EviCore
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Provider Information Tips

A common reason for the denial of a procedure request is that the information submitted is incomplete or inadequate for our medical reviewers to make an informed decision regarding the appropriateness of the procedure. This is often frustrating to the provider as well as the peer reviewer. In an effort to reduce this source of friction, we have created a Provider Information Packet designed to instruct providers on the type of information that our reviewers need to adjudicate a particular case. This is not meant to be all-inclusive, but rather can be used as a guide. Further and more specific information is available by reading the actual evidence-based guidelines.

General Background Information

- EviCore's Gastrointestinal Endoscopy Program applies an evidence-based approach to evaluate the most appropriate care for each patient.
- This evaluation requires collection of clinical information pertinent to the treatment and/or services being requested by the provider.
- If the clinical information provided does not include sufficiently detailed information to understand the patient's current clinical status, then medical necessity for the request has not been demonstrated and the request cannot be approved.
- Specific elements of a patient's medical records commonly required to establish medical necessity include, but are not limited to:
  - Recent virtual or in-person clinical evaluation which includes a detailed history and physical examination
  - Relevant Laboratory studies
  - Relevant Imaging studies
  - Relevant Pathology reports
  - Relevant Procedure reports
  - Reports from other providers participating in treatment of the relevant condition
    - Note: It is important to keep in mind that the information provided be relevant to the intended procedure. Sending many pages of irrelevant material may contribute to delays in adjudication for your patients.

Specific clinical information helpful for commonly requested indications.

This section provides the type of clinical information that our medical reviewers would need in order to properly adjudicate the case. It is most helpful to look at this in concert with our evidence-based guidelines.

- EGD (Esophagogastroduodenoscopy)
  - Documentation including, but not limited to:
    - Red flag symptoms
    - Prior EGD results
    - Pathology results
    - Treatment with anti-secretory therapy, when appropriate as per guideline criteria
    - Specific purpose of the study
    - Results of prior work up by other disciplines if relevant, such as prior a pulmonary or allergy evaluation if an EGD is being requested to assess extra-esophageal reflux
    - Risk factors, when relevant (e.g., relevant family or smoking history, for an EGD to screen for Barrett's esophagus)

- Capsule Endoscopy
  - Crohn's Disease
    - Clinical features of your patient that are consistent with Crohn's Disease (e.g., diarrhea, abdominal pain, etc.)
    - Previous imaging and endoscopic procedure results
  - Gastrointestinal Bleeding
    - Documentation of the type and nature of the suspected bleeding (e.g., melena, observed blood per rectum, etc.).
    - Previous EGD and colonoscopy findings.