eviCore healthcare FAQs for Premera for the Musculoskeletal (MSK) Medical Necessity Review process

Why did the Health Plan partner with eviCore?

The Health Plan owes it to its members to ensure that they receive appropriate care, to assist them with managing a limited benefit, and to be responsible stewards of the cost of healthcare by only paying for necessary service. The purpose of partnering with eviCore is to provide quality support, utilizing eviCore's experience in overseeing physical medicine services.

Why the need for medical necessity review?

Healthcare costs are rising. Limiting unnecessary services will control costs so the Health Plan can continue to offer a quality product at a reasonable price. Through medical necessity review, the Health Plan helps members get the most from their coverage by making sure treatments are right for their condition, effective and medically necessary.

Do I need to obtain medical necessity approval before providing services?

Prior authorization is not required; however a medical necessity approval may be required for claims payment.

Important Note! Washington Senate Bill 6157 changes what providers need to do for outpatient rehabilitation service.

For dates of service June 7, 2018, and after, the health plan won't require providers to request a medical necessity review through eviCore healthcare for the first 6 treatment visits of an episode of care (active treatment within a 90-day period) for outpatient rehabilitation services.

- We'll allow an initial evaluation and management visit, and up to 6 subsequent visits without a treatment plan on file. **Note:** We reserve the right to do reviews for medical necessity for any medical services provided.

- After the 6 consecutive visits, providers **must** submit a request for medical necessity review to eviCore healthcare for any on-going treatment.

What services are managed through the Physical Medicine and Therapy Program?

The Physical Medicine and Therapy UM Program manages outpatient services for:

- Physical Therapy
- Occupational Therapy
- Massage Therapy
- Other specialties that are billing CPT codes listed on the Comprehensive CPT Code List

How can I obtain an authorization for services?
All physical medicine/therapy practitioners may submit a request for medical necessity review within seven days of the requested start date of the authorization request. The authorization request may be submitted by the servicing practitioner or office staff. The preferred method to submit the request is online at **www.evicore.com** Online submissions are available 24/7.
Requests may also be submitted by phone at 800.792.8751 between 7 a.m. and 7 p.m. local time Monday through Friday.

What clinical information will be asked for during the authorization request?
The information is tailored to the patient condition and therefore varies. In general, we ask for the following clinical information:

- Diagnosis/ICD-10 code
- Start date for the request
- Date of the current objective findings
- Date of the initial evaluation
- Date of onset
- Date of surgery if applicable
- Condition specific clinical tests
- Functional assessment using patient reported functional outcome tools

Refer to the condition specific Clinical Worksheets on the eviCore website for the clinical information required using the link below:
https://www.evicore.com/provider/online-forms

How many visits/units will eviCore healthcare approve when I submit my request?
The authorization is based on the member's condition, complexity, and functional status as well as the average number of visits used for the diagnosis and treatment type of service being requested.

Can I request more visits if the member requires more care?
Yes. If the member requires more care after the authorization has been used, you may submit a request for authorization for additional visits/units. The preferred method to submit Treatment Requests is online at www.eviCore.com. With online submission, you may receive an instantaneous review determination. You may also call eviCore at 800.792.8751, 7 a.m. through 7 p.m. local time Monday through Friday or fax 855.774.1319 eviCore requires that fax requests include eviCore's clinical worksheets. Submission of additional information beyond the clinical worksheet is not necessary. If worksheet is completed thoroughly there is enough information needed to perform a medical necessity review. Worksheets are available at eviCore.com. Completion of the worksheet prior to submitting a request will simplify/speed the process.

Do the services provided in an inpatient setting at a hospital or emergency room setting require a medical necessity review?
Therapy services provided during an emergency room treatment visit or inpatient stay do not require a medical necessity review.

If a primary care provider (PCP) refers a patient, will that make any difference in the medical necessity review?
No. There are no changes in requirements in regards to physician referrals. Request will be reviewed for medical necessity based on evidence-based criteria.

Will members receiving massage therapy be required to receive referrals for treatment from their physician?
The rules regarding patient referrals are not changing. Please continue to follow the same referral rules you are currently following.

If a Primary Care Physician refers a patient to a therapist for services that require authorization, who needs to request the authorization?
The therapist/facility would request the authorization.

Can an Athletic Trainer initiate an authorization for physical therapy?
No, an Athletic Trainer may not initiate a case for Physical Therapy. While Washington state law allows athletic trainers to perform specific tasks related to physical therapy, these must be performed under the supervision of a physical therapist. The Physical Therapist is responsible for initiating authorization.

Are the clinical criteria available for review?
Yes. Evidence-based criteria will be available online at
https://www.evicore.com/provider/clinical-guidelines

Can I use my own forms when requesting authorizations?
No. To ensure that clinical peer reviewers receive necessary and complete information, and to make consistent clinical determinations, an eviCore clinical worksheet is required for medical necessity review.

Will separate authorizations be required for a patient with two concurrent diagnoses?
No. Each medical necessity review considers all reported diagnoses for the patient.

What do I enter as the "Start Date" on my request?
The start date should be the date you want the authorization to begin.

How far in advance can I submit a request for more visits?
Submit your request for more visits no earlier than seven days prior to the requested Start Date. Requesting care too far in advance does not allow you to report up-to-date examination findings. The current findings date reported on your Treatment Request should be within ten days of your requested Start Date. To avoid a delay in receiving a review determination, provide current clinical findings, paying particular attention to how you document the patient's progress with the services you have already provided.

Can I include Durable Medical Equipment (DME) supplies on a request to eviCore?
You may document that a patient requires specialized DME equipment; however, orthotics, DME and supplies will not be authorized by eviCore. Follow the normal process for all DME. For more information please check the health plans website.

What is the timeframe for a request to go through the medical necessity review process?
If medical necessity can be established based on evidence-based criteria, visits will be authorized at the time of your Treatment Request submission. When you submit online, this authorization will be instantaneous. When a clinician review is required, eviCore's review determination timeframes will comply with applicable regulations.
The turnaround times are dependent upon all necessary information being provided to eviCore. If there is insufficient information to make a determination, eviCore will fax you a letter indicating the information that is still required. To avoid a delay in approval, have updated clinical information available before contacting eviCore.

Will the clinical reviews be done by a practitioner of the same discipline?
Requests requiring clinical evaluation will be reviewed by appropriate specialty clinicians.

How can I track the status of my authorization requests?
To check the status of a case, log on to www.eviCore.com. From there you can select "Check Status of Existing Prior Authorization".

Can I extend the End Date of an authorization if I didn't use all the approved visits?
Yes. eviCore will approve one extension per Approved Time Period up to 30 days. A date extension will not be granted if requested after the authorization period has expired. A date extension may be requested online at www.eviCore.com, click on Provider login, and select the eviCore portal or by calling eviCore at 800.792.8751. Date extension requests via fax will not be accepted.

Will treatment be authorized for chronic conditions if the condition gets worse without occasional treatment and other options have been exhausted?
Each case is specifically considered. If the care delivered is skilled and meets the guidelines for medical necessity, we will authorize visits/units based on the clinical information presented. We will expect the home management program to be updated and if needed, the patient and caregiver should be instructed in additional procedures to maintain maximum function for the member. We would expect the care to be spread over time and the practitioner should take on a role of a consultant to assist the member in managing the condition.

Is peer-to-peer consultation available?
Yes. You may schedule a peer to peer request online **https://www.evicore.com/provider/request-a-clinical-consultation** or by calling eviCore at
800.792.8751. A scheduled call-back is offered at a time that is convenient for your practice. These timeframes will comply with applicable regulation and law.

Can I file an appeal for cases that have been denied or partially denied?
We recommend that you utilize the reconsideration process before filing a formal appeal. Reconsiderations are completed via the telephone and through peer-to-peer consultations as applicable. If the initial decision is upheld, then the next step is a first-level appeal. The review determination letter will provide instructions for appealing a medical necessity decision, including your right to submit additional information.

Where do I submit claims?
Follow your routine process for claims submission. For more information please check the health plans website.

Does the authorization number need to be on the claim?
No. There are no changes for submitting a claim. Follow the standard claims filing process.

Does the first visit for evaluation need to have an exam code? When requesting more treatment, do I charge the patient for re-evaluation exam CPT code every 30 days?
There are no requirements to use Evaluation & Management (E&M) codes on the first visit. Services should be submitted to the Health Plan and members are only responsible for applicable deductible, coinsurance, copayments and non-covered services.

My practice employs providers of different specialties that bill under my tax identification number. Who should be obtaining the authorization?
As in all cases, services should be performed by appropriately licensed clinicians practicing within the scope of their license. It is best if each clinician type treating Health Plan members obtains the authorization using their credentials.

What information about the authorization will be visible on the eviCore Web site?
The authorization status function on the Web site will provide the following information:

- Authorization Number/Case Number
- Status of Request
- CPT Code(s) and quantities of the code(s)
- Procedure(s) Name
- Site Name and Location
- Authorization Date
- Expiration Date

Using the web portal increases the possibility of an immediate decision. It is available 24/7.

Why is my location not showing correctly on the eviCore site?
If you have any issues finding your location on the website, please call eviCore Provider Relations at 800.646.0418 option 4. Please keep in mind that you should be credentialed at the location that you wish to locate within the eviCore Provider Portal. *Note:* verification of participation of a specific location/demographic updates should be done via the health plan.

Are there tools I can use to get familiar with the site?
eviCore Provider Experience team is happy to provide one-on-one portal training to providers. Additionally, the eviCore website contains videos on registration and web submission, CPT code list, FAQ, and more at: **https://www.evicore.com/provider**

If a request is not approved, what follow up information will the performing provider receive?

The performing provider will be informed of the reason for denial, as well as how to initiate a reconsideration or appeal. If a provider resubmits a medical necessity review request for a service within the timeframe allowed for an appeal that was previously denied, eviCore will consider this request an appeal. If the timeframe to file an appeal has expired, the request will be treated as a new request for authorization. Within fourteen (14) business days after the denial has been issued, the provider may request reconsideration with an eviCore Medical Director to review the decision.

Is there is an appeals process if the authorization is not approved?

Yes. Appeal rights are detailed in communications sent to the providers with each adverse determination. Providers may also request reconsideration from eviCore within fourteen days of the denial decision.

What is the format of the eviCore authorization number?

An authorization number is (1) one Alpha character followed by (9) nine numeric numbers. For example: A123456789.