EviCore By EVERNORTH

Frequently Asked Questions

cigna healthcare

Post-Acute Care (PAC)

Who is EviCore by Evernorth?

EviCore by Evernorth (EviCore) is an independent specialty medical benefits management company that provides Post-Acute Care (PAC) utilization management services for Cigna Medicare members.

Which customers will EviCore by Evernorth manage for PAC?

Beginning May 27th, 2022, EviCore will accept PAC precertification requests for Cigna members with Medicare Advantage coverage for dates of service June 1st, 2022 and beyond. This program does not apply to PAC services for Cigna commercial members.

Which PAC services require prior authorization?

- Skilled nursing facility (SNF) admissions
- Inpatient rehab facility (IRF) admissions
- Long-term acute care (LTAC) admissions

How does a provider check member eligibility and benefits?

Providers should verify member eligibility and benefits on the secured provider log in section through Availity or by calling Cigna Medicare Advantage Provider Services at 800.230.6138.

How does a provider initiate a prior authorization request?

Providers and/or staff may request prior authorization in one of the following ways:

- **EviCore by Evernorth Provider Portal (preferred)**
  The EviCore by Evernorth portal is the quickest, most efficient way to request prior authorization.
  www.evicore.com/ep360
- **Fax**
  Prior authorization requests for PAC may be faxed to 800.575.4429
- **Phone**
  Providers and/or staff may request prior authorization by calling 800.298.4806

Where can a provider find PAC prior authorization request forms?

PAC prior authorization request forms are available on the EviCore provider resource website under ‘Solution Resources’:
Cigna Medicare Advantage Provider Resource | EviCore by Evernorth

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Who is responsible for submitting the initial PAC prior authorization request?

- Hospitals are responsible for submitting the initial inpatient precertification for SNF, IRF or LTAC admissions for customers discharging from an acute care facility.
- PAC Facilities (SNF, IRF and LTAC) are responsible for submitting the initial precertification requests for customers admitting from the community, emergency department, or outpatient setting.
- IRF and LTAC facilities are responsible for submitting the initial precertification for customers transitioning to a lower level of care, such as a SNF.

NOTE: If a patient is transferred to the hospital directly from a PAC facility and stays >24 hours, a new precertification is required and should be requested by the hospital prior to discharge.

What information is required when requesting an initial prior authorization request?

- Admission Details
  - Facility type being requested
  - Accepting facility demographics (if known)
  - Patient demographics
  - Anticipated date of hospital, LTAC, or IRF discharge (if applicable)
- Clinical Information
  - Hospital admitting diagnosis
  - History and physical
  - Progress notes, i.e., attending physician, consults and surgical (if applicable)
  - Medication list
  - Wound or Incision/location and stage (if applicable)
- Mobility and Functional Status
  - Prior and current level of functioning
  - Prior living situation
  - Current therapy evaluations: PT/OT/ST (within 24-48 hours of request)
  - Therapy progress notes, including level of participation

What information is required when requesting date extensions for PAC?

- Extension Request Details
  - Facility name and NPI
  - Patient demographics
  - Facility contact name, phone and fax #
- Clinical Information
  - Current admission ICD-10 code
  - Clinical progress notes
  - Medication list
  - Wound or Incision/location and stage (if applicable)
- Mobility and Functional Status
  - Prior and current level of functioning
  - Focused therapy goals: PT/OT/ST
  - Therapy progress notes, including level of participation
  - Discharge plans (include discharge barriers, if applicable)

NOTE: Clinical is due 72 hours prior to the last covered date. Clinical should be no older than 72 hours from date sent. Only updated information since the last review needs to be sent.

Can we provide EviCore with EMR access to help our facility expedite the clinical review?

EviCore by Evernorth is dedicated to partnering with PAC facilities to make the authorization process as seamless as possible. For qualifying facilities, EviCore can now connect directly to your EMR systems to help manage authorization requests in a timely manner. With this access:

- Required clinical documentation is automatically retrieved by EviCore clinical staff for medical necessity review
- Decreases the time facility staff spend manually submitting clinical documentation to EviCore
- Lowers the risk of denials due to lack of clinical documentation

Please reach out to the PAC Provider Engagement Manager in your region, PAC Provider Relations for more information and to get started.

When will a provider receive the prior authorization determination from EviCore?

Once all information is submitted, EviCore by Evernorth will review and outreach to the provider with a determination. Typical response time is two business days for routine requests and no later than 72 hours for urgent requests.

How will prior authorization determinations be communicated to providers?

EviCore by Evernorth will communicate the determination utilizing the following methods:

- Written notification will be faxed to the requesting provider.
- Prior authorization status can be viewed on demand on the EviCore by Evernorth portal at www.evicore.com/ep360

When does the initial prior authorization approval expire?

PAC: The initial precertification will expire 7 days from the date of issue.

What is the process if EviCore is unable to approve the request for a PAC service?

When a request does not meet criteria during nurse review, it goes to second level MD review. If the MD is unable to approve the request based on the information provided, notification is made to the requesting provider. The provider is given the option to either send additional information to support medical necessity or schedule a Clinical Consultation (peer-to-peer).

Important: If one of these options is not utilized by the requesting provider within one business day, an adverse determination is made and the request is denied.

Alternate Recommendation

The EviCore MD may also offer an alternate recommendation. The requesting provider can either accept or reject the alternate recommendation, or schedule a Clinical Consultation. The provider has up to 48 hours to accept the alternate recommendation. If accepted, the initial requested service will be denied and the alternate recommendation will be approved

What is a Clinical Consultation (Peer-to-Peer) and its advantages?

A Peer-to-Peer (P2P) is a conversation between your clinician (MD, PA, or NP) and an EviCore Medical Director over the phone to discuss a patient's case. A P2P can help clarify the patient's clinical needs, which the clinical record may not always clearly convey. Requesting a P2P before a final denial determination is issued may help reduce the need to file an appeal, should the member still have medical necessity needs. To request a P2P, please call EviCore at 800.298.4806. Medical Directors are available for Clinical Consultations 365 days a year. In some instances, EviCore may initiate a proactive P2P outreach.

In the event of an adverse determination, what post-denial processes are available?

Clinical Consultation

- Providers can request a Clinical Consultation with an EviCore by Evernorth physician to better understand the reason for denial.
- Once a denial decision has been made, however, the decision cannot be overturned via a Clinical Consultation.

Appeal Process

- EviCore by Evernorth is not delegated for appeals.
- Please reference your denial letter you received from EviCore by Evernorth for next steps on where to submit your appeal.

Medicare Advantage customers requesting an appeal of the denial for continued PAC services should follow the process outlined on their denial letter.

Does EviCore by Evernorth review cases retrospectively?

Retrospective reviews are not allowed, with the exception of special circumstances. Please contact Cigna directly for consideration.

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

The servicing provider should contact EviCore by Evernorth with any changes for customers who are still in the PAC facility. Any change(s) requested after the customer is discharged must be submitted to Cigna.

Where do providers submit claims?

All claims will continue to be filed directly with Cigna.

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Where do providers submit inquiries regarding Cigna claims submissions?

If the available self-service tools do not provide claim resolution, providers should contact Cigna Medicare Advantage Provider Customer Service at 800.230.6138. All inquiries regarding Cigna claims submissions should be directed to Cigna.

What are the EviCore hours of operation?

EviCore by Evernorth hours of operation are:

- Monday – Friday 8 a.m. to 8 p.m. CST
- Saturday 8 a.m. to 4 p.m. CST
- Sunday 8 a.m. to 1 p.m. CST
- Holidays 8 a.m. to 1 p.m. CST
- 24 hour on call coverage

How do providers submit a program-related question or concern?

For program-related questions or concerns, please email clientservices@EviCore.com or call 800.575.4517

Who should providers contact for portal support/questions?

To speak with a portal specialist, please call 800.646.0418 (Option 2) or email portal.support@EviCore.com

Our dedicated Portal Support team can assist providers in navigating the portal and addressing any portal related issues during the online submission process.

Where can providers find additional information?

For more information and reference documents, please visit EviCore by Evernorth's provider resources site for this program: Cigna Medicare Advantage Provider Resource | EviCore by Evernorth