eviCore healthcare Musculoskeletal Program

Frequently Asked Questions

Who is eviCore healthcare?

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for certain Scott & White Health Plan members.

Which members will eviCore healthcare manage for the Musculoskeletal program?

eviCore will manage services for:

- Commercial Fully Insured
- Commercial Self-Funded
- Medicare Advantage

What is the relationship between Scott & White Health Plan and eviCore healthcare?

eviCore will manage selected musculoskeletal services for Scott & White Health Plan for dates of service on or after October 1, 2018. Providers can begin submitting prior authorization requests for musculoskeletal services to eviCore healthcare on September 21, 2018.

What is included?

- Spine surgery
- Joint Surgery
- Interventional Pain

How do I submit a precertification request?

The SWHP Provider Portal is the quickest, most efficient way to obtain an authorization. Log onto - **https://portal.swhp.org/ProviderPortal/#/login,** click on the **eviCore link** to initiate a case, view case/authorization details, verify eligibility, and more.

Providers can also obtain prior authorization through the 24/7 self-service web portal at www.evicore.com. eviCore healthcare's prior authorization call center is available from 7:00 a.m. to 8:00 p.m. and can be reached at 888-209-5762.

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
- 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.

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. Urgent requests will be processed within 72 hours and be initiated via phone at 888-209-5762 or the web portal; fax submissions can be submitted to 800-540-2406.

How will all parties be notified of approvals and denials for Musculoskeletal services?

eviCore healthcare is committed to reviewing all requests and giving case decisions within fourteen (14) calendar days of receipt of your request for Medicare Advantage and within three (3) business days for commercial members. In order to ensure timely decision making, it is important that you provide all clinical documentation supporting services(s) being requested. Notifications are faxed to the ordering provider and mailed to the member. Denial notifications are not sent to the facility.

If a prior authorization is not approved, what follow-up information will the rendering provider receive?

For commercial members, the referring provider will receive outreach prior to receiving a denial letter which will contain the reason the request has been recommended for denial. During this outreach a physician consult may be scheduled if needed to allow the opportunity to request a Physician-to-Physician discussion with an eviCore Medical Director, at which point any additional details can be offered for consideration when making a final decision. Please note that due to state mandated time frames you will have one (1) business day to schedule the physician consult.

For Medicare members, the referring provider will receive outreach **prior** to receiving a denial letter which will contain the reason the request has been recommended for denial. During this outreach a physician consult may be scheduled if needed to allow the opportunity to request a Physician-to-Physician discussion with an eviCore Medical Director, at which point any additional details can be offered for consideration when making a final 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 after a denial is rendered is for educational purposes only after which the appeals process will need to be followed.

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

For any CPT code changes to an existing authorization, please contact eviCore healthcare. Please have all clinical information relevant to your request available when you contact eviCore healthcare at 888-209-5762.

Are retrospective requests accepted?

For time-sensitive matters, retrospective requests can be initiated by contacting eviCore at 888-209-5762 and requesting a retro auth. This must be done within seven (7) business days of the date of service. Requests will be reviewed and decisions made based on medical necessity/urgency of service. Retrospective reviews will only be considered for the procedure. Inpatient admission notification must still be made upon member admission to facility.

Can I extend an authorization period on my authorization?

Extensions are not allowed for the musculoskeletal program, a new case will need to be built.

Will eviCore be processing claims for Scott & White Health Plan?
No, eviCore will only manage prior authorization requests. Pre-Certification and Pre-Service approval is not a guarantee of payment of benefits.

Will eviCore grant approval for a series of injections?
A series of 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. eviCore will collect the requested place of service during the precertification process. You will still need to notify Scott & White Health Plan of the inpatient stay, and include the approved prior authorization from eviCore. This will allow for timely processing of the inpatient request. eviCore does not provide concurrent bed day management for inpatient admissions. All modifications/extensions to the approved length of stay are handled by the healthplan using existing concurrent review processes.

This process may still take up to 48 hours to ensure both the procedure and inpatient stay events are in place for the member.

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 on 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), or
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) and
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 or 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 benefit 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, or
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 happens if codes need to be changed/added to after surgery has been completed?

Once surgery has been completed and additional procedures were required please contact eviCore via phone and let us know what codes need to be added. Please be prepared to offer additional documentation to support the change.

What are the parameters of an appeals request?

Medicare: All requests for Medicare appeals will be managed by Scott and White Health Plan, you will have sixty (60) days to appeal. Appeal rights are detailed in organization determination letters sent to the providers with each adverse determination. You can also refer to the Scott and White provider manual for details on how to submit a request for reconsideration.

Commercial: eviCore will manage 1st level Fully Insured appeals. An authorized representative, including a provider, acting on behalf of a member can request an appeal. Appeal rights are detailed in organization determination letters sent to the providers with each adverse determination. Appeals must be made in writing within 180 calendar days unless the request involves urgent care, in which case the request may be made verbally. eviCore will respond within 30 calendar days for general appeals and 24 hours for urgent appeals. Medically urgent appeals 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 requires a medically urgent procedure.

Where should Fully Insured Commercial 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