1199SEIU Benefit and Pension Funds

LABORATORY MANAGEMENT REVIEW PROGRAM FREQUENTLY ASKED QUESTIONS (FAQs)

In 2012, the American Medical Association (AMA) expanded the Current Procedural Terminology (CPT)* codes for Molecular Pathology and Genomic Laboratory tests. To assist providers in ordering the most appropriate Molecular Pathology and Genomic tests, the 1199SEIU Benefit Funds have partnered with eviCore healthcare (eviCore) to review certain outpatient Molecular Pathology and Genomic tests starting May 1, 2014. This document is a resource for providers to use to answer common questions about the program.

What are the elements of the Laboratory Management Program?	The Laboratory Management Program consists of prior authorization medical necessity determinations for specific Molecular and Genomic Testing. In addition, eviCore also reviews claims with Molecular and Genomic Laboratory tests to help ensure standard billing practices are followed.
What is the effective date of the program?	The effective date of the Laboratory Management Program is May 1, 2014.
Is it only for outpatient services?	Yes, it only includes the outpatient setting and does not include services in a hospital emergency department or during an inpatient hospital admission.
Which lab procedures require a prior authorization?	Refer to the list of CPT/HCPCS codes that require prior authorization. This can be found on the Benefit Funds' website at **www.1199SEIUBenefits.org** under the "For Providers" tab. Be sure to check the Benefit Funds' website, as the program may be modified or updated.
Which providers are impacted by this program?	All providers who order Molecular and Genomic testing are required to obtain a medical necessity determination for select lab procedures prior to the test being performed. Please note that the specimen collection date and the test performance date should be identified.
What is eviCore's website address?	www.evicore.com
How can providers request a prior authorization?	**Online** at eviCore's website, www.evicore.com, and by logging into the "Ordering Provider Login" after completing a free registration. The website is available 24 hours a day, 7 days a week, and it is possible to obtain immediate authorization decisions if the evidence-based criteria are met. **OR** **By calling** eviCore toll free at (888) 910-1199, option 4. The *Molecular and Genomic Testing Provider Quick Reference Guide*, a one (1) page quick reference prior authorization guide with contact information, can be found on the Benefit Funds' website at **www.1199SEIUBenefits.org** under the "For Providers" tab.

What are eviCore's hours of operation?	eviCore Call Center hours of operation are from 7:00 am to 7:00 pm, Monday through Friday, in all local time zones.
What information is required to obtain a prior authorization?	On the Benefit Funds' website, there is a *Molecular and Genomic Testing Provider Quick Reference Guide* that lists the information necessary to submit a prior authorization request. This one (1) page reference guide can be found at **www.1199SEIUBenefits.org** under the "For Providers" tab. The required information includes: • Member or Patient's name, date of birth and health plan ID number • Ordering provider's name and TIN • Ordering provider's telephone and fax number • Lab testing facility's name and TIN • Lab testing facility's telephone and fax number • Requested test(s) (CPT code or description) • Relative diagnosis and medical history including: » Signs and symptoms » Family history (if related to requested test) » Known familial mutation » Ethnicity » Patient history. If initiating the prior authorization by telephone, the caller should have the medical records available. » Description of genetic test requested and impact on patient's management » Submission of any additional clinical information that will support the test request
What happens if a provider's office does not know the specific lab code(s) that need to be ordered?	eviCore will assist the provider's office in identifying the appropriate test based on presented clinical information and the current CPT code(s).
What is the process that providers should follow if eviCore is not available when they need to obtain a prior authorization?	A web-based authorization initiation system is available 24 hours a day, 7 days a week.
How long does the medical necessity determination process take?	When a prior authorization is initiated online or by phone and the clinical information provided meets evidence-based criteria, the test may be approved and a time-stamped approval will be available for printing. If the non-urgent request does not meet criteria or requires additional clinical review, a determination will be made within two (2) business days upon receipt of all necessary information to process a medical necessity review.
What happens when the online system does not post an immediate authorization?	eviCore Certified Genetic Counselors will review and issue an authorization if the requested test meets the evidence-based criteria. All other requests will be sent to an eviCore Medical Director for review and determination. All decisions should be made within two (2) business days for non-urgent requests once complete clinical information is received. All determination decisions will be sent in writing to the member or patient, provider and laboratory, if available.

How can providers indicate that the procedure is clinically urgent?	Urgent requests should be made by calling eviCore's toll-free number at (888) 910-1199. The provider must notify the eviCore Clinical Reviewer that the test request is "URGENT" and demonstrate medical necessity by providing the appropriate clinical documentation. A clinically urgent test request is qualified only when following the standard two (2) business day timeframe could result in seriously jeopardizing the member's or patient's life, health or ability to regain maximum function.
What information is available through the Provider Portal located on eviCore's website?	The authorization status function on the eviCore Provider Portal provides the following information: • Medical necessity determination number/Case number • Status of request • Lab site name and location (if available) • Medical necessity determination date • Expiration date In addition, all determination decisions will be sent in writing to the member or patient, provider and laboratory, if available.
How will providers be notified of the medical necessity determination?	The provider and laboratory will be notified of the medical necessity determination via facsimile (fax). If fax is not available, the notice will be sent via USPS. The provider and lab site can validate a prior authorization determination through eviCore's website at www.carecorenational.com or by calling eviCore's Customer Service at (888) 910-1199.
What is the format of the eviCore medical necessity determination number?	An authorization number is one (1) alpha character followed by nine (9) numeric numbers. For example: A123456789
How can the eviCore criteria be viewed?	The program's clinical policy manual is available on the Benefit Funds' website at **www.1199SEIUBenefits.org** under the "For Providers" tab.
How long is a prior authorization approval valid for?	Authorizations are valid up to 60 calendar days from the date of approval.
If a member or patient visits a provider's office or laboratory after the prior authorization expires and requires a Molecular Genomic test, is a new prior authorization required?	Yes. eviCore will not extend an authorization past its expiration date. Therefore, the provider or laboratory will need to contact eviCore again to initiate a new request.
In the event of an adverse determination, can providers request a clinical review?	Yes. A peer-to-peer provider discussion can be conducted anytime during the determination and up to 14 calendar days after the determination to submit additional information that may affect the outcome of the medical necessity decision. Call eviCore at (888) 910-1199.
What are the parameters of an appeals request?	eviCore manages first-level appeals. Appeal rights are detailed in coverage determination letters sent to providers with each adverse determination. Appeals must be made in writing unless the request involves 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:** (844) 545-9214 **Toll Free Phone:** (866) 221-8787, Option 2 *for appeals process questions* The *Molecular and Genomic Testing Provider Quick Reference Guide*, a one (1) page quick reference prior authorization guide with contact information, can be found on the Benefit Funds' website at **www.1199SEIUBenefits.org** under the "For Providers" tab.
Is a medical necessity determination a guarantee of payment?	No. As a member's eligibility can change, this is only a medical necessity determination. Medical necessity determinations are provided based on the patient eligibility data as it appears in the Benefit Funds' eligibility system when the request is made, and is not a guarantee of payment.
Is provider education and training available?	Yes. Check the Benefit Funds' website for updates and announcements, including educational webinars on how to submit prior authorization requests at **www.1199SEIUBenefits.org** under the "For Providers" tab. Additional tools and resources can be found on eviCore's website at www.evicore.com under "Lab Management."
What is eviCore's contingency plan in the event of a power outage?	eviCore has multiple customer service centers in varying geographical locations, which allows eviCore to continue providing support even if one location experiences a power outage. For example, if calls directed to one location were to suffer a power outage, the calls would automatically be routed to another service center so that the service would be seamless to the caller.

***** CPT is a registered trademark of the American Medical Association (AMA).