

Laboratory Management

Provider Presentation for Highmark

Updated May 2021



Empowering
the Improvement
of Care

Program Overview

Applicable Memberships

Prior Authorization is required for Highmark members who are enrolled in the following lines of business/programs in PA, WV, and DE:

Commercial	<ul style="list-style-type: none">• Radiology and Cardiology (Advanced Imaging)• Radiation Oncology• Laboratory Services• MSK: Spine/Joint/Pain Management
Medicare	<ul style="list-style-type: none">• Radiology and Cardiology (Advanced Imaging)• Radiation Oncology• Laboratory Services• MSK: Spine/Joint/Pain Management
Medicaid (Delaware only)	<ul style="list-style-type: none">• Radiology and Cardiology

Highmark Prior Authorization Services

Prior authorization from eviCore applies to the following services:

- Outpatient
- Diagnostic
- Elective / Non-emergent

Prior authorization from eviCore does **NOT** apply to services performed in:

- Emergency Rooms
- Observation Services
- Inpatient Stays

Lab Management Solution

Covered Tests:

- Hereditary Cancer Syndromes
- Carrier Screening Tests
- Tumor Marker / Molecular profiling
- Hereditary Cardiac Disorders
- Cardiovascular Disease and Thrombosis Risk Variant Testing
- Pharmacogenomics Testing
- Neurologic Disorders
- Mitochondrial Disease Testing
- Intellectual Disability / Developmental Disorders



Evidence-Based Guidelines

The foundation of our solutions



Annually
Reviewed
Guidelines



Experts associated with
academic institutions



Current clinical
literature



Evidence-based medical policy incorporating:

- Independent health technology assessments
- Annual review of current clinical literature
- Internal specialty expertise
- National society recommendations
- External academic institution subject matter experts
- Medical Advisory Board

Submitting Requests

Methods to Submit Prior Authorization Requests

Provider Portal (preferred)

To submit a request for Prior Authorization from eviCore healthcare you will need to log in to your NaviNet account.

- ❖ If Highmark has delegated eviCore to manage the Prior Authorization process for the member and requested services, you will be forwarded to the eviCore healthcare provider portal to complete your authorization request submission.

While Call Center Agents are available to create an authorization request, the provider portal is the quickest, most efficient way to request a prior authorization and check authorization status.

Phone Number:

888-564-5492

Monday – Friday, 7AM – 7PM



***Cases for DE Medicaid will be submitted by logging in directly at www.eviCore.com**

Non-Clinical Information Needed

The following information must be provided to initiate the prior authorization request:

Member Information

- First and Last Name
- Date of Birth
- Member Identification Number
- Phone Number (If Applicable)

Ordering Physician Information

- First and Last Name
- Practice Address
- Individual National Provider Identification (NPI) Number
- Tax Identification Number (TIN)
- Phone and Fax Numbers

Rendering Laboratory Information

- Laboratory Name
- Street Address
- National Provider Identification (NPI) Number
- Tax Identification Number (TIN)
- Phone and Fax Numbers



Clinical Information Needed

.....
If clinical information is needed, which may include:

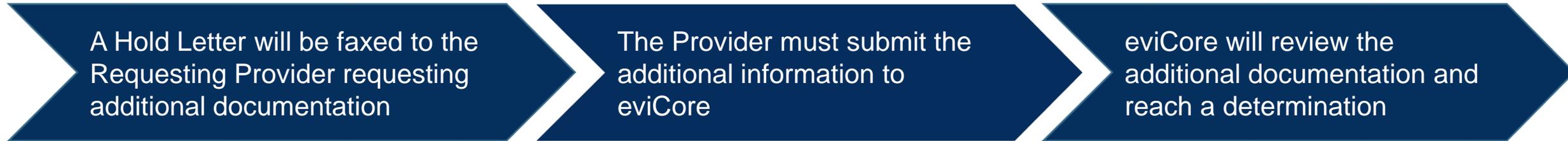
- Details about the test being performed (test name, description and/or unique identifier)
- All information required by applicable policy
- Test indication, including any applicable signs and symptoms or other reasons for testing
- Any applicable test results (laboratory, imaging, pathology, etc)
- Any applicable family history
- How test results will impact patient care



Insufficient Clinical – Additional Documentation Needed

Additional Documentation to Support Medical Necessity

If all required pieces of documentation are not received, or are insufficient for eviCore to reach a determination, the following will occur:



A Hold Letter will be faxed to the Requesting Provider requesting additional documentation

The Provider must submit the additional information to eviCore

eviCore will review the additional documentation and reach a determination

To ensure that a determination is completed within the designated timeframe for each LOB, the case will remain on hold as follows:

- Medicare: 1 calendar day
- Commercial: 3 calendar days for OH; 10 calendar days for PA & WV

Requested information must be received within the timeframe as specified in the Hold Letter.

Determination will be completed within 2 business days after the additional information is received.



Prior Authorization Outcomes & Special Considerations

Prior Authorization Approval

Approved Requests

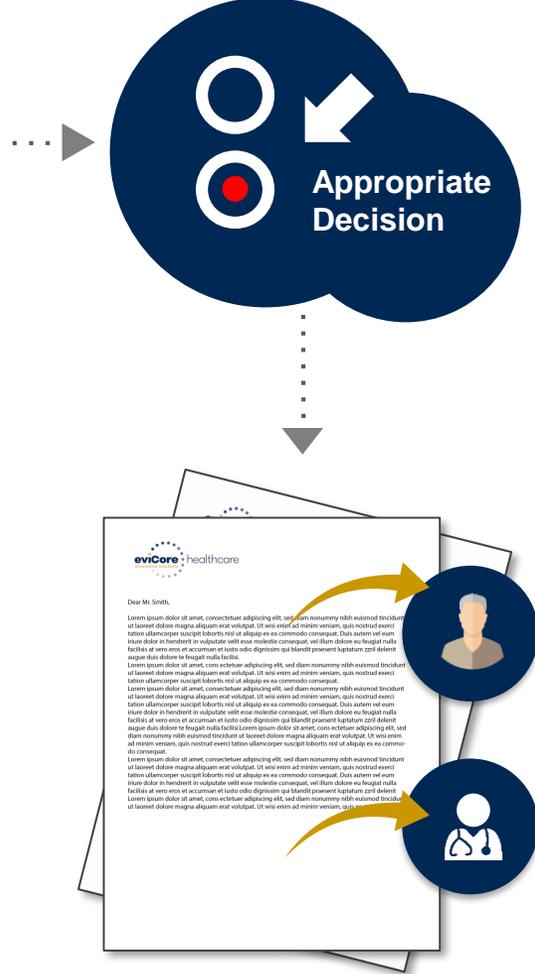
- Standard requests will be processed within 2 business days (*after receipt of all necessary clinical information*)
- Authorizations are valid for 60 calendar days from the date of the final determination
- Authorization letters will be faxed to the ordering physician & rendering facility
- When initiating a case on the web you can receive e-notifications when a determination is made if you provide an email address
- Members will receive a letter by mail
- Approval information can be printed on demand from the eviCore portal: www.eviCore.com



When a Request is Determined as Inappropriate

Based on evidence-based guidelines, request is determined as **inappropriate**.

A denial letter with the rationale for the decision and the appeal rights will be issued to both the provider and member.



Special Circumstances

Retrospective (Retro) Authorization Requests

- Must be submitted
 - Within 730 calendar days from the date of service for Commercial and Medicare cases
- Retro requests submitted beyond this timeframe will be administratively denied
- Reviewed for clinical urgency and medical necessity
- Retro requests are processed within 30 calendar days after receipt of all necessary clinical information
- When authorized, the start date will be the submitted date of service

Urgent Prior Authorization Requests

- eviCore uses the NCQA/URAC definition of **urgent**: when a delay in decision-making may seriously jeopardize the life or health of the member
- Reviewed for clinical urgency and medical necessity
- Can be initiated on provider portal or by phone
- Urgent request will be reviewed within:
 - 24 hours not to exceed 72 hours of the request (*after receipt of all necessary clinical information*) for Commercial and Medicare cases, and within 72 hours for DE Medicaid cases



Special Circumstances cont.

Alternative Recommendation

- An alternative recommendation may be offered, based on eviCore's evidence-based clinical guidelines
- The ordering provider can either accept the alternative recommendation or request a reconsideration for the original request
- Providers have up to 14 calendar days to contact eviCore to accept the alternative recommendation

Authorization Update

- If updates are needed on an existing authorization, you can contact eviCore by phone at 888-564-5492
- If the authorization is not updated and a different facility location or CPT code is submitted on the claim, it may result in a claim denial



Reconsideration Options

Pre-Decision Options: Medicare Members

I've received a request for additional clinical information. What's next?

Submission of Additional Clinical Information

- eviCore will notify providers telephonically and in writing before a denial decision is issued on Medicare cases intent to deny notification)
- You can submit additional clinical information to eviCore for consideration per the instructions received
- Additional clinical information must be submitted to eviCore in advance of the due date referenced on the notification letter via the web portal, fax, or via a pre-decision clinical consultation

Pre-Decision Clinical Consultation

- Providers can choose to request a Pre-Decision Clinical Consultation instead of submitting additional clinical information
- The Pre-Decision Clinical Consultation must occur prior to the due date referenced on the "intent to deny" notification
- If additional information was submitted, we proceed with our determination and are not obligated to hold the case for a Pre-Decision Clinical Consultation, even if the due date has not yet lapsed

Post-Decision Options: Medicare Members

My case has been denied. What's next?

Clinical Consultation

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

Reconsideration

- Medicare cases do not include a Reconsideration option

Appeals

- eviCore will not process appeals for the Medicare membership
- Appeal requests must be initiated within 60 calendar days and need to be submitted to Highmark – refer to the denial letter on how to submit a request for appeal

Post-Decision Options: Commercial Members

My case has been denied. What's next?

Your determination letter is the best and fastest source for accessing information to assess what options exist on a case that has been denied. You can also call us at 888-564-5492 to speak to an agent who can provide available option(s) and instruction on how to proceed.

Reconsiderations

- Providers and/or staff can request a reconsideration review
- Reconsiderations must be requested within 14 calendar days after the determination date
- Reconsiderations can be requested in writing or verbally via a Clinical Consultation with an eviCore physician

Appeals

- eviCore will process first-level appeals
- Appeal requests must be submitted to eviCore within 180 calendar days from the initial determination
- Appeal requests can be submitted in writing or verbally via a Clinical Consultation with an eviCore physician
- All clinical information and the prior authorization request will be reviewed by a physician other than the physician who made the initial determination
- A written notice of the appeal decision will be mailed to the member and faxed to the ordering provider

Provider Portal Overview

NaviNet – Enabled Providers

The screenshot shows the NaviNet web application interface. At the top, there is a navigation bar with the NantHealth logo, 'NaviNet', and dropdown menus for 'WORKFLOWS' and 'HEALTH PLANS'. On the right side of the navigation bar are icons for a flag, a bell, a question mark, and a user profile.

Below the navigation bar, the page title is 'Highmark Blue Cross Blue Shield'. The main content area is divided into three sections:

- Workflows for this Plan:** A vertical list of workflow categories on the left. 'Auth Submission' is highlighted with a red callout bubble that says 'Select Auth Submission Function'.
- News Items Table:** A table with columns for 'AUDIENCE' and 'DATE POSTED'. The table contains several news items with blue hyperlinks for titles.
- In the SPOTLIGHT...:** A section on the right with a spotlight icon, containing two news items with blue hyperlinks for titles.

Below the table, there is a note: 'When news items are removed from this page, they will remain on the Plan Central Library page on the Provider Resource Center.'

At the bottom of the page, there is a disclaimer: 'Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield serves the 20 counties of western Pennsylvania. Blue Cross, Blue Shield and the cross and shield symbols are registered service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc. NaviNet is a registered trademark of NaviNet, Inc. NaviNet, Inc. is an independent company that provides a secure, web-based portal between providers and health care insurance plans.'

	AUDIENCE	DATE POSTED
COVID-19 IN-NETWORK INPATIENT COST SHARE	ALL	4/30/2021
...ABLE	ALL	4/30/2021
HOME HEALTH TIMEOUT NOTIFICATION	ALL	4/21/2021
EXTENDED THROUGH DECEMBER 2021: MEDICARE SEQUESTRATION TEMPORARY PAYMENT INCREASE	ALL	4/15/2021
NAVINET SYTSTEM UNAVAILABLE APRIL 16-17, 2021	ALL	4/14/2021
HIGHMARK'S APRIL CODING KNOWLEDGE COLLEGE WEBINAR	PROFESSIONAL	4/7/2021
PROVIDER PATHWAYS PROGRAM METRICS ENHANCEMENTS EFFECTIVE JUNE 1, 2021	PROFESSIONAL	3/31/2021

NaviNet – Enabled Providers

The screenshot shows the NantHealth NaviNet interface. At the top, the logo and 'NaviNet' are displayed. Below the header, the breadcrumb trail reads 'Highmark Blue Cross Blue Shield | Auth Submission | Billing Provider Selection Form'. The main content area contains the instruction 'Please select a Referred from Billing Provider:' followed by a dropdown menu labeled 'Referred From Billing Provider:'. A red callout bubble points to the dropdown with the text 'Select appropriate referred from provider name from dropdown.' At the bottom of the form, there are two buttons: 'Submit' and 'Save'. A second red callout bubble points to the 'Submit' button with the text 'Then click Submit'.

NaviNet – Enabled Providers

NantHealth | NaviNet

Highmark Blue Cross Blue Shield | Auth Submission | Selection Form

Selection Form

Step 1. Please select a Referred from Service Provider and enter the Proposed Date of Service (both are required): 1

Service Provider: 2

Proposed Date of Service: 5/4/21

Step 2. For faster results, enter Member ID with Date of Birth and/or Member First Name: 3

Member ID:

Member Date of Birth:

Member First Name:

Member Last Name:

Step 3. Please select a Category and then a Service from the selections below: 4

Category: 4

Service:

Category and Services Added:

Category	Service
----------	---------

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NaviNet – Enabled Providers

NantHealth | NaviNet

Highmark Blue Cross Blue Shield | Auth Submission | Selection Form | Request Form

Patient Last Name: _____ Patient First Name: _____
Gender: _____ Date of Birth: _____
Group #: _____
Member ID #: _____

Service Details:
Requested Service: Advanced and Cardiac Imaging - Request
Proposed Date of Service: 05/04/2021

Referred To Provider:
While an authorization request may be approved for medical necessity, such approval does not mean that the service will be processed as an In-Network benefit.
Please enter a provider ID, search for a provider, or select a preferred provider from the dropdown.
Billing Provider: Preferred Providers
Description: _____
Service Provider:
Description: _____
Add Preferred Provider:

Referred To Facility:
While an authorization request may be approved for medical necessity, such approval does not mean that the service will be processed as an In-Network benefit.
Please enter a facility ID, search for a facility, or select a preferred facility from the dropdown.
Facility:
Description: _____
Add Preferred Facility:

Diagnosis Codes:
You may enter or search for up to 3 diagnosis codes. To add an additional diagnosis code, click the "Add Diagnosis Code" button.
Search Type: ICD-10 Description: _____
Diagnosis Code:

Referred From Provider Information:
Billing Provider Name: _____
Address:
Service Provider: _____
Contact Name: Contact Phone:

1
Select a Referred to Provider OR Facility

2

3

4

5

Comments:

History/Symptoms:

Diagnostic Testing:

Treatment Plan:

Discharge Plan:

An authorization means that the requested service has been determined to be medically necessary and/or appropriate. It does not mean that the requested service is covered under the member's benefit plan. Payment is contingent upon benefit coverage for the services rendered and eligibility of the patient.

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SSO - HMK NaviNet to eviCore slides

Single-Sign On for Highmark Providers / NaviNet

© NantHealth | NaviNet Home | Help | Contact Support | Feedback

Welcome, [User Name]

Workflows | Auth Submission | Selection Form | Request Form | Collection Form

Highmark Blue Shield

eviCore healthcare

Home Authorization Lookup Eligibility Lookup Help / Contact Us

Friday, October 26, 2018 9:30 AM

Log Off (SSO)

30% Complete

Provider and NH

(HIGHMARK)

Message from webpage

Please review the fax and phone numbers presented for accuracy. Change as necessary and click CONTINUE to confirm they are correct. Changes apply only to this specific case. If you wish the change to be permanent, please contact the Health Plan.

OK

Fax [] [?]

Phone [] [?]

Ext. [] [?]

Cell Phone []

Email []

Cancel Prev Continue

Click here for help or technical support

Member & Request Information

Add Your Contact Info

Provider's Name:* [?]

Who to Contact:* [?]

Fax:* [?]

Phone:* [?]

Ext.: [?]

Cell Phone:

Email:

BACK **CONTINUE**

[Click here for help](#)

Verify the accuracy of the contact information – this information populates based on the health plan provider data for the NPI number of the ordering practitioner

Requested Service + Diagnosis

Lab Management Program Procedures

Select a Procedure by CPT Code[?] or Description[?]

Don't see your procedure code or type of service? [Click here](#)

Diagnosis

Select a Primary Diagnosis Code (Lookup by Code or Description)

LOOKUP

Trouble selecting diagnosis code? Please follow [these steps](#)

Select a Secondary Diagnosis Code (Lookup by Code or Description)

Secondary diagnosis is optional for Lab Management Program

LOOKUP

Choose the lab test from the menu and enter the ICD10 codes

Verify Service Selection

Requested Service + Diagnosis

Confirm your service selection.

CPT Code: LABTST
Description: MOLECULAR GENETIC TEST
Primary Diagnosis Code: R97.1
Primary Diagnosis: Elevated cancer antigen 125 [CA 125]
Secondary Diagnosis Code:
Secondary Diagnosis:
[Change Procedure or Primary Diagnosis](#)
[Change Secondary Diagnosis](#)

BACK

CONTINUE

[Click here for help](#)

- Verify requested service & diagnosis
- Edit any information if needed by selecting Change Procedure or Primary Diagnosis
- Click **continue** to confirm your selection

Site Selection

Start by searching NPI or TIN for the site where the procedure will be performed. You can search by any fields listed. Searching with NPI, TIN, and zip code is the most efficient.

Add Site of Service

Specific Site Search

Use the fields below to search for specific sites. For best results, search by NPI or TIN. Other search options are by name plus zip or name plus city. You may search a partial site name by entering some portion of the name and we will provide you the site names that most closely match your entry.

NPI:	<input type="text"/>	Zip Code:	<input type="text"/>	Site Name:	<input type="text"/>
TIN:	<input type="text"/>	City:	<input type="text"/>	<input checked="" type="radio"/> Exact match	
				<input type="radio"/> Starts with	

LOOKUP SITE

- Select the **specific site** where the testing/treatment will be performed.

Clinical Certification

Proceed to Clinical Information

You are about to enter the clinical information collection phase of the authorization process.

Once you have clicked "Continue," you will not be able to edit the Provider, Patient, or Service information entered in the previous steps. Please be sure that all this data has been entered correctly before continuing.

In order to ensure prompt attention to your on-line request, be sure to click SUBMIT CASE before exiting the system. This final step in the on-line process is required even if you will be submitting additional information at a later time. Failure to formally submit your request by clicking the SUBMIT CASE button will cause the case record to expire with no additional correspondence from eviCore.

BACK

CONTINUE

- **Verify that all information is entered and make any changes needed**
- **You will not have the opportunity to make changes after this point**

Standard or Urgent Request?

- If your request is **urgent** select **No**
- When a request is submitted as Urgent, you will be required to upload relevant clinical information
- If the case is **standard** select **Yes**
- You can upload up to FIVE documents in .doc, .docx, or .pdf format
- Your case will only be considered Urgent if there is a successful upload

Proceed to Clinical Information

Is this case Routine/Standard?

YES

NO

Clinical Information – Example of Questions

Proceed to Clinical Information

Some tests can be automatically authorized by responding to a set of specific clinical questions. In order to determine the right clinical questions to ask, we need to know exactly which test(s) and procedure code(s) are being considered. The next several questions will guide test and procedure code selection.

1 To the best of your knowledge, has a previous prior authorization request been made for this member and this test?

- Yes
- No
- Unknown

1 Has the specimen been collected?

- Yes
- No
- Unknown

SUBMIT

Proceed to Clinical Information

1 What is the specimen collection or retrieval from storage date? If the date is unknown, please use today's date.



SUBMIT

Proceed to Clinical Information

1 What kind of testing is being done?

- Testing related to cancer
- Testing related to pregnancy
- Other
- Unknown

1 What test is being requested? Please provide the test name or a short description.

1 Do you know the procedure codes that will be billed for this test?

- Yes
- No

SUBMIT

Finish Later

Did you know?
You can save a certification request to finish later.

- **Clinical Certification** questions will populate based upon the information provided

You will not be able to save your request and 'finish later' when you are logged in via the SSO/Navinet

Clinical Information

Proceed to Clinical Information

What is the name of the test you are requesting? A selection from the list below is REQUIRED in order to proceed with this request.

This is a list of commonly requested tests from the lab you selected. They are in alphabetic order by the lab's actual test name, which can usually be found on the test requisition.

Submitting your request will be much faster if the test name can be found.

Test Brand Name	Test Category
<input type="radio"/> None Of These	
<input type="radio"/> ATM Analysis	ATM Sequencing and Deletion/Duplication Analysis
<input type="radio"/> BRACAnalysis {Integrated BRACAnalysis; CPT 81162}	BRCA1/2 Sequencing and Deletion/Duplication Analysis
<input type="radio"/> BRACAnalysis {Integrated BRACAnalysis; CPT 81163, 81164}	BRCA1/2 Sequencing and Deletion/Duplication Analysis
<input type="radio"/> BRACAnalysis and myRisk {Integrated BRACAnalysis and myRisk; CPT 81162, 81479}	Hereditary Breast and Ovarian Cancer Panel Tests
<input type="radio"/> BRACAnalysis and myRisk {Integrated BRACAnalysis and myRisk; CPT 81163, 81164, 81479}	Hereditary Breast and Ovarian Cancer Panel Tests
<input type="radio"/> BRACAnalysis and PALB2 {2019 codes; Integrated BRACAnalysis and PALB2; 81162, 81406}	Hereditary Breast and Ovarian Cancer Panel Tests
<input type="radio"/> BRACAnalysis and PALB2 {2019 codes; Integrated BRACAnalysis and PALB2; 81163, 81164, 81406}	Hereditary Breast and Ovarian Cancer Panel Tests
<input type="radio"/> BRACAnalysis and PALB2 {2019 codes; Integrated BRACAnalysis and PALB2; 81163, 81164, 81406}	Hereditary Breast and Ovarian Cancer Panel Tests
<input type="radio"/> BRACAnalysis and PALB2 {2020 codes; Integrated BRACAnalysis and PALB2; 81162, 81307}	Hereditary Breast and Ovarian Cancer Panel Tests

1 2 3 4 5 6 7

All A B C E G M N P S T

** NOTE: If you know the name of the test, choose the first letter of the test name above. Otherwise, you can scroll through all tests using the page numbers. If you cannot find the test, please return to page 1 of the "All" tab and select "None of These".

***FOR LAB REPRESENTATIVES: If you would like to correct or add to this list, please email labmanagement@evicore.com.

Clinical Certification questions will populate based upon the information provided

Criteria not met

If criteria is not met based on clinical questions, you will receive a similar request for additional info:

i Is there any additional information specific to the member's condition you would like to provide?

- I would like to upload a document after the survey
- I would like to enter additional notes in the space provided
- I would like to upload a document and enter additional notes
- I have no additional information to provide at this time

SUBMIT

Summary of Your Request

Please review the details of your request below and if everything looks correct click CONTINUE

Your case has been sent to Medical Review.

Provider Name:	[REDACTED]	Contact:	[REDACTED]
Provider Address:	[REDACTED]	Phone Number:	[REDACTED]
		Fax Number:	[REDACTED]
Patient Name:	[REDACTED]	Patient Id:	[REDACTED]
Insurance Carrier:	[REDACTED]		
Site Name:	[REDACTED]	Site ID:	[REDACTED]
Site Address:	[REDACTED]		
Primary Diagnosis Code:	R68.89	Description:	Other general symptoms and signs
Secondary Diagnosis Code:		Description:	
Date of Service:	Not provided	Description:	MOLECULAR GENETIC TEST
CPT Code:	LABTST		
Case Number:	[REDACTED]		
Review Date:	7/15/2020 5:27:45 PM		
Expiration Date:	N/A		
Status:	Your case has been sent to Medical Review.		

CANCEL **PRINT** **CONTINUE**

Tips:

- Upload clinical notes on the portal to avoid any delays by faxing
- Additional information uploaded to the case will be sent for clinical review
- Print out summary of request that includes the case # and indicates 'Your case has been sent to clinical review'

Criteria not met – Free Text Questions

Proceed to Clinical Information

Answer the following questions in clinical detail:

1 Why is this test being requested and how will the results be used to change management?

2 Describe any applicable current or past medical history, lab testing, or procedure results.

3 If relevant to the testing, describe the family history, including the applicable clinical findings, diagnoses, and/or test results.



Free text answers allow for further explanation that may be needed.

Criteria Met

If your request is authorized during the initial submission you can print out the summary of the request for your records.

Summary of Your Request

Please review the details of your request below and if everything looks correct click CONTINUE

The following testing is approved: BRCA1 and/or 2 Gene Testing. Procedure code(s) approved: 81162.

Provider Name:		Contact:	
Provider Address:		Phone Number:	
		Fax Number:	
Patient Name:		Patient Id:	
Insurance Carrier:			
Site Name:		Site ID:	
Site Address:			
Primary Diagnosis Code:	Z01.419	Description:	Encounter for gynecological examination (general) (routine) without abnormal findings
Secondary Diagnosis Code:		Description:	
Date of Service:	Not provided	Description:	MOLECULAR GENETIC TEST
CPT Code:	LABTST		
Authorization Number:			
Review Date:	7/15/2020 5:21:21 PM		
Expiration Date:	1/9/2021		
Status:	The following testing is approved: BRCA1 and/or 2 Gene Testing. Procedure code(s) approved: 81162.		

CANCEL **PRINT** **CONTINUE**

Additional Provider Portal Features

Authorization Lookup

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Authorization Lookup

Search by Member Information Search by Authorization Number/ NPI

- You can look-up authorization status on the portal
- Search by member information OR
- Search by authorization number with ordering NPI
- View and print any correspondence

Authorization Lookup example

Authorization Lookup

Authorization Number: NA

Case Number: **P2P AVAILABILITY**

Status: Pending eviCore Review

P2P Status:

Approval Date:

Service Code: LABTST

Service Description: MOLECULAR GENETIC TEST

Site Name: MOUNT SINAI GENOMICS

Expiration Date:

Date Last Updated: 7/15/2020 5:30:44 PM

Correspondence: **UPLOADS & FAXES**

Clinical Upload:

**The option to attach clinical information is not available for this case at this time:
Please fax clinical information to 800-540-2406**

A final decision has not yet been rendered on this case OR it requires special handling. If you have received a request for additional clinical information, please respond to our notice per the instructions received. If you would like to understand additional options available, please contact our Physician Support Unit at 1-800-792-8744, option 1

Authorization Number:

Case Number: **P2P AVAILABILITY**

Status: Approved

P2P Status:

Approval Date: 7/13/2020 12:00:00 AM

Service Code: LABTST

Service Description: MOLECULAR GENETIC TEST

Site Name: MOUNT SINAI GENOMICS

Expiration Date: 1/9/2021

Date Last Updated: 7/15/2020 5:25:14 PM

Correspondence: **UPLOADS & FAXES**

Uploads & Faxes

Attached Faxes | **Sent Letters & Faxes** | Document Uploads

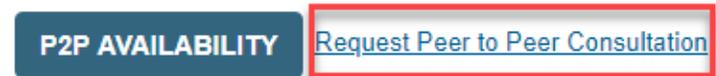
3 documents sent.

Episode ID	Date Sent	Time Sent	Document Name	Recipient	View
<input type="text"/>	07/15/2020	17:25:44	OSC0101 - Approval Standard PHYS	Physician	VIEW
<input type="text"/>	07/15/2020	17:25:44	OSC0104 - Approval Standard SITE	Site	VIEW
<input type="text"/>	07/15/2020	17:25:45	OSC0100 - Approval Standard MBR	Patient	VIEW

CLOSE

How to schedule a Peer to Peer Request

- Log into your account at www.evicore.com
- Perform Authorization Lookup to determine the status of your request.
- Click on the “P2P Availability” button to determine if your case is eligible for a Peer to Peer conversation:
- If your case is eligible for a Peer to Peer conversation, a link will display allowing you to proceed to scheduling without any additional messaging.



Authorization Lookup

Authorization Number:	NA
Case Number:	
Status:	Denied
P2P Status:	



How to schedule a Peer to Peer Request

Pay attention to any messaging that displays. In some instances, a Peer to Peer conversation is allowed, but the case decision cannot be changed. When this happens, you can still request a Consultative Only Peer to Peer. You may also click on the “All Post Decision Options” button to learn what other action may be taken.

Authorization Lookup

Authorization Number:	NA	
Case Number:		Request Peer to Peer Consultation
Status:	Denied	
P2P Eligibility Result:	Post-decision options for this case have been exhausted or are not delegated to eviCore. You may continue to schedule a Peer to Peer discussion for this case but it will be considered consultative only and the original decision cannot be modified.	
P2P Status:		

ALL POST DECISION OPTIONS

Once the “Request Peer to Peer Consultation” link is selected, you will be transferred to our scheduling software via a new browser window.

How to Schedule a Peer to Peer Request

Case Info Questions Schedule Confirmation

New P2P Request

eviCore healthcare P2P Portal

Case Reference Number

Member Date of Birth

+ Add Another Case

Lookup Cases >

Upon first login, you will be asked to confirm your default time zone.

You will be presented with the Case Number and Member Date of Birth (DOB) for the case you just looked up.

You can add another case for the same Peer to Peer appointment request by selecting “Add Another Case”

To proceed, select “Lookup Cases”

You will receive a confirmation screen with member and case information, including the Level of Review for the case in question. Click Continue to proceed.

New P2P Request

eviCore healthcare P2P Portal

Case Ref #: Remove P2P Eligible

! Reconsideration allowed through eviCore until 11/11/2020 12:00:00 AM.

Member Information	Case P2P Information
Name	Episode ID
DOB	P2P Valid Until 2020-11-11
State	Modality MSK Spine Surgery
Health Plan	Level of Review Reconsideration P2P
Member ID	System Name ImageOne

Continue

How to Schedule a Peer to Peer Request

Case Info

1st Case

Case #

Episode ID

Member Name

Member DOB

Member State

Health Plan

Member ID

Case Type MSK Spine Surgery

Level of Review Reconsideration P2P

Questions

Please indicate your availability

Preferred Days

Mon	Tues	Wed	Thurs	Fri
✓	✓	✓	✓	✗

Preferred Times

Morning					Afternoon						
7:00 to 8:00	8:00 to 9:00	9:00 to 10:00	10:00 to 11:00	11:00 to 12:00	12:00 to 1:00	1:00 to 2:00	2:00 to 3:00	3:00 to 4:00	4:00 to 5:00	5:00 to 6:00	6:00 to 7:00
✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Time Zone

US/Eastern

[Continue >](#)

You will be prompted with a list of eviCore Physicians/Reviewers and appointment options per your availability. Select any of the listed appointment times to continue.

The list of physicians returned are all trained and prepared to have a Peer to Peer discussion for this case.

← Prev Week 5/18/2020 - 5/24/2020 (Upcoming week) Next Week →

1st Priority by Skill

Mon 5/18/20	Tue 5/19/20	Wed 5/20/20	Thu 5/21/20	Fri 5/22/20	Sat 5/23/20	Sun 5/24/20
6:15 pm EDT 6:30 pm EDT 6:45 pm EDT	-	-	-	-	-	-

1st Priority by Skill

Mon 5/18/20	Tue 5/19/20	Wed 5/20/20	Thu 5/21/20	Fri 5/22/20	Sat 5/23/20	Sun 5/24/20
3:30 pm EDT 3:45 pm EDT 4:00 pm EDT 4:15 pm EDT Show more...	2:00 pm EDT 2:15 pm EDT 2:30 pm EDT 2:45 pm EDT Show more...	4:15 pm EDT 4:30 pm EDT 4:45 pm EDT 5:00 pm EDT Show more...	3:15 pm EDT 3:30 pm EDT 3:45 pm EDT 4:00 pm EDT Show more...	-	-	-

You will be prompted to identify your preferred Days and Times for a Peer to Peer conversation. All opportunities will automatically present. Click on any green check mark to deselect the option and then click Continue.

How to Schedule a Peer to Peer

Confirm Contact Details

- Contact Person Name and Email Address will auto-populate per your user credentials

The screenshot displays a web interface for scheduling a Peer-to-Peer (P2P) appointment. At the top, a progress bar shows four steps: Case Info (checked), Questions (checked), Schedule (checked), and Confirmation (active). The main content is divided into two panels. The left panel, titled 'P2P Info', shows the appointment date as 'Mon 5/18/20' at '6:30 pm EDT' and lists 'Case Info' including '1st Case' details like Case #, Episode ID, Member Name, Member DOB, Member State, Health Plan, Member ID, Case Type (MSK Spine Surgery), and Level of Review (Reconsideration P2P). The right panel, titled 'P2P Contact Details', contains several input fields: 'Name of Provider Requesting P2P' (filled with 'Dr. Jane Doe'), 'Contact Person Name' (filled with 'Office Manager John Doe'), 'Contact Person Location' (dropdown menu set to 'Provider Office'), 'Phone Number for P2P' (filled with '(555) 555-5555'), 'Phone Ext.' (filled with '12345'), 'Alternate Phone' (placeholder '(xxx) xxx-xxxx'), 'Phone Ext.' (placeholder 'Phone Ext.'). Below these is the 'Requesting Provider Email' field (filled with 'droffice@internet.com') and 'Contact Instructions' (filled with 'Select option 4, ask for Dr. Doe'). A 'Submit >' button is located at the bottom right of the form.

- Be sure to update the following fields so that we can reach the right person for the Peer to Peer appointment:

- Name of Provider Requesting P2P
- Phone Number for P2P
- Contact Instructions

- Click submit to schedule appointment. You will be presented with a summary page containing the details of your scheduled appointment.

The screenshot shows a 'Scheduling' summary page. It features a 'Scheduled' section with a calendar icon, a clock icon, and the text 'Mon 5/18/20 - 6:30 pm EDT'. To the right of this text is a red oval containing the word 'SCHEDULED' in white capital letters.

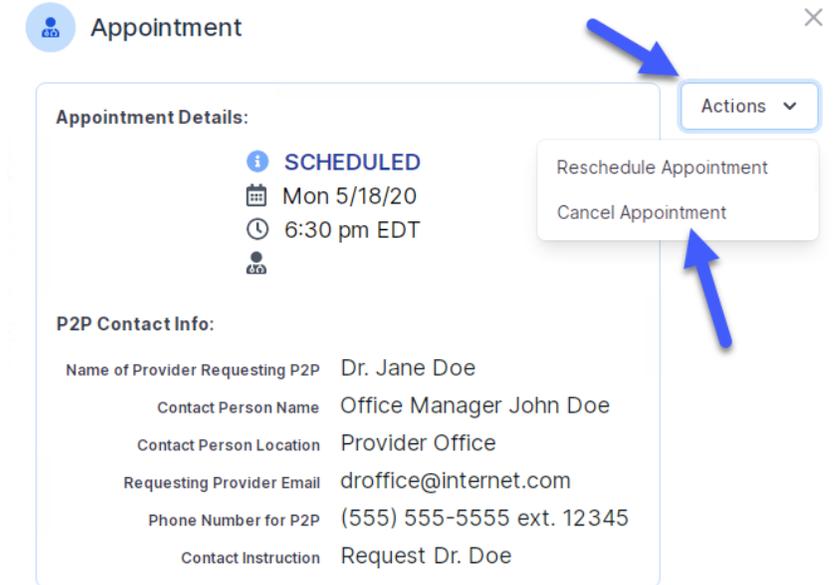
Canceling or Rescheduling a Peer to Peer Appointment

To cancel or reschedule an appointment

- Access the scheduling software per the instructions above
- Go to “My P2P Requests” on the left pane navigation.
- Select the request you would like to modify from the list of available appointments
- Once opened, click on the schedule link. An appointment window will open
- Click on the Actions drop-down and choose the appropriate action

If choosing to reschedule, you will have the opportunity to select a new date or time as you did initially.

If choosing to cancel, you will be prompted to input a cancellation reason



- Close browser once done

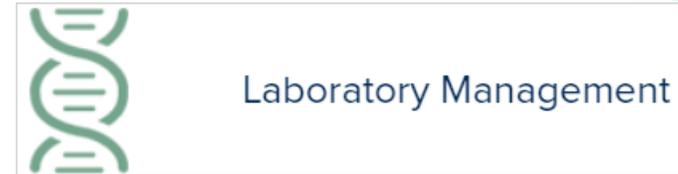
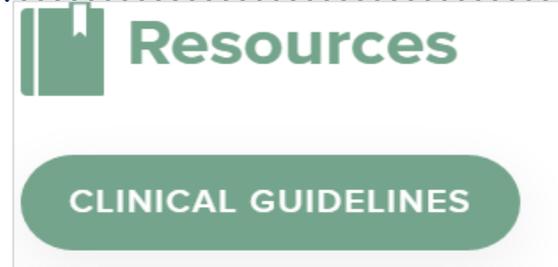
Clinical Guidelines

How to access our Guidelines

1. Go to www.evicore.com and select the 'Resources' drop down menu on the far right hand side of your browser.
2. Then select the 'Clinical Guidelines' button to be directed to the main clinical guidelines page.
3. Scroll down and select the 'Laboratory Management' solution.
4. Type in desired health plan in the 'Search Health Plan' search bar and press enter.
5. Select the appropriate guideline specific to the requested test(s).

Examples:

- Specific genetic testing
- Molecular and genomic testing
- Huntington Disease testing



Laboratory Management

Instructions for accessing the guidelines:

1. Search by health plan name to view clinical guidelines.
2. Locate the **reason for denial** section found in your letter. Identify the guideline title and then search by the provided guideline title. Select appropriate guideline document.

Example for 4Kscore for Prostate Cancer Risk Assessment: *We based this decision on the guidelines listed below: 4Kscore for Prostate Cancer Risk Assessment (MOL. TS. 120).*

Search Health Plan ...



Clinical Guidelines

Health Plan specific Guidelines

1. Current, Future, and Archived lists and Guidelines are found here.
2. You can select the entire Code List or the health plan specific Policy Book.
3. Shown here is an example of the Administrative Guidelines you will find on our resource site.
4. There are also Lab Guidelines for Clinical Use and Test Specific Guidelines on our resource site. (not shown on this screen)

CURRENT FUTURE ARCHIVED

Code Lists
Lab Management Code List

Guidelines
Commercial Lab Policy Book
Effective 07/01/2020

ADMINISTRATIVE 

Date of Service and Effective Date of the Authorization Period
Effective 07/01/2020

Molecular Pathology Tier 2 Molecular CPT Codes
Effective 07/01/2020

Information Requirements for Medical Necessity Review
Effective 07/01/2020

Unique Test Identifiers for Non-Specific Procedure Codes
Effective 07/01/2020

Provider Resources

Dedicated Call Center

Prior Authorization Call Center – 888-564-5492

Our call centers are open from 7 a.m. to 7 p.m. (local time).

Providers can contact our call center to perform the following:

- Request Prior Authorization
- Check Status of existing authorization requests
- Discuss questions regarding authorizations and case decisions
- Change facility or CPT Code(s) on an existing case
- Request to speak to a clinical reviewer
- Schedule a clinical consultation with an eviCore Medical Director



Provider Resource Website

Provider Resource Pages

eviCore's Provider Experience team maintains provider resource pages that contain client- and solution-specific educational materials to assist providers and their staff on a daily basis. The provider resource page will include, but is not limited to, the following educational materials:

- Frequently Asked Questions
- Quick Reference Guides
- Provider Training
- CPT code list

To access these helpful resources, please visit <https://www.evicore.com/resources/healthplan/highmark>

Receive tips and stay updated eviCore's provider newsletter. Subscribe at www.eviCore.com. Just scroll down and add a valid email so that we can send you monthly updates.



Provider Resource Review Forums

The eviCore website contains multiple tools and resources to assist providers and their staff during the prior authorization process.

We invite you to attend a Provider Resource Review Forum, to navigate www.eviCore.com and understand all the resources available on the Provider's Hub. Learn how to access:

- eviCore's evidence-based clinical guidelines
- Clinical worksheets
- Check-status function of existing prior authorization
- Search for contact information
- Podcasts & Insights
- Training resources

I want to learn how to...

Learn how to...
Find Contact Information

Health Plan
Select a Health Plan...*

Solution
Select a Solution...*

START

PROVIDERS: Check Prior Authorization Status Login Resources ^

Resources

CLINICAL GUIDELINES

- Clinical Worksheets
- Network Standards/Accreditations
- Provider Playbooks

I Would Like To

- Request a Consultation with a Clinical Peer Reviewer
- Request an Appeal or Reconsideration
- Receive Technical Web Support
- Check Status Of Existing Prior Authorization

Learn How To

- Submit A New Prior Authorization
- Upload Additional Clinical
- Find Contact Information

GO TO PROVIDER'S HUB >

How to register for a Provider Resource Review Forum?

You can find a list of scheduled **Provider Resource Review Forums** on www.eviCore.com → Provider's Hub → Scroll down to eviCore Provider Orientation Session Registrations → Upcoming

Client & Provider Operations Team

Client and Provider Services

Dedicated team to address provider-related requests and concerns including:

- Questions regarding Accuracy Assessment, Accreditation, and/or Credentialing
- Requests for an authorization to be resent to the health plan
- Consumer Engagement Inquiries
- Eligibility issues (member, rendering facility, and/or ordering physician)
- Issues experienced during case creation
- Reports of system issues

How to Contact our Client and Provider Services team

Email: ClientServices@evicore.com (preferred)

Phone: 1 (800) 646 - 0418 (option 4)

For prompt service, please have all pertinent information available. When emailing, make sure to include the health plan in the subject line with a description of the issue, with member/provider/case details when applicable.



Provider Engagement Team

Provider Engagement team

Regional team that on-boards providers for new solutions and provides continued support to the provider community. How can the provider engagement team help?

- Partner with the health plan to create a market-readiness strategy for a new and/or existing program
- Conduct onsite and WebEx provider-orientation sessions
- Provide education to supporting staff to improve overall experience and efficiency
- Create training materials
- Monitor and review metrics and overall activity
- Conduct provider-outreach activities when opportunities for improvement have been identified
- Generate and review provider profile reports specific to a TIN or NPI
- Facilitate clinical discussions with ordering providers and eviCore medical directors

How to contact the Provider Engagement team?

You can find a list of Regional Provider Engagement Managers at [evicore.com](https://www.evicore.com) → Provider's Hub → Training Resources

Thank You!

