eviCore healthcare Musculoskeletal Program
Joint/Spine 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

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 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.