Specialized Musculoskeletal Therapies

Frequently Asked Questions

Overview

Who is eviCore healthcare?

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for Health Partners Plans.

Which members will eviCore healthcare manage for the Specialized Therapies program?

eviCore will manage prior authorization for Health Partners Plans members who are enrolled in the following programs:

Medicare **Medicaid**

Note: eviCore is not managing prior authorizations for Commercial or Dual membership at this time

What is the relationship between eviCore and Health Partners Plans?

Beginning on September 1, 2020 eviCore will manage outpatient musculoskeletal therapy services and Chiropractic services for HPP Medicaid and Medicare members on the eviCore portal and will no longer accept prior authorization request through our Landmark portal.

Prior Authorization

Which Specialized Therapies require prior authorization for Health Partners Plans?

This program manages outpatient member services for the following Musculoskeletal Therapy services:

- *Physical Therapy*
- *Occupational Therapy*
- *Speech Therapy*
- *Chiropractic Services*

The list of CPT codes that require pre-service authorization can be viewed on the provider resource website at https://www.evicore.com/resources/healthplan/health-partners-plans

Do services provided in an emergency room/ 24 hour observation/inpatient hospitalization require an authorization?

Therapy services provided during an emergency room treatment visit, or hospitalization, including services provided while the member is in observation status, do not require an authorization.

Which specialty types/clinicians are required to obtain prior authorization for specialized therapy?

- Chiropractor
- Occupational Therapist
- Physician
- Physical Therapist
- Speech Language Pathologist

Can an Athletic Trainer initiate an authorization for physical therapy?

No, an athletic trainer may not initiate a case for physical therapy.

Am I required to wait for pre-authorization before treating my patient?

{Option #1} You can perform the initial evaluation and provide treatment on the initial date of service without the need for prior authorization. For any treatment after this, prior authorization is required through eviCore. If treatment is initiated on a different date than the initial evaluation date, you would need to obtain prior authorization before the initial treatment visit occurs.

{Option #2} You can perform the initial evaluation and provide treatment on the initial date of service. Authorization is not required for the initial evaluation but it **is required for all treatment**. You must submit a request for authorization within **7** days of the requested start date

*If a patient is undergoing treatment before the start of the program on **September 1, 2020** will the treatment need authorization?*

For treatments already underway, please register the patient with eviCore so the claim will process appropriately. Use the web portal (www.evicore.com) and enter the current date when the date of service is being requested. Complete the clinical questions as needed and note the auth number if one is generated. If additional information is being requested please add "Patient is already in treatment" in the "additional notes" section. Any additional information you can provide regarding the treatment would be helpful.

How do I request a prior authorization through eviCore healthcare?

Providers and/or staff can request prior authorization in one of the following ways:

Web Portal

The eviCore portal is the quickest, most efficient way to request prior authorization and is available 24/7.Providers can request authorization by visiting www.evicore.com

Call Center

eviCore's call center is open from 7 a.m. to 7 p.m. local time. Providers and/or staff can request prior authorization and make revisions to existing cases by calling 888-444-6178

Fax

Providers and/or staff can fax prior authorization requests to 855-774-1319, **NOTE:** the clinical worksheets found on eviCore's website at www.evicore.com/provider/online-forms must be completed and faxed with the request for services

What is the most effective way to get authorization for urgent requests?

Urgent requests are defined as a condition that is a risk to the patient's health, ability to regain maximum function and/or the patient is experiencing severe pain that require a medically urgent procedure. Urgent requests may be initiated on our web portal at evicore.com or by contacting our contact center at 888-444-6178. Urgent requests will be processed within 72 hours from the receipt of complete clinical information.

When creating an authorization for a specialized therapy request, which CPT code should I choose?

Cases for Specialized Therapy should be created under program codes, not specific CPT codes. For example, Physical Therapy cases should be created under MSMPT, Occupational Therapy cases should be created under MSMOT, etc.

After the initial request, when should a pre-service authorization request be submitted for therapy services?

Requests for ongoing care may be submitted as early as seven (7) days prior to the requested start date. Include current clinical with your pre-service authorization request. Delays may occur if the request is made too far in advance and/or if the clinical information is incomplete or too old.

Will the clinical reviews be done by a practitioner of the same discipline?

Requests requiring clinical evaluation will be reviewed by appropriate specialty clinicians.

Member eligibility

How do I check the eligibility and benefits of a member?

Member eligibility and benefits should be verified through Health Partners Plan before requesting prior authorization through eviCore; this will also ensure that eviCore is delegated to manage prior authorization requests for that specific member/benefit type.

Web portal

What are the benefits of using eviCore healthcare's Web Portal?

Our web portal provides 24/7 access to submit or check on the status of your request. The portal also offers additional benefits for your convenience:

- **Speed** – Requests submitted online require half the time (or less) than those taken telephonically. They can often be processed immediately.
- **Efficiency** – Medical documentation can be attached to the case upon initial submission, reducing follow-up calls and consultation.
- **Real-Time Decisions** – Cases may be eligible for a real time decision when initiated via the web portal.
- **Member History** – Web users are able to see both existing and previous requests for a member

Is registration required on eviCore's web portal?

Yes. A one-time registration is required for each practice or individual. You will be required to log-in prior to submitting pre-service authorization requests on the web. If you have an existing account, a new account is not necessary.

Can one user submit pre-service authorization requests for multiple providers with different Tax ID numbers on the portal?

Yes, you can add the providers to your account once you have registered. In the Options Tool section at the top right of the portal, choose "Preferences" from the drop-down menu to set preferred Tax IDs for a physician or facility. By adding the preferred Tax IDs for a physician or facility to your account, you will be able to view the summary of cases submitted for those providers and facilities.

Who do I contact for online support/questions?

Web portal inquiries can be emailed to portal.support@evicore.com or call 800-646-0418 (Option 2).

How do I check an existing prior authorization request for a member?

Our web portal provides 24/7 access to check the status of existing authorizations. To check the status of your authorization request, please visit www.evicore.com and sign in with your login credentials.

What information is required when requesting prior authorization?

When requesting prior authorization, please ensure the proprietary information is readily available:

Member

- First and Last Name
- Date of Birth
- Member ID

Ordering Provider Note: For specialized therapy requests, the ordering and rendering provider are usually the same. Do not enter the *referring* physician's information.

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

Rendering (Performing) Provider Note: For specialized therapy requests, the ordering and rendering provider are usually the same. Do not enter the *referring* physician's information.

- Facility Name
- National Provider Identification (NPI) Number – use the group NPI if applicable
- Tax Identification Number (TIN)
- Street Address

Clinical(s)

- Diagnosis/ICD-10
- Date of current objective findings
- Date of the initial evaluation
- Date of onset
- Date and type of surgery (If Applicable)
- Co-morbidities/Complexities
- Functional Assessment Patient reported Functional Outcome Measures (see clinical worksheets for details)
- Patient response to care (after the initial request)

Will separate pre-service authorizations be required for a member with two concurrent diagnoses?

No. Each medical necessity review considers all reported diagnoses for the member.

What is the turnaround time for a determination on a standard pre-service authorization request?

All requests are processed within 2 days from receipt of request, not to exceed 14 calendar days. Please make certain all necessary clinical information has been submitted initially.

If a member goes to a new provider for services, will a new pre-service authorization request be required?

Yes. When a member changes to a treating provider who is not within the same practice, a new authorization request is required. If the member has discontinued care with the original provider, please include the discharge date with the original provider when submitting your request. **eviCore will not provide authorization for overlapping services or duplicate care as it is not medically necessary.**

What do I enter as the "Start Date" on my authorization request?

The start date of each authorization request should reflect the date in which you need an authorization to begin. For continuing care requests, the start date should reflect the first visit that requires authorization after expiration of any previously approved visits or authorization timeframe. Do not enter the first date of the member's treatment episode/evaluation for continued care requests.

What is the authorization period for approved services?

The authorization period may differ based on the member's condition and or health plan/State specific rules.

What will eviCore authorize?

eviCore will authorize visits OR units OR visits/units over an approved period of time. eviCore typically does not approve specific CPT codes for Specialized Therapy.

If eviCore does not approve specific CPT codes, why does my letter include a CPT code?

If a CPT code is referenced in the letter, it is a placeholder code used to inform the health plan's claims payment system that services have been authorized. The CPT code represents any of the CPT codes that require prior authorization for this program.

How many visits will eviCore approve when I submit a pre-service authorization request?

When the requested care is medically necessary, eviCore will approve a number of visits/units to be utilized over a specific period of time to treat the patient's condition, demonstrate progress and allow for a meaningful evaluation of the need to continue care beyond what has already been approved. The number of visits approved for the initial course of care will vary based on the diagnosis and treatment type of service being requested.

Will a medical necessity review specify the number of services/units approved?

Yes, the authorization will included visits/units and an approved time period. The number of approved visits and units is based on the clinical information provided at the time of the request.

Can I request additional visits beyond what was already approved?

Yes. eviCore will review and approve services in accordance with what is required for the member to demonstrate progress over a specific period of time. Upon expiration of an approved authorization, you may request additional visits as early as seven (7) days prior to the requested start date by submitting another authorization request via web or phone. The request should include current clinical information (collected within the prior 10 days), including the patient's response to any treatment already approved and rendered. Authorizations cannot overlap, be certain that the start date for a continuing care request is after the expiration of your previous authorization.

My authorization will expire soon, but I still have visits remaining. Can I request an extension?

Yes. A date extension can be granted for a therapy case in which a provider has visits authorized, but was unable to perform those visits in the amount of time given. You may request a date extension via our web portal or telephonically by calling eviCore at 888-444-6178

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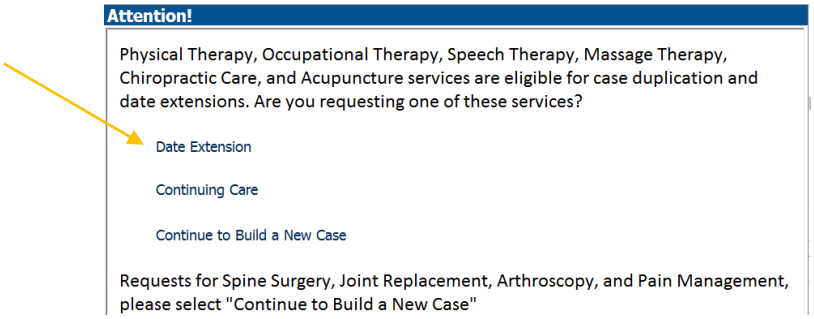

Please note the following conditions for a date extension:

- There must be one or more visits from an existing authorization that have not been used.
- An extension can only be requested during an open coverage period. If the coverage period has already expired, a new pre-service authorization request is required.
- Only one (1) extension is allowed per authorization.
- Authorizations can only be extended for up to an additional 30 days.
- An extension cannot overlap with another request for the same specialty.

Decisions

When will I receive the authorization number once the prior authorization request has been approved?

Once the prior authorization request has been approved, the authorization information will be provided to the ordering and rendering provider via fax. The member will receive an approval letter by mail.

How will the authorization determinations be communicated to the providers?

eviCore will fax the authorization and/or denial letter to the requesting provider.
Providers may also visit www.evicore.com to view the authorization determination.

Note: The authorization number will begin with the letter ‘A’ followed by an eight-digit number.

Denials/Appeals

If denied, what follow-up information will the referring provider receive?

The referring provider will receive a denial letter that contains the reason for denial as well as Appeal rights and processes. Please note that after a denial has been issued for a Medicare member, no changes to the case decision, such as a reconsideration, can be made. Speaking with an eviCore Medical Director is for educational purposes only.

What are my options when there is an adverse determination on my request?

The referring provider will receive a denial letter that contains the reason for denial as well as Appeal rights and processes. Please note that after a denial has been issued for a Medicare member, no changes to the case decision, such as a reconsideration, can be made. Speaking with an eviCore Medical Director is for educational purposes only

Timely Filing

Does eviCore review cases retrospectively if no authorization was obtained?

Retrospective requests must be initiated by fax within 180 days following the date of service. Your fax should include the following:

- List each date of service you are requesting retrospective authorization for
- # of visits and units you are requesting retrospective authorization for
- Clinical notes for each date of service
- Initial assessment
- Progress reports for the period you are requesting retrospective authorization for
- Patient reported functional outcomes
- ***Retrospective authorization requests are reviewed for clinical urgency and medical necessity***

Network Status

How do I determine if a provider is in network?

Participation status can be verified by Health Partners Plans. Providers may also contact eviCore healthcare at 888-444-6178.

eviCore receives a provider file from Health Partners Plans with all independently contracted participating and non-participating providers.

Claim Submission

Where do I submit my claims?

All claims will continue to be filed directly to Health Partners Plans.

Resources

Where can I access eviCore healthcare's clinical worksheets and guidelines?

eviCore's clinical worksheets and guidelines are available online 24/7 and can be found by visiting one of the following links:

Clinical Worksheets
www.evicore.com/provider/online-forms

Clinical Guidelines
www.evicore.com/provider/clinical-guidelines

How can the accepting provider confirm that the prior authorization number is valid?

Providers can confirm that the prior authorization is valid by logging into our web portal, which provides 24/7 access to view prior authorization numbers. To access the portal, please visit www.evicore.com.

To request a fax letter with the prior authorization number, please call eviCore healthcare at 888-444-6178 to speak with a customer service specialist.

How do I submit a program related question or concern?

For program related questions or concerns, please email: clientservices@evicore.com

Where can I find additional educational materials?

For more information and reference documents, please visit our resource page at https://www.evicore.com/resources/healthplan/health-partners-plans