Pain Management Program Frequently Asked Questions
Aetna Better Health of West Virginia

Who is eviCore healthcare?

Triad, an eviCore healthcare company, was established in 1996 and acquired by eviCore in 2013. eviCore healthcare (eviCore) is a specialty medical benefits management company that provides utilization management services for Health Plans.

What is the relationship between Aetna Better Health of West Virginia (ABH WV) and eviCore healthcare?

ABH WV has partnered with eviCore to provide authorization for pain management services.

What is changing with the current prior authorization process that has been in place since 2012?

There are several enhancements to the current program offering. You will now have access to a web portal to check member eligibility, submit a request for prior authorization and check case status. The web portal is user friendly and the preferred method to initiate a request. You will now be able to initiate prior authorization requests telephonically by calling (888) 693-3211. The current fax form will also be updated and available at www.evicore.com. Click on "Solutions" at the top, and choose Musculoskeletal. Select Online Forms and choose Aetna Better Health WV and then select from the dropdown options to obtain the updated fax forms.

The list of codes that require prior authorization have also been updated and can be viewed on the provider resource website: http://www.medsolutions.com/implementation/abhwv.

Will eviCore be processing claims for ABH WV?

No, eviCore will only manage prior authorization requests.

How do I submit a prior authorization request?

There are three ways to submit requests to eviCore healthcare for outpatient diagnostic imaging procedures:

- Web portal: www.eviCore.com (preferred method)
- Phone: (888) 693-3211
- Fax: (844) 82AETNA

The 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. They can often be processed immediately.

- Efficiency – Medical documentation can be attached to the case upon initial submission, reducing follow-up calls and consultation.
- Real Time Access – See real-time status of a request.
- Patient History – See existing and previous requests for a member.

Is registration required on eviCore's web portal?

Yes. A one-time registration is required for each practice or individual. You will be required to log-in prior to submitting prior authorization requests on the web. If you have an existing account, a new account is not necessary.

Can one user submit for authorization for multiple providers with different tax ID numbers on the portal?

Yes, you can add the providers to your account once you have registered. In the Options Tool section at the top right of the portal, choose "Preferences" from the drop down to set up preferred tax ID's for a physician or facility. By adding the preferred tax ID's for a physician or facility to your account will allow you to view the summary of cases submitted for those providers and facilities.

Who do I contact for online support/questions?

Web portal inquiries can be emailed to portal.support@evicore.com.

What clinical information will a provider need to initiate a prior authorization request?

Imaging studies, prior test results and office notes related to the current diagnosis. You can use the clinical quick reference guide and checklist as a tool when submitting prior authorization requests.

What clinical guidelines will be used to make a determination of medical necessity?

eviCore will follow the Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) when available, then the Aetna Clinical Policy Bulletins (Aetna CPBs) and if there is not a LCD, NCD or Aetna CPB, then the eviCore clinical guidelines will be used and are available on www.eviCore.com.

What is the turnaround time for a determination on a prior authorization request?

Standard requests will be processed within 7 calendar days of the initial requests. Urgent requests are processed within 72 hours of the initial request. You could receive a real-time authorization if criteria is met when submitting your request by web or phone. It's important to answer all clinical survey questions and provide all supporting clinical information on the initial request to avoid delays in making a determination.

How will I be notified of a determination?

A determination letter will be faxed to the rendering provider and the facility. Members are notified by mail.

Can a retrospective request for services be submitted for authorization?

No, retrospective review is not permitted.

How do I request an urgent procedure?

All urgent requests must meet the NCQA medically urgent criteria which are defined as conditions that are a risk to the patient's life, health, ability to regain maximum function, or the patient is having severe pain that required a medically urgent procedure. All urgent requests must be initiated telephonically. Most requests will receive a real-time approval, however if clinical documentation is requested, then a determination will be processed within 72 hours of receiving all clinical information.

Important note: Requests submitted by web portal and fax are treated as standard requests.

What is the process to make an update on my existing authorization?

All updates to an authorization must be made telephonically by calling (888) 693-3211. Post-decision update requests that require clinical review will be allowed up to and including 60 calendar days following the date of service.

Can I extend an authorization period on my authorization?

Yes, you can call (888) 693-3211 and extend the authorization 60 days.

What are my options when there is an adverse determination on my request?

There are two options: A reconsideration review or a peer-to-peer discussion. A reconsideration review can be requested if there is additional clinical information available without the need for the provider to participate in a discussion. A peer-to-peer discussion can be requested and will be scheduled with an eviCore Medical Director of the same specialty expertise. The rendering provider, nurse practitioner or physician assistant can conduct the peer-to-peer with an eviCore Medical Director. During the conversation, the reason for the denial will be discussed and additional information can be provided to support the medical necessity of the request. The ordering provider will be notified at the end of the peer-to-peer discussion if the denial is overturned or upheld. A reconsideration review and a peer-to-peer discussion can be requested by calling (888) 693-3211 within 5 business days following the date of service.

Important note: Only one post-decision request is allowed. If a reconsideration review results in upholding the denial then the next option would be to appeal, same with a peer-to-peer. eviCore is not delegated appeals; your appeal rights will be included in the denial letter you receive.

Who should I contact with questions?

If you have additional questions about the medical necessity review program, please contact the Client Services department at eviCore healthcare via the following email address: clientservices@evicore.com.