Clover Health

Specialized Outpatient Therapies

Physical, Occupational and Speech Therapy

Provider Orientation Session for **Clover Health**

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eviCore healthcare
Empowering the Improvement of Care

Company Overview

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250M Members Managed

10 Comprehensive Solutions

The industry's most **comprehensive clinical evidence-based guidelines**

5k+ employees including **1k clinicians**

Engaging with 570k+ providers

Advanced, innovative, and intelligent technology

Headquartered in Bluffton, SC
Offices across the US including:

- Lexington, MA
- Colorado Springs, CO
- Franklin, TN
- Greenwich, CT
- Melbourne, FL
- Plainville, CT
- Sacramento, CA
- St. Louis, MO

NCQA Certification Utilization Management

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT

SIX SIGMA

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

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3

Evidence-Based Guidelines

The foundation of our solutions

Guidelines updated at least annually

Experts associated with academic institutions

Current clinical literature

Aligned with National Societies:

- American Academy of Neurology
- American College of Rheumatology
- American Association of Neurological Surgeons
- American Academy of Orthopedic Surgeons
- American Society of Interventional Pain Physicians
- North American Spine Society
- American College of Occupational and Environmental Medicine
- American Academy of Physical Medicine and Rehabilitation
- American Association of Hip and Knee Surgeons
- American Pain Society
- Official Disability Guidelines
- Medicare Guidelines
- Spine Intervention Society
- American Academy of Orthopedic Surgeons
- The American Orthopedic Society for Sports Medicine
- Cochrane Reviews
- American Physical Therapy Association
- American Chiropractic Association
- American Occupational Therapy Association
- American Speech Language Hearing Association
- American Society of Anesthesiologists

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Our Service Model

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Enabling Better Outcomes

Enhancing outcomes through Client and Provider engagement

Client and Provider Operations Team –

Client Provider Representatives are cross-trained to investigate escalated provider and client related issues.

Client Experience Manager –

Client Service Managers lead resolution of complex service issues and coordinate with partners for continuous improvement.

Regional Provider Engagement Manager –

Regional Provider Engagement Managers are on-the-ground resources who serve as the voice of eviCore to the provider community.

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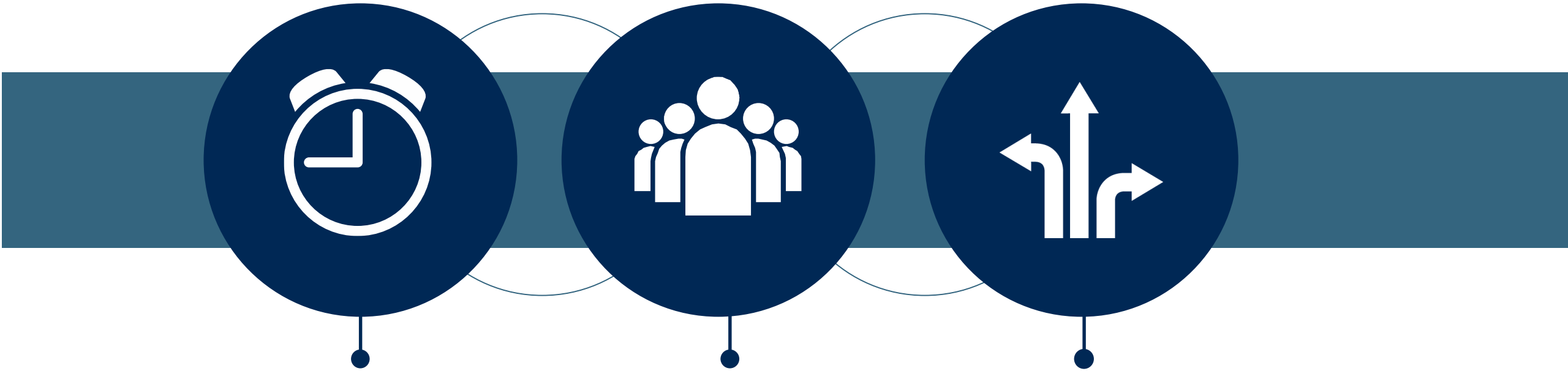
Why Our Service Delivery Model Works



One centralized intake point allows for timely identification, tracking, trending, and reporting of all issues. It also enables eviCore to quickly identify and respond to systemic issues impacting multiple providers.

Complex issues are escalated to resources who are the subject matter experts and can quickly coordinate with matrix partners to address issues at a root-cause level.

Routine issues are handled by a team of representatives who are cross trained to respond to a variety of issues. There is no reliance on a single individual to respond to your needs.

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Prior Authorization Overview

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Clover Health Prior Authorization Services

Effective 2/1/2023, eviCore healthcare will begin accepting prior authorization requests for Specialized Outpatient Therapy for Clover Health Medicare Members.

Prior authorization applies to the following services:	Prior authorization does **NOT** apply to services performed in:
• Outpatient • Diagnostic • Elective / Non-emergent	• Emergency Rooms • Observation Services • Inpatient Stays

It is the responsibility of the ordering provider to request prior authorization approval for services.

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Specific Therapy

Clover will continue to allow the first 15 Physical Therapy, Occupational Therapy, and/or Speech Therapy sessions without prior authorization per discipline, per year. All outpatient therapy visits beyond 15 require prior authorization.

To find a list of CPT
(Current Procedural Terminology)
codes that require pre-service authorization through eviCore, please visit:

https://www.evicore.com/resources/healthplan/cloverhealth

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Needed Information

Non-Clinical Information

Member Information

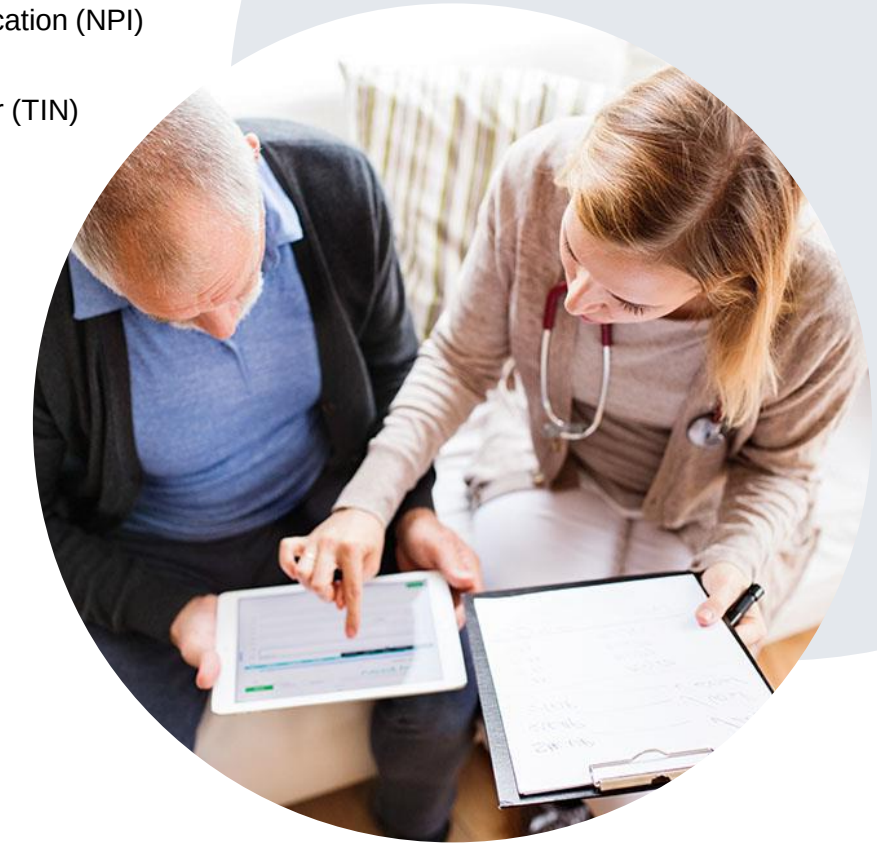
- First and Last Name
- Date of Birth
- Member Identification Number
- Phone Number (If Applicable)

Ordering Physician Information

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

Rendering Facility Information

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



Supporting Clinical Information

Supporting clinical information is only needed if request is not approved immediately

- Imaging studies and prior test results related to the diagnosis
- Office notes related to the current diagnosis
- Therapy notes related to the current diagnosis

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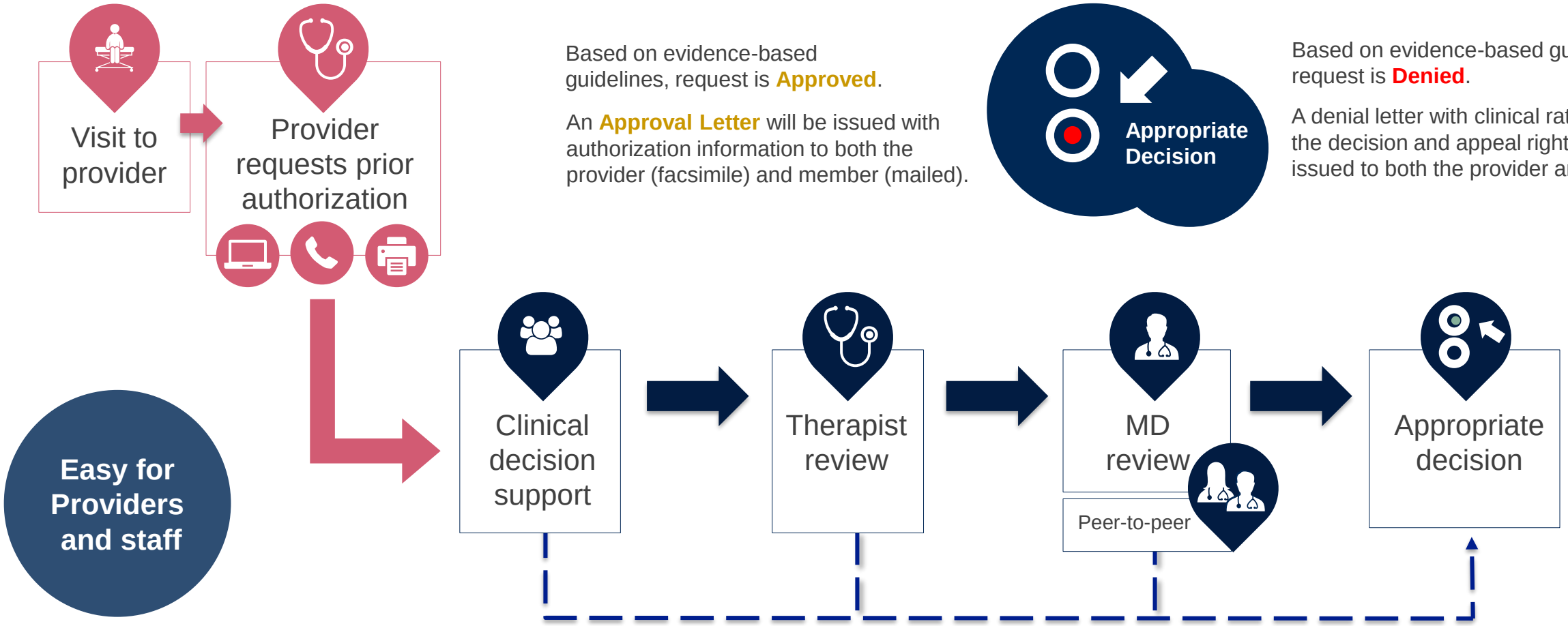
Utilization Management – the Prior Authorization Process



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corePath

Evidence-based, condition-specific approach

Focused on the patient: Authorization strategy emphasizes the unique attributes of a patient's condition and any associated complexities

Streamlined for providers: Providers will experience a simplified and consistent prior authorization process that requires only key clinical information

Condition-specific approvals: Visits allocated in accordance with condition severity / complexity, functional loss, and confirmation that care is progressing as planned

Therapy corePath: How it Works

1

Initial Visit Allocation

Based on each patient's needs

2

Authorization of Additional Visits

Based on each patient's confirmed progress

Getting to the Right Yes vs the Wrong No

- Collects only key clinical information
- Uses validated measurement tools
- Considers complexities

- Focuses on progress
- Captures reasons for lack of progress
- Confirms effectiveness of treatment

Ongoing care requires more detailed review to identify the individual patient's need

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Prior Authorization Process

Clinical Information – What eviCore needs and why we need it

- Clinical information is required to determine whether the services requested are medically necessary.
- Use clinical worksheets located at eviCore.com as a guide to determine what clinical information is required.
- Be prepared to provide patient reported functional outcome measures with your submission (for example: ODI, NDI, DASH/QuickDASH, LEFS, HOOS JR, KOOS JR).
- Clinical information should be current – typically something collected within 14 days prior of the request.
    - Exception – for peds neurodevelopmental, information may be up to 20 days old and the standardized testing should have been completed within up to one year prior to the requested start date.
- **Missing or incomplete clinical information will delay case processing.**
- **<u>Medicare</u> cases with incomplete or missing information will receive special handling. CMS allows eviCore to reach out multiple times over a 14 day period to obtain the information required to complete our review.**

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Prior Authorization Process

Timely Filing

- **Clover Health** allows 15 visits per discipline, per year. All outpatient treatment beyond 15 will require authorization.
- The evaluation code does not require prior authorization, but treatment does.
- Authorization for treatment beyond the initial 15 visits allowed by plan must be requested prior to providing care.
- Retrospective requests will be accepted up to 7 business days. Please note that any cases after 7 business days will be expired.

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Care Management Process – Important Concepts

Authorization decisions include:

- **Visits** – represent the total # visits per authorization period
- **Approved Time Period**

<u>Spread the visits over the approved period to prevent a gap in care.</u>

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Date Extensions

Date extensions are available if you are unable to use all visits within the approved period

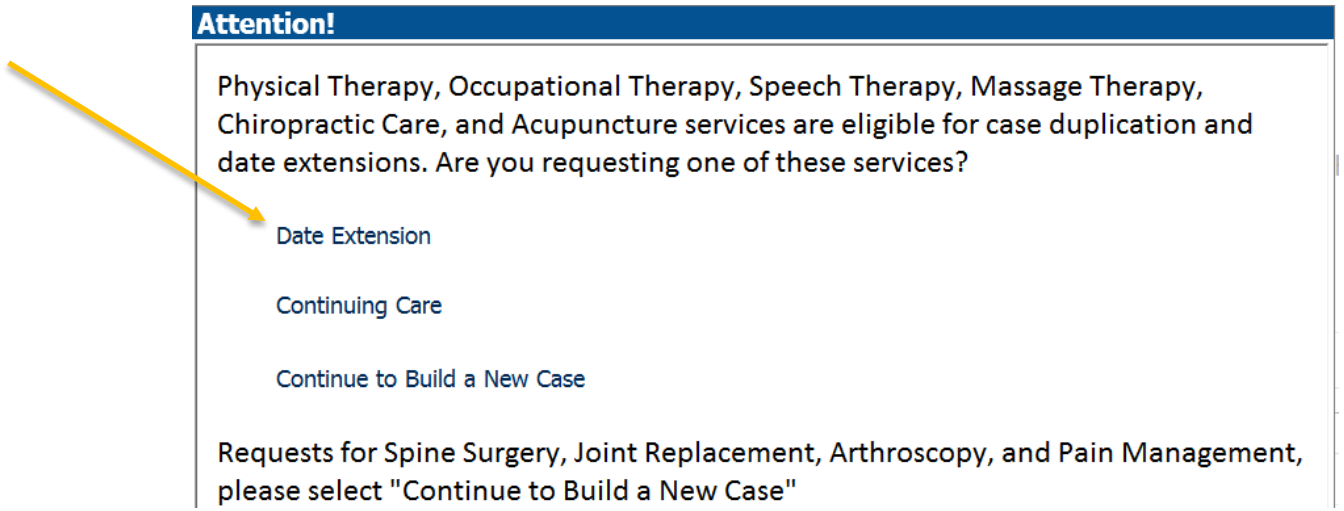
- Extend for the period that is needed, up to a maximum of 30 days
- One date extension is available per case

•Must be requested prior to the expiration of the authorization

Available

- By phone 800-421-7592
- Online

  www.evicore.com



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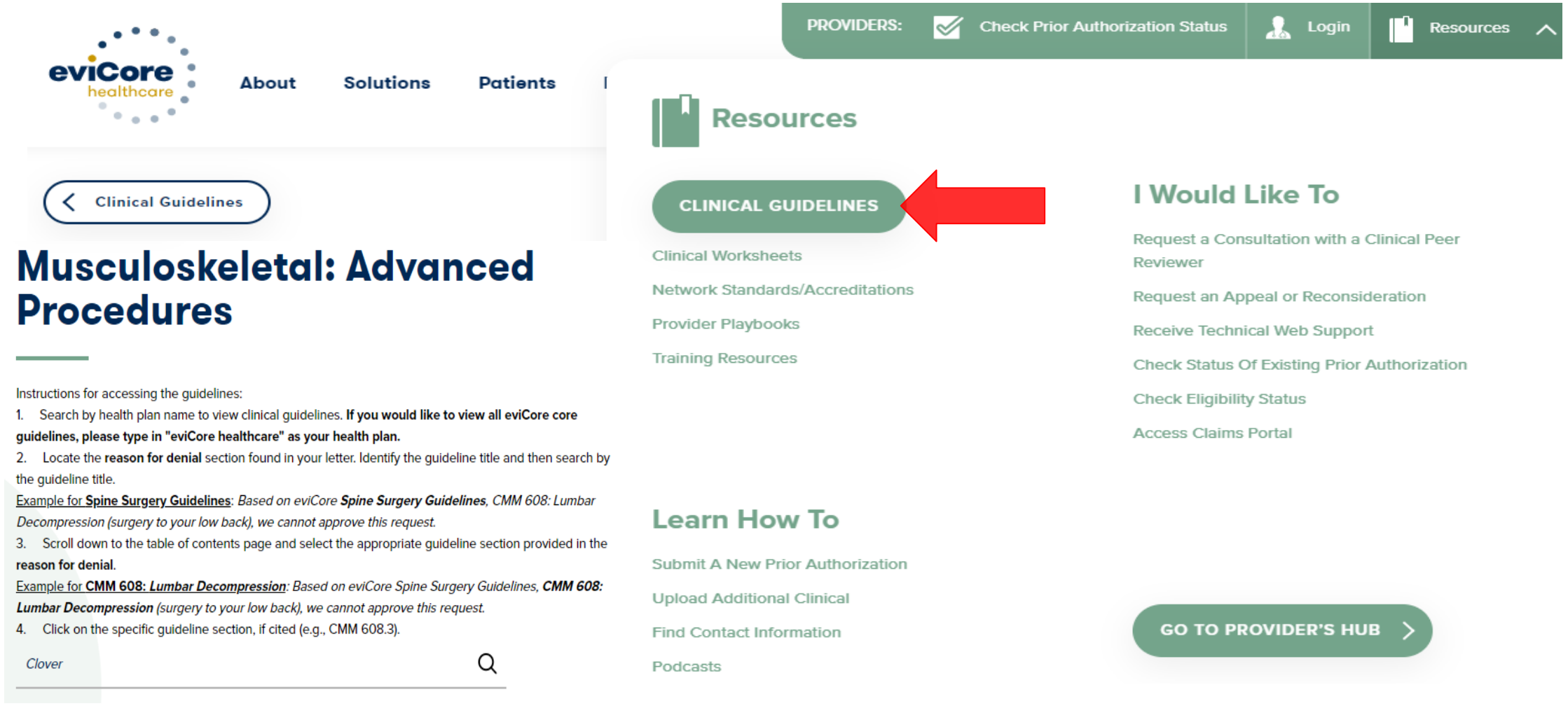
Clinical Certification – Clinical Guidelines



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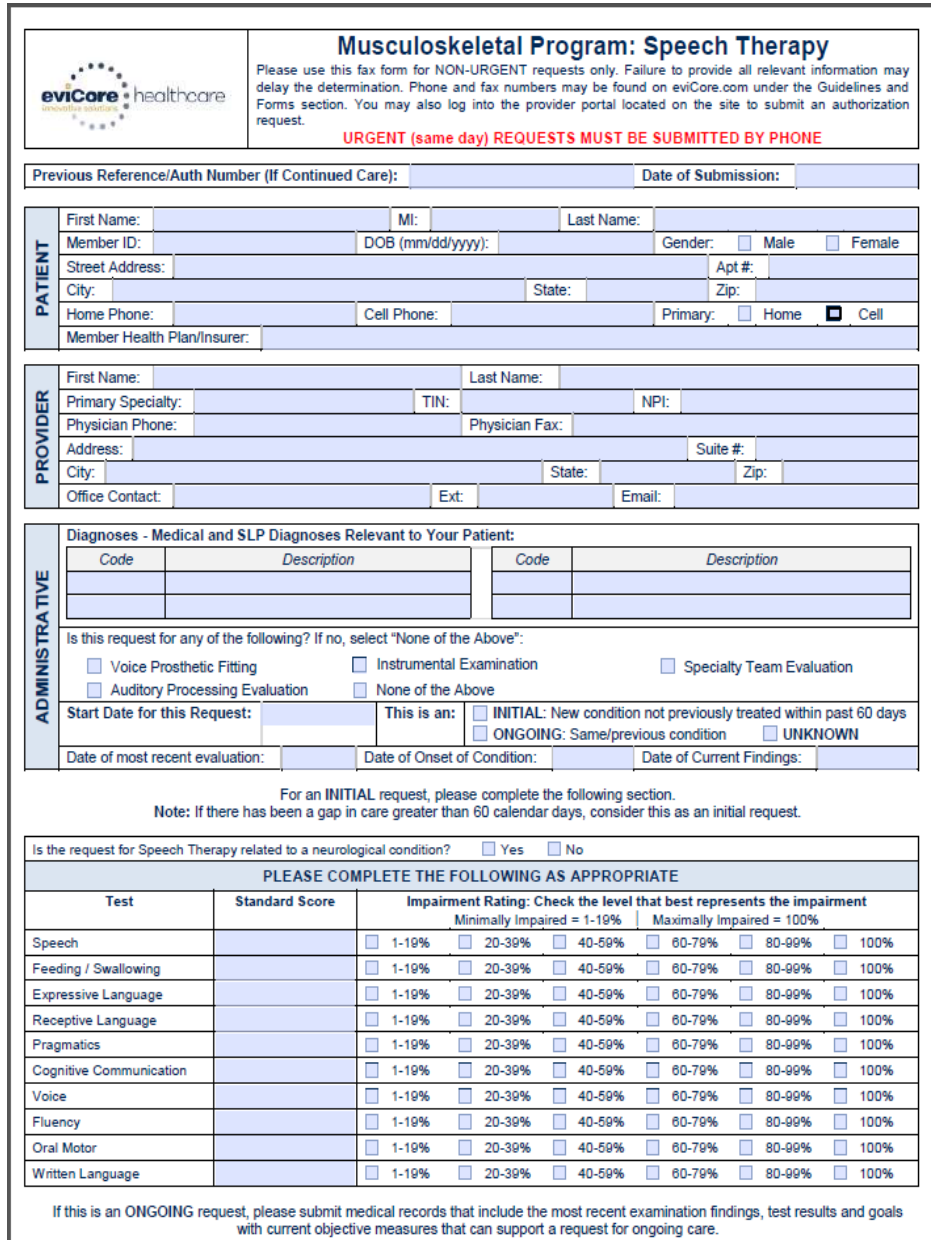
Sample Speech Therapy corePath® Form

Worksheets for corePath® are available for:

Speech Therapy
Physical Therapy
Occupational Therapy

For Clinical Worksheets / Intake Forms, Please visit;

https://www.evicore.com/provider/online-forms



eviCore healthcare

Musculoskeletal Program: Speech Therapy

Please use this fax form for NON-URGENT requests only. Failure to provide all relevant information may delay the determination. Phone and fax numbers may be found on eviCore.com under the Guidelines and Forms section. You may also log into the provider portal located on the site to submit an authorization request.

URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE

Previous Reference/Auth Number (If Continued Care): | Date of Submission:

PATIENT

First Name: | MI: | Last Name:
Member ID: | DOB (mm/dd/yyyy): | Gender: ☐ Male ☐ Female
Street Address: | Apt #:
City: | State: | Zip:
Home Phone: | Cell Phone: | Primary: ☐ Home ☒ Cell
Member Health Plan/Insurer:

PROVIDER

First Name: | Last Name:
Primary Specialty: | TIN: | NPI:
Physician Phone: | Physician Fax:
Address: | Suite #:
City: | State: | Zip:
Office Contact: | Ext: | Email:

ADMINISTRATIVE

Diagnoses - Medical and SLP Diagnoses Relevant to Your Patient:

Code	Description	Code	Description

Is this request for any of the following? If no, select "None of the Above":

☐ Voice Prosthetic Fitting ☐ Instrumental Examination ☐ Specialty Team Evaluation
☐ Auditory Processing Evaluation ☐ None of the Above

Start Date for this Request: | This is an: ☐ INITIAL: New condition not previously treated within past 60 days ☐ ONGOING: Same/previous condition ☐ UNKNOWN

Date of most recent evaluation: | Date of Onset of Condition: | Date of Current Findings:

For an **INITIAL** request, please complete the following section.
Note: If there has been a gap in care greater than 60 calendar days, consider this as an initial request.

Is the request for Speech Therapy related to a neurological condition? ☐ Yes ☐ No

PLEASE COMPLETE THE FOLLOWING AS APPROPRIATE

Test	Standard Score	Impairment Rating: Check the level that best represents the impairment (Minimally Impaired = 1-19% | Maximally Impaired = 100%)
Speech		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%
Feeding / Swallowing		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%
Expressive Language		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%
Receptive Language		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%
Pragmatics		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%
Cognitive Communication		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%
Voice		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%
Fluency		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%
Oral Motor		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%
Written Language		☐ 1-19% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80-99% ☐ 100%

If this is an **ONGOING** request, please submit medical records that include the most recent examination findings, test results and goals with current objective measures that can support a request for ongoing care.

Portal Demonstration

The eviCore online portal is the quickest, most efficient way to request prior authorization and check authorization status.

Right Click for Portal demonstration.

Choose export hyperlink

Provider Portal Overview

Account Access and Adding Ordering Providers

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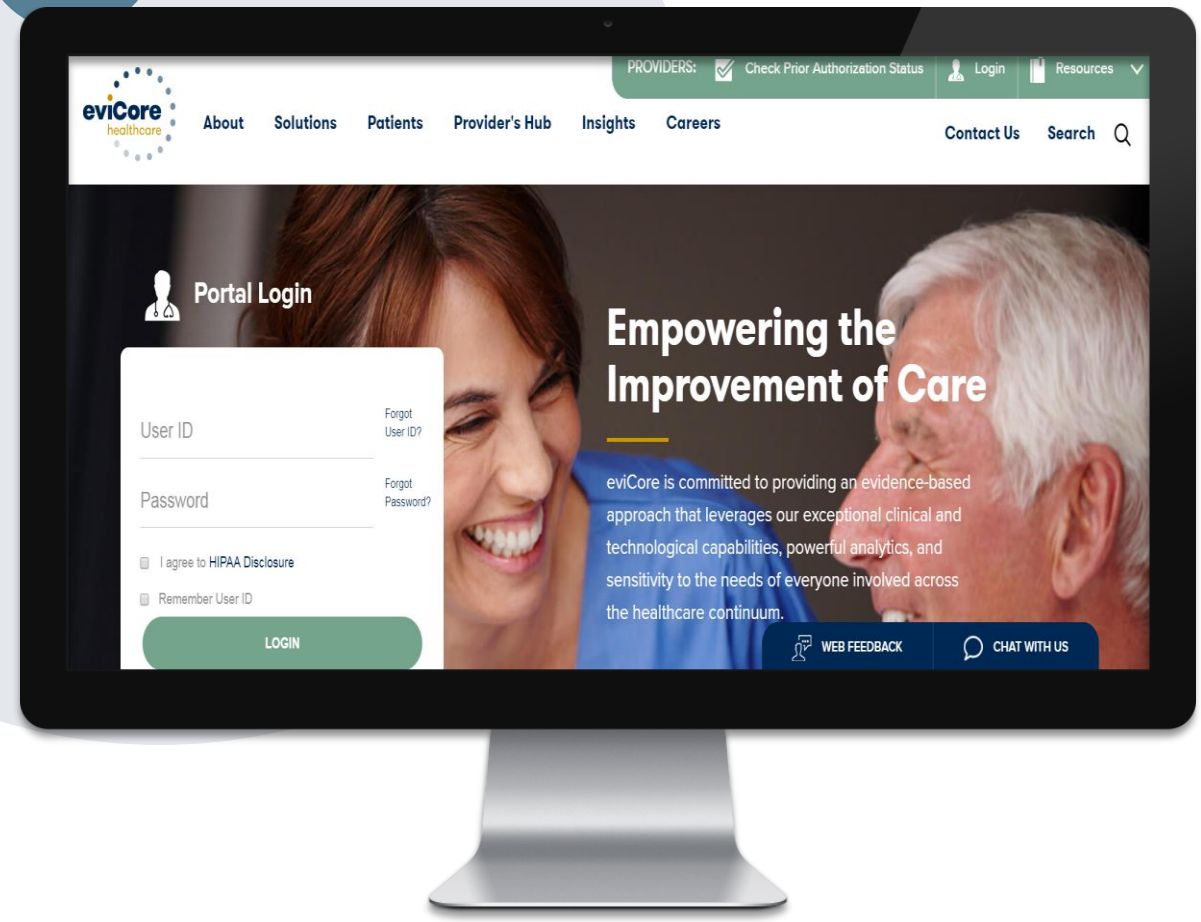
eviCore Provider Portal



The eviCore online portal is the quickest, most efficient way to request prior authorization and check authorization status and is available 24/7.

By visiting www.eviCore.com providers can spend their time where it matters most — with their patients!

Or by phone:

Phone Number:
800-421-7592
7:00 a.m. to 7:00p.m.
Monday - Friday

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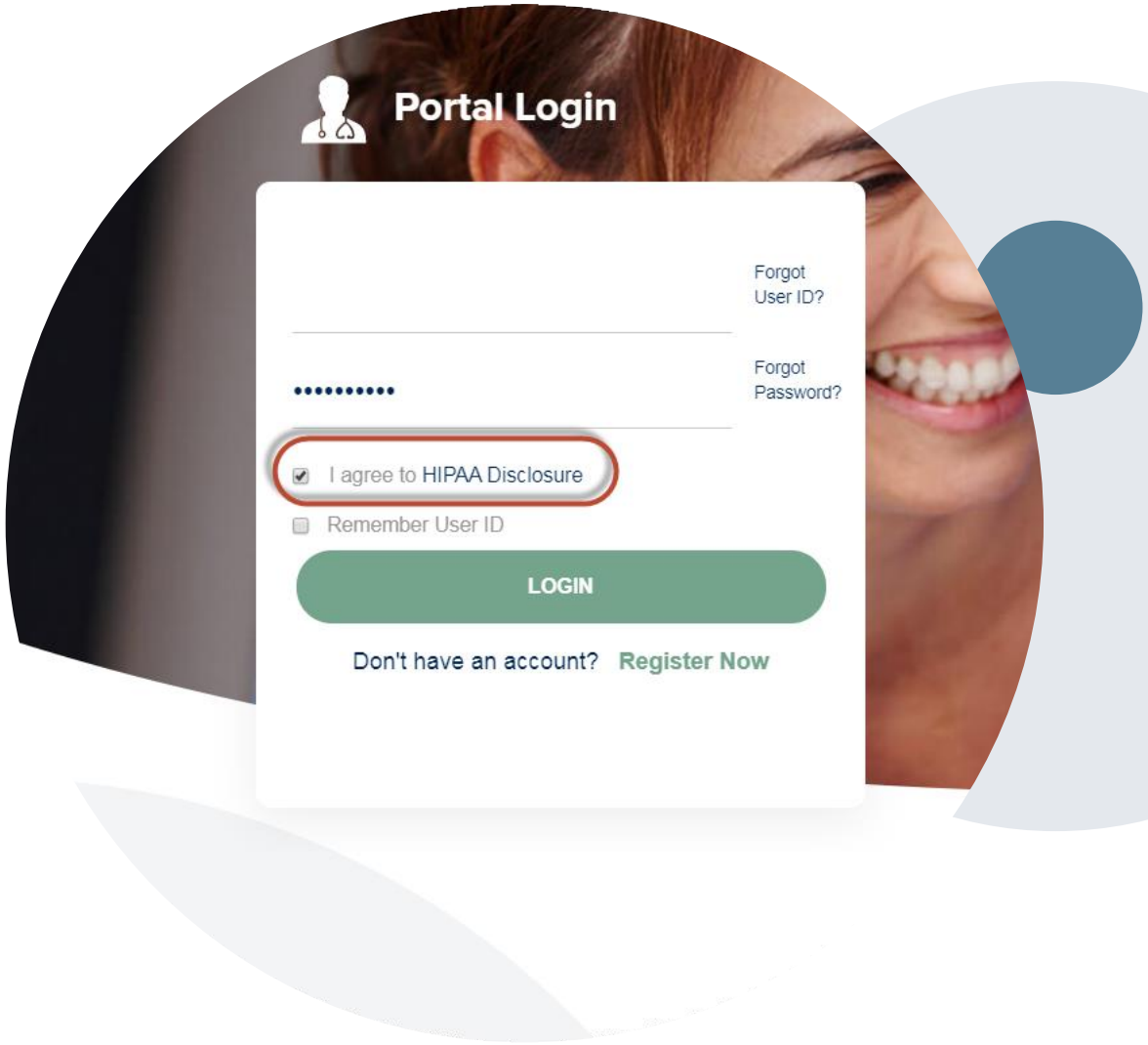
Account Login

To log-in to your account, enter your User ID and Password.

Agree to the HIPAA Disclosure, and click “Login.”



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Add Practitioner

Under the “Manage Your Account” tab Click the “Add Provider” button.

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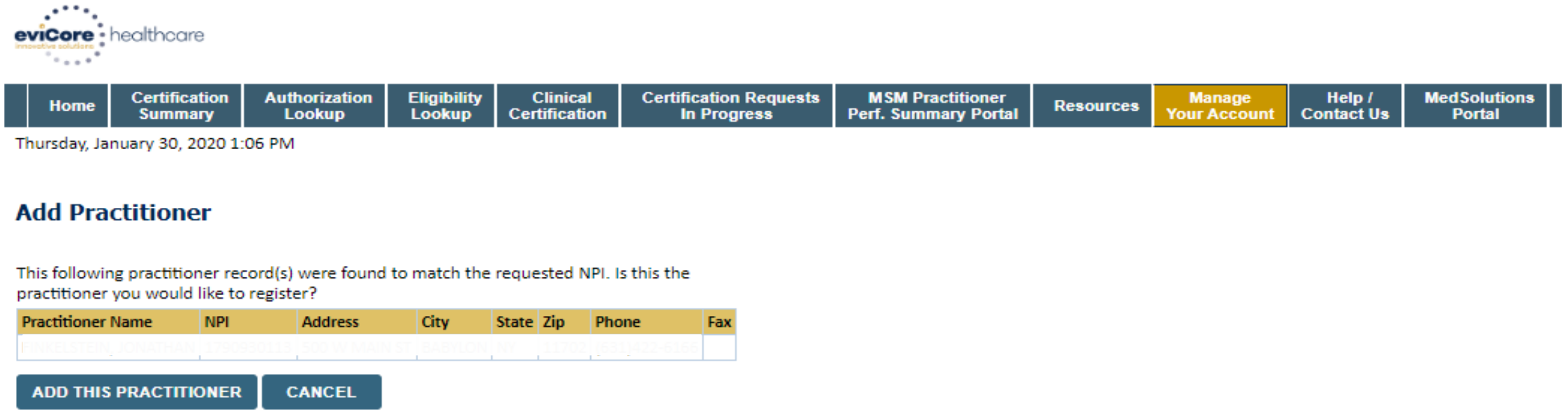
Add Practitioner



Select the matching record based upon your search criteria

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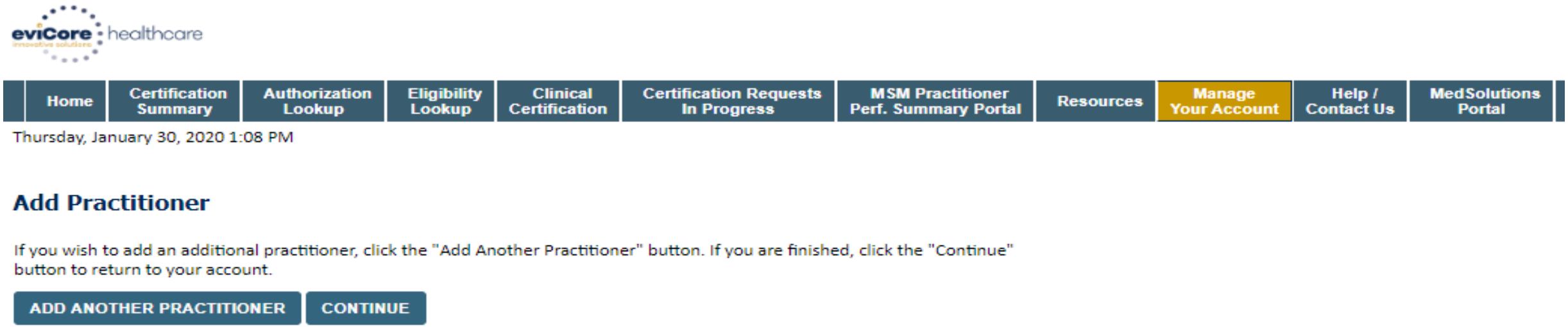
Add Practitioner



Once you have selected a practitioner, your registration will be completed. You can then access the “Manage Your Account” tab to make any necessary updates or changes.

You can also click “Add Another Practitioner” to add another provider to your account.

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Provider Portal Overview

Submitting Online Prior Authorization Requests

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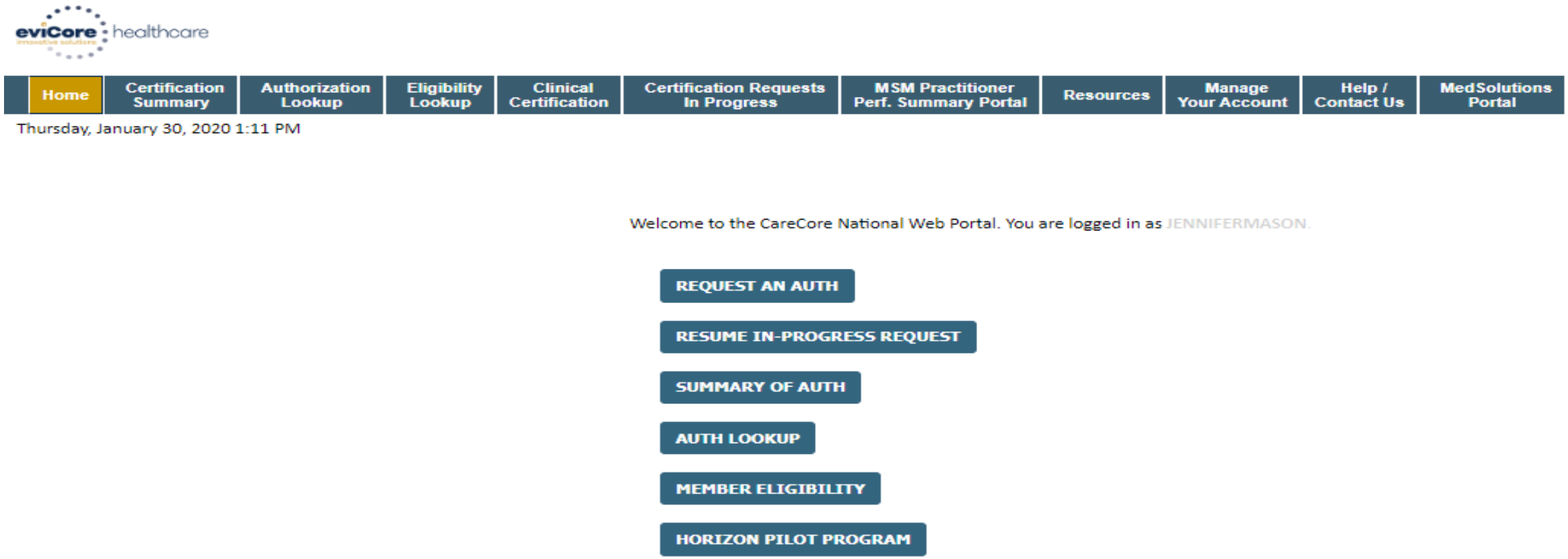
Initiating A Request



Choose “request a clinical certification/procedure” to begin a new case request.

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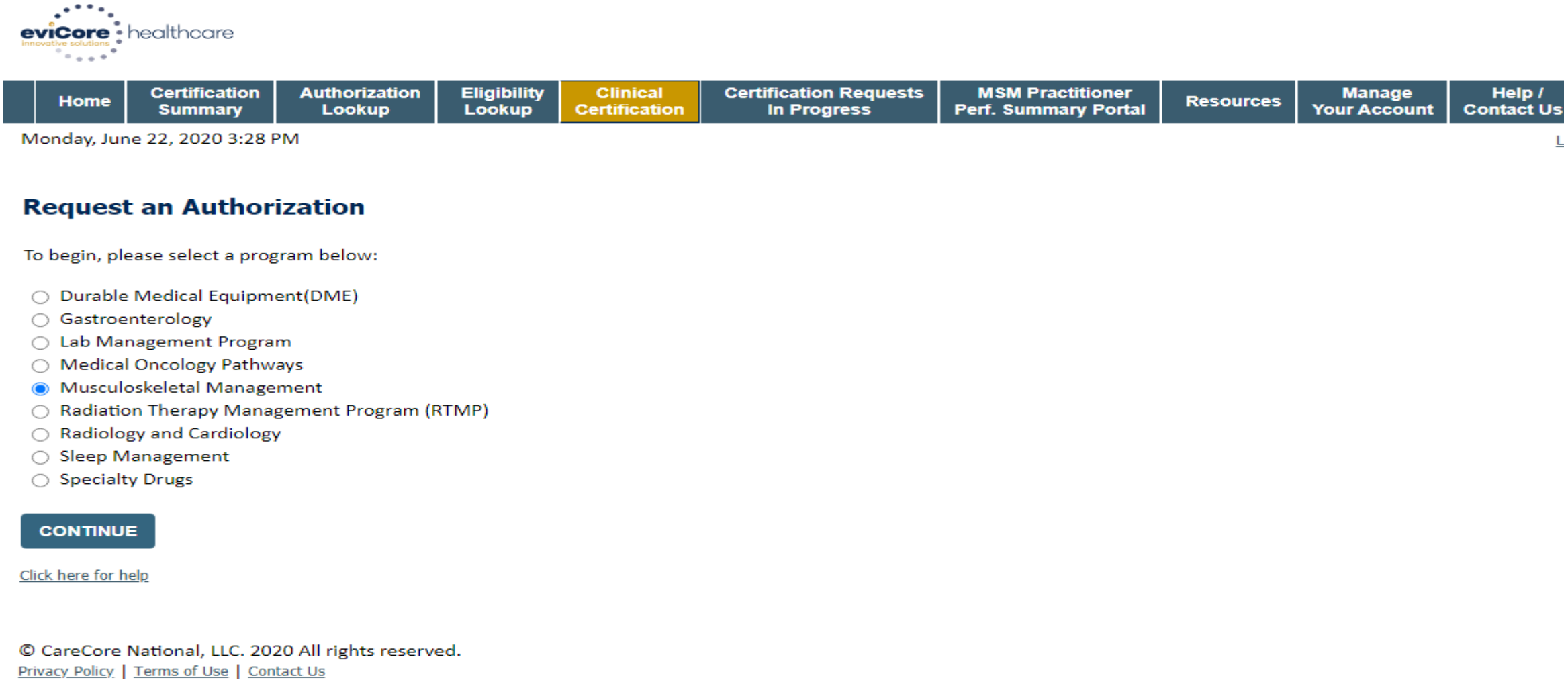
Select Program



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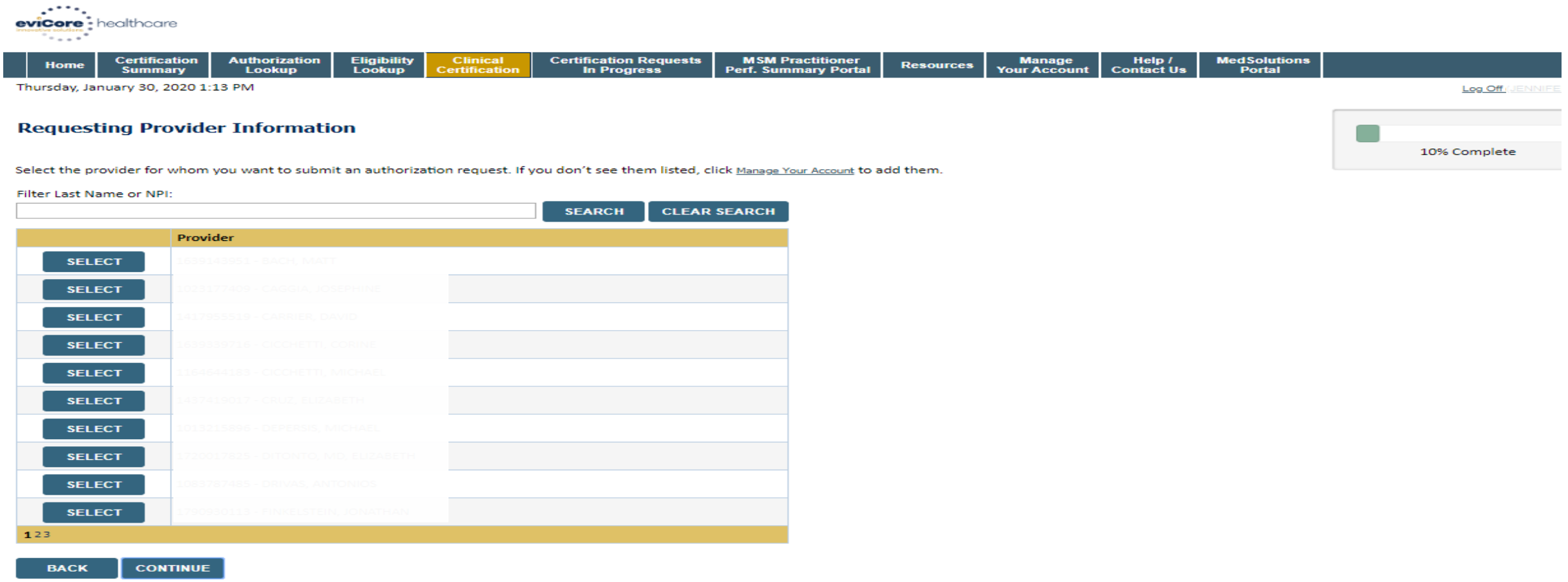
Select Provider



Select the provider for whom you want to build a case.

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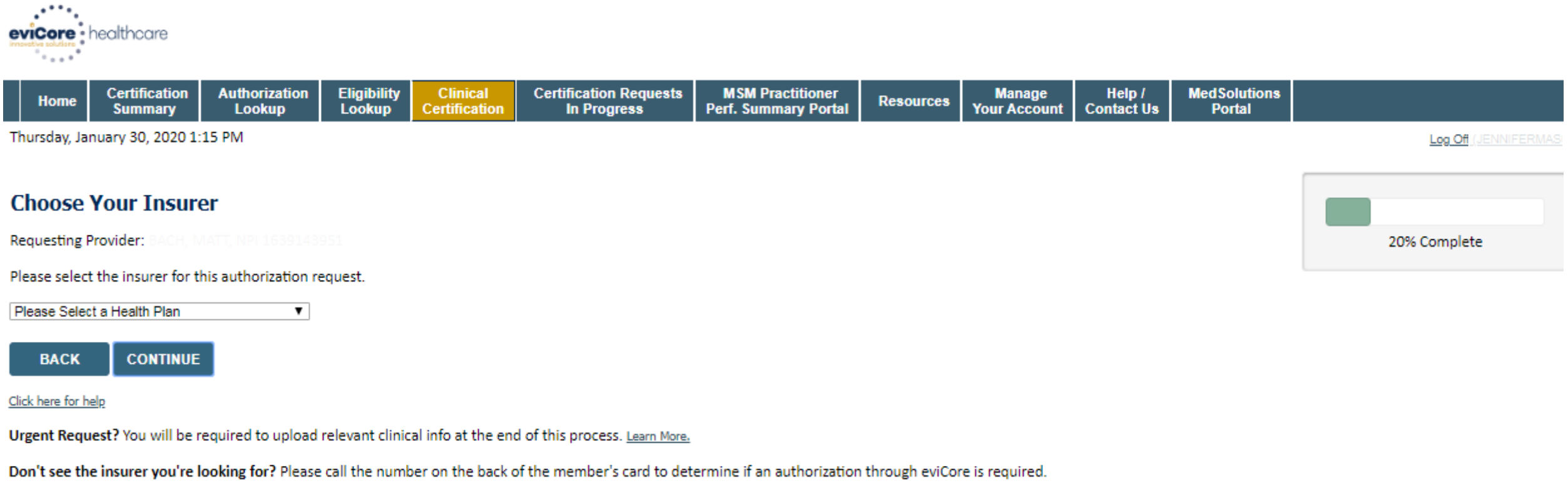
Select Health Plan



Choose the appropriate Health Plan for the case request. If the health plan does not populate, please contact the plan at the number found on the member's identification card.

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Contact Information

Enter the point of contact and verify phone and fax numbers.

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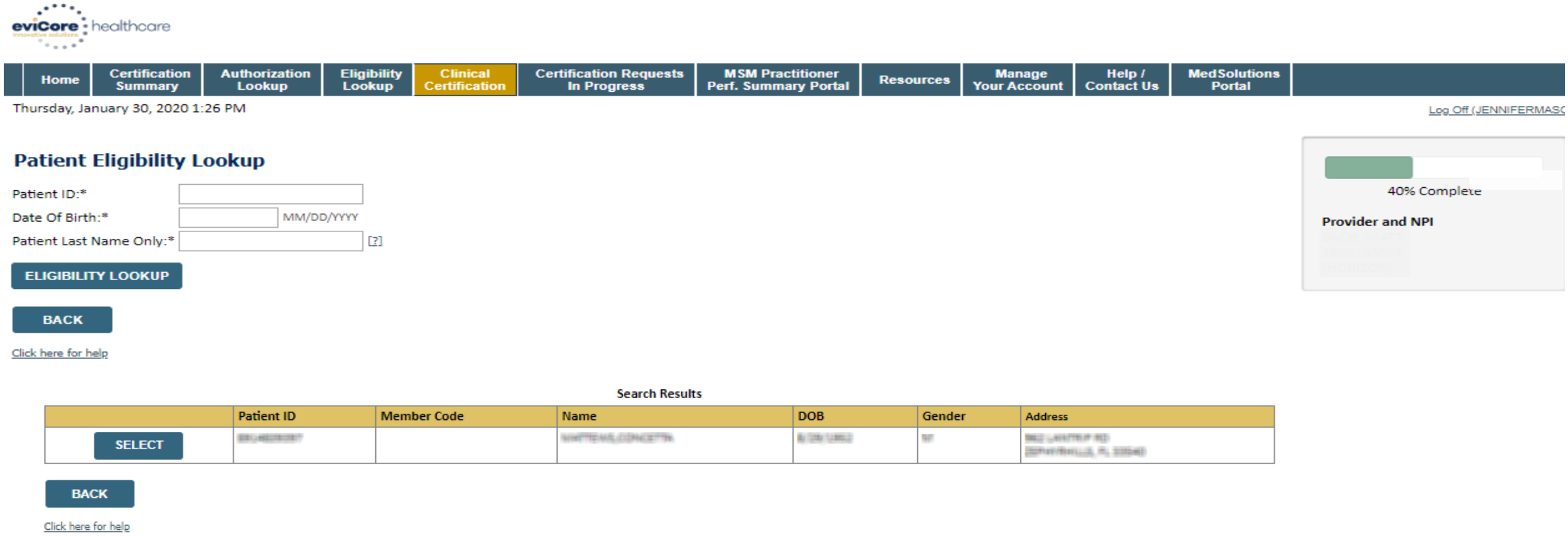
Member Information



Enter the member health plan ID number, date of birth, and the patient's last name. Click "Eligibility Lookup."

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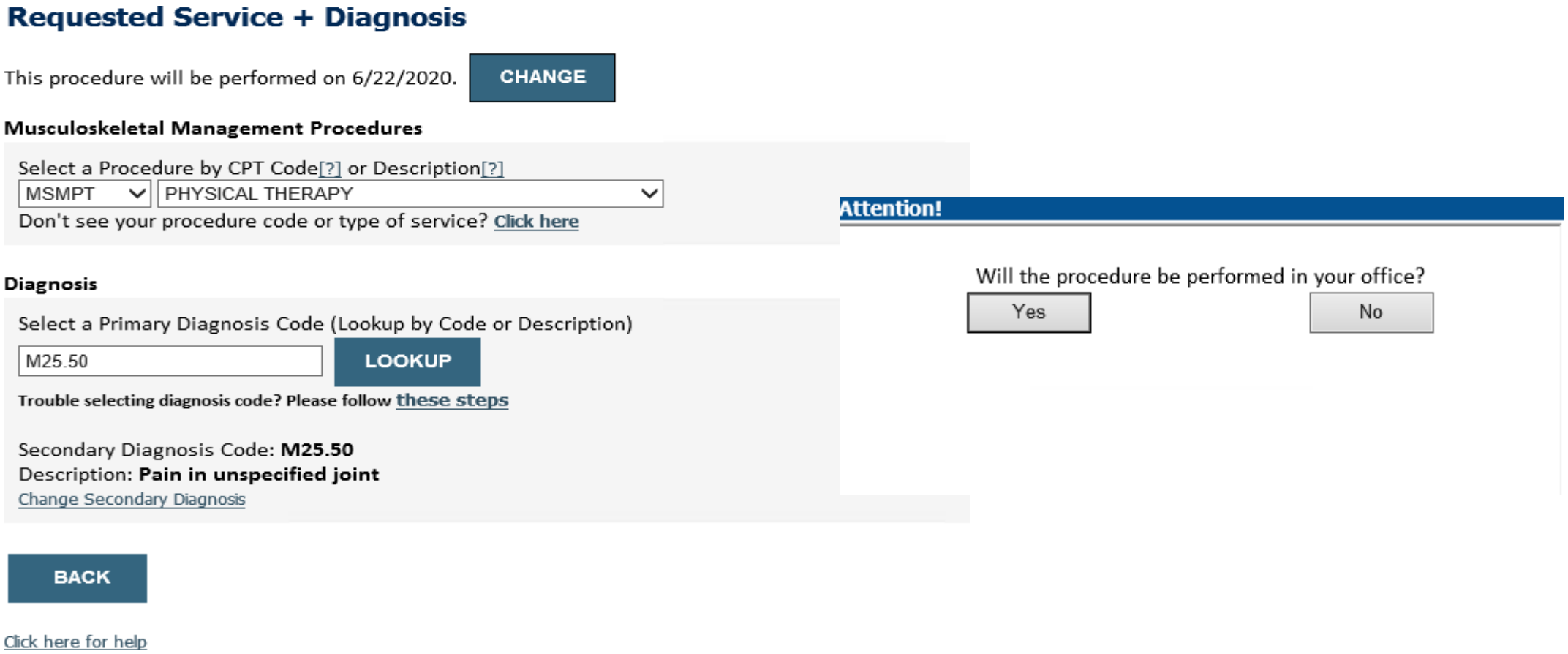
Request Information



- Next you can enter CPT code (MSMPT, MSMOT, or MSMST)
- Also add diagnosis code(s)
- Note: Place of service vary depending on health plan rules.

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Verify Service Selection

Requested Service + Diagnosis

Confirm your service selection.

Procedure Date:	6/22/2020
CPT Code:	MSMPT
Description:	PHYSICAL THERAPY
Primary Diagnosis Code:	M25.50
Primary Diagnosis:	Pain in unspecified joint
Secondary Diagnosis Code:	
Secondary Diagnosis:	

Change Procedure or Primary Diagnosis

Change Secondary Diagnosis

BACK CONTINUE

Click here for help

Attention!

Patient ID: [redacted] Time: 6/19/2020 6:38 PM

Patient Name: [redacted]

Please review the patient's MSM history. You may be asked about this history during clinical review.

MSM History

Episode Date	Episode ID	Patient Name	CPT Code	CPT Description	Case Status
4/7/2020	[redacted]	[redacted]	MSMPT	PHYSICAL THERAPY	A
3/18/2020	[redacted]	[redacted]	MSMOT	OCCUPATIONAL THERAPY	A
9/17/2019	[redacted]	[redacted]	MSMOT	OCCUPATIONAL THERAPY	A
7/18/2019	[redacted]	[redacted]	MSMOT	OCCUPATIONAL THERAPY	A
4/26/2019	[redacted]	[redacted]	MSMPT	PHYSICAL THERAPY	A

- Review the patient's history
- Verify requested service & diagnosis
- Edit any information if needed by selecting change procedure or primary diagnosis
- Click continue to confirm your selection

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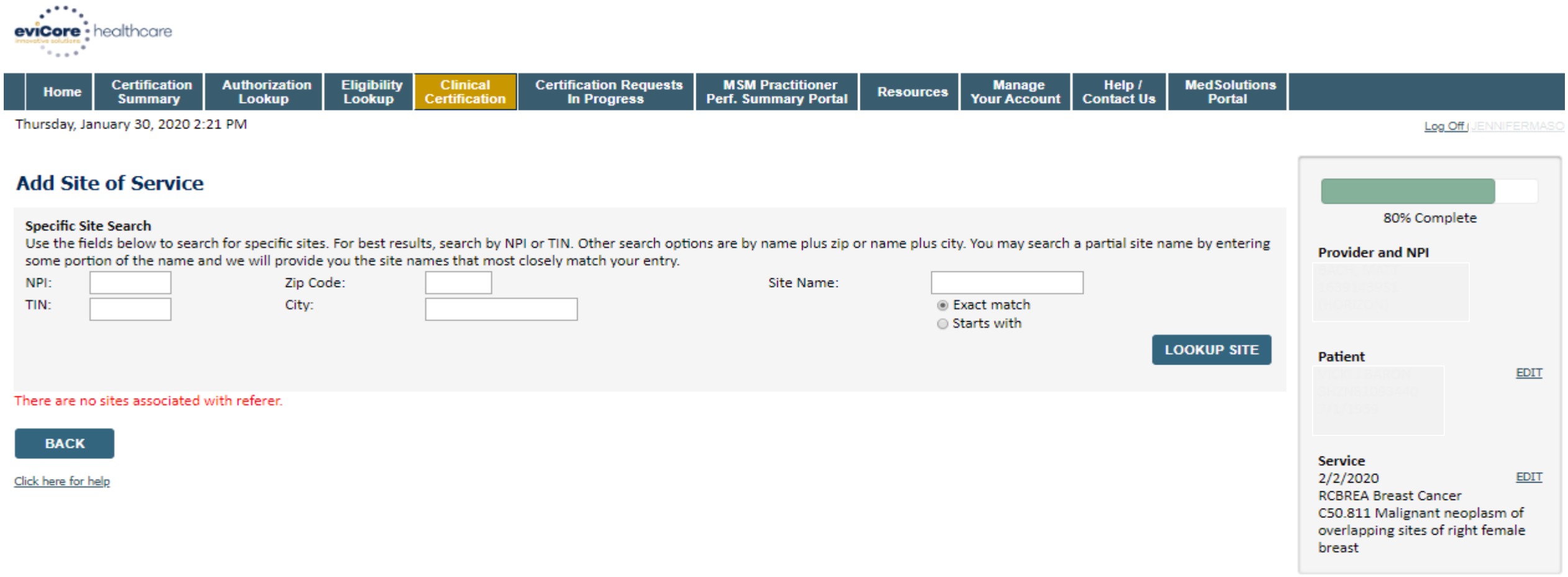
Site Selection



Search and select the specific site where the testing/treatment will be performed.

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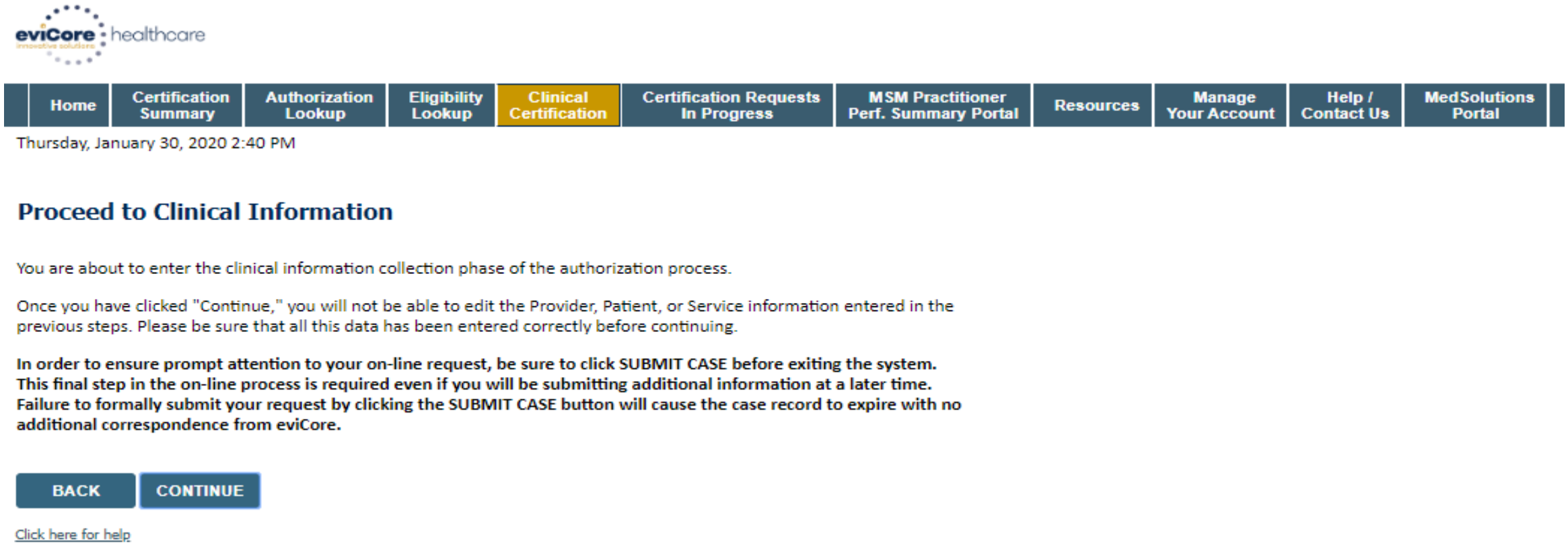
Clinical Collection Process



Verify all information entered and make any needed changes prior to moving into the clinical collection phase of the prior authorization process

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Clinical Collection Process - Urgency Indicator

- Selecting “urgent” results in an expedited review. Such review, however, is conducted in the context the information submitted with limited liability to conduct a p2p (if a case can no be approved)
- Please select urgent for those cases that truly are urgent and not simply for a “quicker” review.
- If a request is selected as urgent, but does not meet guidelines to be considered urgent, the case may be reassigned as routine and follow those time frames.

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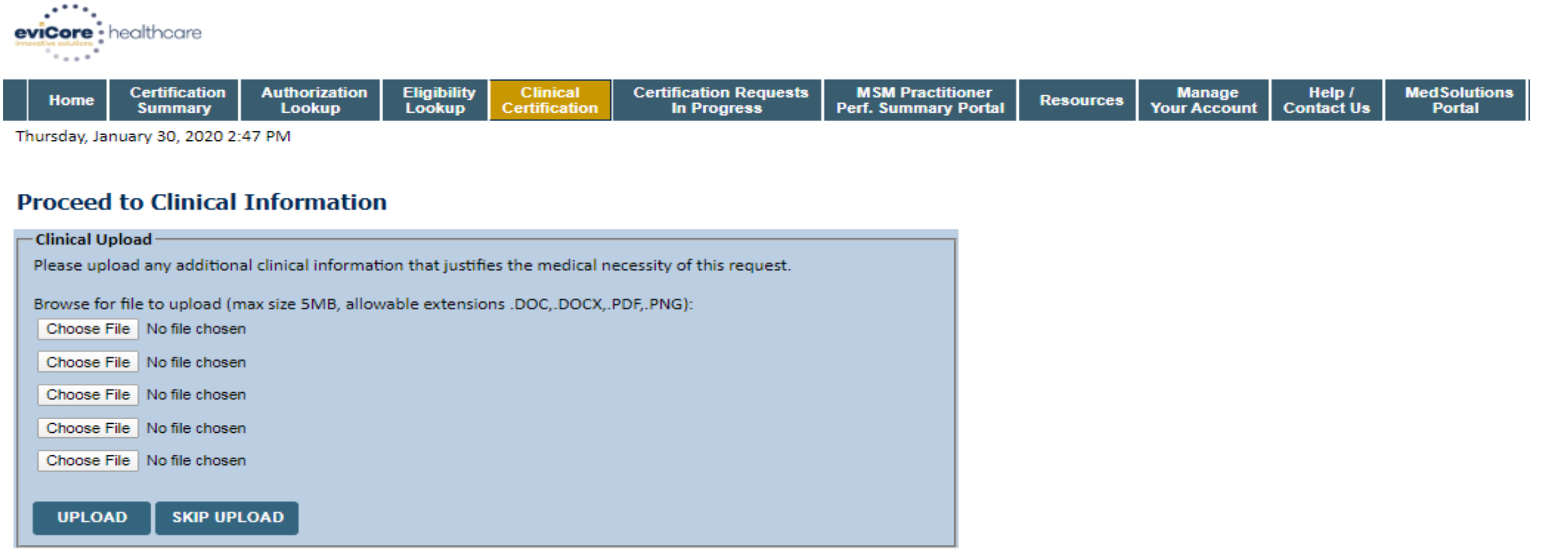
Clinical Collection Process – Clinical Upload



Providing clinical information via the web is the quickest, most efficient method.

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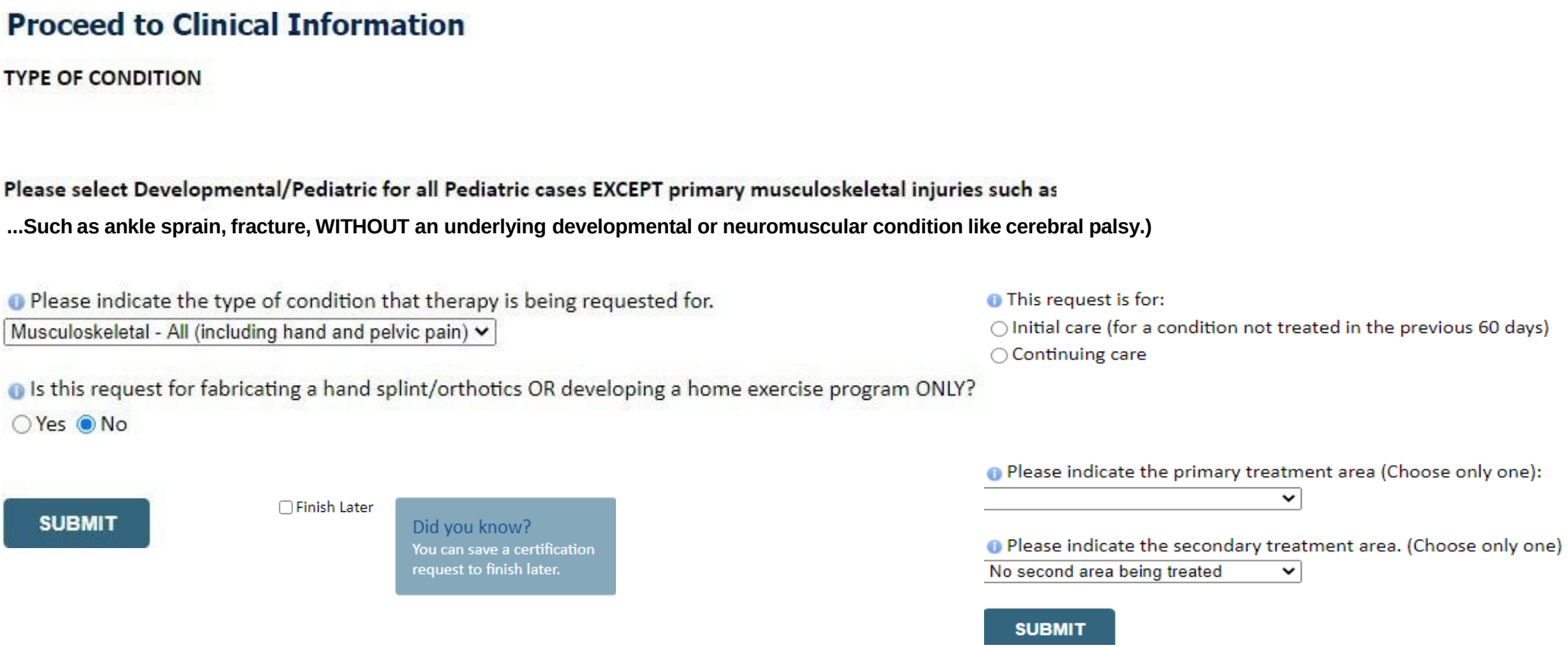
Clinical Information – Example of Pathway Questions



Clinical Certification questions may populate based upon the information provided

Note: The worksheets are available to offer insight into the clinical questions that will be asked in the pathway

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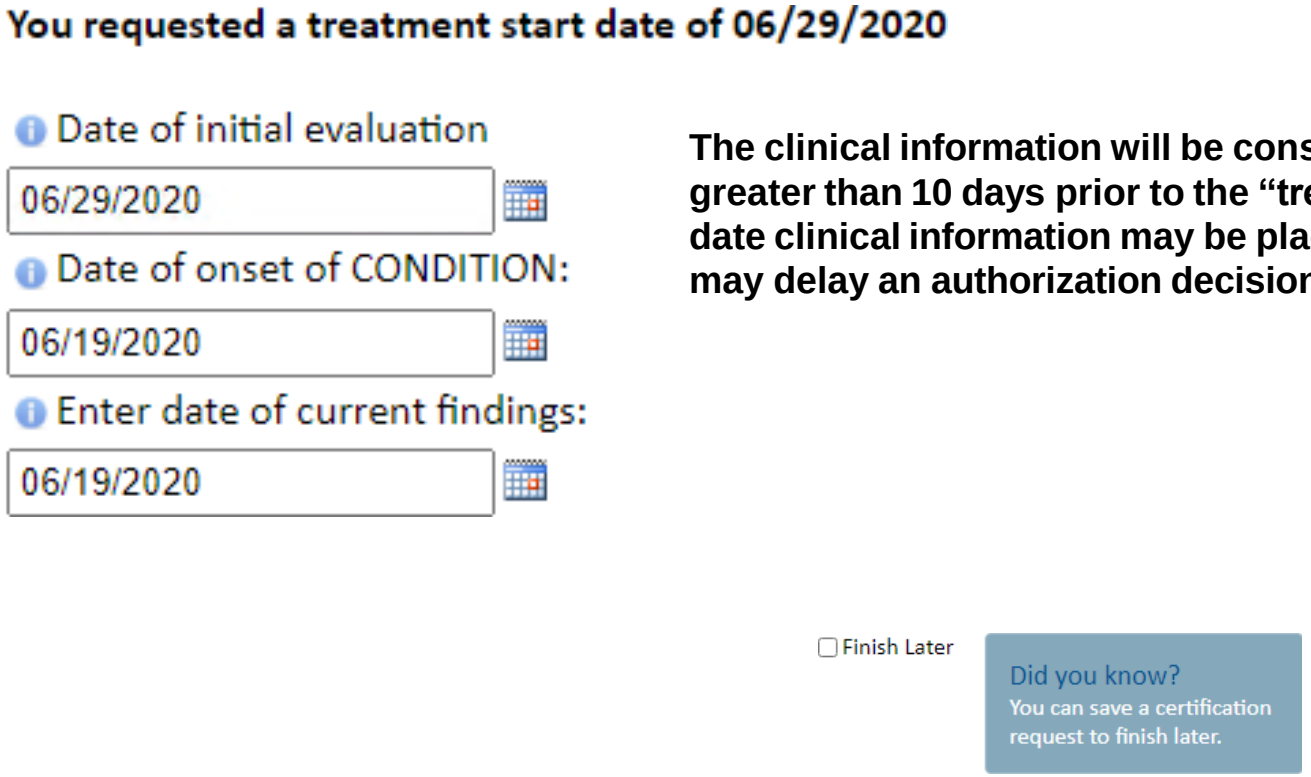
Clinical Information – Imbedded messages



The clinical information will be considered out-of-date if the "date of current findings" is greater than 10 days prior to the "treatment start date" for this request. Cases with out-of-date clinical information may be placed on hold awaiting current clinical information. This may delay an authorization decision.

- Questions may populate based upon the information provided
- Many screens have imbedded messages that help you understand the criteria.

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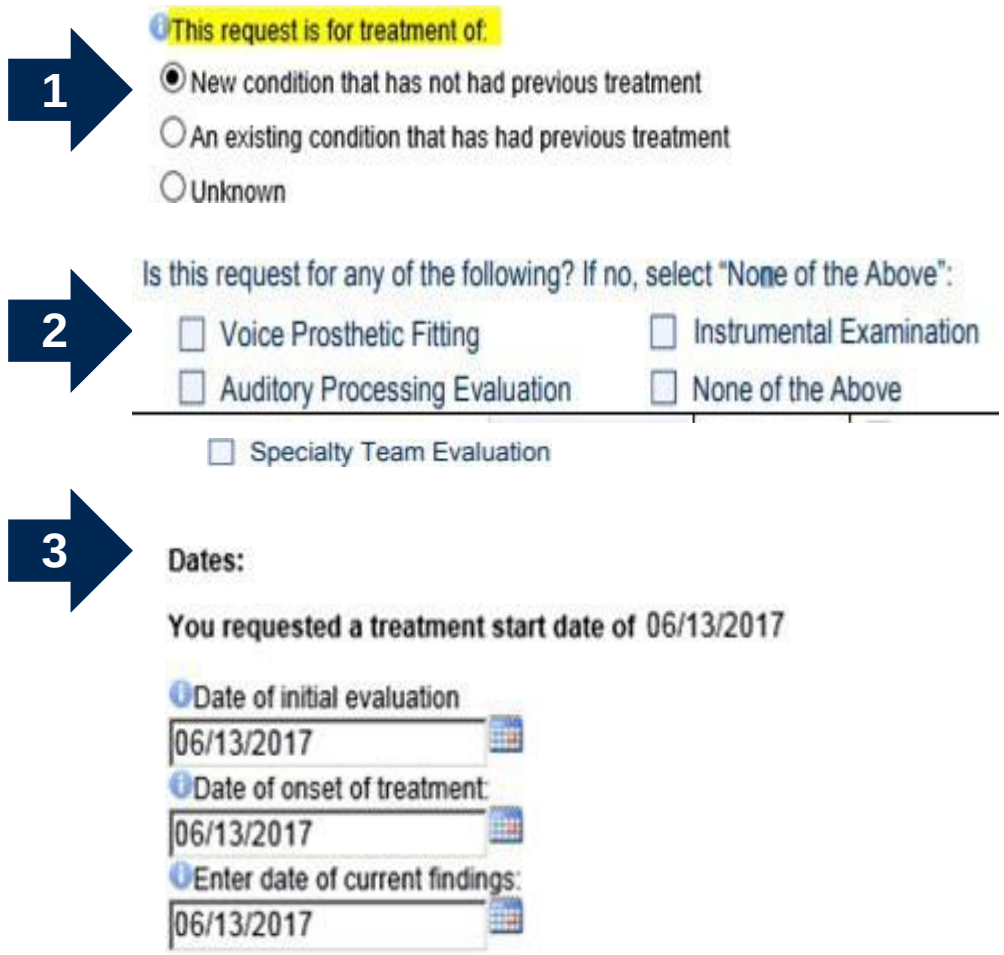
Sample Speech Therapy corePath® Pathway

Initial Requests



Case related questions:

- Identify new care vs. continuing care based on treatment area, not time
- Request for specialty evaluations
- First indicator of complexity – second unrelated treatment area

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Sample Speech Therapy corePath® Pathway

Initial Requests

1

Is the request for Speech Therapy related to a neurological condition?

○ Yes ○ No

2

Indicate all area(s) in which standardized testing was performed or deficit has been identified, if any

☐ Speech	☐ Voice
☐ Feeding/Swallowing	☐ Fluency
☐ Expressive Language	☐ Oral Motor
☐ Receptive Language	☐ Written Language
☐ Pragmatics	☐ No testing was performed
☐ Cognitive Communication	

3

Speech

Standard Score - If not done or score unknown please leave score as 0.

45

Impairment Rating - If not done or rating unknown please select 0%.

40-59% ⌄

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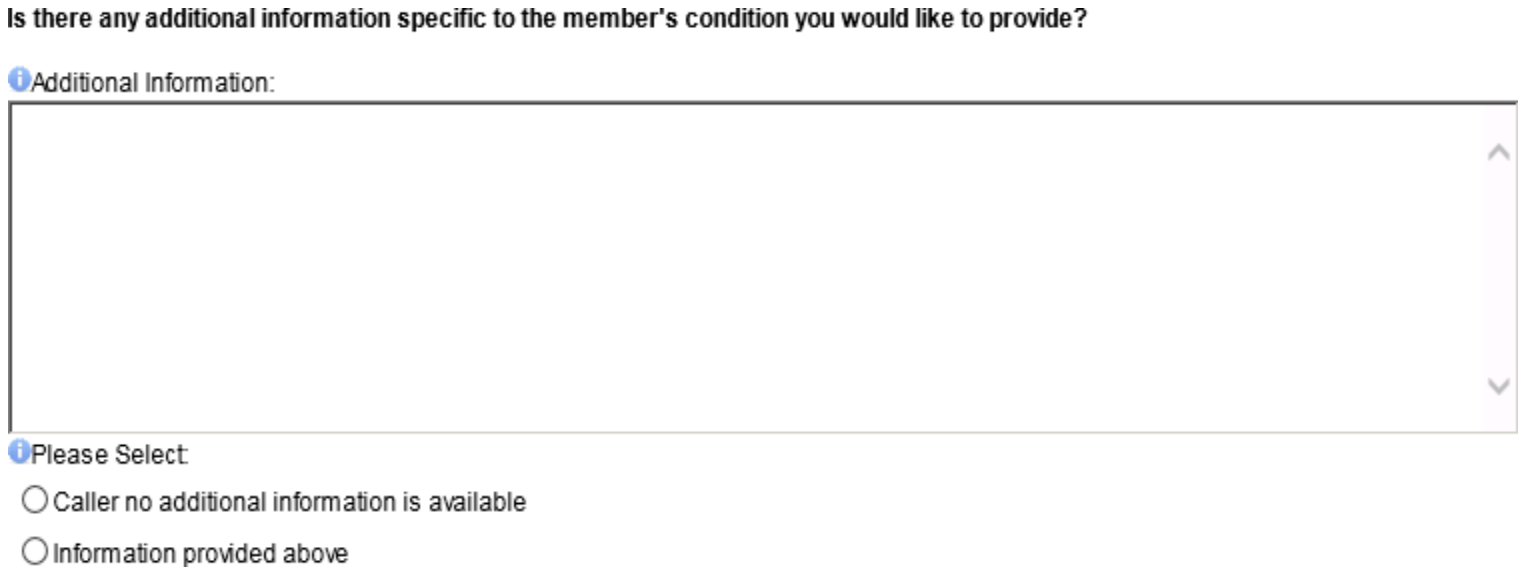
Sample Speech Therapy corePath® Pathway

- Providers will have the ability to add information into a drop box- however- any additional information will make the request drop to review for initial requests.



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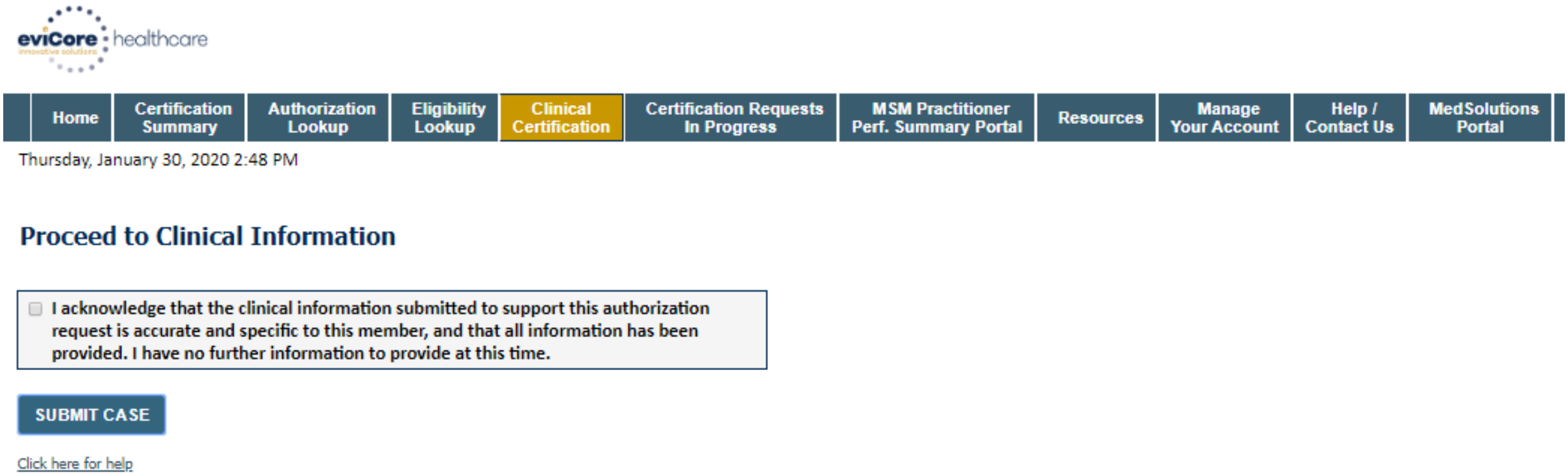
Clinical Certification Statements



Acknowledge the Clinical Certification statements, and hit “Submit Case.”

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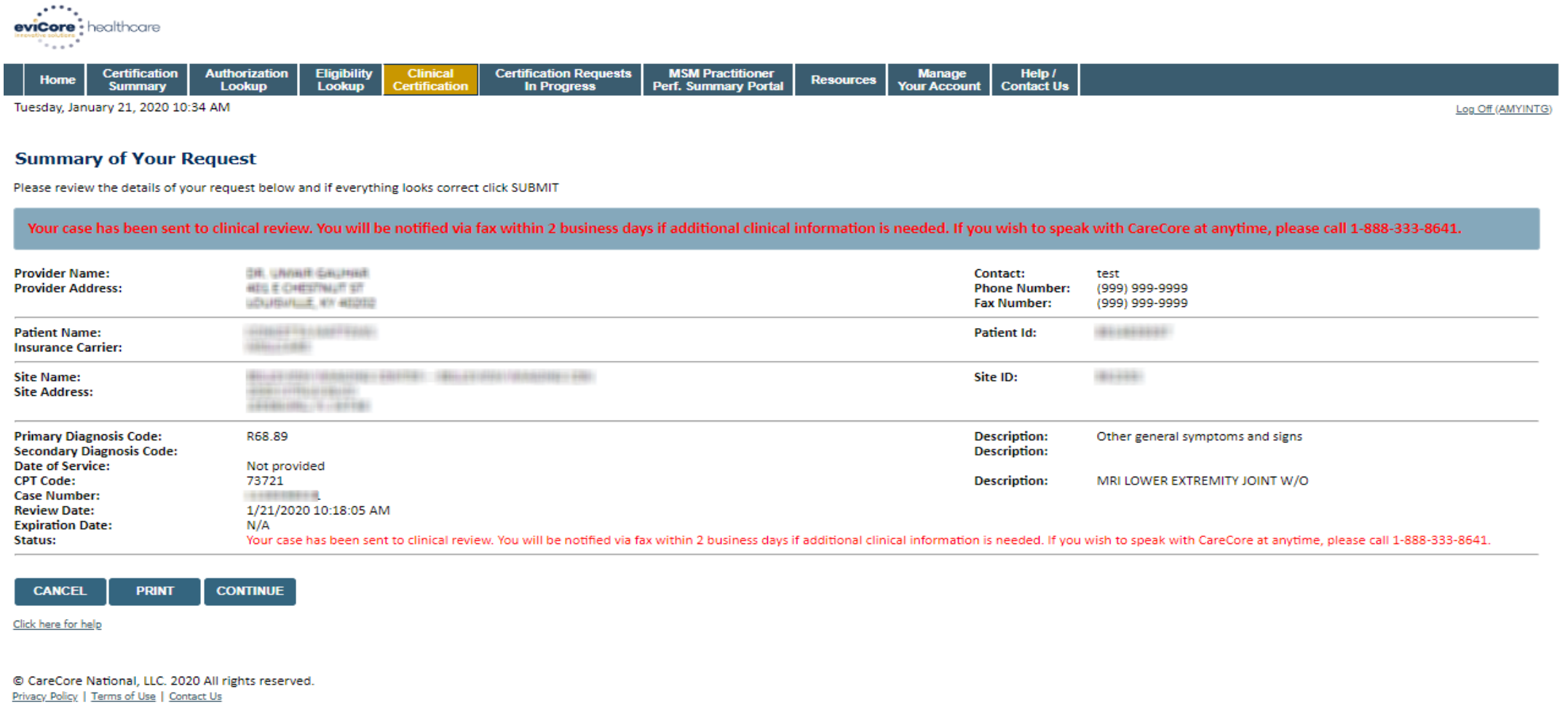
Clinical Certification – Case Summary



Once the clinical pathway questions are completed and the case has not meet clinical review. The status will reflect pending and at the top "Your case has been sent to Medical Review".

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Clinical Certification – Case Summary

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:		**Contact:**	me
Provider Address:		**Phone Number:**	(
		Fax Number:	(
Patient Name:		**Patient Id:**	
Insurance Carrier:			
Site Name:		**Site ID:**	IL5086
Site Address:			
Primary Diagnosis Code:	M50.20	**Description:**	Other cervical disc displacement, unspecified cervical region
Secondary Diagnosis Code:		**Description:**	
Date of Service:	7/5/2020		
CPT Code:	SPINE	**Description:**	SPINE SURGERY
Case Number:			
Review Date:	7/1/2020 3:28:51 PM		
Expiration Date:	N/A		
Status:	Your case has been sent to Medical Review.		

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Clinical Certifications – Case Summary

Clinical Certification

Your case has been Approved.

Provider Name:	**Contact:**
Provider Address:	**Phone Number:**
	Fax Number:
Patient Name:	**Patient Id:**
Insurance Carrier:	
Site Name:	**Site ID:**
Site Address:	

Primary Diagnosis Code:	M25.562	**Description:**	Pain in left knee
Secondary Diagnosis Code:		**Description:**	
Date of Service:	Not provided		
CPT Code:	73721	**Description:**	MRI LOWER EXTREMITY JOINT W/O
Authorization Number:			
Review Date:	[redacted] 2:12:39 PM		
Expiration Date:	[redacted]		
Status:	Your case has [redacted] roved.		

Print Continue

Once the clinical pathway questions are completed and if the answers have met the clinical criteria, an approval will be issued.

Print the screen and store in the patient's file.

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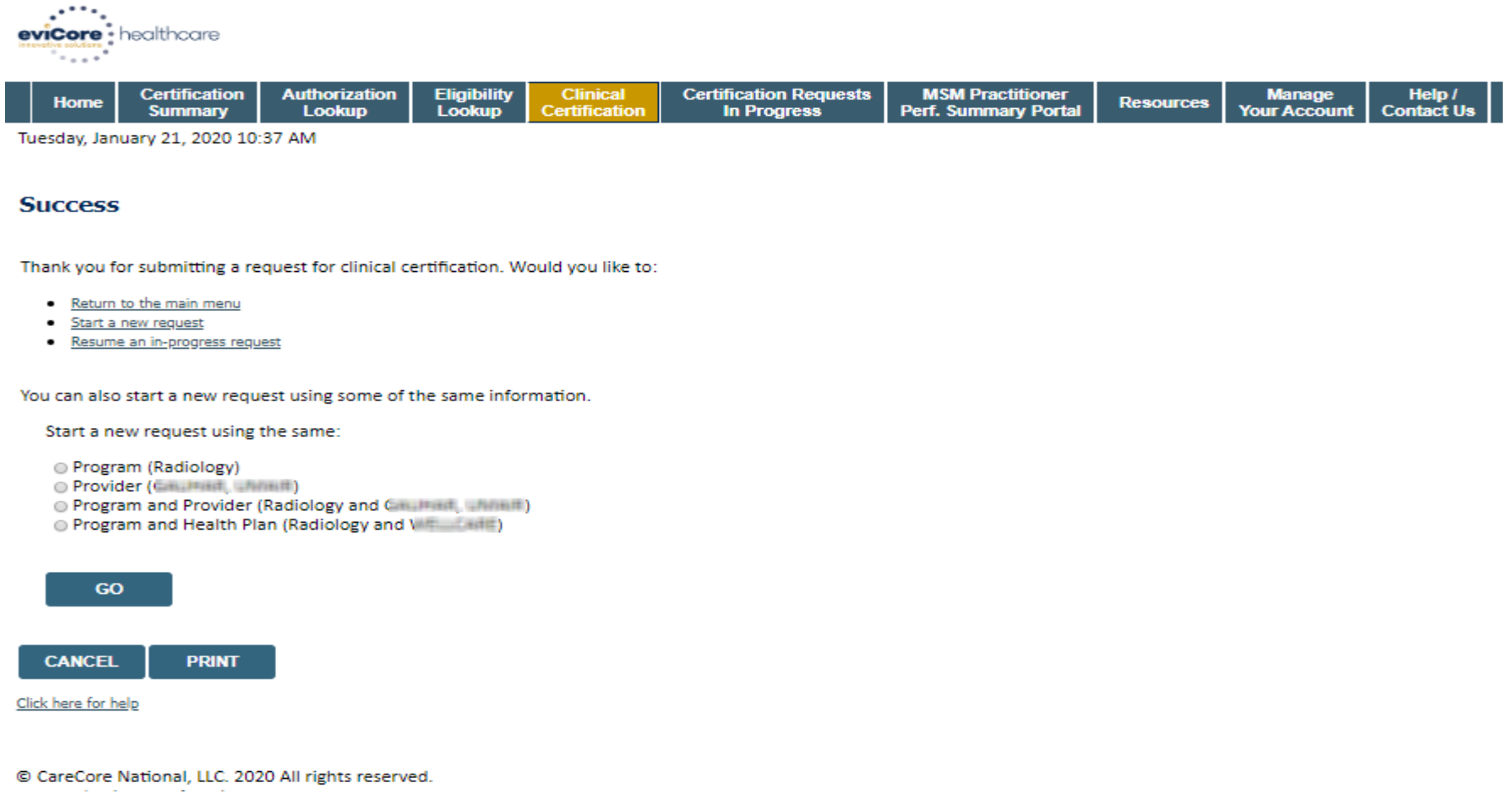
Building Additional Cases



Once a case has been submitted for clinical certification, you can return to the Main Menu, resume an in-progress request, or start a new request. You can indicate if any of the previous case information will be needed for the new request.

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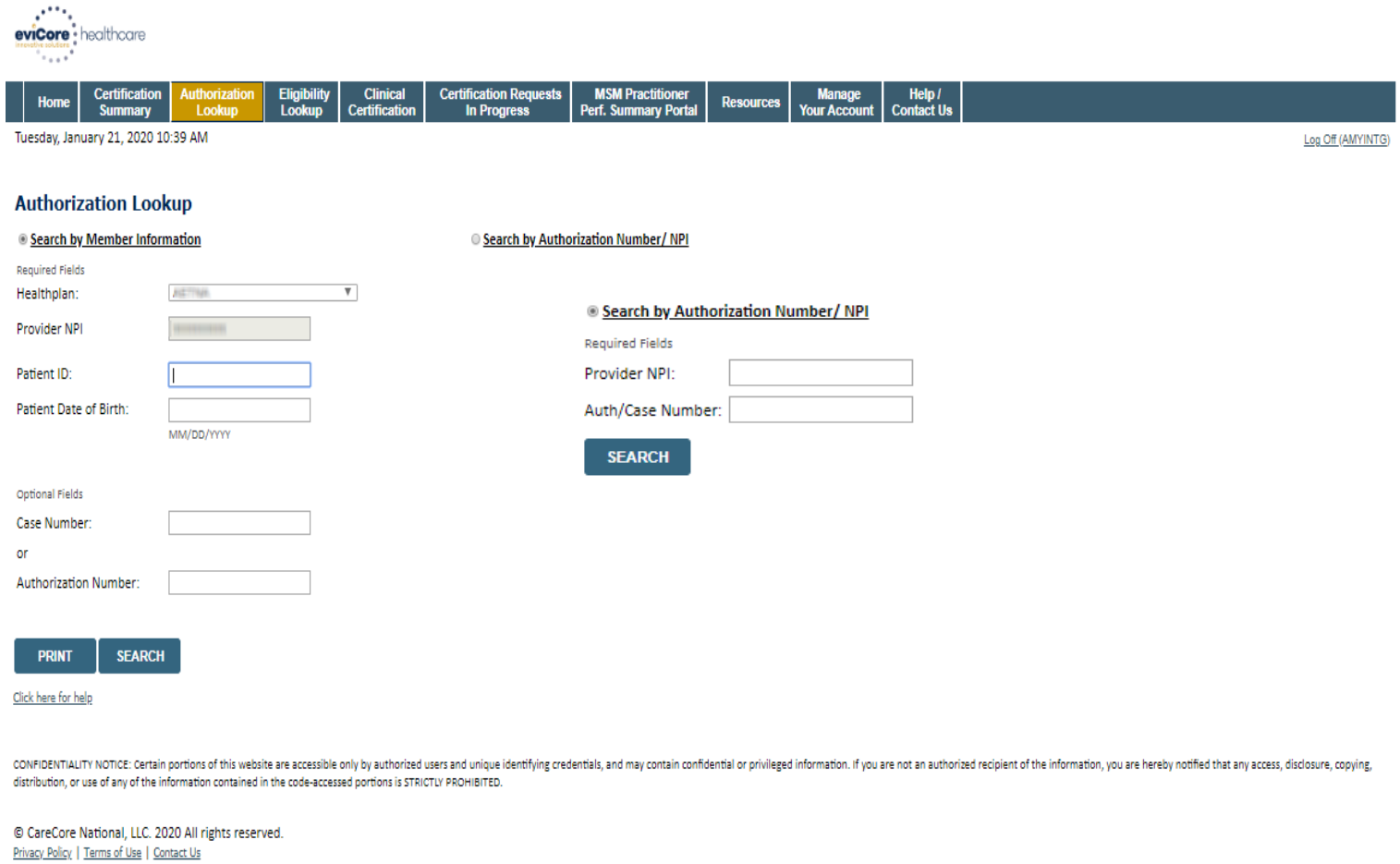
Authorization look up



- Select Search by **Authorization Number/NPI**. Enter the provider's NPI and authorization or case number. Select **Search**.
- You can also search for an authorization by **Member Information**, and enter the health plan, Provider NPI, patient's ID number, and patient's date of birth.

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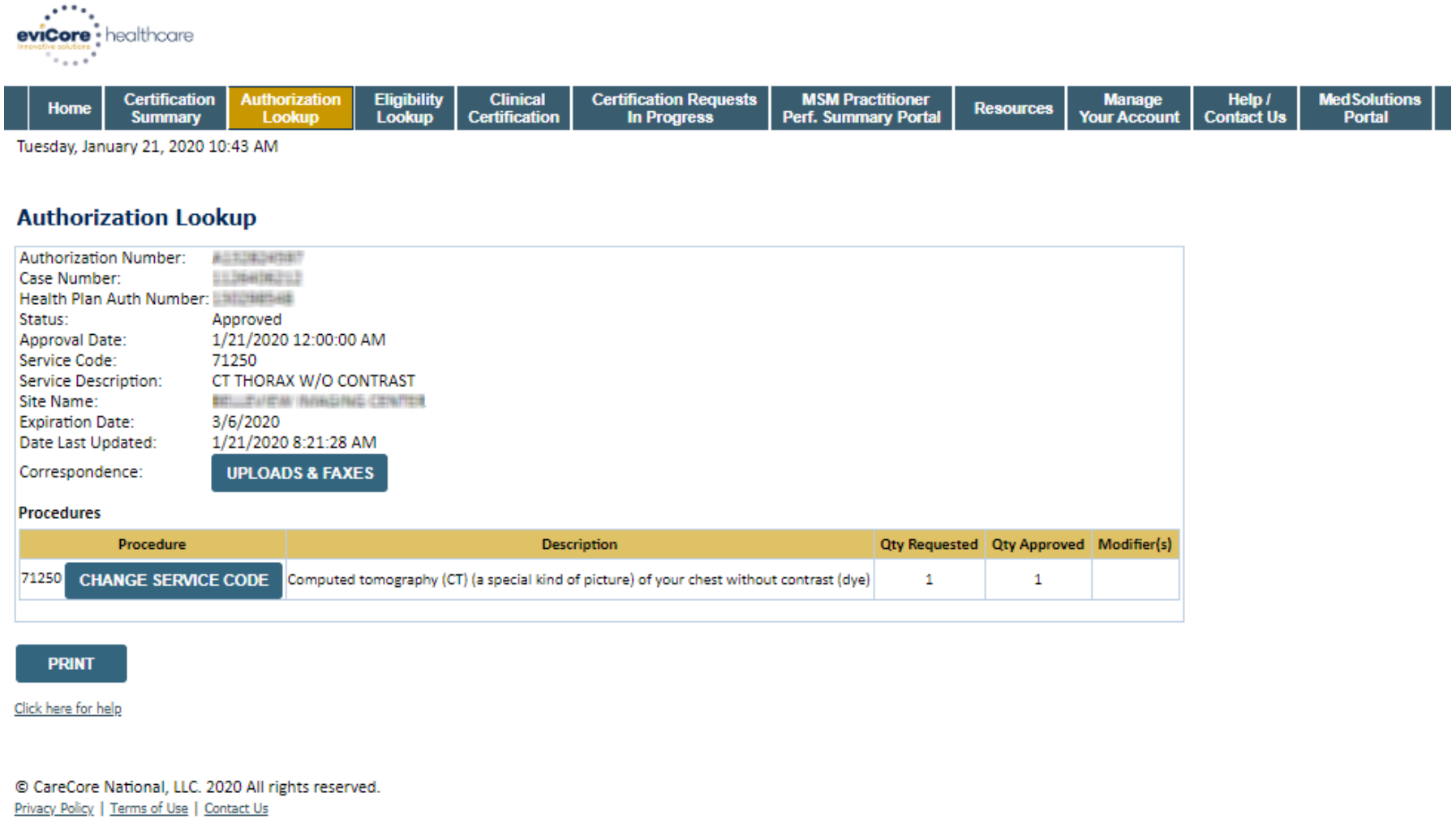
Authorization Status



The authorization will then be accessible to review. To print authorization correspondence, select Uploads & Faxes.

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Online P2P Scheduling Tool

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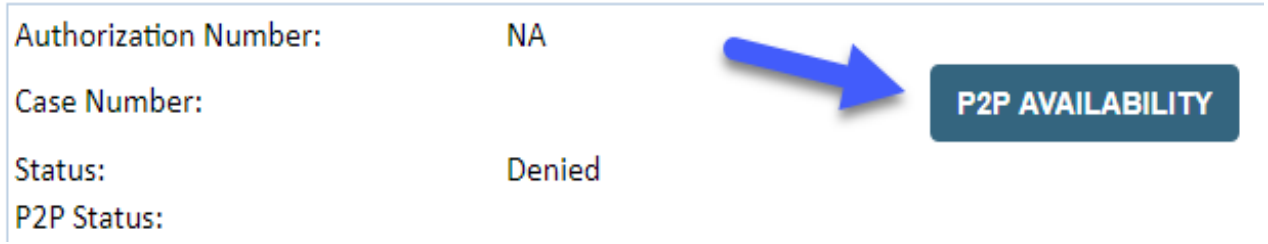
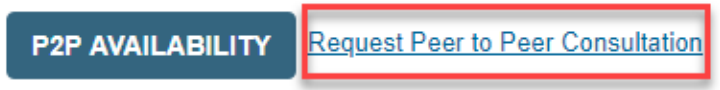
How to schedule a Peer to Peer Request

- 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.



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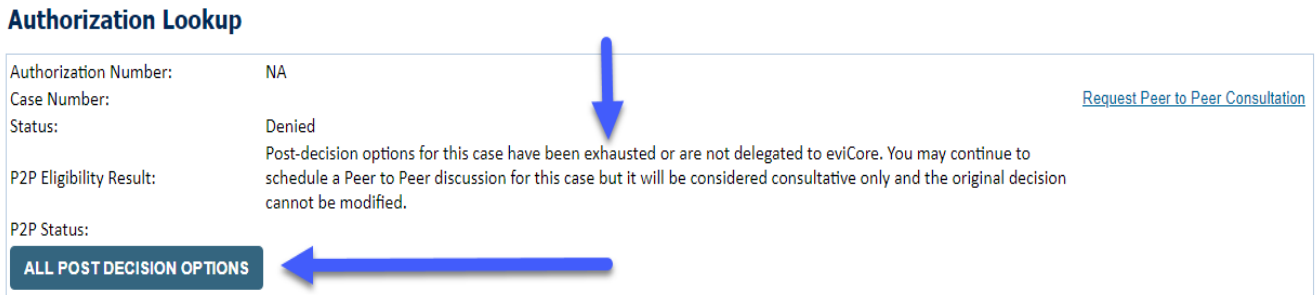
How to schedule a Peer to Peer Request

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.



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

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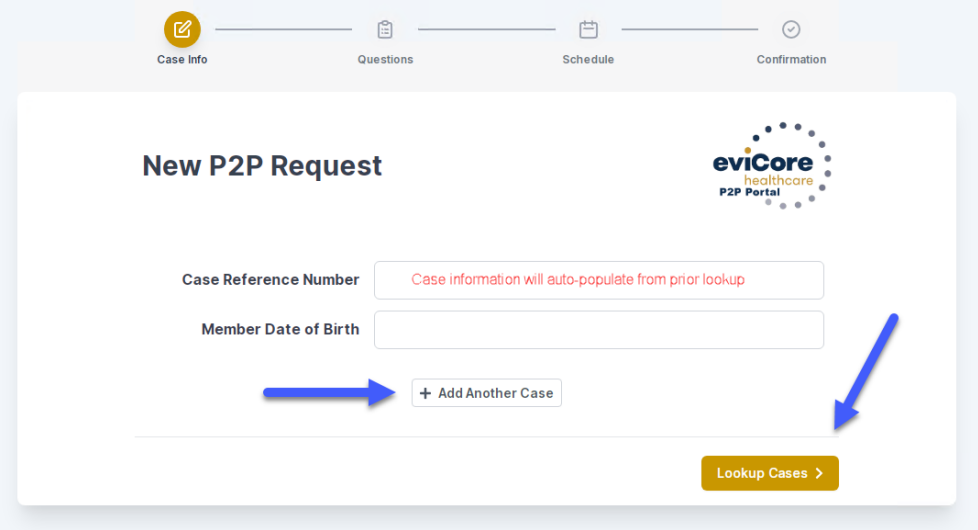
How to Schedule a Peer to Peer Request



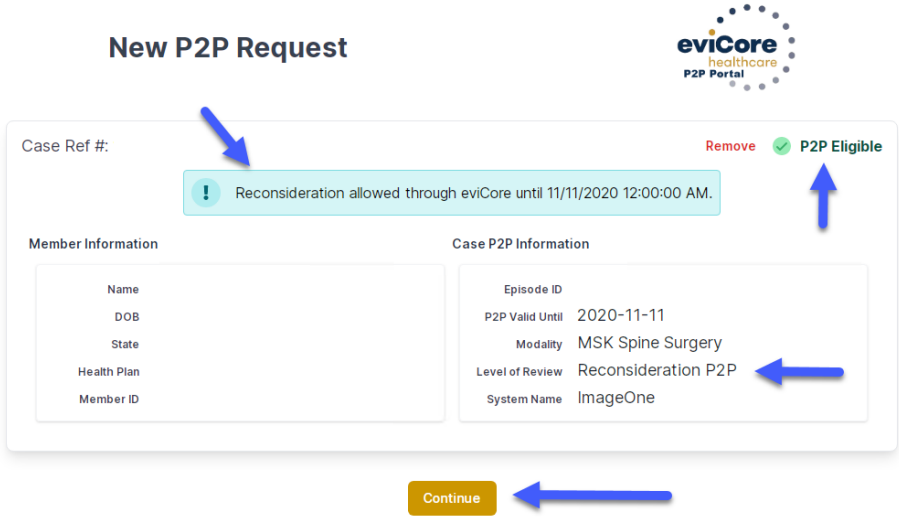
Upon first login, you will be asked to confirm your default time zone.

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.



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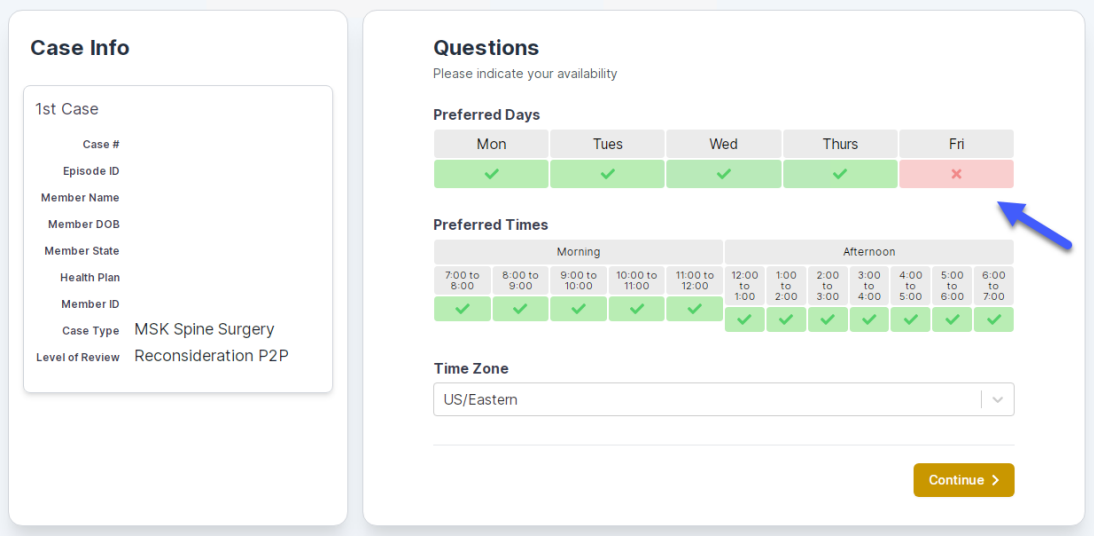
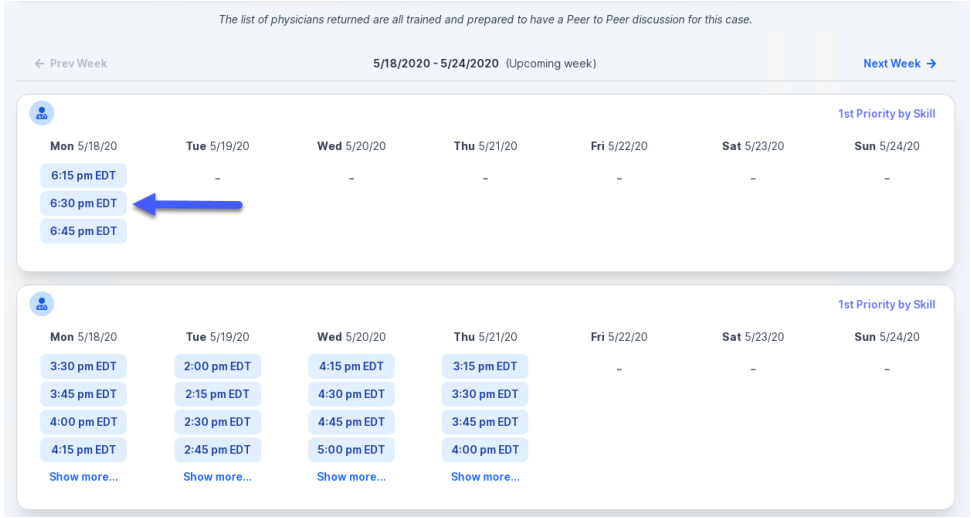
How to Schedule a Peer to Peer Request



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.



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.

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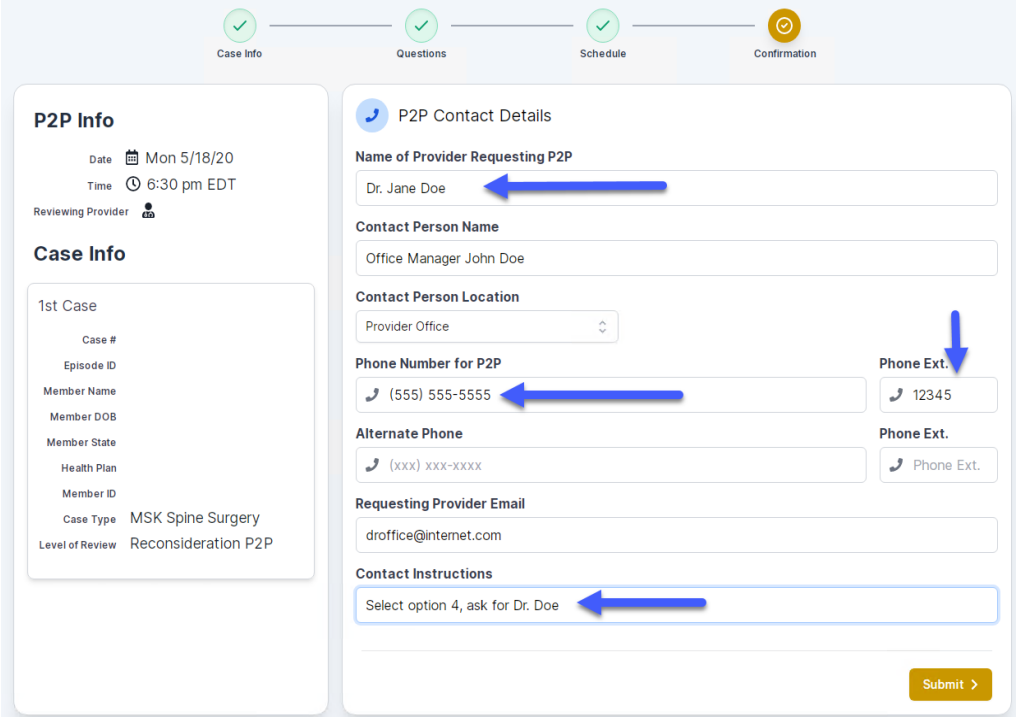
How to Schedule a Peer to Peer

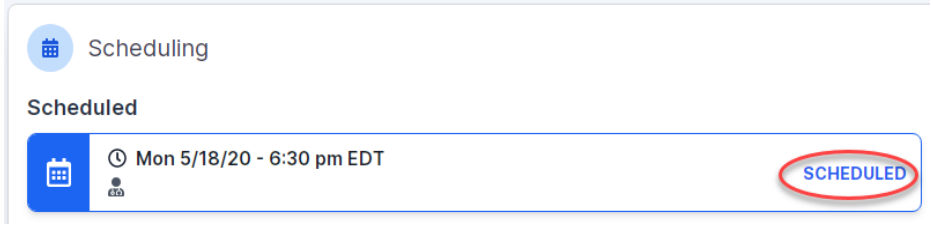
Confirm Contact Details

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



- 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.



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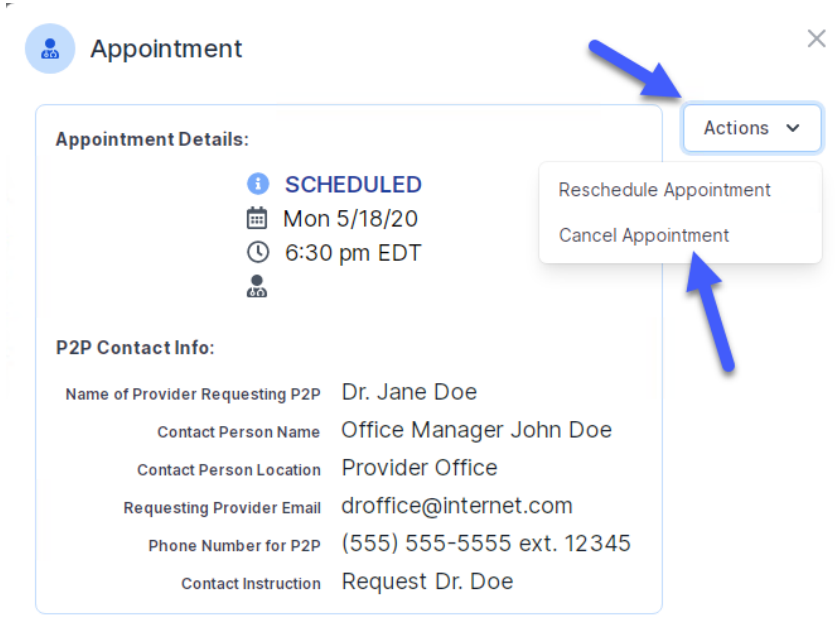
Canceling or Rescheduling a Peer to Peer Appointment

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

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Provider Resources

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Provider Resources

Prior Authorization Call Center – 800-421-7592

Our call centers are open from 7:00 a.m. to 7:00 p.m. (local time).

Providers can contact our call center to do one of 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

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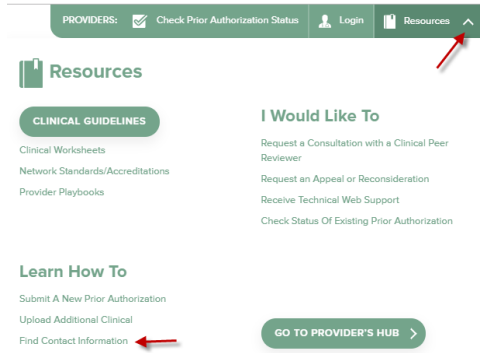
Provider Resources

Web Based Services and Online Resources

- You can access important tools, health plan specific contact information and resources at www.evicore.com
- Select the Resources to view Clinical Guidelines, Online Forms, and more.
- The Quick Reference Tool can be found by clicking the resources tab then select Find Contact Information, under the Learn How to section. Simply select the Health Plan and Solution to populate the contact phone and fax numbers as well as the appropriate legacy portal to utilize for case requests.



The quickest, most efficient way to request prior authorization is through our provider portal. We have a dedicated **Web Support** team that can assist providers in navigating the portal and addressing any web related issues during the online submission process.

To speak with a Web Specialist, call (800) 646-0418 (Option #2) or email portal.support@evicore.com

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Provider Resources

Client and Provider Services

eviCore healthcare has a dedicated Client and Provider Services team to address provider related requests and concerns. In most instances, this team can provide a resolution within 24-48 hours from the date the request was submitted. Here are some common requests that can be sent to our Client and Provider Services team for assistance:

- 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

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

Email: ClientServices@evicore.com

For prompt service, please have all pertinent information available when calling Client Services. If emailing, make sure to include a description of the issue with member/ provider/case details when applicable. Outside of normal business hours, please e-mail Client Services with your inquiry.

eviCore uses the Cherwell Ticketing System for all email inquiries. You will be assigned a ticket number starting with T. This number will identify a specific issue which you have provided for review.

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Provider Resources

Client Specific 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
- Solution PowerPoint Overview
- Training Sessions
- Announcement Letter

To access these helpful resources, please visit

https://www.evicore.com/resources/healthplan/cloverhealth

Provider Enrollment Questions – Contact Provider Services at 877-853-8019

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Thank You!

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