



Specialized Therapy Frequently Asked Questions

Creating a Prior Authorization Request

Why does eviCore recommend that providers initiate prior authorization via eviCore’s web portal?

Advantages of web:

- **Saves time:** The process is faster than submitting authorization requests over the phone.
- **Receive a real-time decision:** Get a decision in real time, depending on the complexity of a request.
- **Available 24/7:** You can access the portal any time, on any day.
- **Save your progress:** If you need to step away, you can save your progress and resume later. You have two calendar days to complete your request.
- **Upload additional clinical information:** No need to fax supporting clinical documentation; it can be uploaded to the portal to support a new request or when additional information is requested. Upload clinical information that supports/demonstrates the need for medically necessary skilled therapy, such as the initial evaluation, a recent progress report/re-evaluation or patient-reported outcome tools.
- **View and print determination information:** Check case status in real time.
- **Dashboard:** View all recently submitted cases. This enhancement allows providers to easily review and track the status of a submission.
- **Duplication feature:** If you are submitting more than one prior authorization request, you can duplicate information to expedite submissions:

You can also start a new request using some of the same information.

Start a new request using the same:

- Program (Radiology)
- Provider (Chiropractic, Acupuncture)
- Program and Provider (Radiology and Chiropractic, Acupuncture)
- Program and Health Plan (Radiology and eviCore)

- **TIP:** Group eviCore authorization requests together to reduce the need to log in for each individual request.
- **TIP:** Eligibility for a real-time decision depends on the method of submission, condition type, request number and completeness of information provided with the request. Real-time decisions are limited to requests initiated by web or phone. Musculoskeletal (MSK) conditions are eligible to receive real-time decisions at the initial request and first follow-up, as long as sufficient clinical information is provided. Non-MSK conditions are only eligible for a real-time decision at the initial request.

Why do I need to enter the discipline when requesting authorization via www.eviCore.com?

In situations where health plans allow multiple provider types to utilize a physical medicine benefit, eviCore currently allows a variety of provider types to create a case using the musculoskeletal management physical therapy (MSMPT) code. Entering the specialty type (discipline) ensures that the request will route to the correct specialty reviewer (e.g., physical therapist, chiropractor, acupuncturist, massage therapist) for review.

I want to change my answer. Why am I unable to move backward in a case created via the web portal?

Depending where you are in the case, your ability to move backward to correct answers may be limited. If you are answering the initial administrative questions, you can move backward to correct errors. However, once you enter the clinical portion of the process, you are unable to go back to change answers. This limitation is intentional, as it prevents providers from modifying answers if they are not satisfied with the determination they obtain. While this may not be a concern for therapy cases, it is for cases submitted for some of the other specialties eviCore manages.

- **TIP:** Once you enter the clinical portion of the pathway, review your answers before submitting and moving to the next page.

When I create a case on the web, why am I asked if the request is for routine care?

This question helps identify requests that are urgent to ensure each request is processed correctly. The following is presented when creating a case on the web:

Proceed to Clinical Information

Is this case Routine/Standard?

- If your request is urgent select **No**
- When a request is submitted as Urgent, you will be required to upload relevant clinical information
- You can upload up to FIVE documents in .doc, .docx, or .pdf format
- Your case will only be considered Urgent if there is a successful upload
- If the case is standard select **Yes**

- **TIP:** Unless the request is to be processed as urgent, answer “Yes” to the question “Is this case Routine/Standard?” to continue with case creation.

What clinical information do I need to submit?

In general, for the *initial request*, eviCore asks for information about the condition, complexity and functional status. If the request is for *continuing care*, the focus is on the resolution of complexities, change in functional status, and response to care. eviCore has created clinical worksheets to help you prepare a case via web or phone. In many offices, the therapist will answer the clinical questions on the worksheet. This reduces the potential for errors and eliminates the need for a non-clinical employee to retrieve information from the clinical record. Most of the information you will be required to enter (except for an updated patient-reported outcome score) is collected via routine assessment. There is no need to perform a formal re-evaluation or progress report.

Worksheets are available at <https://www.evicore.com/provider/online-forms-details?solution=msk%20therapies>.

- **TIP:** Have the clinician provide answers to the clinical questions included in the worksheet. This allows non-clinical staff to quickly provide the answers when creating a case by web or phone.

Why must I enter a patient-reported outcome with each request?

eviCore’s decision considers the condition, complexities, functional status and response to care, as well as historical information available at the time of the review. Each component is important in determining the medical necessity of the request. If any questions are unanswered, the visit allocation may be less than if the outcome score was included (see the following TIP).



- **TIP:** The answer entered for each question is considered when the visit/unit allocation is determined. If relevant information is lacking, fewer visits may be allocated. For example, a patient with shoulder pain and no patient-reported outcome score may only receive an approval for six visits. However, if a DASH or QuickDASH score is reported and demonstrates functional impairment, eight or more visits may be approved.
- **TIP:** When submitting your request via the web, the fields associated with outcome scores are pre-populated with numbers that do not make sense. This is intentional; these fields must be populated to enable the user to move to the next question. If you have a score to report, replace the pre-populated score. If you do not have a score to report, leave the pre-populated scores and move to the next question.
- **TIP:** When submitting a follow-up outcome score, please re-administer and submit scores from the same functional outcome tool used initially. This will allow eviCore to assess the patient's functional change since the last request.

How can I request visits for a limited service, for example instruction in a home exercise program, or fabrication of a splint (only)?

If ongoing care is not necessary but 1–2 visits are required for a limited service, answer “Yes” to the question asking if care is for a home program or splint/orthotic only. This pathway shortcut allows a provider to obtain 1–2 visits without requiring a therapist to submit clinical information for review.

Why can't I attach clinical documents when requesting an authorization via eviCore's web portal?

To allow the opportunity for a real-time decision, eviCore limits the ability to upload additional clinical documentation. For MSK conditions, you can begin uploading clinical documentation at the third request. For non-MSK conditions, you can begin uploading clinical documentation at the second request.

When can I expect a review to be completed?

Your review will be completed within two business days from the receipt of request.

- **TIP:** Submitting requests by web or phone increases the likelihood of receiving a real-time decision with reduced care delays.

How long will an authorization remain valid?

Adult authorizations will be valid for **60 days**.

- **TIP:** Check with the specific health plan to determine what specific rules apply in determining the authorization duration.

If my patient requires more therapy, how early can I submit my request?

Requests for additional visits may be submitted as early as seven days before the requested start date of the additional therapy.

- **TIP:** If additional care is required, do not wait until all approved visits have been exhausted before submitting a request for additional care. Submitting a request in advance of the requested start date will reduce the likelihood of interrupting the patient's care.

Post-decision Activities

Post-decision options

Information related to reconsideration/appeal is included in the letter you received with the prior authorization determination.

Peer-to-peer/Clinical consultation

Providers have five business days after the denial notification to request a peer-to-peer consultation or submit additional clinical information for review. To schedule a peer-to-peer consultation via the web, log in to your account at www.evicore.com.

Perform “Authorization Lookup” to determine the status of your request.

Select the “P2P Availability” button to determine if your case is eligible for a peer-to-peer consultation:

Authorization Lookup

Authorization Number:	NA	
Case Number:		
Status:	Denied	
P2P Status:		

P2P AVAILABILITY

If your case is eligible for a peer-to-peer consultation, a link will display allowing you to proceed to scheduling without additional messaging.

P2P AVAILABILITY [Request Peer to Peer Consultation](#)

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 select the “All Post-Decision Options” button to learn what other action may be taken.

Authorization Lookup

Authorization Number:	NA	
Case Number:		
Status:	Denied	
P2P Eligibility Result:	Post-decision options for this case have been exhausted or are not delegated to eviCore. You may continue to schedule a Peer to Peer discussion for this case but it will be considered consultative only and the original decision cannot be modified.	
P2P Status:		

[Request Peer to Peer Consultation](#)

ALL POST DECISION OPTIONS

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

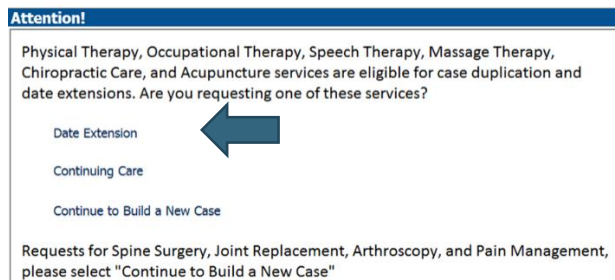
- **TIP:** A peer-to-peer must be conducted by a clinician (e.g., therapist to therapist).
- **TIP:** Be prepared to share new supporting information that explains why additional care is medically necessary. If the original decision can be modified based on a peer-to-peer consultation, new information (not previously presented) must be provided.

Date extension

Date extensions are available if you are unable to use all visits within the approved period. You may extend for the amount of time needed, up to a maximum of 30 days. One date extension is available per case.

- **TIP:** The extension must be requested *prior* to the expiration of the authorization.

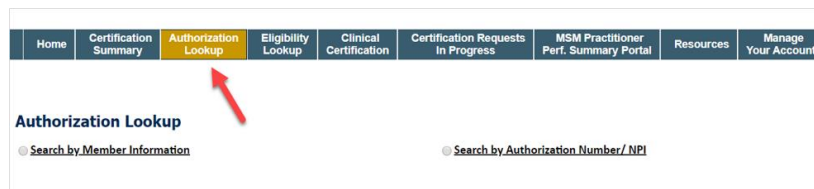
You can request a date extension by visiting www.eviCore.com and logging into your portal account:



- **TIP:** If your patient experiences a gap in care due to vacation, illness, etc., requesting a date extension allows you to use approved visits without the need to provide additional clinical information. Once the approved visits are used, you can submit a request for additional care if necessary. Updated clinical information must be submitted with the new request.

Checking authorization status

You can look up authorization status on the portal. Search by member information or by authorization number with the ordering National Provider Identifier (NPI). You can view and print all correspondence.





Resources Available to Providers

Prior authorization call center: 844.224.0495

Call centers are open from 7 a.m. to 7 p.m. Providers can contact our prior authorization (PA) call center to perform the following:

- Request prior authorization
- Check status of existing authorization requests
- Discuss questions regarding authorizations and case decisions
- Change facility or Current Procedural Terminology (CPT) code(s) on an existing case
- Request to speak to a clinical reviewer
- Schedule a clinical consultation with an eviCore medical director

Web-based services and online resources

You can access important tools, health plan-specific contact information and helpful resources at www.evicore.com

- Select **Resources** in the upper right-hand corner of the webpage to view Clinical Guidelines, Online Forms and more.
- Select **Provider's Hub** section includes many resources.
- **Provider forums and portal training are offered regularly.** You can find a session by going to www.evicore.webex.com, selecting Webex Training, and searching "upcoming" for an "eviCore Portal Training" or "Provider Prior Authorization Online Portal Tips and Tools."
- The fastest, most efficient way to request prior authorization is through our provider portal. Our dedicated **Web Support** team can assist providers in navigating the portal and addressing 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.**

Client and provider services

This dedicated team addresses provider-related requests and concerns, including:

- Questions regarding accuracy assessment, accreditation and/or credentialing
- Requests for an authorization to be re-sent to the health plan
- Eligibility issues (member, rendering facility and/or ordering physician)
- Issues experienced during case creation

The team can be reached via email at ClientServices@eviCore.com (preferred), or phone by calling 800.646.0418 (option 4). For prompt service, please have all pertinent information available. When emailing, make sure to include the health plan in the subject line. Please include a description of the issue and include enrollee case details in the body of the email, when applicable.



A review of our TIPs for improving your experience:

- Check with the health plan to determine what specific rules apply in determining the authorization duration.
- Timely filing rules vary by health plan. Please consult the specific health plan's guidance to determine what the plan allows.
- Submitting requests by web or phone increases the likelihood of receiving a real-time decision as the episode of care begins.
- Eligibility for a real-time decision depends on the method of submission, condition type, request number and completeness of information provided with the request. For example, real-time decisions are limited to requests initiated by web or phone.
- MSK conditions are eligible to receive real-time decisions at the initial request and first follow-up as long as sufficient clinical information is provided. Non-MSK conditions are eligible for a real-time decision only at the initial request.
- Have the clinician provide answers to the clinical questions included in the worksheet. This allows non-clinical staff to quickly provide the answers when creating a case by web or phone.
- The answer entered for each question may be key when the visit/unit allocation is determined. If there is information lacking, fewer visits may be allocated. For example, a patient with shoulder pain and no patient reported outcome score may receive approval for only six visits. However, if a reported DASH or QuickDASH score demonstrates functional impairment, eight or more visits may be approved.
- When submitting your request via the web, the fields associated with outcome scores are pre-populated with numbers that do not make sense. This is intentional; these fields must be populated to allow the user to move to the next question. If you have a score to report, replace the pre-populated score. If you do not have a score to report, leave the pre-populated scores and move to the next question.
- When submitting a follow-up outcome score, please re-administer and submit scores from the same functional outcome tool used initially. This enables eviCore to assess the patient's functional change.
- Once you enter the clinical portion of the pathway, review your answers before submitting and moving to the next page.
- Unless the request meets the definition of urgent, answer "Yes" to the question, "Is this case Routine/Standard?" to continue to create your request.
- If additional care is required, do not wait until all approved visits are exhausted to submit a request for additional care. Submitting a request for additional care in advance of the requested start date will reduce the likelihood of interrupting the patient's care. A peer-to-peer consultation must be conducted by a clinician, for example, therapist to therapist. Be prepared to share additional (new) information that explains why additional care is medically necessary.
- Group eviCore authorizations together to reduce the need to log in for each individual request.
- If your patient experiences a gap in care due to vacation, illness, etc., requesting a date extension will allow you to use remaining approved visits without the need to provide additional clinical information. Once the approved visits are used, you can submit a request for additional care if necessary. Updated clinical information must be submitted with the new request.