Health Plan would deny a claim for the code that wasn't approved. The provider would need to contact eviCore to receive a separate approval for the second capsule endoscopy code.

What if an authorization is issued and revisions need to be made?

Authorized requestors should contact eviCore with changes to the authorization as noted below. It is very important to update eviCore healthcare of any changes to the authorization in order for claims to be correctly processed for the facility that receives the member.

- If the date of service changes, but falls within the 90-day timeframe for which the approval indicates, there is no need to makes changes.
- If the rendering provider changes, please call eviCore at 844.303.8454 to make those changes. Otherwise, you do not need to submit a new request unless the member does not have the approved procedure by the end of the 90-day expiration date.
- If the rendering site changes, please contact eviCore at 844.303.8454 to change the requested rendering facility location.

- If the CPT code changes:
  - If a provider's requested EGD code is approved and a different EGD code on the CPT code list is needed, there is no need to submit a new case or request a different EGD, as approval received for one EGD procedure code represents approval for any respective EGD codes within the billable code list performed on the same date of service.
  - If a provider's requested colonoscopy code is approved and a different colonoscopy code on the CPT code list is needed, there is no need to submit a new case or request a different colonoscopy, as approval received for one colonoscopy procedure code represents approval for any respective colonoscopy codes within the billable code list performed on the same date of service.
  - If a provider's requested EGD or colonoscopy code is approved and needs to change to a Capsule Endoscopy (or vice versa), the provider will have to cancel the case and start a new case build with the correct procedure on the eviCore portal (www.eviCore.com).
  - If a provider's requested Capsule Endoscopy is approved and needs to change to a different Capsule Endoscopy code, the provider will have to cancel the case and start a new case build with the correct procedure on the eviCore portal (www.eviCore.com).

Do services performed in the Emergency Room (ER), during an observation, or inpatient stay require authorization?

Prior authorization is not required for services provided in an ER, observation, or inpatient setting.

How long is the authorization valid?

Authorizations are normally valid for 90 calendar days.

Will authorization extensions be allowed for the Gastroenterology program?

eviCore will not allow for extensions on previously approved authorizations.

Will eviCore healthcare be processing claims for Prominence Health Plan?

eviCore is not delegated to manage claims processing and will only manage prior authorization requests for Gastroenterology services. Prior authorization and pre-service approval is required but does not guarantee claims payment.

Where should appeal requests be submitted?

eviCore is not delegated to manage appeals for Prominence Health Plan Gastroenterology program at this time. For additional assistance, please contact the Prominence Health Plan Customer Service department at 855.969.5882.

How do I submit a program-related question, or report an issue?

For program related questions or concerns, please contact Client Services at either ClientServices@evicore.com (preferred), or 800.646.0418 (option 4):

- Eligibility issues (member, rendering facility, and/or ordering physician)
- Issues experienced during case creation
- Inquiries regarding standard processes and procedures
- Questions regarding Accuracy Assessment, Accreditation, and/or Credentialing
- Request for an authorization be resent to the health plan

Does Average Risk Screening Colonoscopy require prior authorization?

No. Average-risk screening colonoscopy (CPT code G0121) does not require prior authorization. If the provider believes the individual meets average risk criteria for screening as defined in Medicare Benefit Policy Manual, Chapter 15, Section 280.2.2 and 280.2.3, you may proceed with the procedure without contacting eviCore.

Does High Risk Screening Colonoscopy require prior authorization?

Yes. Requests for high-risk screening colonoscopies (CPT code G0105) as defined in Medicare Benefit Policy Manual, Chapter 15, Section 280.2.3 require prior authorization.

Does Non-Screening Colonoscopy require prior authorization?

Yes. All other colonoscopies (diagnostic and therapeutic) require prior authorization.

Please refer to the **Provider Information Tips** document for a more detailed discussion regarding colonoscopy. Provider Information Tips and a detailed list of CPT codes that require prior authorization can be found on the Prominence resource page at https://www.evicore.com/resources/healthplan/prominence.

How are authorizations treated if a provider is conducting a screening colonoscopy but finds polyps or other abnormalities that change the code to a therapeutic colonoscopy? Does the provider need to have an additional authorization for this situation?

No, an additional authorization is not required for this situation. If a screening colonoscopy turns therapeutic (for example, a colonoscopy with polypectomy is performed for the finding of a colon polyp), providers should report an appropriate screening diagnosis as the primary diagnosis and any abnormal diagnoses as secondary and/or subsequent diagnoses. In addition, providers should report the appropriate therapeutic CPT code with a PT modifier, signifying that the colonoscopy started as screening but changed to therapeutic due to the detection of polyps or other abnormalities during the course of the procedure. (E.g. CPT code 45385-PT would be reported for a screening colonoscopy that turned therapeutic and a polyp was removed.)

Where can I find additional educational materials?

For more information and reference documents, please visit our resource page at www.evicore.com/provider.