Frequently Asked Questions

Gastroenterology

Who is eviCore healthcare?
eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for Network Health Wisconsin.

What is eviCore healthcare's Gastroenterology Prior Authorization Program?
eviCore's Prior Authorization Program consist of requests for Prior Authorization Medical Necessity Determinations for the following services.

- Esophagogastroduodenoscopies (EGD) (commercial and Medicare lines of business)
- Capsule endoscopies (commercial and Medicare lines of business)
- Non-screening colonoscopies (commercial and Medicare lines of business)

Important Note: Providers and staff can refer to a detailed list of CPT codes that require prior authorization by visiting https://www.evicore.com/resources/healthplan/network-health-wisconsin.

How do I check the eligibility and benefits of a member?
Member eligibility and benefits should be verified on https://networkhealth.com/ before requesting prior authorization through eviCore.

Who needs to request prior authorization through eviCore?
A representative of the ordering provider's staff can request prior authorization. This could be someone from clinical, front office, or billing staff acting on behalf of the ordering provider. Alternatively, the rendering facility can also request a prior authorization.

How do I request a prior authorization through eviCore healthcare?
Providers and/or staff can request prior authorization in one of the following ways:

Web Portal
The eviCore portal is the quickest, most efficient way to request prior authorization and is available 24/7. Providers can request authorization by visiting www.evicore.com

Call Center
eviCore's call center is open from 7 a.m. to 7 p.m. local time. Providers and/or staff can request prior authorization and make revisions to existing cases by calling 855-727-7444

Do services performed in the Emergency Room (ER), during an observation or inpatient stay require authorization?
Prior authorization is not required for services provided in an ER, observation, or inpatient setting.

What information is required when requesting prior authorization?
When requesting prior authorization, please ensure the proprietary information is readily available:

Member
- First and Last Name
- Date of Birth
- Member ID

Ordering Provider
- First and Last Name
- National Provider Identification (NPI) Number
- Tax Identification Number (TIN)
- Phone and Fax Number

Clinical(s)

- A relevant history and physical examination
- A relevant summary of the patient's clinical condition
- Imaging and/or pathology and/or laboratory reports as indicated relevant to the requested procedure
- Co-morbidities (if applicable)
- The indication for the specified procedure
- Prior treatment regimens
- Results of prior endoscopic procedures if relevant
- Genetic testing results (if applicable)

How to avoid inappropriate denials when services are appropriate?

Services that are deemed appropriate are those that follow clinical and/or medical necessity guidelines. You can find those guidelines at www.eviCore.com. Click the resources drop down button at the top right side of the web page to find the link to those guidelines.
If a provider follows guidelines that govern clinical and/or medical necessity criteria, but still experiences high denial rates, the reason may be due to clinical information missing from the case request. This is a list of information usually required:

- A relevant history and physical exam
- Summary of patient's condition
- Imaging and/or pathology and/or lab reports indicated relevant to the
- requested procedure
- Co-morbidities if relevant
- The indication for the specified procedure
- Prior treatment regimens (for example, appropriate clinical trial of
- conservative management , if indicated)
- Results of prior endoscopic procedures if relevant
- Genetic testing

Where can I access eviCore healthcare's clinical guidelines?

eviCore's clinical guidelines are available online 24/7 and can be found by visiting the following link:

Clinical Guidelines
www.evicore.com/provider/clinical-guidelines

How do I submit a claim for monitored anesthesia or moderate sedation in conjunction with the EGD?

If an EGD request has been approved, providers can submit monitored anesthesia or moderate sedation codes in the same claim and Network Health Wisconsin will reimburse per normal processes. However, if the EGD procedure is denied, Network Health Wisconsin will not reimburse for the anesthesia or sedation codes.

What if I don't know the specific gastroenterology CPT code I plan to perform at the time PA is requested?

It is not required that you know the specific CPT code for the procedure you plan to perform at the time the PA is requested. You can choose a more general diagnostic EGD or colonoscopy code, such as CPT 43235 or 45378, or another that might more closely resemble your anticipated procedure. We recognize that you may not know beforehand what procedure may be performed during the course of the planned endoscopy. You may submit billing for any of the codes included on the list of EGD or colonoscopy CPT Codes managed by eviCore. You will not have to contact eviCore if the procedure ultimately performed is different than the one initially approved.

What if, during the course of the EGD or colonoscopy, more than one type of therapeutic or diagnostic maneuver is carried out? Can I submit billing for multiple CPT Codes that reflect the nature of the procedure performed?

Yes, as long as the procedures performed are included on the list of gastroenterology CPT Codes managed by eviCore. We recognize that multiple maneuvers (e.g., polypectomy of one lesion, and then destruction of a different lesion by electrocautery, etc.) may occur during an EGD or colonoscopy. The additional codes can be submitted and will be reimbursed based on Network Health Wisconsin policy for payment in this circumstance. You will not have to contact eviCore if you need to perform multiple delegated procedure(s) different from the one requested.

How are authorizations treated if a provider is conducting a screening colonoscopy (which does not require an authorization) but finds polyps or other abnormalities that change the code to a diagnostic or therapeutic colonoscopy? Does the provider need to have an authorization for this situation?

No, an authorization is not required for this situation. However, if during the same operative session the colonoscopy begins as a screening and turns to diagnostic or therapeutic, providers must report an appropriate screening diagnosis as the primary diagnosis and any abnormal diagnoses as secondary and/or subsequent diagnoses. In addition, providers should report the appropriate PT or 33 modifier, signifying that the colonoscopy started as screening but changed to therapeutic due to the detection of polyps or other abnormalities during the procedure.

What does eviCore consider a Screening Colonoscopy that does NOT need a prior authorization?

Generally speaking, no prior authorization is required if the primary and intended purpose of the colonoscopy is for asymptomatic average risk screening, defined as no previously diagnosed colorectal cancer, colonic adenomas, or inflammatory bowel disease involving the colon. However, please refer to the Network Health Wisconsin Gastroenterology Tip Sheet for a more detailed delineation regarding colonoscopies that require prior authorization.

Can a claim for monitored anesthesia and/or moderate sedation be submitted in conjunction with an approved capsule endoscopy?

No, it is generally not medically necessary to administer anesthesia or moderate sedation in conjunction with capsule endoscopies unless an EGD is considered medically necessary to place the capsule directly into the stomach or duodenum, in which case the request for sedation would be paid in conjunction with the EGD. Otherwise, Network Health Wisconsin will not reimburse for these codes.

If the provider performs two capsule endoscopies (e.g., 91110 and 91111) but only has an authorization for one of these codes, will Network Health Wisconsin pay for both?

No. Unlike the EGD and colonoscopy procedures, the capsule endoscopy procedures are not substitutable for one another. As a result, Network Health Wisconsin would deny a claim for the code that wasn't approved. The provider would need to contact eviCore to receive a separate approval for the second capsule endoscopy code.

What is the process if an EGD with Botox is needed?

Two separate authorizations are required for these requests: one for the drug (Botox) and one for the procedure to administer the drug (EGD).

Providers must obtain prior authorization from Care Continuum/CCUM for the Botox portion of these requests. Care Continuum/CCUM can be submitted via seamless access to ExpressPAth through the Network Health provider portal, or directly via the ExpressPAth portal at https://provider.express-path.com/. Once CCUM authorization is obtained, providers can submit prior authorization from eviCore for EGD (2 authorizations are required for these situations). eviCore will require the CCUM authorization number in order to proceed with the EGD procedure review process.

Does eviCore allow site changes after receiving prior authorization?

eviCore will permit authorized requestors to contact eviCore after an approval has been rendered for the purpose of changing the requested Rendering Facility Location.

What is the most effective way to get authorization for urgent requests?

Urgent requests are defined as a condition that is a risk to the patient's health, ability to regain maximum function and/or the patient is experiencing severe pain that require a medically urgent procedure. Urgent requests may be initiated on our web portal at www.evicore.com, or by contacting our contact center at 855- 727-7444.

Once prior authorization has been requested, how long will it take for eviCore to make the determination?

- Decisions for non-urgent precertification requests are typically made within two 2-3 business days of receipt of all necessary clinical information, but would not take longer than 14 calendar days.
- When gastroenterology services are required due to a medically urgent condition, eviCore healthcare will usually give a decision within 24 hours of receiving all necessary demographic and clinical information, but would not take longer than 72 hours. Please indicate that the authorization is for medically urgent care.

When will I receive the authorization number once the prior authorization request has been approved?

Once the prior authorization request has been approved, the authorization information will be sent to provider's office via fax. It's possible to receive a 'real time' authorization immediately after web submission, and provider's offices may also visit www.evicore.com to view the authorization determination. The member will receive an approval letter by mail.

Note: The authorization number will begin with the letter 'A' followed by an eight-digit number.

How long is the authorization valid?

Authorizations are normally valid for 90 calendar days.

Does eviCore review cases retrospectively if no authorization was obtained?

Retrospective requests must be initiated within 7 business days following the date of service. Please submit all relevant clinical information at the time of your request.

What if an authorization is issued and revisions need to be made?

The requesting provider or member should contact eviCore with any change to the authorization. It is very important to update eviCore healthcare of any changes to the authorization in order for claims to be correctly processed for the facility that receives the member.

How can the provider confirm that the existing prior authorization number is valid?

Providers can confirm that the prior authorization is valid by logging into our web portal, which provides 24/7 access to view prior authorization numbers. To access the portal, please visit www.evicore.com. To request a fax letter with the prior authorization number, please call eviCore healthcare at 855-727-7444 to speak with a customer service specialist.

What options do I have if eviCore healthcare denies a prior authorization request?

All post-decision options will be detailed in the denial letter sent to the requesting clinician and the member/participant. For commercial members, eviCore has a reconsideration process in which a provider can contact eviCore with additional information, or engage in a peer-to-peer consultation (P2P) with an eviCore gastroenterologist. During the P2P, additional evidence or circumstances can be shared which could lead to an approval. For Medicare cases, providers are contacted multiple times prior to denial as part of the "unable to approve" process. During this hold time, providers can engage in a P2P with an eviCore gastroenterologist similar to the process for commercial members. However, if the case goes to denial before that P2P can occur, the provider will need to file an appeal with NWH. Please note that eviCore healthcare welcomes P2Ps between the provider and the eviCore healthcare Medical Director. To avoid delay, or a lengthy appeal process, P2Ps should occur prior to a final denial.

Other than an appeal, what options do I have for Medicare members after a denial?

For Medicare members, a provider may request a reopening for a case if it meets Centers for Medicare & Medicaid Services (CMS) criteria:

- Denied incorrectly due to issues such as a technical, or clerical, error made by the health plan or health plan delegate, and/or
- New material or information available that was not known or available at time of the original decision.

Where do I submit my claims?

All claims will continue to be filed directly to Network Health Wisconsin. Please note that Network Health follows national guidelines, including Centers for Medicare & Medicaid Services (CMS) guidelines, when making claim determinations.

How do I submit a program-related question, or report an issue?

For program related questions or concerns, please email: clientservices@evicore.com

- Eligibility issues (member, rendering facility, and/or ordering physician)
- Issues experienced during case creation
- Inquiries regarding standard processes and procedures
- Questions regarding Accuracy Assessment, Accreditation, and/or Credentialing
- Request for an authorization be resent to the health plan

Where can I find additional educational materials?

For more information and reference documents, please visit our resource page at www.evicore.com/provider.