eviCore healthcare Musculoskeletal (MSK) Program Frequently Asked Questions About Joint, Spine and Pain Management

Who is eviCore healthcare?

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides targeted utilization management services for Community Health Options.

What is the relationship between Community Health Options and eviCore healthcare?

Beginning on December 22, 2017, eviCore will manage musculoskeletal Prior Approval services for Community Health Options for dates of services January 1, 2018 or later.

What type of eviCore services are addressed in this MSK FAQ document?

- Interventional Pain Management
- Joint Surgery (Shoulder, Hip, Knee)
- Spine Surgery

How do I submit a Prior Approval request?

The quickest, most efficient way to obtain Prior Approval is through the 24/7 self-service web portal at www.evicore.com. When a case is initiated on the web portal and meets clinical criteria, a real-time authorization may be received. Prior Approval can also be obtained via phone at (855) 316-2673 or fax at (855) 774-1319.

What information will a provider need to initiate a Prior Approval request?

- Member's name, date of birth, plan name and plan ID number
- Ordering provider'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 Prior Approval request should be submitted to support medical necessity.

Does medically urgent care require Prior Approval?

The services managed under eviCore's Interventional Pain Management, Joint and Spine surgery programs are unlikely to be required on an urgent basis. Procedures done in an Emergency Department (ED) do not require Prior Approval. If an urgent service is approved without Prior Approval due to the clinical presentation, retrospective submission to eviCore to demonstrate both medical necessity and medical urgency is required within ten (10) business days of the date of service.

What is the turnaround time for a determination on a standard Prior Approval 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 will all parties be notified if the requested service has been approved?
Requesting and rendering providers will be notified of the Prior Approval via faxed and mailed letters. Both providers can validate a Prior Approval by using the eviCore website or by calling eviCore Customer Service. Members will be notified in writing.

What are my options when a Prior Approval 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. If additional clinical information is available without the need for a provider to participate, a reconsideration review can be requested by phone within fifteen (15) calendars days from the date of the determination. If additional clinical information is available but there is a need for the requesting provider to participate in a discussion, (s)he may schedule a call to speak with an eviCore Medical Director in the same specialty expertise. Peer-to-peer discussions can be requested within 15 calendar days from the date of the determination.

If a Prior Approval request is not approved, what follow-up information will the provider receive?
The requesting and rendering provider will receive a denial letter that contains the reason for denial as well as Reconsideration and Appeal rights and processes. Please note that after the denial has been issued (and within 15 calendar days of the adverse determination), the requesting provider may request a reconsideration review or a peer-to-peer discussion with an eviCore Medical Director to review the decision.

Can a facility update the date of service after the authorization window has expired, or does the ordering provider need to call?
The procedure(s) should be performed during the authorization timeframe and extensions are generally not approved. If there are unavoidable circumstances that prevent the provider from performing the service within the approved date range, the provider needs to call eviCore prior to the authorization end date to request an extension due to extenuating circumstances. Extensions will be reviewed on a case-by-case basis.

How should I handle a retrospective request for authorization?
Retrospective requests for urgent clinical presentations should be initiated by phone within ten (10) business days of the date of service. The services must have been clinically urgent and medically necessary. Please have all clinical information relevant to your request available when you contact eviCore healthcare.

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

For any CPT code changes to an existing authorization before services are rendered, please contact eviCore healthcare.

If surgical services have already been performed and you need to request a CPT code change due to intraoperative findings, you must do so within ten (10) business days from the date services were performed. All interventional pain management authorization CPT code updates must be made prior to the service being performed.

All changes must be requested before the coverage period has expired.

Please have all clinical information relevant to your request available when you contact eviCore healthcare

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

eviCore healthcare will review medical necessity of the requested surgical procedure but eviCore does not review or approve level of care. If the requested procedure will be performed in an inpatient setting, you must notify Community Health Options Medical Management team within 48 hours of the inpatient admission (surgical procedure date) to establish the goal length of stay and to initiate concurrent review, when applicable. Please call Health Options Medical Management team for further information about inpatient admissions at [855] 542-0880, Monday-Friday, 8am-5pm or leave a voice message if you are calling after hours.

What are the parameters of an appeals request?

eviCore manages 1st level appeals. The Member or an authorized representative, which includes the treating provider, may file an appeal on behalf of a Member. Appeals rights and process are included in the denial letter.

Where should first-level appeals be sent?

Appeals must be submitted by mail, fax or email to:

Mail: eviCore healthcare
Attn: Clinical Appeal Dept.
400 Buckwalter Place Blvd,
Bluffton, SC 29910

Fax: 866-699-8128

E-mail: Appealsfax@evicore.com

Toll Free Phone: (800)792-8744 ext. 49100 or (800)918-8924 ext. 49100