eviCore healthcare Musculoskeletal
Program Frequently Asked Questions

Who is eviCore healthcare?
evienceCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for Priority Health.

What is the relationship between Priority Health and eviCore healthcare?
Beginning on May 25, 2017 eviCore will manage musculoskeletal prior authorizations for Priority Health.

Which members will eviCore healthcare manage for the musculoskeletal program?
evienceCore will manage musculoskeletal services for Priority Health Commercial, Medicaid and Medicare members.

How do I submit a prior authorization request?
The quickest, most efficient way to obtain prior authorization is through the 24/7 self-service web portal at www.priorityhealth.com/provider. Log into your provider account then click “Auth Request”. When a case is initiated on the web portal and meets clinical criteria, a real-time authorization may be received. Prior authorization can also be obtained via phone at 844-303-8456 or fax at 800-540-2406.

Note that services approved by eviCore in an inpatient setting will require separate authorization for the hospital stay. Facilities must log-in to their priorityhealth.com provider account and click “Auth Request” to obtain an inpatient authorization through Clear Coverage.

What information will a provider need to initiate a prior authorization request?
- Member’s name, date of birth, plan name and Priority Health member 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
- Medical records related to the current diagnosis, results of diagnostic imaging studies and the duration/type/outcome of prior treatment related to the current diagnosis. All clinical information related to the prior authorization request should be submitted to support medical necessity.

Does medically urgent care require preauthorization?
The services managed under eviCore’s joint and spine surgery programs are unlikely to be required on an emergent basis. However, procedures done in an emergency room or medically urgent care facility are excluded from the program. Retrospective rules for payment of claims for these procedures are health plan specific and may include requiring a retroactive submission to eviCore to demonstrate both medical necessity and medical urgency in order to have the claim paid.
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.
Eastern Time, Monday through Friday. The phone number is 844-303-8456. The web portal is
available for access 24/7.

What is the turnaround time for a determination on a standard prior authorization request?
We complete requests within two (2) business days from the receipt of complete clinical
information. When a case is initiated on the web portal and meets clinical criteria, you could
receive a real-time, immediate authorization.

Who can request a prior authorization?
A representative of the ordering physician’s staff can ask for authorization. This could be
someone from the clinical, front office or billing staff, acting on behalf of the ordering physician.

What services require prior authorization through this program?
For a full list of CPT codes, you may go to the provider information page at:
https://www.evicore.com/healthplan/priorityhealth

How will all parties be notified if the prior authorization has been approved?
Referring and rendering providers will be notified of the prior authorization via fax. To check the
status of an authorization, you may contact eviCore at 844-303-8456 or check the
authorization inquiry tool at www.priorityhealth.com. Members will be notified in writing and via
phone. Written notification is provided upon request if the rendering provider contacts
eviCore’s customer service department.

What are my options when a prior authorization request is denied?
There are two options after requested services are denied. A reconsideration review or a
clinical peer-to-peer discussion can be requested within 14 calendar days from the denial. If
additional clinical information is available without the need for a provider to participate, a
reconsideration review can be requested by phone. If additional clinical information is available
but there is a need for the rendering physician to participate, he or she may speak with an
eviCore medical director with the same specialty expertise. Please refer to the peer-to-peer
frequently asked questions document on the resource site or the quick reference guide for
market specific phone numbers.

If a prior authorization is not approved, what follow-up information will the referring
provider receive?
Commercial membership: The referring and rendering provider will receive a denial letter that
contains the reason for denial as well as Reconsideration and Appeal rights and processes.
Please note that after the denial has been issued, the referring provider may request a peer-to-
peer discussion with an eviCore Medical Director to review the decision.

Medicare and Medicaid membership: The referring and rendering provider will receive a denial
letter that contains the reason for denial as well as Reconsideration and Appeal rights and
processes. Please note that after a denial has been issued, no changes to the case decision
Can a facility update the date of service after the authorization window has expired, or does the ordering physician need to call?
The procedure(s) should be performed during the authorization timeframe. Some health plans will allow for extensions to existing authorizations. Please contact eviCore healthcare for additional information.

How should I handle a retrospective request for authorization?
Retrospective requests must be initiated by phone within 120 calendar days following the date of service for Commercial membership or within 30 calendar days following the date of service for Medicaid membership. No retrospective review will be allowed for Medicare membership.

In many instances, the services must have been medically urgent and medically necessary. Please have all clinical information relevant to your request available when you contact eviCore healthcare.

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 healthcare. Please have all clinical information relevant to your request available when you contact eviCore healthcare.

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.

What would be the process if a patient is receiving a procedure where prior authorization is required by eviCore healthcare for an inpatient stay?
eviCore healthcare will review the surgery precertification request for medical necessity and make a determination based on the clinical information provided by the rendering provider. Facilities will need to notify Priority Health when the patient has arrived for a service. To complete this authorization, facilities should go to www.priorityhealth.com/provider and log into their account. Once logged in, click on “auth request” and select the “inpatient admission” option. This will take facilities to Clear Coverage where they can make the request. Facilities can confirm the provider’s office received authorization of the service by contacting eviCore or using the “Auth Inquiry” tool at www.priorityhealth.com/provider.

What are the parameters of an appeals request?
eviCore will manage 1st level provider appeals only. Appeal rights are detailed in coverage determination letters sent to the providers with each adverse determination. Appeals must be made in writing unless the request involves medically urgent care, in which case the request may be made orally.

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