Specialty Therapy

Frequently Asked Questions

Who is eviCore healthcare?

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides targetedutilization management services for Security Health Plan**.**

What is eviCore's Specialized Therapy Program?

eviCore's Specialized Therapy program, which is a part of our Musculoskeletal (MSK) solution, is a Member-centric approach to utilization management. Our program has been designed to approve the appropriate amount and durationof treatment needed to enhance Member outcomes, based on the individual Member's specific condition, via a streamlined Prior Approval process.

What services are managed through eviCore's MSK Specialized Therapy Program?

- Occupational Therapy
- Physical Therapy
- Speech Therapy

Which Members require Prior Approval through eviCore?

eviCore will review outpatient therapy services for all Security Health Plan Commercial,Medicaid, and Medicare Members.

Security Health Plan will review home health therapy services for all Security Health PlanMembers.

How do I verify Member eligibility?

Follow your routine Security Health Plan process for eligibility verification.

Who needs to request Prior Approval?

Primary care and specialty providers can continue to make referrals for therapy services. The initial evaluation does not require Prior Approval. The therapists who are rendering the specialized therapy services will be submitting the Prior Approval requests based on the initial evaluation and proposed plan of care.

How do I request Prior Approval?

You may request Prior Approval online at www.eviCore.com. Online submissions are the quickest and most efficient way to request Prior Approval and have the highest potential of returning an immediate approval when a medical necessity criterion is met!

You may also request authorization telephonically by calling eviCore at 888-444-6185**.** eviCore is available for telephonic case initiation Monday through Friday between 7 AM and 7 PM (CT) except holidays.

Fax submissions may be submitted to our toll-free fax number at 888-774-1319. Prior Approval requests submitted by fax require manual review of submitted information. To avoid delays, we encourage web submission using the applicable clinical worksheet available at https://www.evicore.com/healthplan/shp.

Does the Member's initial evaluation require Prior Approval?

No, the Member's initial evaluation does not require Prior Approval; however, if additional services (e.g., treatment) areperformed the same day, Prior Approval will be required for those services. You have seven (7)

calendar days from the initial date of service to initiate the Prior Approval request in this scenario.

What clinical information is collected during the Prior Approval process?

The clinical information requested by eviCore during Prior Approval may differ per each specialized service, Member ageand condition, and request type (i.e., initial request, second or more).

Baseline clinical information should **always** be included when submitting an **initial** request. This avoids delays in the medical necessity review.
This typically includes:

- Diagnostic information
- History of surgery, as applicable
- Complexities and additional information about recent surgery (i.e. type and date)
- Primary area of complaint; pain distribution
- Select examination findings, i.e. range of motion and strength
- Outcome Measurement Test scores: Refer to "*What Outcomes Measurement Tests are commonly used by eviCore?*"
- Standardized test scores, as applicable

The following may be collected during a request for Prior Approval of continuing care:

- Member response to treatment
- Updated Outcome Measurement Test scoring, including change from previously reported score
- Identification of reasons associated to lack of progress from treatment provided

How to avoid inappropriate denials when services are appropriate?

Services that are deemed appropriate are those that follow clinical and/or medical necessity guidelines. You can find those guidelines at www.eviCore.com. Click the resources drop down button at the top right side of the web page to find the link to those guidelines.
If a provider follows guidelines that govern clinical and/or medical necessity criteria, but still experiences high denial rates, the reason may be due to clinical information missing from the case request. This is a list of information usually required:

- Primary and Secondary Diagnosis/ICD10
- Co-morbidities/Complexities that will affect the therapy plan of care
- Date of current findings
- Standardized test scores (a minimum of annually for pediatric neurodevelopmental conditions
- Functional Outcome Measures/Patient Reported Outcome Scores
- Surgery – Date and type
- Provide current pain medication
- Patient's status to Provider prescribed pain medication
- New condition not previously treated or previous condition
- Average level of pain (Rate 1 - 10)
- List of activities the patient is not able to perform within the last week (Rate level of difficulty 1 - 10)
- Patient's response to care
- Reasons for patient not responding to care
- How many new re-occurrences has the patient experienced in last 12 months?
- Additional information for non-MSK conditions: date of most recent medical evaluation, current medical co-management, and condition-specific outcome measures

Can I attach additional clinical information when requesting Prior Approval?
You may be able to submit additional clinical information in limited scenarios.

Web initiated cases for initial and second requests may restrict your ability to include attachments or notes for review.This is intentional. Our clinical pathways have been specifically designed to collect all clinical information we need to make a decision for a Member's condition during these intervals of treatment. Completed pathways will likely yield an instant approval of services. If we are unable to render a real time approval, and require additional clinical informationfor review, the option to upload attachments or notes will become available after all pathway questions are answered.

You may also include additional clinical information that you would like to be considered during the Prior Approval process for a fax initiated case; ***however***, submissions that include journal notes or attachments **will** require additionalclinical review and are less likely to yield an immediate approval.

What Outcome Measurement Tests are commonly used by eviCore?
eviCore uses the following Outcome Assessment tests during its Prior Approval review processes based on the Member'sregion of complaint:

Neck Disability Index (NDI)	Oswestry Disability Index (ODI)
Lower Extremity Functional Scale (LEFS)	Roland Morris Disability Questionnaire
HOOS JR	KOOS JR
Disabilities of Arm, Shoulder and Hand (DASH/QuickDASH)	

Note! eviCore has carefully selected the above Outcome Measurement Tests based on a number of factors, including consideration of tests that have broad application, validated and consistent scoring methodology, defined clinimetrics and ease of use. eviCore closely monitors the evolution of standard practices and may expand upon this list over time, asappropriate.

What Standardized Test Scores does eviCore consider?
eviCore considers Standardized Test Scores for Pediatric cases. Please see the clinical worksheet for full list.

Can an Athletic Trainer initiate a Prior Approval request to provide physical therapy?
No. While certain states may allow athletic trainers to perform specific tasks related to physical therapy, theymust be performed under supervision of a physical therapist and the therapist is responsible for Prior Approval of services.

Will separate authorizations be required for a Member with two concurrent diagnoses?
No. eviCore considers all diagnoses reported during the Prior Approval process and allows for collection of additionalinformation specific to secondary treatment areas, as applicable.
Note! Separate requests for Prior Approval are required if the Member is receiving care from multiple healthcare providers or specialties.

How long do I have to submit a request for Prior Approval?
Prior Approval must be submitted before treating your Member. If treatment is provided during the initial evaluationvisit, the rendering provider has up to seven (7) calendar days to submit the Prior Approval request for the treatmentrendered during the initial visit.

What do I enter as the start date on my Prior Approval request?
The Start Date should reflect the date you want the authorization period to begin.

How far in advance can I submit a request for Prior Approval?
Requests for authorization must be submitted no more than **seven (7)** days prior to the requested start date. Requestingcare too far in advance does not allow you to report current examination findings and clinical information.

Is there a timelime associated to consideration of current clinical findings?
Clinical information must be less than **fourteen (14)** days old from your requested start date to be considered current.Prior Approval requests with out-of-date clinical information may be placed on hold awaiting current clinical information.

How can I initiate Prior Approval for a medically urgent request?
Medically urgent requests – defined as conditions that are a risk to the Member's life, health, ability to regain maximumfunction or cause severe pain that may require a medically urgent procedure – must be initiated by phone. All web and fax cases will be considered standard.
Note! Cases should not be classified as medically urgent solely for convenience ofthe Member or healthcare provider.

Do services provided in an inpatient setting at a hospital require Prior Approval by eviCore healthcare?
No. eviCore's Specialized Therapy Program manages outpatient services only. Services performed during in inpatientstay are outside the scope of this program.

Do services provided in the Emergency Department require Prior Approval?
No. Services provided in the Emergency Department do not require Prior Approval.

Are retrospective review requests allowed?
Retrospective requests are allowed with this program. Clinical information should be submitted within 7 businessdays. If the information is not submitted within 7 days the case will be expired.

How long is an approved authorization period?
Therapy service cases will have up to 180 day timeframe from request of treatment date. The timeframe is condition dependent.

How many visits are generally approved?
Approved visits will vary based on each individual Member's condition, severity and complexity and response totreatment received once provided.

Can additional visits be requested?
Yes. Additional requests for Prior Approval may be submitted after the approved visits expire.

Can I extend the approved timeframe if I have not used all approved visits?
Yes. eviCore will allow up to one (1) extension per approved coverage period for up to thirty (30) days. The extensionmust be requested online or telephonically before the approved coverage period expires. Date extensions cannot berequested via fax.

How long will it take for a determination to be rendered?
Completed cases that were initiated online have the highest potential to receive an instant approval; however, if yourrequest requires additional clinical review, eviCore will follow the contractual and/or compliance and regulatory turn-around-times as stipulated below:

- Urgent – Within 24 (Medicare/Medicaid) hours of receipt of **all necessary information** needed to render a decision. eviCore standard is within 4 hours.
- Urgent – Within 72 (Commercial) hours of receipt of **all necessary information** needed to render a decision. eviCore standard is within 4 hours.
- Routine – Within two (2) business days of receipt of **all necessary information** needed to render a decision.
- Please a web submission increases the likelihood of a real time decision.

Will eviCore's medical necessity decision specify the number of services and/or units approved?
Yes. Our decision will include the total number of units and visits approved over a specific coverage period duration. **Note!** eviCore's decision is based solely on medical necessity of the requested services and does not guarantee payment.Payment is subject to Member eligibility and claim processing edits.

What is the format of the eviCore Authorization Number?
An authorization number is one (1) alpha character followed by nine (9) numeric values: i.e., A123456789.

Is the clinical criteria available for review?
Yes. Our clinical criteria is available online at https://www.evicore.com/provider/clinical-guidelines.

How can I track the status of my Prior Approval request?
You may track the status of your Prior Approval request online at www.evicore.com. After logging in, select **"Check status of Existing prior Authorization"** to view the current status of your request.

What authorization information will be visible on the eviCore website?
The authorization status function on our website will provide the following information:

Auth/Case Number	Status of Request	Service Type (MSMPT/ MSMOT, etc.)
Procedure Name	Site Name and Location	Authorization Date
Expiration Date		

Can I speak to a reviewer regarding a denied request?
Yes. You may request a Peer-to-Peer discussion within 15 calendar days of the adverse medical necessity determinationonline at **www.evicore.com** or telephonically by calling eviCore at (888) 444-6185.

Can I file an appeal for requests that have been fully or partially denied?
It is recommended that you utilize reconsideration processes before submitting request for formal appeal. Reconsiderations may be initiated telephonically or through a peer-to-peer conversation. Requests upheld viareconsideration processes may be appealed further through Security Health Plan.

Determination letters associated to the denied service(s) will contain additional information specific to applicable appealprocesses.

Where do I submit claims?
Follow your routine Security Health Plan process for claims submission.

Will we be using visits allowed with start and end date? Do we need to worry about the number of CPT codes?
The approval will include visits/units/approved period. You will need to spread both the visits/units out over the period. Specific COTcodes will not be approved allowing the provider to use the interventions that are most appropriate for the patient at a given point intime.
Note: You are able to modify the # of units billed/visit as long as the total # of units and visits is not exceeded. For example, as care for an acute condition begins, you may decide to bill 5 units/visit, and then reduce to 3 units/visit as the condition becomes less acute. If you exhaust visits but have units remaining, you will need to submit a request for ongoing care. If you exhaust the units but have visits remaining, you will need to submit a request for ongoing care.

I noticed that eviCore has (2) portals MedSolutions and CareCore National. Which one do we use for Security HealthplanPlan Therapy cases?
CareCore National

We have existing patients with a prior authorization from Security Health Plan that will expire as of 04-30-19. Do wecount the request as a concurrent prior authorization?
All therapy cases with a date of service after 5/1/2019 need a new authorization from eviCore. eviCore cannot extend authorizationsoriginally provided by SHP.