Interventional Pain, Spine & Joint Surgeries

Frequently Asked Questions

Who is eviCore healthcare?

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for The Health Plan.

Which members will eviCore healthcare manage for the Musculoskeletal Management program?

eviCore will manage prior authorization for The Health Plan Medicare, Medicaid and Commercial members.

What is the relationship between eviCore and The Health Plan?

eviCore manages outpatient prior authorization of interventational pain management injections and joint and spine surgery services.

Which Musculoskeletal services require prior authorization for The Health Plan?

eviCore has a list of covered services that will now require authorization for The Health Plan specific to Pain Management /Joint and Spine Surgeries. The list of covered services can be found by visiting: https://www.evicore.com/resources/healthplan/thp

How do I request a prior authorization through eviCore healthcare?

Providers and/or staff can request prior authorization in one of the following ways:

Web Portal

The eviCore portal is the quickest, most efficient way to request prior authorization and is available 24/7.Providers can request authorization by visiting https://myplan.healthplan.org/Account/Login

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 make revisions to existing cases by calling 877-791-4104.

Fax

Providers and/or staff can fax additional clinical information or prior authorization requests by completing the clinical worksheets found on eviCore's website at www.evicore.com/provider/online-forms to 855-774-1319.

Who needs to request prior authorization through eviCore?

All ordering (requesting) physicians are required to obtain a prior authorization for services prior to the service being rendered in an office, inpatient or outpatient setting.

What information is required when requesting prior authorization?

When requesting prior authorization, please ensure the proprietary information is readily available:

Member

- First and Last Name
- Date of Birth
- Member ID

Ordering Provider
- First and Last Name
- National Provider Identification (NPI) Number
- Tax Identification Number (TIN)
- Phone and Fax Number

Rendering (Performing) Provider
- Facility Name
- National Provider Identification (NPI) Number
- Tax Identification Number (TIN)
- Street Address

Clinical(s)
- Requested Procedure Code (CPT Code)
- Signs and symptoms (Diagnosis)
- Imaging Study Results
- Results of relevant test(s)
- All additional clinical information associated with the authorization request

Note: eviCore suggests utilizing the clinical worksheets when requesting authorization for Pain Management services

Where can I access eviCore healthcare's clinical worksheets and guidelines?

eviCore's clinical worksheets and most up to date clinical guidelines are available online 24/7 and can be found by visiting one of the following links:

Clinical Worksheets
www.evicore.com/provider/online-forms

Clinical Guidelines
www.evicore.com/provider/clinical-guidelines

When will I receive the authorization number once the prior authorization request has been approved?

Once the prior authorization request has been approved, an authorization number will be provided immediately.

How will the authorization determinations be communicated to the providers?

eviCore will fax the authorization and/or denial letter to the requesting and servicing provider. Providers may also visit www.evicore.com to view the authorization determination.

Note: The authorization number will begin with the letter 'A' followed by a nine-digit number (example: A123456789)

How can the servicing provider confirm that the prior authorization number is valid?

Providers can confirm that the prior authorization is valid by logging into our web portal, which provides 24/7 access to view prior authorization numbers. To access the portal, please visit www.evicore.com.

To request a fax letter with the prior authorization number, please call eviCore healthcare at 877-791-4104 to speak with a customer service specialist.

How long is the authorization valid?

Authorizations are valid for 90 calendar days. If the service is not performed within 90 calendar days from the issuance of the authorization, please contact eviCore healthcare.

What qualifies a request as urgent?

Urgent requests are defined as a condition that a) could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or b) in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case. Urgent requests may be initiated on our web portal at evicore.com or by contacting our contact center at. Urgent requests will be processed within 24-72 hours from the receipt of complete clinical information.

What is the most effective way to get authorization for urgent 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 evicore.com or by contacting our contact center at 877-791-4104. Urgent requests will be processed within 24 hours from the receipt of complete clinical information.

What happens if codes need to be changed/added to after surgery has been completed?

Once surgery has been completed and additional procedures were required, please contact eviCore via phone at 877-791-4104 and let us know what codes need to be added. Please be prepared to offer additional documentation to support the change.

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

Member eligibility and benefits should be verified on https://myplan.healthplan.org/Account/Login.

If denied, what follow-up information will the requesting provider receive?

The requesting provider will receive a denial letter that contains the reason for denial as well as Appeal rights and processes.

Where do I submit my claims?

All claims will continue to be filed directly to "The Health Plan"**.**

Does eviCore review cases retrospectively if no authorization was obtained?

Retrospective requests must be initiated by phone within 2 days following the date of service. Please have all clinical information relevant to your request available when you contact eviCore healthcare. **Requests made after 2 days from the date of service will need to be submitted to The Health Plan for processing.**

How do I submit a program related question or concern?

For program related questions or concerns, please email: clientservices@evicore.com

Where can I find additional educational materials?

For more information and reference documents, please visit our resource page at **https://www.evicore.com/resources/healthplan/thp**

Interventional Pain:

Does a patient have to have objective symptoms to qualify for an injection?

Yes. 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 three (3) of five (5) positive stress maneuvers of the sacroiliac joint.

How much conservative care is needed prior to an injection?

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

Is advanced imaging required prior to an epidural steroid injection?

Yes. For cervical and thoracic epidural injections, advanced imaging must be performed within the last 24 months.

Is imaging guidance needed for chronic pain procedures?

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

Will eviCore grant approval for a series of injections?

No. A series of injections will not be pre-service authorized. eviCore requires a separate pre-service authorization request for an Interventional Pain procedure for each date of service. The patient's 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.

Will eviCore grant approval for multiple injections on the same date of service?

No, 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.

Will eviCore grant approval of more than 1 level interlaminar epidural, 2 levels transforaminal epidural, 3 level facet/medial branch nerve blocks in a single session?

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

Will eviCore grant approval of "Series of Three" injections (one a week)?

Not permitted, as deemed medically unnecessary (see prior question(s) for additional information).

Is there an annual limit of injections?

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

How should I space my procedures?

Epidural injections require a two (2) week outcome prior to preauthorization of a subsequent epidural. Radiofrequency ablation of the medial branch nerves from C 2 -3 to L 5- S 1 require a six (6) month interval. Therapeutic sacroiliac joint injections require a two (2) month interval

Are there thresholds for outcome from a prior procedure to obtain certification for a subsequent procedure?

Yes. An epidural steroid injection must have at least two (2) of the following: 1) 50% or greater relief of radicular pain, 2) increased level of function / physical activity, 3) 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. Two (2) facet/medial branch nerve blocks with at least 80% relief are needed for radiofrequency ablation. A therapeutic sacroiliac joint injection following a diagnostic injection must have ≥75% pain relief. A repeat therapeutic sacroiliac joint injection must have ≥75% pain relief and either an increase in level of function or reduction in use of pain medication and/or medical services such as PT/chiropractic care.

Are there cases which use the interlaminar epidural CPT 62323 which are not part of the delegated eviCore preauthorization program?

Yes. eviCore manages CPT 62323 when the injectate includes a steroid, local anesthetic, or contrast for interventional pain injections. Requests for injectates other than steroid, local anesthetic, or contrast will be directed to the health plan for management.

Spine and Joint Surgery:

What would be the process if a patient is receiving a procedure where pre-service authorization is required by eviCore healthcare for an inpatient stay?

eviCore healthcare will review the surgery pre-service authorization request for medical necessity and make a determination for the procedure based on the clinical information provided. eviCore will collect the requested place of service during the pre-service authorization process. If the requested procedure is approved, the provider will need to seek a separate approval for the inpatient stay from the health plan.

When should a request for prior authorization of spinal surgery be submitted?

Prior authorization requests should be submitted at least two weeks prior to the anticipated date of an elective spinal surgery.

What documentation will be required for spinal surgery?

- CPT codes, disc levels, or motion segments involved for planned surgery and ICD-10 codes.
- Detailed documentation of the type, duration, and frequency of provider directed non-surgical treatment with response to each with details if less than clinically meaningful improvement to treatment.
- Written reports/interpretations of the most recent advanced diagnostic imaging studies by independent radiologist.
- Acceptable imaging modalities for purposes of the Spine Surgery guidelines are: CT, MRI and Myelography.

What documentation is required for spinal fusion surgery requests?

- Documentation of flexion-extension plan X-rays based upon indications for instability and/or other plain X-rays that document failure of instrumentation, fusion, etc.
- Evidenced by blood cotinine lab results of <10ng/mL. (In order to complete the prior authorization process for spinal fusion surgery, allow for sufficient time for submission of lab results performed after the 6-week cessation period.

- Documentation of nicotine-free status, as evidenced by either of the following, unless this is an urgent/emergent request, for decompression only without fusion, disc arthroplasty, or when myelopathy is present.

Some procedures in the eviCore Spine Surgery Guidelines require a trial of epidural steroid injections (ESI)/nerve root blocks (SNRBS) unless there is a documented contraindications to ESIs/SNRBs. Contraindications to ESIs/SNRBs include the presence of any of the following:

- Allergy to the medication to be administered
- A significantly altered or eliminated epidural space (e.g. congenital anatomic anomalies or previous surgery)
- Anticoagulation therapy
- Bleeding disorder
- Localized infection in the region to be injected
- Systemic infection
- Other co-morbidities which could be exacerbated by steroid usage (e.g. poorly controlled hypertension, severe congestive heart failure, diabetes, etc.)

What determines medical necessity for the performance of knee replacement (partial or total)?

Medical Necessity is determined on a case by case basis. Evidenced based criteria are used to adjudicate all requested. As noted in list of requirements.

What are the requirements for a partial knee or total knee replacement surgery?

- 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.

Is total knee replacement considered medical necessary for a fracture of the distal femur?

Yes, 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.

The determination of medical necessity for the performance of shoulder surgery?

Medical necessity for shoulder surgery is always made on a case by case basis. Evidenced based criteria are used to adjudicate all requested.

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.**

Are there other procedures for the shoulder that require prior authorization?

Yes, there are multiple shoulder procedures that require prior authorization review.

***Above is an example of the necessary requirements for shoulder surgery. Please refer to the health plan CPT Code list located on the eviCore resource page.**

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