# eviCore Therapy Provider Orientation FAQ

Q: For children with authorizations that are expiring soon, when will we need new authorizations based on Continuity of Care of members coming over from Staywell/WellCare?
A: Any authorization already in place is valid until the end of that treatment period. Once the treatment period ends, a new request is needed through eviCore. Note: The existing authorization numbers from WellCare are valid beyond 10/1/21 until the treatment period ends, at which time you should request a new authorization via eviCore and obtain a new authorization number.

Q: Should we request authorization for treatment the day after the initial evaluation?
A: You have up to 7 days from the date treatment begins to submit your authorization request to eviCore, regardless of if the treatment begins on the date of evaluation or a later date. The evaluation does not require authorization, but the treatment does.

Q: Under WellCare we could request authorization 14 days in advance. Has this changed to 7 days?
A: eviCore's standard is 7 days. This standard increases the likelihood of receiving the most current clinical information that is available. However, the system will be lenient and will not block you from requesting 14 days out.

Q: When submitting a request, how do we choose which therapy we need on the eviCore web portal?
A: When you get to the Case Details screen asking for CPT and Diagnosis Code, you will be able to choose MSMPT for Physical Therapy, MSMOT for Occupational Therapy, or MSMST for Speech Therapy.

Q: If a member shows up on the eviCore portal when you enter their information, does that mean they are an active member with Sunshine Health/Children's Medical Services?
A: Yes. When you enter the member information on the portal and click "Eligibility Lookup," it will verify that member's eligibility with the health plan. If they are not showing up as eligible, the portal will allow you to continue the request as an "eligibility case" or you can call it in to eviCore.

Q: We operate as a group and bill as a company. The ordering and rendering providers are often different. Should we enter our authorizations on the eviCore portal as a group or does it have to be an individual provider?
A: You should add the group under your web portal account instead of individual providers, so that you can enter your authorizations under the group information. If therapy is billed under a group ID, the prior authorization request would also be created under the group ID. This allows all therapists covered under that group ID to provide services under the authorization.

Q: Whom do we contact if we are having issues with the eviCore web portal?
A: If you need assistance with the eviCore web portal, you can contact our web support team by phone at 1-800-646-0418 (option #2) or by email at portal.support@evicore.com. If you need assistance with the Sunshine Health's Secure Provider Portal, please reach out to their Provider Services team at 1-844-477-8313.

Q: During the prior authorization submission, are the PT/OT/ST worksheets the only thing needed or should something else submitted with it via fax?
A: The worksheets that are available at www.evicore.com are designed to be a tool for you to gather the information needed for a prior authorization request, but they are not required as long as you use the web portal. If you need to fax in the request, the completed worksheet will be required. The eviCore fax number to use is 1-855-774-1319. If additional clinical information is required, eviCore will contact you.

Q: Do we need the MD's signature/signed Plan of Care prior to submitting for authorization?
A: No. While a signed plan of care is required to meet state and health plan regulations, it is not required to obtain prior authorization. You may initiate the request while waiting for the signed plan of care.

Q: How far back do you retroactively approve authorizations?
A: Retrospective requests are allowed up to 365 days. However, as the member's coverage may have recently changed to Sunshine Health/CMS, make sure you create a case under the correct health plan. Note: If you need a retrospective authorization for Speech Therapy with dates of service prior to 10/1/21, you will need to contact WellCare since eviCore did not manage ST requests prior to 10/1/21.

Q: If a child has language delay and feeding/swallowing concern, should we include all under speech or language CPT? In the past FL Medicaid has not recognized the CPT code for feeding. We were told that we can request authorization for feeding and language at the same time. What CPT code will we receive with the authorization?
A: Speech Therapy cases should be created on the portal as a request for MSMST. Do not create a case under a specific CPT code. eviCore does not approve specific codes. eviCore will approve visits and units for an approved period. For claims submission please follow the guidance provided by Sunshine Health.

Q: Will the frequency of plan care be followed or is there a clinical judgement or peer review to determine frequency?
A: If the plan of care meets criteria, it will be approved as requested. If it does not meet criteria, the case will be reviewed by a Speech Pathologist (eviCore Speech Therapy reviewer) and the reviewer will request additional information if necessary before a decision is finalized.

Q: Can you please clarify the syncing plan of care duration?
A: In order to reduce due dates for the prior authorization requirement and plan of care requirement, the first request to eviCore should reflect the time left on the existing plan of care. For example, if the existing plan of care expires 12/30/21, the request would be for 13 weeks (10/1/21 through 12/30/21). Then, when the child is re-evaluated and the plan of care is updated, submit a corresponding prior authorization request to obtain authorization for the new period.

Q: What standards are you using to determine severity rating for speech/language impairments?
A: We use standardized test scores and impairment rating. Please see below.

Conditions can be classified as mild, moderate, or severe.

- Mild conditions: assessment indicates delay that minimally interferes with communication and may impact acquisition or result in a loss of educational, social, and vocational skills. Mild (-1 to -1.5 standard deviation from the mean or a score of 84 to 78).
- Moderate conditions: assessment indicates delay that interferes with communication and usually impacts acquisition or results in a loss of educational, social, and vocational skills. Moderate (-1.5 to -2 standard deviation from the mean or a score of 77 to 70).
- Severe conditions: assessment indicates limited functional communication that always interferes with acquisition or results in a loss of educational, social, and vocational skills. Severe (>2 standard deviation from the mean or a score of 69 or below).

Q: Will eviCore be taking care of PPEC authorizations or just CMS kids?
A: The PT/OT/ST program that eviCore is managing for Sunshine Health only pertains to Children's Medical Services (CMS) members but also includes Prescribed Pediatric Extended Care (PPEC).

Q: If a child has an authorization from another provider and is changing providers, how is that handled with eviCore? Does the prior provider need to notify eviCore that the child is no longer being seen by them or can the parent call Sunshine Health?
A: If the child changes providers, the new provider should submit a new request for authorization to eviCore. Note: If the new provider is in the same group as the original provider and both providers submit claims as part of a group, a new authorization is not required if the existing authorization was built under the group. The parent can contact eviCore on behalf of their child to inform us of the provider change. Note: The new authorization can include a different treatment plan since it is a new provider. The new provider should request services based on their own evaluation and assessment.

Q: When a patient has both office visits and telehealth, do we need a separate authorization for each?
A: One authorization covers both places of service.

For additional health plan specific question related to billing, claims, Continuity of Care, credentialing, provider rosters, etc., please reach out to the health plan directly or visit the following website:

https://www.sunshinehealth.com/providers/Specialty-services/Therapy.html