Sleep Management
The Health Plan
Quick Reference Guide

Required Authorization
Sleep Management

To find a complete list of Sleep Current Procedural Terminology (CPT) codes that require prior authorization through eviCore, please visit:
https://www.evicore.com/resources/healthplan/thp

Prior authorization is required for the following:

- Facility Based Polysomnography
- Facility Based PAP Titration
- Facility Based Split-Night Studies
- Home Sleep Testing
- Home APAP Titration
- PAP Therapy Devices and Supplies
- PAP Therapy Compliance
- Oral Appliances

Required Information

To ensure the authorization process is as quick and efficient as possible, the requesting provider submitting requests will need to provide the following:

1. Member Name, Date of Birth, Member ID
2. Ordering physician, NPI, Tax ID, Phone and Fax
3. Rendering facility NPI, Tax ID, Phone and Fax
4. Supporting Clinical Information

Prior Authorization Scope

Prior authorization is required for select CPT codes that will be used in a home setting and applies to the following requests:

- Outpatient or Home Based
- Medically Necessary
- Elective / Non-emergent

Clinical Worksheets and Guidelines

eviCore provides clinical worksheets and guidelines to assist providers and/or their staff in the prior authorization process. By utilizing these educational resources, providers have the potential to receive real-time authorization.

Clinical Worksheets

www.evicore.com/provider/online-forms

Clinical Guidelines

www.evicore.com/provider/clinical-guidelines

Authorizations Approvals

Once all information is submitted to eviCore, an authorization notification letter will be faxed to the referring Physician, Facility and/or DME Provider and mailed to the member via standard US Mail. Information can be printed on demand via The Health Plan website: https://myplan.healthplan.org/Account/Login.

Contact eviCore at 877-791-4104, select options 1, 2, 1 to update CPT code if changes are needed on an existing case.

Denial Notifications

Verbal outreach will be made to requesting Facility and/or DME Provider, as well as the Member. Written notification letter will be faxed to the referring Physician, Facility and/or DME Provider and mailed to the member via standard US Mail. The denial notification sets forth the appeal options. The denial rationale and appeal process are communicated verbally to the requesting provider and are outlined on the written denial notification.

Need Clinical Support?

Providers and/or staff can request to speak to an eviCore Medical Director by scheduling a clinical consultation. To schedule a clinical consultation, please visit:

www.evicore.com/provider/request-a-clinical-consultation

Retrospective Requests

Retrospective reviews are not allowed, with the exception of special circumstances.

Claim Denials

Please contact The Health Plan directly at 800.624.6961 to discuss reconsideration of claims payment.

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Convenient Web Portal

THP's Web Portal remains the quickest, most efficient way to verify eligibility, and more. Available 24/7, 365 days a year. You can also start a case and check case status at eviCore's provider portal and request a clinical consultation online https://www.evicore.com.

eviCore Web Portal assistance:

e: portal.support@evicore.com

p: 800-646-0418 (Option 2)

Call Center 877-791-4104 Sleep-Options 1,2,1

Hours of Operation: Monday-Friday: 8am–7pm EST, Saturday: 9am–5pm EST, Sunday and Holidays: 9am–2pm EST. For faster service, you'll need all pertinent clinical information before you call. Outside of normal business hours, you may call eviCore and leave a message for a return call the next business day.

Fax 866-999-3510

Provider Resource Page

The eviCore Provider Resource site contains clinical guidelines, web registration/ submission information, FAQ documents, a comprehensive CPT code list, and other important resources that are kept up-to-date for your convenience:

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

Authorization from eviCore healthcare does not guarantee claim payment. Services must be covered by The Health Plan and the member must be eligible at the time services are rendered. Claims submitted for services may be subject to benefit denial. Please verify the member's benefits and eligibility with The Health Plan. Regardless of the benefit determination, the final decision regarding any health care services or treatment is between the member and their health care provider.