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EviCore healthcare Sleep Diagnostics
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 Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma, and Texas.

What BCBS plans or lines of business are covered under this agreement?
EviCore will manage services for:

- Blue Cross and Blue Shield (BCBS) Medicare members located in the states listed above.
- BCBS Medicaid members located in Illinois.

What is the relationship between BCBS and EviCore healthcare?
Beginning June 1, 2017, EviCore will manage Diagnostic Sleep Testing, positive airway pressure (PAP) Therapy Devices, and PAP therapy Supplies for BCBS. In addition, EviCore will track compliance with PAP therapy via our TherapySupport℠ program.

How can I initiate a prior authorization request?
The preferred, most efficient method is to initiate a request online at www.EviCore.com. You may also initiate requests via phone at 855.252.1117.

What are the hours of operation for the prior authorization department?
EviCore healthcare's prior authorization call center is available from 7:00 a.m. to 7:00 p.m, Monday through Friday local time. For auth requests originating from Texas hours of operation are 6 am to 6 pm central time Monday through Friday and between 9 am-noon central time on Saturdays, Sundays, and legal holidays. The web is available 24/7.

What are the elements of the Sleep Management Program?
The main components of the Sleep Management Program are prior authorization for all diagnostic sleep procedures as well as all sleep-related positive airway pressure devices (PAP) and PAP therapy supplies. In addition, compliance with PAP therapy will be monitored and tracked via EviCore's TherapySupport℠ program.

What procedures will require prior authorization?
All Diagnostic Sleep Tests, PAP Therapy Devices, and PAP therapy supplies will require prior authorization through EviCore healthcare. This will include all attended sleep studies as well as home sleep studies. A complete list of CPT codes that require authorization can be found on the implementation page at https://www.EviCore.com/healthplan/bcbs

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What will happen if the referring provider's office does not know the specific test code (CPT) that needs to be ordered?
EviCore healthcare will assist the physician's office in identifying the appropriate test based on presented clinical information and the Physicians' Current Procedural Terminology (CPT) code.

Is a separate authorization needed for each CPT code?
Yes, providers will only be requesting an authorization for one code at a time.

What medical providers will be affected by this agreement?
Any Physicians requesting sleep testing are required to obtain a prior authorization for services prior to the service being rendered.

What information will be required to obtain a prior authorization?

- Member's plan name
- Patient's name, date of birth, and member ID number
- Ordering Physician's name, provider NPI number, address, telephone and fax numbers
- Sleep facility's name, telephone and fax numbers
- Requested test(s) CPT Code(s) or description(s)
- Working Diagnosis
- Signs and symptoms
- Epworth Sleepiness Score (ESS)
- Co-Morbidities
- AHI/RDI
- Results of relevant tests
- Relevant medications
- If initiating the authorization via phone, the caller should have the medical record available

How do I request a "Split-Night" Study?
A "Split Night" request is initiated and approved as a 95810 attended sleep study. If the "Split-Night" is successfully completed, 95811 may be billed using the existing authorization number. Only one code (95811 or 95810) can be billed.

How long are authorization approvals valid?
Prior Authorizations for attended studies and home sleep tests are valid for BCBS 90 calendar days from the date of the approval. Prior authorizations for PAP therapy devices and supplies are valid for 180 days.

If the patient comes in after the authorization expires and requires a study, do we need a new authorization?
Yes. EviCore will not extend an authorization.

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How will the referring or rendering provider know that a prior authorization has been completed?

Ordering and rendering providers will receive written notification via fax and urgent requests via phone. You can also validate the status using the EviCore provider portal at www.EviCore.com or by calling EviCore healthcare at 855.252.1117. Members will be notified in writing by mail and urgent requests via phone.

How will all parties be notified of approvals and denials for sleep diagnostic and PAP therapy services?

EviCore healthcare is committed to reviewing all requests and giving case decisions within fourteen (14) calendar days of receiving all necessary clinical information.

What information about the prior authorization will be visible on the EviCore healthcare provider web portal?

- The authorization status function on the website will provide the following information:
- Prior authorization number/Case number
- Status of request
- CPT code
- Procedure name
- Site name and location
- Prior authorization date
- Expiration date

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

For Medicaid BCBS IL, the referring provider will receive a denial letter that contains the reason for denial as well as Reconsideration and Appeal rights and processes. A reconsideration allows providers the chance to provider additional information to support the request and includes the opportunity to request a Peer-to-Peer discussion with an EviCore Medical Director to review the decision.

For Medicare BCBS members, the referring provider will receive a denial letter that contains the reason for denial as well as Appeal rights and processes. Please note that after a denial has been issued for a Medicare member, no changes to the case decision, such as a reconsideration, can be made. Speaking with an EviCore Medical Director is for educational purposes only.

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What is the format of the EviCore healthcare authorization number?

An authorization number is (1) one Alpha character followed by (9) nine numeric numbers, and then the CPT code of the procedure authorized. For example: A123456789-70553.

What are the parameters of an appeals request?

EviCore will manage 1st level appeals. An authorized representative, including a provider, acting on behalf of a member, with the member's written consent may file an appeal on behalf of a member. A member patient authorization form must be completed for all first level appeals. Appeal rights are detailed in coverage determination letters sent to the providers with each adverse determination. Appeals must be made in writing within 120 calendar days and 30 calendar days for IL Medicaid unless the request involves urgent care, in which case the request may be made verbally. EviCore will respond within 30 calendar days, and 15 business days for IL Medicaid requests.

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

PAP ADHERENCE/COMPLIANCE REQUIREMENTS

What are the PAP adherence/compliance requirements?

- For the first 90 days of PAP therapy, DME providers must install PAP devices with remote monitoring capability via modem.
- Consistent with good medicine, all DME providers will be directly responsible for monitoring and supporting their patients' compliance with therapy and conducting outreach to members on a regular basis.
- Beyond 90 days of therapy, periodic monitoring through SD card (or similar) reporting of daily adherence/compliance is required.
- PAP compliance is defined as use of PAP therapy for at least 4 hours per night for 70% of days during the first 90 days of therapy.

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What is the process for registering patients in the PAP manufacturer systems?

DME's will utilize their existing accounts with AirView (ResMed), EncoreAnywhere (Respironics), or FPInfoSmart (Fisher & Paykel). More detailed information regarding the registration process can be found behind the provider login at https://www.EviCore.com/solution/pages/sleep.aspx.

What information is required when registering patients?

- Member's first and last name
- Date of birth
- Insurance Carrier
- Member's health plan ID number

How does EviCore healthcare's compliance System work?

EviCore healthcare will monitor the member's data while their PAP Device is connected to a modem. Periodic reminders will be sent to the DME provider of record if the member is non-compliant with therapy. If the member is compliant with therapy during the first 90 days of use, EviCore healthcare will issue an authorization for the remaining 7 units and send the authorization to the DME. The DME will not need to contact EviCore healthcare for the purchase authorization.

What happens if the member is not compliant with PAP Therapy after 90 days of use?

DME providers are expected to work with members and optimize PAP usage. However, if the member is not compliant with therapy during the first 90 days, EviCore healthcare will communicate with the DME periodically and notify them that the member is not meeting BCBS's requirements for compliance. The DME supplier, and the referring physician, may receive additional communications from EviCore healthcare if the member continues to be noncompliant with therapy.

- After 90 days of therapy, if the member is non-compliant, the DME provider will need to assess the member's willingness and commitment to continue therapy. The DME provider should continue to work with the member until compliance is achieved. If the member is not compliant and will not continue with therapy at any time during or after the first 90 days of use, the DME provider will need to follow their normal protocol for recovery of the machine.

Will EviCore be processing claims for BCBS?

No, EviCore will only manage prior authorization requests. Pre-Certification and Pre-Service approval is not a guarantee of payment of benefits.

Medicare: Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for

services, supporting medical documentation and other terms, conditions, limitations and exclusions of your Certificate of Benefits booklet and/or Summary of Benefits.

Medicaid: For services to be paid by Blue Cross and Blue Shield, members must be eligible for Medicaid at the time of treatment. Payment depends on the amount allowed for the treatment. It also depends on a review of supporting records. Other terms and limits of your plan may also apply.