eviCore healthcare Musculoskeletal Program
Interventional Pain Frequently Asked Questions

Which members will eviCore healthcare manage for the Musculoskeletal program?
eviCore will manage preauthorization services for Health Alliance's commercial and Medicare Advantage members.

How do providers initiate a preauthorization request?
Providers in the Health Alliance network will access eviCore through YourHealthAlliance.org for providers. Out-of-network providers must fax 1-800-540-2406 or call 1-844-303-8452 with preauthorization requests.

What information will a provider need to initiate a precertification request?
- Member's name, date of birth, plan name and plan ID number
- Ordering Physician's name, National Provider Identifier (NPI), Tax Identification Number (TIN), Fax number
- Service being requested (CPT codes and diagnosis codes)
- Rendering facility's name, NPI, TIN, street address, fax number
- Medical records related to the current diagnosis, results of diagnostic imaging studies and the duration/type/outcome of prior treatment related to the current diagnosis. All clinical information related to the precertification request should be submitted to support medical necessity.

Does medically urgent care require preauthorization?
The services managed under eviCore's Joint and Spine surgery programs are unlikely to be required on an emergent basis. However, procedures done in an emergency room or medically urgent care facility are excluded from the program. If a service requiring authorization is medically urgent, the provider must call 1-844-303-8452. Urgent requests are defined by National Committee for Quality Assurance (NCQA) 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 requires a medically urgent procedure. Expedited or urgent requests must contain a provider's attestation that urgent services are necessary. Once all information is provided, eviCore can typically process expedited or urgent requests within 24 hours.

What are the hours of operation for the call center?
eviCore healthcare's preauthorization call center is available from 7:00 a.m. to 7:00 p.m. local time, Monday through Friday at 1-844-303-8452. The web portal is available for access 24/7.

What is the turnaround time for a determination on a standard precertification request?
It is our business practice to complete requests within two (2) business days from the receipt of complete clinical information. When a case is initiated on the web portal and meets clinical criteria, you could receive a real-time, immediate authorization.

How do providers check the status of a preauthorization request?
Network providers can check the authorization status by accessing eviCore via YourHealthAlliance.org for providers or by calling 1-844-303-8452. Out-of-network providers must call 1-844-303-8452 to check the status of an authorization.

How will eviCore notify members and ordering providers of approvals/denials?
Written notices will be sent to the member as well as the ordering provider(s).

Will the rendering facility be notified of determinations?
The facility will not receive notification of the determination. It is imperative that the facility verify that authorization was obtained before rendering services.

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 within 14 calendar days from the denial. 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 Medical Director with the same specialty expertise. Please refer to the peer-to-peer frequently asked questions document on the resource site or the quick reference guide for market specific phone numbers.

How do providers schedule a peer-to-peer consultation?
Providers must call 1-844-303-8452 to schedule a peer-to-peer consultation. Additionally, this program allows Post-Decision Review requests for 14 calendar days after the date of service.

How does a provider verify credentialing status?
Verify your credentialing status with Health Alliance. Contact the Contracting and Provider Services department at 1-800-851-3379, ext. 4668, or email PSC@healthalliance.org.

How does a provider join the Health Alliance provider network?
To join the Health Alliance provider network, visit YourHealthAlliance.org and create an account as a Prospective Provider.

How do providers check the eligibility of a member?
Member eligibility can be verified via YourHealthAlliance.org for providers.

How does eviCore determine if a provider is in-network?
Health Alliance provides eviCore a list of all participating providers daily. Participation status can be verified via YourHealthAlliance.org for providers. Providers can also contact Health Alliance's Customer Service department at 1-800-851-3379.

How does as a provider file a formal complaint?
Provider complaints should be submitted to Health Alliance by phone at 1-800-851-3379, ext. 4668, or via email at PSC@healthalliance.org.

How do providers appeal a preauthorization denial?

All appeals will be handled by Health Alliance and must be submitted in writing. Instructions to appeal the preauthorization decision are in the denial letter. The request must include the:

- Member name
- Member ID number
- Reason for appeal
- Any evidence to support the request for appeal

How do providers access the eviCore system?

Providers in the Health Alliance network will access the eviCore system through YourHealthAlliance.org for providers. Out-of-network providers must call 1-844-303-8452 or fax 1-800-540-2406 to request a preauthorization.

If a preauthorization is not approved, what follow-up information will the referring provider receive?

The ordering provider will receive a denial letter by mail that contains the reason for denial as well as appeal rights and processes. Please note that after the denial has been issued for a Commercial member, the referring provider may request a Peer-to-Peer discussion with an eviCore Medical Director to review the decision. Please note that after a denial has been issued for a Medicare member, no changes to the case decision can be made. Speaking with an eviCore Medical Director is for educational purposes only.

Can a facility update the date of service after the authorization window has expired, or does the ordering physician need to call?

The procedure(s) should be performed during the authorization timeframe. Some health plans will allow for extensions to existing authorizations. Please contact eviCore healthcare for additional information.

How should I handle a retrospective request for authorization?

Retrospective requests are not allowed for this program.

What is the process to update an authorization with a new CPT code or facility?

For any CPT code or facility changes to an existing authorization, please contact eviCore healthcare by phone. Please have all clinical information relevant to your request available when you contact eviCore healthcare

Can I extend an authorization period on my authorization?

No. Date extensions are not permitted. If services are not rendered within the 60 day authorization period, a new authorization will be required.

Will eviCore grant approval for a series of injections?

No. A series of interventional pain injections will not be prior authorized. eviCore requires a separate prior 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 may help avoid processing delays.

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

eviCore healthcare will review the surgery precertification request for medical necessity and make a determination based on the clinical information provided by the rendering provider. Once the inpatient surgery decision is made, the event will be sent to Health Alliance who will then handle approval for the length of stay.

What criteria are required for prior authorization of a repeat epidural steroid injection (ESI)?

The criteria needed for a repeat epidural steroid injection is any of the following for the duration of two weeks or more:

1. At least 50 percent pain relief,
2. Increase in the level of function (i.e., return to work), or
3. Reduction in the use of pain medication or additional medical services such as physical therapy or chiropractic care.

Are facet joint injections/medial branch blocks allowed for the treatment of radiculopathy?

Facet joint injections/medial branch blocks should only be performed for neck pain or low back pain in the absence of an untreated radiculopathy.

Can I perform more than two facet joint injections/medial branch blocks at the same level?

More than two facet injections/medial branch blocks at the same level are considered to be therapeutic rather than diagnostic. There is no scientific evidence to support the use of a therapeutic facet joint injection/medial branch block and it is considered experimental, investigational or unproven.

Can I perform injections/blocks at more than three facet levels?

No, the performance of facet injections/blocks at more than three levels is considered not medically necessary.

Can I perform an epidural steroid injection on patients if they are not complaining of disabling or burning pain, pins and needles, or altered sensation?

The definition of radiculopathy, for the purpose of this policy, is defined as the presence of pain, dysaethesia(s), or paraesthesia(s) reported by the individual in a specified dermatomal distribution of an involved named spinal root(s) causing significant functional limitations resulting in diminished quality of life and impaired, age-appropriate activities of daily living, and **one** or **more** of the following:

1. Documented loss of strength of specific named muscle(s) or myotomal distribution(s), or demonstrated on detailed neurologic examination (within the prior three months), concordant with nerve root compression of the involved named spinal nerve root(s),

2. Documented altered sensation to light touch, pressure, pin prick, or temperature demonstrated on a detailed neurologic examination (within the prior three months) in the sensory distribution concordant with nerve root compression of the involved named spinal nerve root(s),
3. Documented diminished, absent, or asymmetric reflex(es) (within the prior three months) concordant with nerve root compression of the involved named spinal nerve root(s)
4. Documentation of either of the following:
    - A concordant radiologist's interpretation of an advanced diagnostic imaging study (MRI or CT scan) of the spine demonstrating compression of the involved named spinal nerve root(s) or foraminal stenosis at the concordant level(s) (performed within the prior 12 months), or
    - An electromyogram (EMG) or nerve conduction (NCV) diagnostic study of nerve root compression of the involved named spinal nerve root(s) (performed within the prior 12 months).

Is there a period of conservative care that is required prior to requesting a therapeutic ESI?

An epidural steroid injection is considered medically necessary for presumed radiculopathy resulting from disease, injury, or surgery that has not responded sufficiently to a reasonable course (four week minimum) of conservative treatment (e.g. physical therapy, chiropractic care, NSAIDs, analgesics, etc.).

What are the clinical criteria for radiofrequency ablation of the medial branch nerve innervating the facet joint?

A radiofrequency joint denervation/ablation is considered medically necessary for facet mediated pain resulting from disease, injury, or surgery and confirmed by provocative testing when **both** of the following criteria are met:

1. Failure of at least three months of conservative therapy (e.g., physical therapy, chiropractic care, NSAIDs, analgesics, etc.), and
2. Two positive diagnostic facet joint injections/medial branch blocks using either a local anesthetic or a local anesthetic combined with corticosteroid as evidenced by **either** of the following:

- A beneficial clinical response to dual (two) sequential intra-articular facet injections or medial branch blocks performed with a local anesthetic with greater than 80 percent pain relief for the duration of the effect of the local anesthetic used, or
- A beneficial clinical response to dual (two) sequential intra-articular facet joint injections or medial branch blocks performed with a local anesthetic and a corticosteroid with at least a 50 percent reduction in pain for at least two weeks.

What needs to be documented for a patient to be approved for facet injection/medial branch nerve block?

An initial diagnostic facet joint injection/medial branch block is considered medically necessary to determine whether chronic neck or back pain is of facet joint origin when **all** of the following criteria are met:

1. Pain is exacerbated by extension and rotation,
2. Pain has persisted despite appropriate conservative treatment (e.g., physical therapy, chiropractic care, NSAIDs, analgesics, etc.),
3. Clinical findings and imaging studies suggest no other obvious cause of the pain (e.g., spinal stenosis, disc degeneration or herniation, infection, tumor, or fracture).

What physical examination signs should be documented to justify a facet based procedure?

Facet joint injections/medial branch blocks are considered medically necessary for facet mediated pain resulting from disease, injury, or surgery and confirmed by provocative testing resulting in reproducible pain (i.e., hyperextension, rotation).

Is there a limit to the amount of sessions during which epidural steroid injections are administered?

No more than three (3) sessions during which epidural steroid injections are administered per episode of pain and no more than four (4) epidural steroid injections per spinal region per year.

May I perform an epidural steroid injection as an isolated treatment?

Based on the limited long-term benefits of performing an epidural steroid injection as an isolated intervention for the management of radicular pain, and a goal of increasing functional capacity, epidural steroid injections should be performed in association with an active rehabilitation program and/or therapeutic exercise.

Can multiple epidurals be approved on a single request for services?

There is insufficient scientific evidence to support the scheduling of a “series-of-three” injections in either a diagnostic or therapeutic approach. The medical necessity of subsequent injections should be evaluated individually and be based on the response of the individual to the previous injection with regard to clinically relevant sustained reductions in pain, decreased need for medication, and improvement in the individual’s functional abilities.

What needs to be documented for a patient to be approved for an epidural steroid injection?

An epidural steroid injection may be considered medically necessary when a detailed neurologic exam within the last three months demonstrated any of the following consistent with spinal nerve root compression:

1. Loss of strength of a specific named muscle(s) or myotomal distribution(s),
2. Altered sensation to light touch, pressure, pin prick or temperature,
3. Diminished, absent or asymmetric reflex(es).

4. An epidural steroid injection may also be considered medically necessary when a CT, MRI, or EMG/NCV performed within the last 12 months demonstrated compression of the involved named spinal nerve root(s).

What type of image guidance is appropriate for a facet joint injection/medial branch nerve block?

Facet joint injection/medial branch nerve block under fluoroscopic or CT guidance is acceptable. The performance of a facet joint injection/medial branch block injection under ultrasound guidance is considered experimental, investigational, or unproven for any indication.

What amount of conservative care is required for radiofrequency ablation of the medial branch nerves?

The criteria required for radiofrequency ablation of the medial branch nerves includes failure of at least three months of conservative therapy (e.g., exercise, physical therapy, chiropractic care, NSAID's, analgesics, etc.).

How frequently can repeat radiofrequency ablation of the medial branch nerve be performed?

A repeat radiofrequency joint denervation/ablation is considered medically necessary when there is documented pain relief of at least 50 percent that has lasted for a minimum of 12 weeks. While repeat radiofrequency joint denervations/ablations may be required, they should not occur at an interval of less than six months from the first procedure. No more than two procedures at the same level(s) should be performed in a 12-month period.

May radiofrequency ablation of the medial branch nerve take place at a previously fused spinal level?

A radiofrequency joint denervation/ablation is considered medically necessary when performed at spinal levels above or below a prior spinal fusion.

What are the parameters of an appeals request?

eviCore does not manage 1st level appeals. These are handled by Health Alliance. An authorized representative, including a provider, acting on behalf of a member, with the member's written consent may file an appeal to the health plan on behalf of a member. Appeal rights are detailed in coverage determination letters sent to the providers with each adverse determination.