Cigna Musculoskeletal Program
Administrative Frequently Asked Questions

Note: Prior authorization requests should *only* include those codes for the current treatment plan and *not* codes for every contingency treatment plan. Should additions, deletions and/or other changes be required for a current authorization, please contact eviCore to provide supporting documentation for review of the medical necessity of requested additions, deletions and/or other changes.

How do I submit a precertification request?

The web portal is the quickest, most efficient way to submit authorizations, check case status and is available 24 hours a day, 7 days a week. By utilizing the web portal, you have real-time access to patient authorization and eligibility information as well as the ability to submit requests at a time that best fits your schedule. The web portal can be accessed at: https://www.evicore.com. Precertification requests can also be requested telephonically or by fax. Please refer to the quick reference guide for the phone and fax number.

Is registration required on eviCore healthcare's web portal?

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

Who do I contact for online support/questions?

There are three (3) different options for web support:

- Click online chat
- Call a web support specialist: 800.646.0418
- Email: portal.support@evicore.com

What information will a provider need to initiate a precertification request?

Office notes related to the current diagnosis, imaging studies and prior test results related to the diagnosis. All clinical information related to the precertification request should be submitted to support medical necessity.

Do providers who currently have procedures scheduled after January 1, 2016 have to go back and have the procedure authorized?

Providers would need to obtain an authorization through eviCore for any services on or after January 1, 2016. eviCore will begin accepting precertification requests on December 15, 2015.

Note: If Cigna has already authorized a procedure prior to January 1, 2016, then the Cigna authorization will be sufficient. However, going forward, eviCore would need to be contacted for future musculoskeletal authorizations.

Will urgent requests be accepted?

Yes. Medically urgent requests 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. It's important to note that urgent requests must be initiated by telephone. Web and fax submissions will be considered standard requests. Urgent requests will be processed within twenty four (24) hours from the receipt of complete clinical information.

What is the turnaround time for a determination on a standard precertification request?

It is our business practice to typically complete requests within two (2) business days from the receipt of complete clinical information. When a case is initiated on the web and if it meets clinical criteria then you could receive a real-time authorization.

How will I be made aware that a precertification request is approved or denied?

An email or fax notification will be sent to the provider. Facilities will receive notification by fax and Cigna customers are notified by mail.

What would be the process if a patient is already inpatient and needs services included in the musculoskeletal program that requires precertification through eviCore?

While the expectation is that the health plan provider will contact eviCore for precertification prior to admittance to the hospital for these services, if a patient is already in the hospital when the service is determined to be required, then the precertification and length of stay are managed by the Cigna inpatient case manager.

If a patient is discharged from an inpatient stay and is scheduled for an outpatient procedure that is included in the musculoskeletal program, what would the process be for precertification?

If there is a request for an outpatient procedure to be done following the hospital stay, the request would go to eviCore for precertification.

What would be the process if a patient is approved for an inpatient stay and the provider has questions/concerns on the approved length of stay in the hospital?

Any additional length of stay requests would be handled during the patient's hospital stay by the Cigna Inpatient Case Manager.

How would an authorization be updated if a patient is authorized for an outpatient procedure but has to be admitted due to complications?

Once the patient is admitted to the hospital, any updates should be handled with the Cigna Inpatient Case Manager.

What is the process if a procedure is authorized but during the surgery, the provider performs a different type of procedure that is not approved on the authorization?

For outpatient procedures eviCore will accept post-decision update requests within fifteen (15) business days following the date of service. If the request is to update the procedure code on the authorization then clinical review is necessary and a decision will be rendered based on medical necessity. An updated letter will be sent to the provider, facility and member. If the authorization is for an inpatient procedure, then Cigna must be contacted for any changes to the authorization once the patient has been admitted.

What are my options when a precertification request is denied?

There are two options after requested services are denied: a reconsideration review or a clinical peer-to-peer discussion can be requested either before or on the anticipated date of service. If additional clinical information is available without the need for a provider to participate, a reconsideration review can be requested by phone. If additional clinical information is available but there is a need for the rendering physician to participate, he or she may speak with an eviCore provider of the same specialty expertise. Please refer to the quick reference guide for market specific phone numbers.

Important note: The Centers for Medicare and Medicaid Services (CMS) do not allow submission of additional information once a decision has been made for a precertification request on a Medicare member. Reconsiderations and clinical peer-to-peer discussions are not allowed on an adverse determination for a Medicare member. A clinical peer-to-peer discussion can be scheduled to discuss the adverse determination for a Medicare member but the call is for educational purposes only and the final decision will not be revised, the next option would be to appeal. Your appeal rights can be found on the determination letter.