EviCore
By EVERNORTH

Specialty Therapy Clinical Quick Reference Guide (QRG)

Health Plan Provider Resource Website – Provider Resources | EviCore by Evernorth

These webpages are tailored to each specific health plan. The websites include the CPT code list (list of codes that require prior authorization for a specific health plan), Frequently Asked Questions (FAQ), Quick Reference Guides (QRG), links to clinical worksheets, and links to EviCore's evidence-based guidelines.

Schedule a Clinical Consultation (P2P) via the Provider Web Portal – Provider's Hub | EviCore by Evernorth

1. Log in to the Provider Web Portal and navigate to the Authorization Lookup feature.
2. Enter the necessary case information to locate the specific authorization.
3. On the case summary screen, look for the P2P Availability button.
4. If the case is eligible for a peer-to-peer consultation, a link labeled "Request Peer-to-Peer Consultation" will be visible.
5. Click the link to proceed with scheduling the clinical conversation.

Important note: Depending on the line of business and/or status of the case, the clinical consultation (P2P) may not result in EviCore's ability to approve the case. If the clinical consultation occurs outside of the reconsideration period or during an appeal, EviCore may not be delegated for the re-open. In those cases, the clinical consultation would be consultative only.

Date extension

A date extension can be granted for a therapy case in which a provider was authorized visits but was unable to perform those visits within the amount of time given. You can request a date extension via our Web Portal or telephonically. A one-time date extension will be granted for up to 30 days. The extension must be requested before the authorization expires.

How do I submit documents for review for prior authorization or a medical necessity review?

The preferred method of submission is via our Web Portal. However, you can also call EviCore or fax in your request; the fax number is (855) 744-1319. While EviCore discourages submission by fax, if you must fax your request, include a completed EviCore clinical worksheet. If the worksheet is completed, there is no need to include additional clinical notes.

What information is needed to request authorization of Physical and Occupational Therapy services?

EviCore requires clinical information to determine if services are medically necessary. Submitted cases lacking complete clinical information often take longer to process and may result in a reduction of services or denial. To reduce the time needed to create a case on the web or phone, have the following information available:

- Member information, including Name, Date of Birth, Address, Phone #, Health Plan ID
- Provider information, including Name, NPI #, TIN, Phone #, Fax #, Address, Specialty Type
- Current Clinical information
  - Adult – use EviCore's clinical worksheets to identify the clinical information needed
  - Pediatrics - use EviCore's clinical worksheets to identify the clinical information needed, including:
    - Standardized test scores within 1 year
    - Current clinical (typically collected within the prior 20 days)
- Progress toward goals
- Patient reported functional outcome measures (ODI, NDI, LEFS, HOOS JR, KOOS JR, or DASH/QuickDASH)
- Requested start date – this is the date you would like the authorization to begin.

How soon can I request additional visits?

To prevent interruption in care, submit requests for additional visits **as early as 7 days prior to the requested start date.**

Will EviCore approve visits or units?

Depending on the health plan, EviCore will approve visits, units, or visits and units for use within an approved period. Please refer to the authorization letters to clarify visits or units approved.

Visits/units should be spread over the approved period to prevent a gap in care.

EviCore reduces or denies a request (also known as an adverse determination), the letter will include clinical rationale to explain why. The rationale is written in language a member can understand in order to comply with regulatory standards. If there has been an adverse determination, the letter will include directions for reconsiderations, clinical consultation (Peer to Peer), or the appeal process. Please review your letter for information on next steps.

Will EviCore approve services performed by two providers (same specialty) within the same period of time?

EviCore authorizations for a specific specialty, such as Physical Therapy (PT), cover all conditions treated within the approved authorization period. We do allow members to switch providers without requiring a formal discharge date from the previous provider. Ultimately, it is the member's responsibility to track their benefit usage.

In cases involving duplicate providers for specialty conditions, whether in the same clinic or different clinics, approval may be granted if the clinical rationale supports the need for specialized or concurrent care. For example, the first therapist is providing care for lower back conditions, and the second therapist is providing care for vestibular problems.

Will EviCore approve services performed by two providers (different specialties) within the same period of time?

Approval for care by multiple specialties during the same authorization period depends on the conditions being treated and the providers' plans of care. EviCore may approve care from two different specialties when:

1. Providers are treating distinct conditions (e.g., Chiropractic care for a lumbar condition and Occupational Therapy for a hand injury), or
2. Providers are treating the same condition but with different goals and plans of care (e.g., PT and OT services following a brain injury). However, each discipline must have separate treatment plans.

What documentation should be submitted for a Retrospective Authorization Request?

If the health plan allows retrospective requests, EviCore must review clinical information to determine if the services provided were medically necessary. Requests for retrospective review should be faxed to EviCore. Please include the following with any retrospective request:

- List all dates of service for which you are requesting authorization
- The initial evaluation and progress reports/re-evaluation. Submitted Documentation should include objective test and measures and clinical assessment reporting member's response to care.

How can I determine if services are medically necessary?

To be considered medically necessary, the following conditions must be met:

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.
- The services shall be of such a level of complexity and sophistication, or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy, by or under the supervision of a therapist.
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

Important: Please refer to the specific guidelines referenced in the decision letter.

What services are not considered medically necessary?

The following services are generally not considered medically necessary. (Refer to specific health plan policy for specific-coverage policies.)

- Service(s) that can be self-administered or safely and effectively furnished by an unskilled person without the direct or general supervision of a therapist.
- Training in nonessential self-help, recreational tasks, or sport-specific performance.
- Services related to activities for the general good and welfare of the members, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation.

- Passive modalities that extend beyond the acute phase of recovery.
- Non-skilled routine, repetitive and reinforced procedures that do not require one-to-one intervention, such as stationary bike riding, progressive resistive exercise after instruction, and passive range of motion.
- Services not provided under a therapy plan of care.
- Services provided by staff who are not qualified or appropriately supervised. (The unavailability of a competent person to provide a non-skilled service does not mean it becomes a skilled service when the therapist furnishes it.)