EviCore
By EVERNORTH

MSK Pain/Joint/Spine
Frequently Asked Questions

Who is EviCore By Evernorth?

EviCore By Evernorth (EviCore) is an independent specialty medical benefits management company that provides utilization management services Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma, and Texas.

Which members will EviCore manage for the Musculoskeletal program?

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 and Texas

What is the relationship between BCBS and EviCore?

Beginning on June 1, 2017, EviCore started managing outpatient pain management services and inpatient/outpatient spine surgery/joint surgery services for BCBS.

How do I submit a precertification request?

- **Web Portal:** The web portal is the quickest, most efficient way to submit authorizations and check case status. The web portal is available 24 hours a day, 7 days a week. By utilizing the web portal, you have real-time access to patient authorization and eligibility information as well as the ability to submit requests at a time that best fits your schedule. The web portal can be accessed online at www.evicore.com.

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- **Phone:** EviCore'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.

What information will a provider need to initiate a precertification request?

- Member's name, date of birth, plan name and plan ID number
- Ordering Physician's name, National Provider Identifier (NPI), Tax Identification Number (TIN), Fax number
- Service being requested (CPT codes and diagnosis codes)
- Rendering facility's name, NPI, TIN, street address, fax number
- Office notes related to the current diagnosis, imaging studies, and prior test results related to the diagnosis. All clinical information related to the precertification request should be submitted to support medical necessity.

Will urgent requests be accepted?

Yes. Medically urgent requests are defined as conditions that are a risk to the patient's life, health, ability to regain maximum function, or the patient is having severe pain that required a medically urgent procedure. Urgent requests can be initiated on the portal or by phone. Urgent requests will be processed within 72 hours from the receipt of complete clinical information.

What is the turnaround time for a determination on a standard precertification request?

EviCore is committed to reviewing all requests and giving case decisions within seven (7) calendar days of receiving all necessary clinical information with the exception of Texas Medicaid that will be processed within 3 calendars days.

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How will all parties be notified if the prior authorization has been approved?

Ordering and rendering providers will receive notification via fax . You can also validate the status using the EviCore provider portal at www.evicore.com or by calling EviCore at 855.252.1117. Members will be notified by mail.

If a prior authorization is not approved, what follow-up information will be sent?

For Medicaid BCBS IL & TX members, 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 can be made. A consultation with an EviCore Medical Director is for educational purposes only.

What is the process to update an authorization with a new CPT code?

For any CPT code changes to an existing authorization, please contact EviCore. Please have all clinical information relevant to your request available when you contact EviCore.

Can I extend an authorization period on my authorization?

Pain management requests can be extended up to 60 calendar days. Spine or joint extensions will be approved based on initial length of stay.

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.

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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.

Will EviCore grant approval for a series of injections?

No. A series of injections will not be prior authorized. EviCore requires a separate prior authorization request for an Interventional Pain procedure for each date of service. The patient's response to prior interventional pain injections will determine if a subsequent injection is appropriate. Including the response to the prior interventional pain injection in the office notes may help avoid processing delays.

What would be the process if a patient is receiving a procedure where precertification is required by EviCore for an inpatient stay?

EviCore will review the surgery precertification request for medical necessity and make a determination based on the clinical information provided by the rendering provider. EviCore will collect the requested place of service during the precertification process. If the requested procedure is approved and an inpatient place of service is appropriate, EviCore will communicate an inpatient length of stay to both the provider and BCBS. The provider will not need to seek a separate approval for the inpatient stay. EviCore does not provide concurrent bed day management for inpatient admissions. All modifications/extensions to the approved length of stay are handled by BCBS using existing concurrent review processes. This process may still take up to 48 hours to ensure both the procedure and inpatient stay events are in place for the member. To view both of your events for your member, please continue to use the online EDI vendor.

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What criteria are required for prior authorization of a repeat epidural steroid injection?

The criteria needed for a repeat epidural steroid injection (ESI) are any of the following for the duration of two weeks or more:

1. At least 50 percent pain relief,
2. Increase in the level of function (i.e., return to work), or
3. Reduction in the use of pain medication or additional medical services such as physical therapy or chiropractic care.

Are facet joint injections/medial branch blocks allowed for treatment of radiculopathy?

Facet joint injections/medial branch blocks should only be performed for neck pain or low back pain in the absence of an untreated radiculopathy.

Can I perform more than two facet joint injections/medial branch blocks at the same level?

More than two facet injections/medial branch blocks at the same level are considered to be therapeutic rather than diagnostic. There is no scientific evidence to support the use of a therapeutic facet joint injection/medial branch block. It is considered experimental, investigational or unproven.

Can I perform injections/blocks at more than three facet levels?

No, the performance of facet injections/blocks on at more than three levels is considered not medically necessary.

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Can I perform an epidural steroid injection on patients if they are not complaining of disabling or burning pain, pins and needles, or altered sensation?

The definition of radiculopathy, for the purpose of this policy, is defined as the presence of pain, dysaethesia(s), or paraesthesia(s) reported by the individual in a specified dermatomal distribution of an involved named spinal root(s) causing significant functional limitations resulting in diminished quality of life and impaired, age-appropriate activities of daily living, and **one** or **more** of the following:

1. Documented loss of strength of specific named muscle(s) or myotomal distribution(s), or demonstrated on detailed neurologic examination (within the prior three months), concordant with nerve root compression of the involved named spinal nerve root(s),
2. Documented altered sensation to light touch, pressure, pin prick, or temperature demonstrated on a detailed neurologic examination (within the prior three months) in the sensory distribution concordant with nerve root compression of the involved named spinal nerve root(s), or
3. Documented diminished, absent, or asymmetric reflex(es) (within the prior three months) concordant with nerve root compression of the involved named spinal nerve root(s) and
4. Documentation of either of the following:
    - A concordant radiologist's interpretation of an advanced diagnostic imaging study (MRI or CT scan) of the spine demonstrating compression of the involved named spinal nerve root(s) or foraminal stenosis at the concordant level(s) (performed within the prior 12 months), or
    - An electromyogram (EMG) or nerve conduction (NCV) diagnostic study of nerve root compression of the involved named spinal nerve root(s) (performed within the prior 12 months).

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Is there a period of conservative required prior to requesting a therapeutic ESI?

An epidural steroid injection (ESI) is considered medically necessary for presumed radiculopathy resulting from disease, injury, or surgery that has not responded sufficiently to a reasonable course (four week minimum) of conservative treatment (e.g. physical therapy, chiropractic care, NSAIDs, analgesics, etc.).

What are the clinical criteria for radiofrequency ablation of the medial branch nerve innervating the facet joint?

A radiofrequency joint denervation/ablation is considered medically necessary for facet mediated pain resulting from disease, injury, or surgery and confirmed by provocative testing when **both** of the following criteria are met:

1. Failure of at least three months of conservative therapy (e.g., physical therapy, chiropractic care, NSAIDs or analgesics, etc.), and
2. Two positive diagnostic facet joint injections/medial branch blocks using either a local anesthetic or a local anesthetic combined with corticosteroid as evidenced by **either** of the following:

- A beneficial clinical response to dual (two) sequential intra-articular facet injections or medial branch blocks performed with a local anesthetic with greater than 80 percent pain relief for the duration of the effect of the local anesthetic used, or
- A beneficial clinical response to dual (two) sequential intra-articular facet joint injections or medial branch blocks performed with a local anesthetic and a corticosteroid with at least a 50 percent reduction in pain for at least two weeks.

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What needs to be documented for a patient to be approved for facet injection/medial branch nerve block?

An initial diagnostic facet joint injection/medial branch block is considered medically necessary to determine whether chronic neck or back pain is of facet joint origin when **all** of the following criteria are met:

1. Pain is exacerbated by extension and rotation,
2. Pain has persisted despite appropriate conservative treatment (e.g., physical therapy, chiropractic care, NSAIDs, analgesics, etc.)
3. Clinical findings and imaging studies suggest no other obvious cause of the pain (e.g., spinal stenosis, disc degeneration or herniation, infection, tumor, or fracture).

What physical examination signs should be documented to justify a facet-based procedure?

Facet joint injections/medial branch blocks are considered medically necessary for facet mediated pain resulting from disease, injury, or surgery and confirmed by provocative testing resulting in reproducible pain (i.e., hyperextension, rotation).

Is there a limit to the number of sessions during which epidural steroid injections are administered?

No more than three (3) sessions during which epidural steroid injections are administered per episode of pain and no more than four (4) epidural steroid injections per spinal region per year.

Can providers perform an epidural steroid injection as an isolated treatment?

Based on the limited long- term benefit of performing an epidural steroid injection as an isolated intervention for the management of radicular pain, and a goal of increasing functional capacity, epidural steroid injections should be performed in association with an active rehabilitation program and/or therapeutic exercise.

Can multiple epidurals be approved on a single request for services?

There is insufficient scientific evidence to support the scheduling of a “series-of-three” injections in either a diagnostic or therapeutic approach. The medical necessity of subsequent injections should be evaluated individually and be based on the response of the individual to the previous injection with regard to clinically relevant sustained reductions in pain, decreased need for medication, and improvement in the individual’s functional abilities.

What needs to be documented for a patient to be approved for an epidural steroid injection?

An epidural steroid injection may be considered medically necessary when a detailed neurologic exam within the last three months demonstrated any of the following consistent with spinal nerve root compression:

1. Loss of strength of a specific named muscle(s) or myotomal distribution(s),
2. Altered sensation to light touch, pressure, pin prick or temperature, or
3. Diminished, absent or asymmetric reflex(es).
4. An epidural steroid injection may also be considered medically necessary when a CT, MRI, or EMG/NCV performed within the last 12 months demonstrated compression of the involved named spinal nerve root(s).

What type of image guidance is appropriate for a facet joint injection/medial branch nerve block?

Facet joint injection/medial branch nerve block under fluoroscopic or CT guidance is acceptable. The performance of a facet joint injection/medial branch block injection under ultrasound guidance is considered experimental, investigational, or unproven for any indication.

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What amount of conservative care is required for radiofrequency ablation of the medial branch nerves?

The criteria required for radiofrequency ablation of the medial branch nerves includes failure of at least three months of conservative therapy (e.g., exercise, physical therapy, chiropractic care, NSAID's, analgesics, etc.).

How frequently can repeat radiofrequency ablation of the medial branch nerve be performed?

A repeat radiofrequency joint denervation/ablation is considered medically necessary when there is documented pain relief of at least 50 percent that has lasted for a minimum of 12 weeks. While repeat radiofrequency joint denervations/ablations may be required, they should not occur at an interval of less than six months from the first procedure. No more than two procedures at the same level(s) should be performed in a 12-month period.

May radiofrequency ablation of the medial branch nerve take place at a previously fused spinal level?

A radiofrequency joint denervation/ablation is considered medically necessary when performed at spinal levels above or below a prior spinal fusion.

What happens if codes need to be changed/added to after surgery has been completed?

Once surgery has been completed and additional procedures were required, please contact EviCore via phone and let us know what codes need to be added. Please be prepared to offer additional documentation to support the change.

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What are the parameters of an appeals request?

EviCore will manage first 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?

Please refer to the appeal instructions on the denial letter for guidance.

Fax: 866-699-8128

E-mail: Appealsfax@evicore.com

Toll Free Phone: (800) 792-8744 ext 49100 or (800) 918-8924 ext 49100

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