Horizon Blue Cross Blue Shield of New Jersey

Medical Information Requirements for Programs Administered by eviCore

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Horizon Blue Cross Blue Shield of New Jersey partners with eviCore Healthcare (eviCore) to help ensure the delivery of safe, effective and appropriate care to our members, to provide clinical consultation to our participating health care professionals and to assist in the scheduling of services.

The list below identifies the key medical information that is required at the time a Prior Authorization (PA) or Medical Necessity Determination (MND) is requested from eviCore. eviCore will complete a standard case request within three business days of receiving all required clinical information.

Program	Required Medical Information
Radiology/Imaging Program	• Rule out/diagnosis • Symptoms • Physical exam findings • Treatment such as medications, physical therapy, surgery, chemotherapy • Re-evaluation post treatment for some indications • Recent relevant imaging • Recent relevant laboratory work • Pertinent medical history and family history • For imaging exam requests for cancer, indicate if the exam is requested for initial staging or restaging following treatment or surveillance. Please provide the type and stage of cancer, date of diagnosis, type of treatment and date of treatment completion.
Cardiology Imaging Program	• Current office notes • Lipid panels • Reports of current electrocardiograms (EKGs) signed by doctors • Reports of previously performed left heart catheterizations, nuclear stress tests, routine exercise stress tests, echocardiograms and stress echocardiograms (as applicable).
Molecular and Genomic Testing Program	• Specimen Collection or Shelf Retrieval Date if known • Test Name • CPT Code (s) and Units • ICD Code(s) Relevant to Requested Test • Test Indication (Personal history of condition being tested, age at initial diagnosis, relevant signs and symptoms if application) • Relevant Past Test Results • Member or Patient's Ethnicity • Relevant Family History of Applicable (maternal or paternal relationship, medical history including ages at diagnosis, genetic testing) • Is there a Known Familial Mutation? If yes, what is the Specific Mutation? • How will the Test Results be used in the Member or Patient's care?

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Program	Required Medical Information
Musculoskeletal Program for Pain Management	• CPT® code(s) and specific level(s) of injection and/or specific muscle groups to be injected. • Specific prior injection history with dates/level/side/response to injection, especially if it is an injection into the same vertebral region (e.g. cervical, thoracic or lumbar spine). • Total number of injections/procedures in the past 12 months for the diagnoses (to include all prior doctors). • Date of most recent physical exam along with physical exam findings and patient complaints. • Medical history/duration of complaints • Other pertinent medical history/comorbidities • Name of injectant • Type or method of radiofrequency ablation and/or percutaneous decompression • Dates/duration/response to conservative treatment such as medication and various therapies (please specify). • Date of MRI and other imaging with findings • Indication whether this is related to workers' compensation or a motor vehicle accident. If so, please include date of injury/accident. • Specify imaging guidance type • Proposed date of service for current request • Any anesthesia requirements
Musculoskeletal Program for Spine Surgery	• Ordering health care professional name, address and office telephone number • Rendering health care professional name, address and office telephone number (if different from Ordering) • Rendering facility name, NPI, Tax Identification Number (TIN) , address and fax number • Anticipated date of surgery • Member height, weight and body surface area • Procedure codes and description • Past therapeutic failures including physical therapy, interventional pain procedures, medications, and any other conservative treatment • When applicable, co-surgeon and assistant surgeon information: Name, Federal Tax Identification Number (FTIN) • Relevant Diagnostic/Imaging and x-ray results • Relevant clinical notes and any anticipated implant, technology or hardware to be used • If applicable, co surgeon/assistant surgeon information
Radiation Therapy Program	• Site being treated • Reason for treatment • Staging of the cancer, if applicable • Technique to be used • Number of phases of treatment (if more than one), gantry angles (if applicable) and number of fractions

For specific information by disease, refer to the doctor worksheets located at www.evicore.com.
See *Criteria* under *Health Plan Providers*.