EviCore Prior Authorization Process Overview

Prior Authorization request through EviCore does not always require the provider to submit additional clinical information, but there are scenarios that may warrant submitting additional clinical details for medical necessity determination or for an authorization reconsideration or appeal.

Initial Request Pends—Provider receives request for additional clinical information

Alternative Recommendation

If the communication for additional clinical information includes an alternative service recommendation, the provider office representative can accept the service offered by notifying EviCore via phone (recommended) or fax within **10 calendar days**. EviCore will accept the alternative recommendation in the portal, triggering a new case, which will be immediately approved. The **new case number** will be provided to the caller and/or the approval notification will be sent to provider.

Additional Clinical

OR, If clinical documentation exists that addresses the missing criteria outlined in the letter for the requested service, the provider office representative can submit additional clinical documentation through the EviCore Provider Portal or via fax.

Physician documentation OR Peer-to-Peer Consultation

OR, If clinical documentation does NOT exist to address the missing criteria outlined in the letter for the requested service, but the physician believes there are additional indicators to consider in the case, the provider office representative may:

- → Submit documentation from physician providing additional case information to impact the determination through the EviCore Provider Portal or via fax.
- → OR Schedule a Peer-to-Peer pre-decision clinical consultation for the provider on the EviCore Provider Portal or by phone.

NOTE: *If additional clinical information is NOT received within the timeframe as specified in the letter (10 calendar days), EviCore will render a determination based on the original submission details.*

SUBMISSION OPTIONS

EviCore Provider Portal (accessible via Wellmark Auth Table) or EviCore Intake Call Center (Fax: 800-540-2406 – Phone: 844-253-9502)

Initial Request Decision – Not Approved

If the prior authorization request is determined to NOT be medically necessary

Reconsideration – Alternative Recommendation or Additional Clinical

- **If the communication includes an alternative service recommendation,** the provider office representative can accept the service offered by notifying EviCore via phone (recommended) or fax within 10 calendar days. EviCore will accept the alternative recommendation in the portal, triggering a new case, which will be immediately approved. The new case number will be provided to the caller and/or the approval notification will be sent to provider.
- **OR, If the physician wants to proceed with the originally requested service:**
  - If clinical documentation exists that addresses the missing criteria outlined in the determination letter for the requested service, the provider office representative can submit additional clinical documentation through the EviCore Provider Portal or via fax.
  - If clinical documentation does NOT exist to address the missing criteria outlined in the determination letter for the requested service, but the physician believes there are additional indicators to consider in the case, the provider office representative may:
    - → Submit documentation from physician providing additional case information to impact the determination through the EviCore Provider Portal or via fax.
    - → OR Schedule a Peer-to-Peer clinical consultation for the provider on the EviCore Provider Portal or by phone.
- **If reconsideration period has expired after 14 calendar days or reconsideration is upheld, see 1st level appeal.**

1st Level Appeal

- Provider office representative can submit new clinical documentation to EviCore as a 1st level appeal on the original case through the EviCore Provider Portal or via fax.
- Peer-to-Peer clinical consultation is still available after 14-calendar day reconsideration period, but it will not result in a determination change without a 1st level appeal submission. The provider office representative may schedule the Peer-to-Peer clinical consultation for the provider on the EviCore Provider Portal or by phone.
- **This 1st level appeal exhausts the appeal rights on this case and subsequent appeals submitted to Wellmark will not be considered. If the physician wants to proceed with the service and 1st level appeal is upheld, see External Review.**

External review

- Physician office representative can submit an external review through the respective Division of Insurance. Additional details are provided in the appeal upheld letter.
- **External review is the highest-level review available for an adverse determination.**

Complete Medical Necessity Criteria

If the prior authorization request is determined to NOT be medically necessary:
At any time, the physician can follow the medical necessity criteria for the service as outlined in the clinical guideline and a provider office representative can submit updated clinical documentation on the EviCore Web Portal or via fax as a(n):

- → Reconsideration (if under 14 calendar days from decision)
- → 1st level appeal (if not exhausted)
- → New case (after 45-calendar day wait period has ended from the most recent determination date)

NOTE: *New case build by provider office representative is not available for the same/similar CPT code and provider for 45 calendar days from the most recent determination date (original decision, reconsideration upheld, or appeal upheld date). Duplicate cases will expire, unless the 45-calendar day wait period has ended.*

Medical Policy—Clinical Guidelines

Wellmark Medical Policy and EviCore Clinical Guidelines can be accessed via the Wellmark Medical Authorization Table.

SUBMISSION OPTIONS
EviCore Provider Portal (accessible via Wellmark Auth Table) or EviCore Intake Call Center (Fax: 800-540-2406 – Phone: 844-253-9502)