Musculoskeletal Management

Outpatient Therapy and Chiropractic Services

Provider Orientation Session The Health Plan

Agenda

- Company Overview
- Clinical Approach
- Program Overview
- Submitting Requests
- Prior Authorization Outcomes & Special Considerations
- Reconsideration Options
- Provider Portal Overview
- Additional Provider Portal Features
- Provider Resources
- Q & A

Company Overview

Medical Benefits Management (MBM)

Addressing the complexity of the healthcare system

10 Comprehensive solutions

Evidence-based clinical guidelines

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

Advanced, innovative, and intelligent technology

Clinical Approach

Evidence-Based Guidelines

The foundation of our solutions

- Dedicated pediatric guidelines
- Contributions from a panel of community physicians
- Experts associated with academic institutions
- Current clinical literature

Aligned with National Societies:

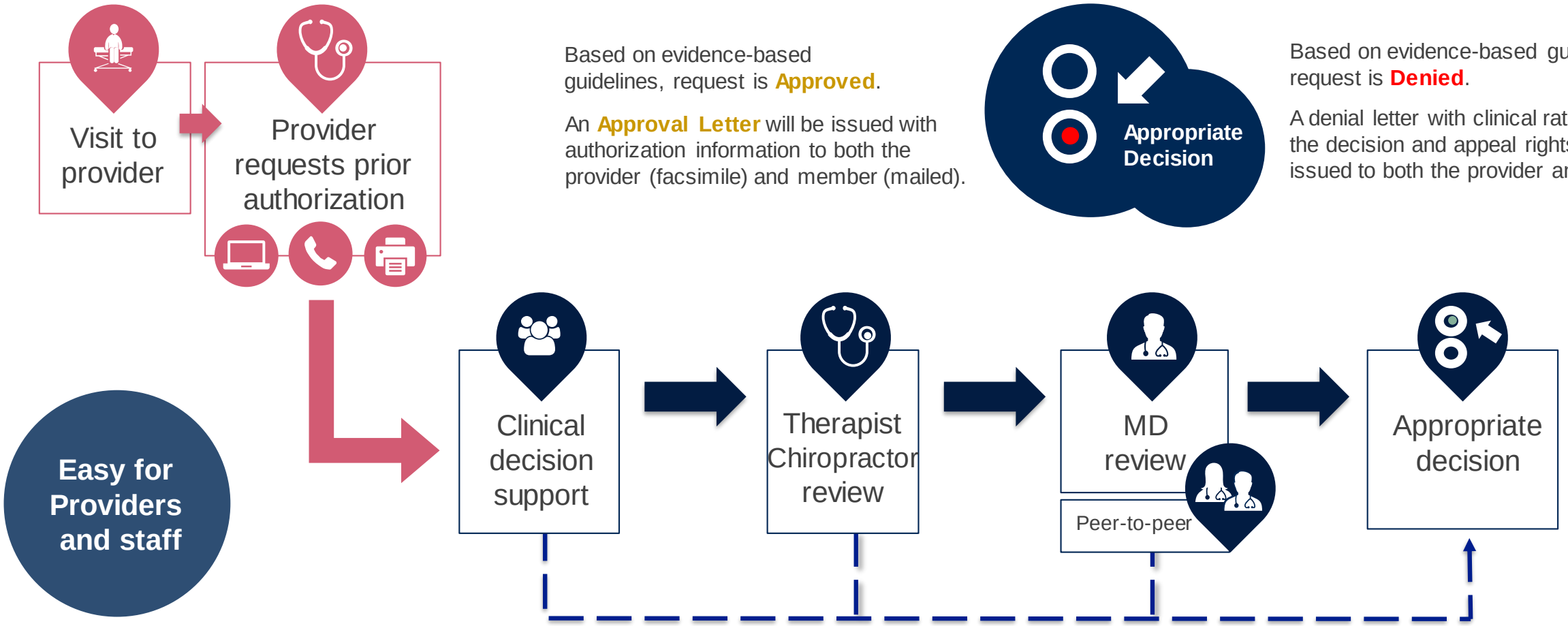
- American College of Cardiology
- American Heart Association
- American Society of Nuclear Cardiology
- Heart Rhythm Society
- American College of Radiology
- American Academy of Neurology
- American College of Chest Physicians
- American College of Rheumatology
- American Academy of Sleep Medicine
- American Urological Association
- National Comprehensive Cancer Network
- American Society for Radiation Oncology
- American Society of Clinical Oncology
- American Academy of Pediatrics
- American Society of Colon and Rectal Surgeons
- American Academy of Orthopedic Surgeons
- North American Spine Society
- American Association of Neurological Surgeons
- American College of Obstetricians and Gynecologists
- The Society of Maternal-Fetal Medicine
- American Occupational Therapy Association
- American Physical Therapy Association

Clinical Staffing – Multispecialty Expertise

Dedicated nursing and physician specialty teams for a wide range of solutions

- **Anesthesiology**
- **Cardiology**
- **Chiropractic**
- **Emergency Medicine**
- **Family Medicine**
  - Family Medicine / OMT
  - Public Health & General Preventative Medicine
- **Gastroenterology**
- **Internal Medicine**
  - Cardiovascular Disease
  - Critical Care Medicine
  - Endocrinology, Diabetes & Metabolism
  - Geriatric Medicine
  - Hematology
  - Hospice & Palliative Medicine
  - Medical Oncology
  - Pulmonary Disease
  - Rheumatology
  - Sleep Medicine
  - Sports Medicine
- **Medical Genetics**
- **Nuclear Medicine**
- **OB / GYN**
  - Maternal-Fetal Medicine
- **Occupational Therapy**
- **Oncology / Hematology**
- **Orthopedic Surgery**
- **Otolaryngology**
- **Pain Mgmt. / Interventional Pain**
- **Pathology**
  - Clinical Pathology
- **Pediatric**
  - Pediatric Cardiology
  - Pediatric Hematology-Oncology
- **Physical Medicine & Rehabilitation**
  - Pain Medicine
- **Physical Therapy**
- **Radiation Oncology**
- **Radiology**
  - Diagnostic Radiology
  - Neuroradiology
  - Radiation Oncology
  - Vascular & Interventional Radiology
- **Sleep Medicine**
- **Sports Medicine**
- **Surgery**
  - Cardiac
  - General
  - Neurological
  - Spine
  - Thoracic
  - Vascular
- **Urology**

Utilization Management – the Prior Authorization Process



Program Overview

The Health Plan Prior Authorization Services

eviCore healthcare (eviCore) will begin accepting prior authorization requests for physical therapy, occupational therapy, and chiropractic services on December 13,2021 for dates of service January 1, 2022 and after.

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

Providers can reach out to Palladian for questions regarding authorizations with start of care date prior to January 1, 2022

Providers should verify member eligibility and benefits on the secured provider log-in section at: https://myplan.healthplan.org/Account/Login

Applicable Memberships

Prior Authorization is required for The Health Plan members who are enrolled in the following lines of business/programs:

Medicare	• SecureCare HMO, SecureChoice PPO, and Dual Eligible Special Needs plans in West Virginia and Ohio
Medicaid	• Mountain Health Trust, SSI and WV Health Bridge plans
Commercial	• HMO, PPO, POS, and WV PEIA plans

Outpatient Therapy requests for PT and OT and Chiropractic services

- PT/OT - the first 20 combined visits for physical therapy (PT) and occupational therapy (OT) per year **do not require** prior authorization
  - eviCore healthcare will review services for medical necessity and determine authorization status beginning with the 21st combined PT/OT visit
    - Ex. If a member uses their 20 visits related to one body part, and then requires care for another body part, they would require a prior authorization for the 1st visit.
  - eviCore is not responsible for counting visits; if prior authorization is requested, it is assumed the initial 20 visits have been utilized.

- Chiropractic care – the first 20 visits for chiropractic services per event and/or year **do not require** prior authorization
  - eviCore healthcare will complete medical necessity review beginning with the 21st chiropractic visit.
  - All x-rays performed in the chiropractic setting require prior authorization

Therapy corePath: How it Works

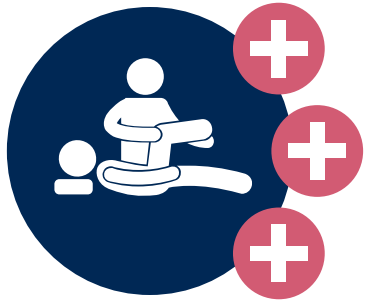
1

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

Prior Authorization Process

corePath

- Simplified approach to clinical collection attempting to reduce administrative efforts for providers.
- “Gets out of the way” of providers who are practicing efficiently and effectively.
- Adds quality measures via inclusion of patient reported functional outcomes.
- Acknowledges complexities that may require a greater frequency or intensity of care.
- Allows therapists to provide additional information for cases that are not “average”.

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.**

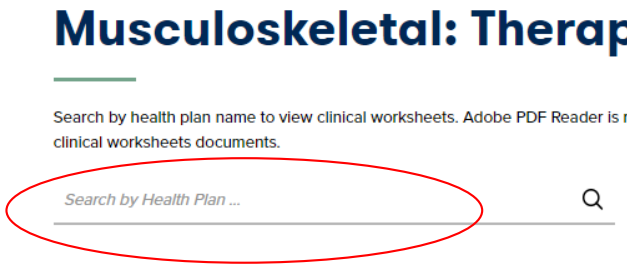
Clinical Worksheets:

Start at www.evicore.com, click on Resources

From the Resources dropdown, select Clinical Worksheets

Select Musculoskeletal: Therapies

Enter Health Plan name in the search field



Choose worksheets for Chiropractic or Physical Therapy and Occupational Therapy care

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Pathway Questions

Questions are included in the pathway to help eviCore create a case correctly

- For example, you may be asked questions about the site (location) of the service.
  - Reason – Prior authorization may not be required for some sites of service.
    - Example – Emergency Department, Inpatient Services.

- Is the care requested following a mastectomy?
  - Should present only when the request is for a cervical or upper extremity condition.
  - Presents for both males and females since mastectomy applies to both.
  - There is a federal mandate related to post-mastectomy care.

Duplicates

- eviCore will approve care by two different providers within the same period only when it is medically necessary.
- Examples – PT and OT for therapy following a CVA; PT treating a knee condition and PT treating a vestibular condition.
- eviCore will not approve care by two providers within the same period if the care is duplicative.
- If a provider submits a request for authorization and there is an existing authorization for the same condition with a different provider, eviCore will reach out to the second provider to ask if the member has discontinued care with their original therapist. If this has occurred, please provide the date of discharge from the original therapist.
- If the condition being treated is the same and the member has not discontinued care with their original provider, the request for duplicate care will be denied.

Treating Multiple Conditions

- If you are treating multiple conditions within the same period, there is no need to request authorization for treatment for each condition.

- The authorization covers all conditions treated within the same period of time.

- If you are treating more than 1 condition, advise eviCore to ensure adequate units are approved.
  - When submitting by the web, you will be asked if you are treating a second condition.
    - Answer = Yes; report information specific to the second condition
  - When requesting authorization over the phone, inform the agent that you are requesting authorization for two conditions
  - If submitting by fax, complete clinical worksheets for both conditions

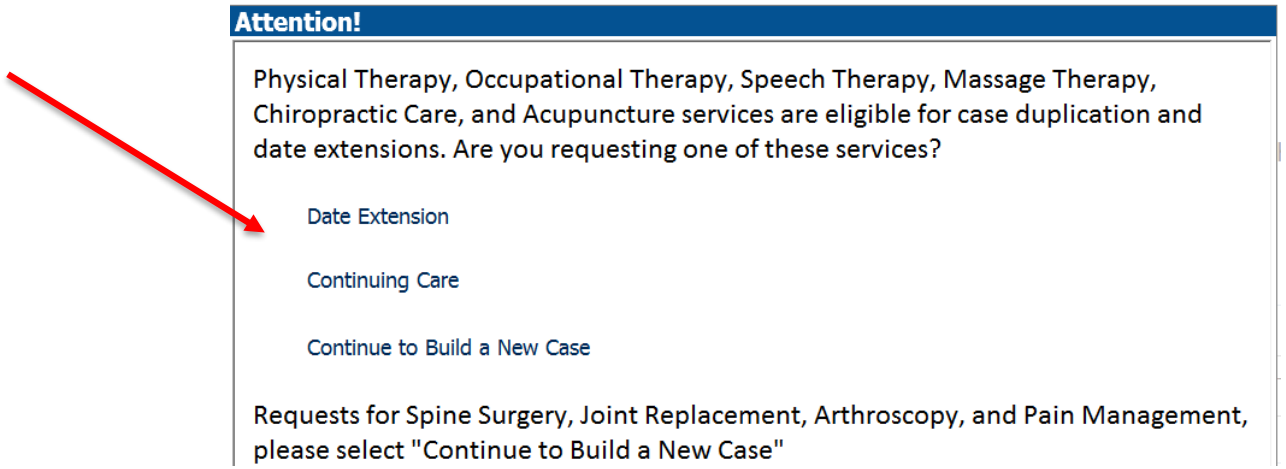
Date Extensions

Date extensions are available if you are unable to use all units 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

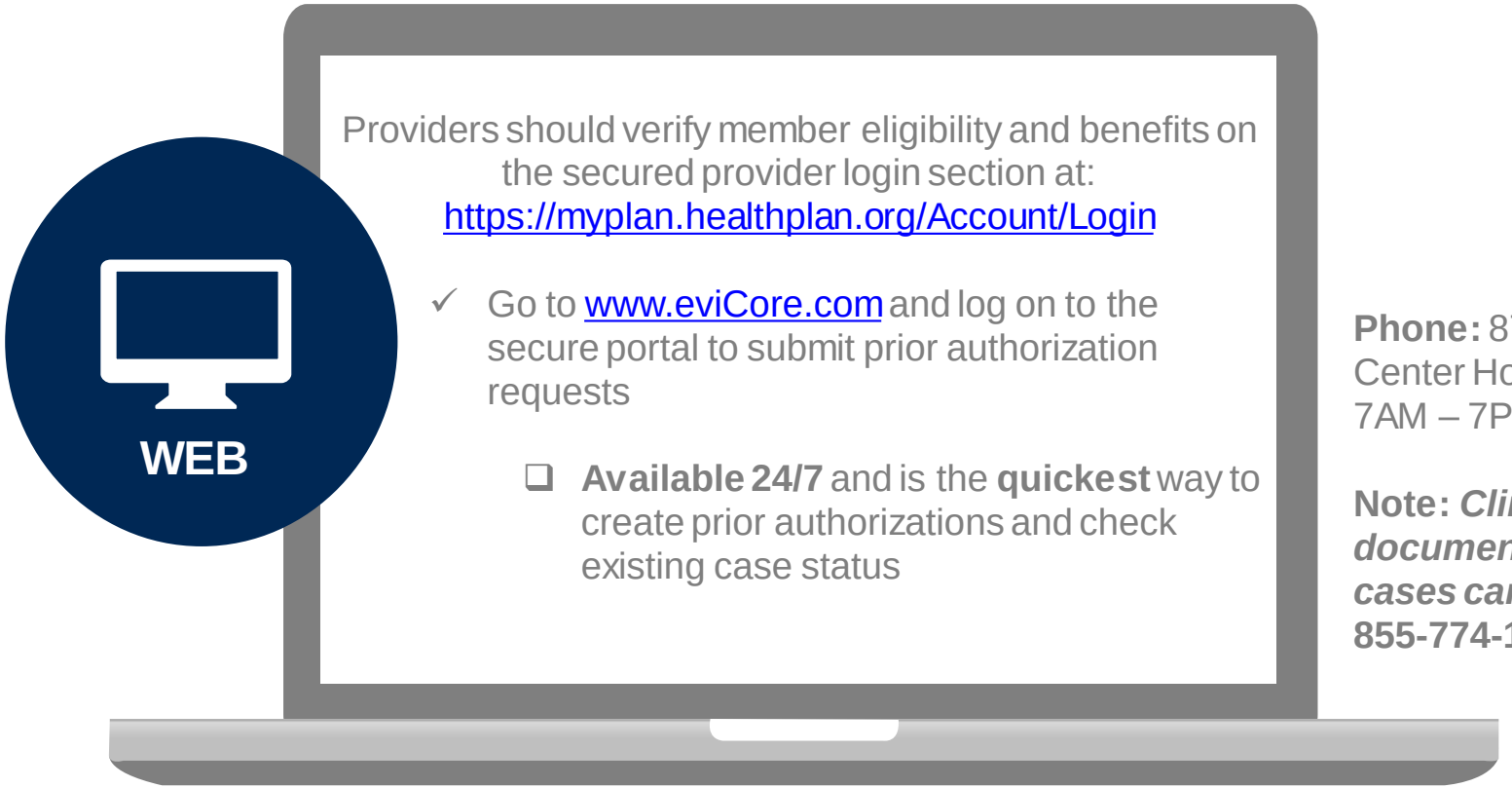
Available

- By phone 877.791.4104
- Online - log on to the CareCore National portal at www.eviCore.com



Submitting Requests

Methods for Authorization Requests



Phone: 877.791.4104 Call Center Hours:
7AM – 7PM Monday – Friday

Note: ***Clinical documentation for existing cases can be faxed to*** **855-774-1319**

Important: *Providers will access eviCore web portal directly through eviCore.com - However we recommend you go to THP's website to ensure redirection to eviCore for the appropriate CPT Code(s)*

Benefits of Provider Portal

Did you know that most providers are already saving time submitting prior authorization requests online? The provider portal allows you to go from request to approval faster. Following are some benefits & features:

- Saves time: Quicker process than phone authorization requests
- Available 24/7: You can access the portal any time and any day
- Save your progress: If you need to step away, you can save your progress and resume later
- Upload additional clinical information: No need to fax in supporting clinical documentation, it can be uploaded on the portal to support a new request or when additional information is requested
- View and print determination information: Check case status in real-time
- Dashboard: View all recently submitted cases
- Duplication feature: If you are submitting more than one prior authorization request, you can duplicate information to expedite submittals

Keys to Successful Prior Authorizations

To obtain prior authorization on the very first submission, the provider submitting the request will need to gather four categories of information:

1. Member
- ID
- Member name
- Date of birth (DOB)

2. Referring (Ordering) Physician
- Physician name
- National provider identifier (NPI)
- Phone & fax number

3. Rendering Facility
- Facility name
- Address
- National provider identifier (NPI)
- Tax identification number (TIN)
- Phone & fax number

4. Supporting Clinical
- Pertinent clinical information to substantiate medical necessity for the requested service
- CPT/HCPCS Code(s)
- Diagnosis Code(s)
- Previous test results

Insufficient Clinical – Additional Documentation Needed

Additional Documentation to Support Medical Necessity

If all required pieces of documentation are not received, or are insufficient for eviCore to reach a determination, the following will occur:

A Hold Letter will be faxed to the Requesting Provider requesting additional documentation	The Provider must submit the additional information to eviCore	eviCore will review the additional documentation and reach a determination
To ensure that a determination is completed within the designated standard timeframe for each LOB, the case will remain on hold as follows: • Medicare: 1 days • Medicaid: 4 days • Commercial: 3 days	Requested information must be received within the timeframe as specified in the Hold Letter.	Determination will be completed within 14 calendar days

Prior Authorization Outcomes & Special Considerations

Prior Authorization Approval

Approved Requests

- Each case is reviewed in the order that it was received, and are typically handled within 2 business days from the receipt of relevant clinical information and will not exceed 10 calendar days for OH COM, not to exceed 7 calendar days for WV COM, not to exceed 14 calendar days for Medicare, and not to exceed 7 calendar days for Medicaid
- Authorizations are valid for 90 days from the date of the submission
- Authorization letters will be faxed to the ordering physician & rendering facility
- When initiating a case on the web you can receive e-notifications when a determination is made
- Members will receive a letter by mail
- Approval information can be printed on demand from the eviCore portal: www.eviCore.com

When a Request is Determined as Inappropriate

Based on evidence-based guidelines, request is determined as **inappropriate**.

A denial letter with the rationale for the decision and the appeal rights will be issued to both the provider and member.

Special Circumstances

Retrospective (Retro) Authorization Requests

Retrospective Requests are only allowed when a study had to be performed on an urgent basis, on a holiday or over a weekend (notification to eviCore within 2 business days from date of service); All other retro requests will be directed to The Health Plan

Urgent Prior Authorization Requests

- eviCore uses the NCQA/URAC definition of **urgent**: when a delay in decision-making may seriously jeopardize the life or health of the member
- Can be initiated on provider portal or by phone
- Urgent cases are typically reviewed within 24 to 72 hours

Reconsideration Options

Post-Decision Options

My case has been denied. What's next?

- Providers are often able to utilize post-decision activity to secure case review for overturn consideration

- Your determination letter is the best immediate source of information to assess what options exist on a case that has been denied. You can also call us at 877.791.4104 to speak to an agent who can provide available option(s) and instruction on how to proceed.

Post-Decision Options: Commercial and Medicaid Members

My case has been denied. What's next?

Reconsiderations

- Providers and/or staff can request a reconsideration review
- Reconsiderations must be requested within 14 calendar days for WV COM and Medicaid, and 7 calendar days for OH COM, from date of determination
- Reconsiderations can be requested via a Clinical Consultation with an eviCore physician

Appeals

- eviCore will process first-level appeals for Commercial and Medicaid requests
- Appeal requests must be submitted to eviCore within 60 calendar days from the initial determination
- Appeal requests can be submitted in writing or verbally
- All clinical information and the prior authorization request will be reviewed by a physician other than the physician who made the initial determination
- A written notice of the appeal decision will be mailed to the member and faxed to the ordering provider

Pre-Decision Options: Medicare Members

I've received a request for additional clinical information. What's next?

Submission of Additional Clinical Information

- eviCore will notify providers telephonically and in writing before a denial decision is issued on Medicare cases
- You can submit additional clinical information to eviCore for consideration per the instructions received
- Additional clinical information must be submitted to eviCore in advance of the due date referenced

Pre-Decision Clinical Consultation

- Providers can choose to request a Pre-Decision Clinical Consultation instead of submitting additional clinical information
- The Pre-Decision Clinical Consultation must occur prior to the due date referenced
- If additional information was submitted, we proceed with our determination and are not obligated to hold the case for a Pre-Decision Clinical Consultation, even if the due date has not yet lapsed

Post-Decision Options: Medicare Members

My case has been denied. What's next?

Clinical Consultation

- Providers can request a Clinical Consultation with an eviCore physician to better understand the reason for denial
- Once a denial decision has been made, however, the decision cannot be overturned via Clinical Consultation

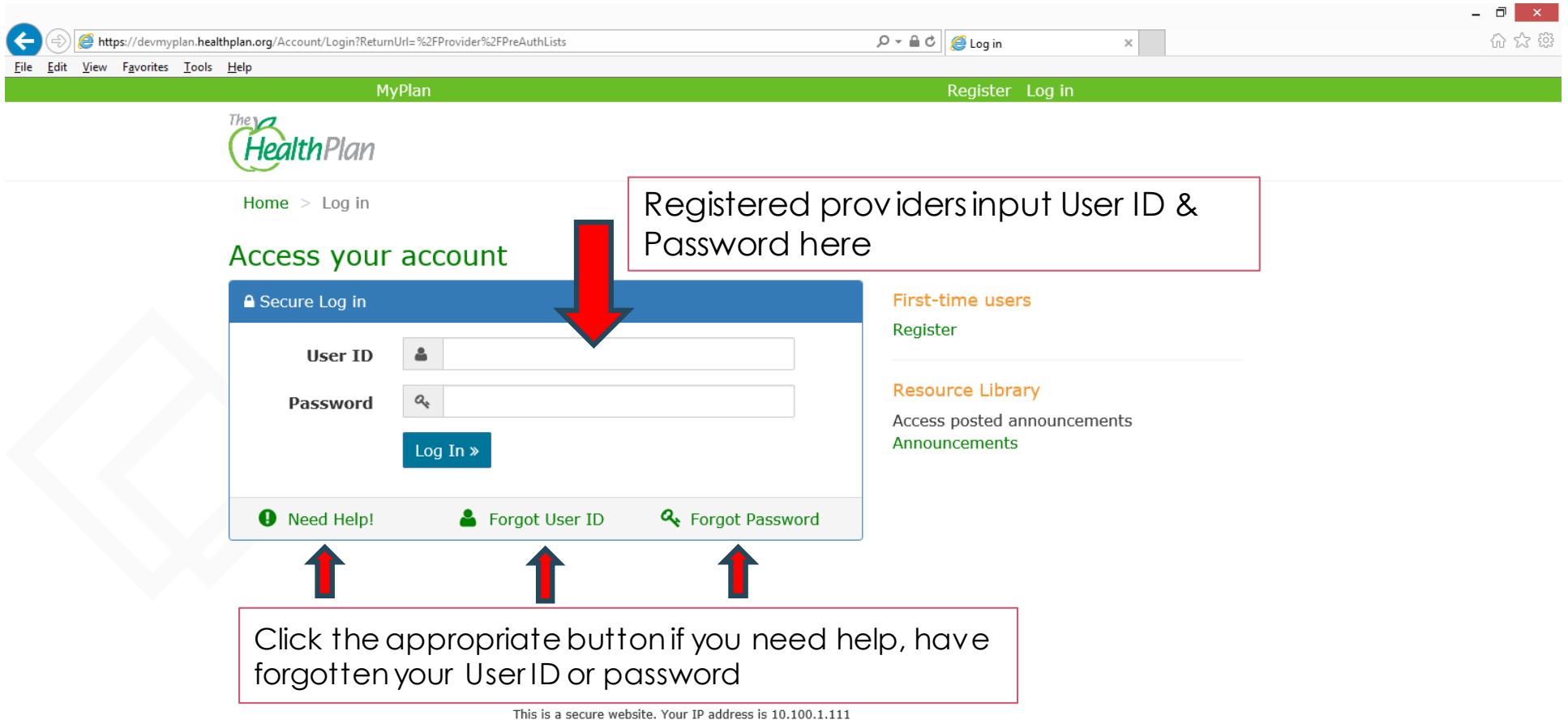
Reconsideration

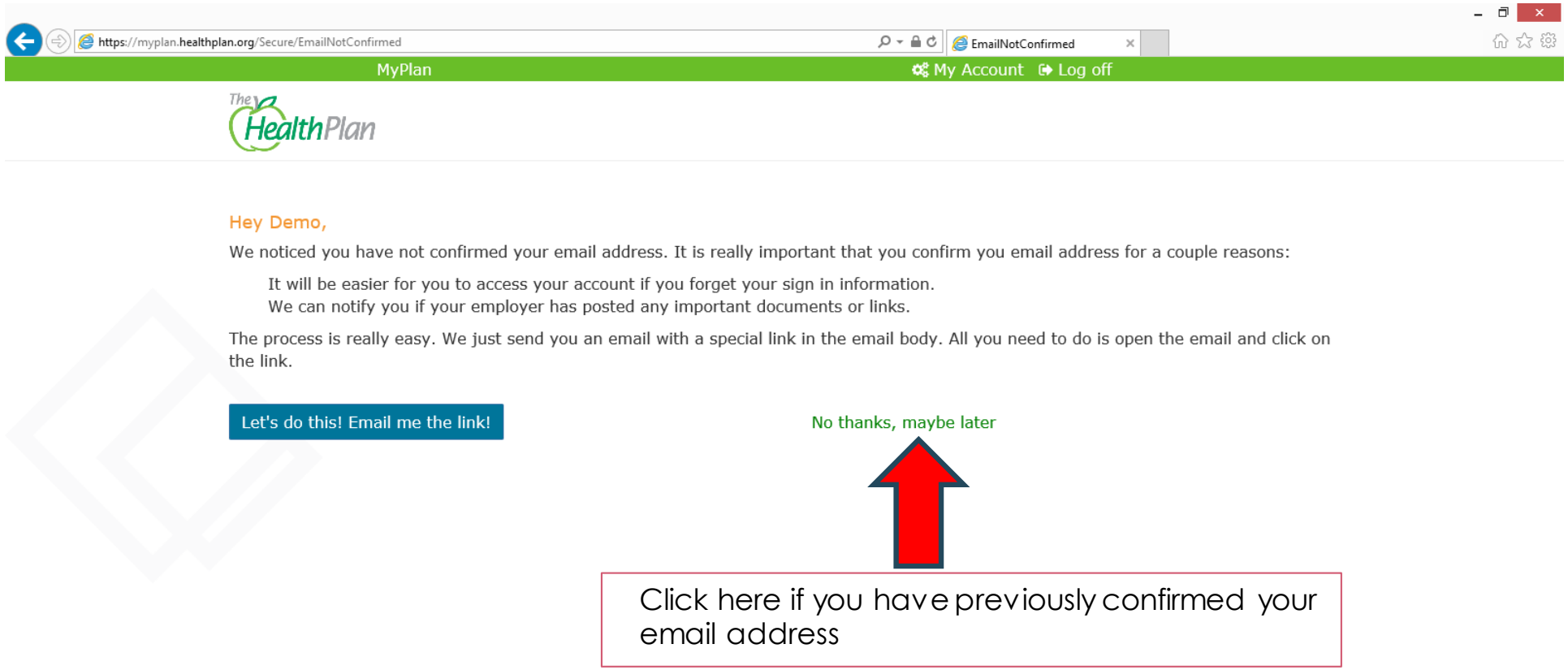
- Medicare cases do not include a Reconsideration option

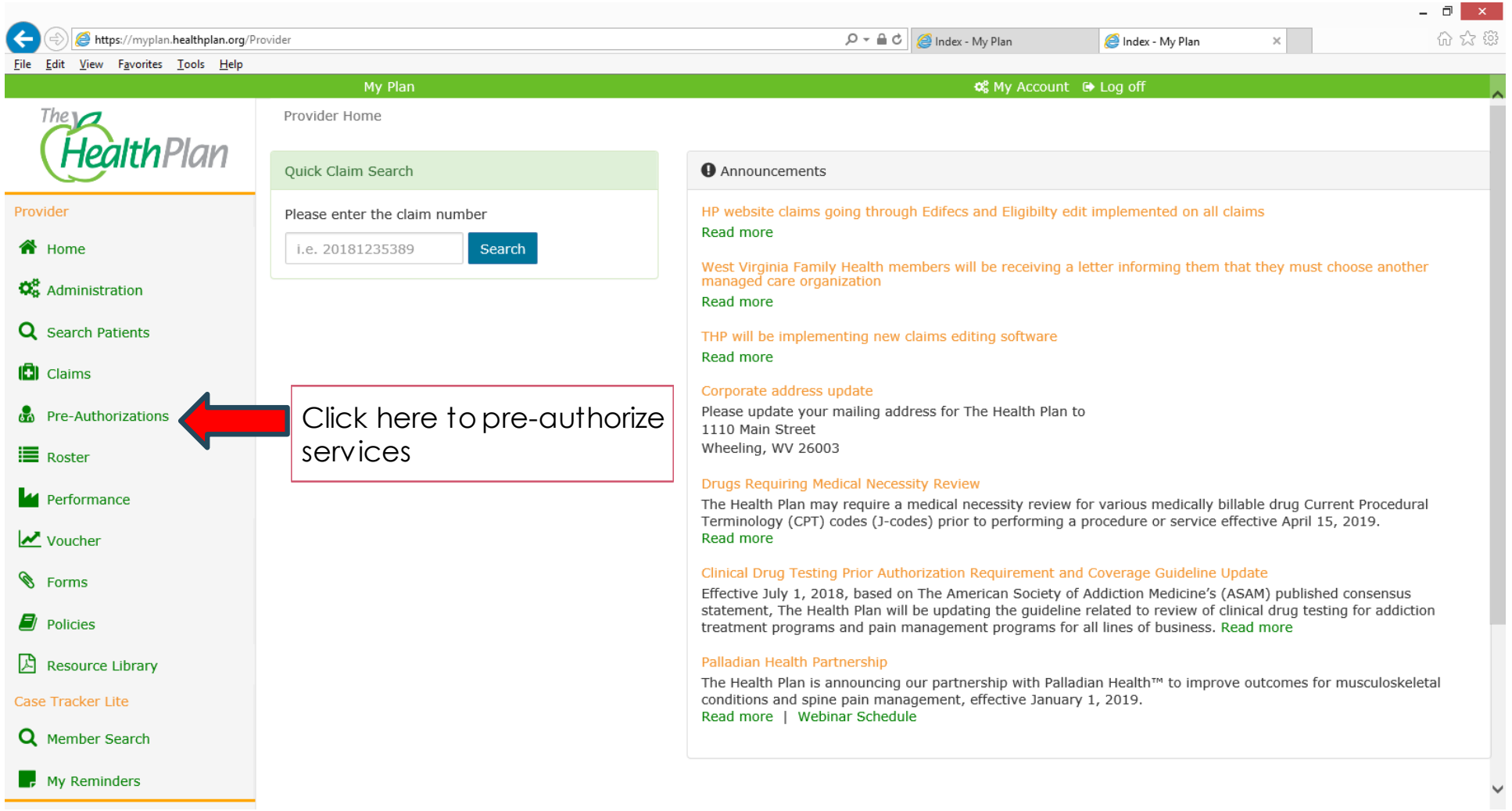
Appeals

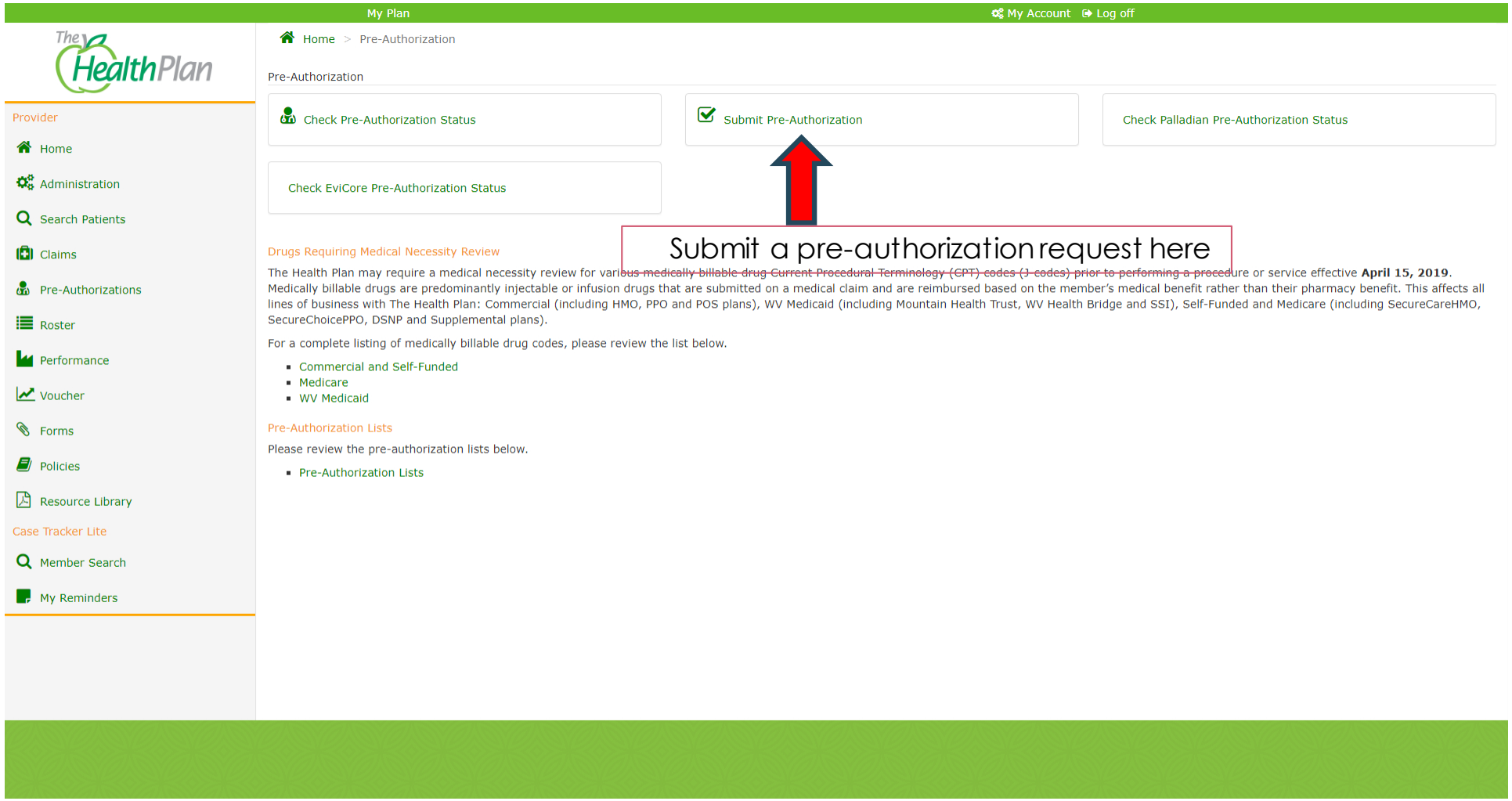
- eviCore will not process first-level appeals
- Information on how to initiate an appeal with The Health Plan will be outlined on the denial notification letter

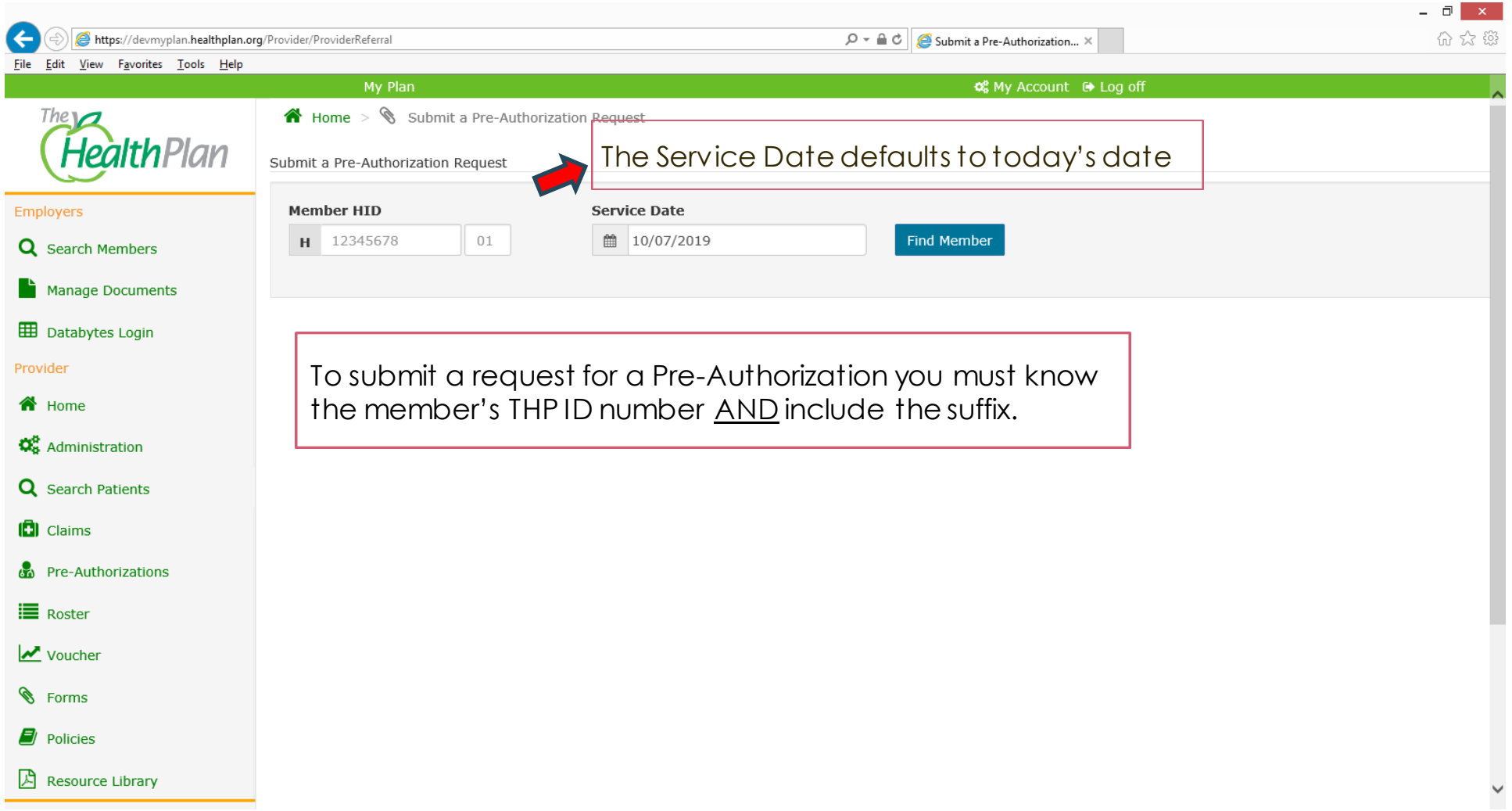
Provider Portal Overview

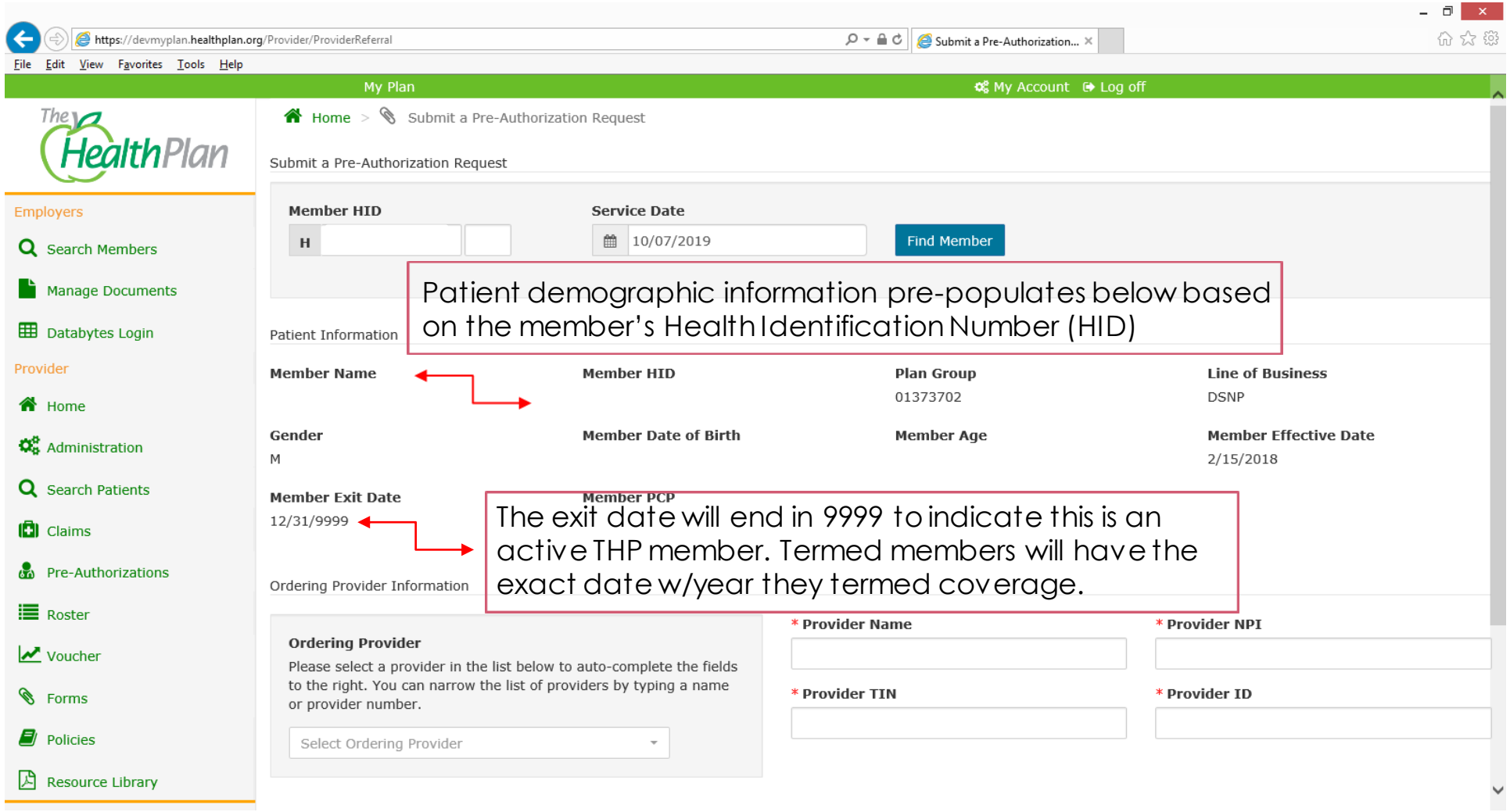


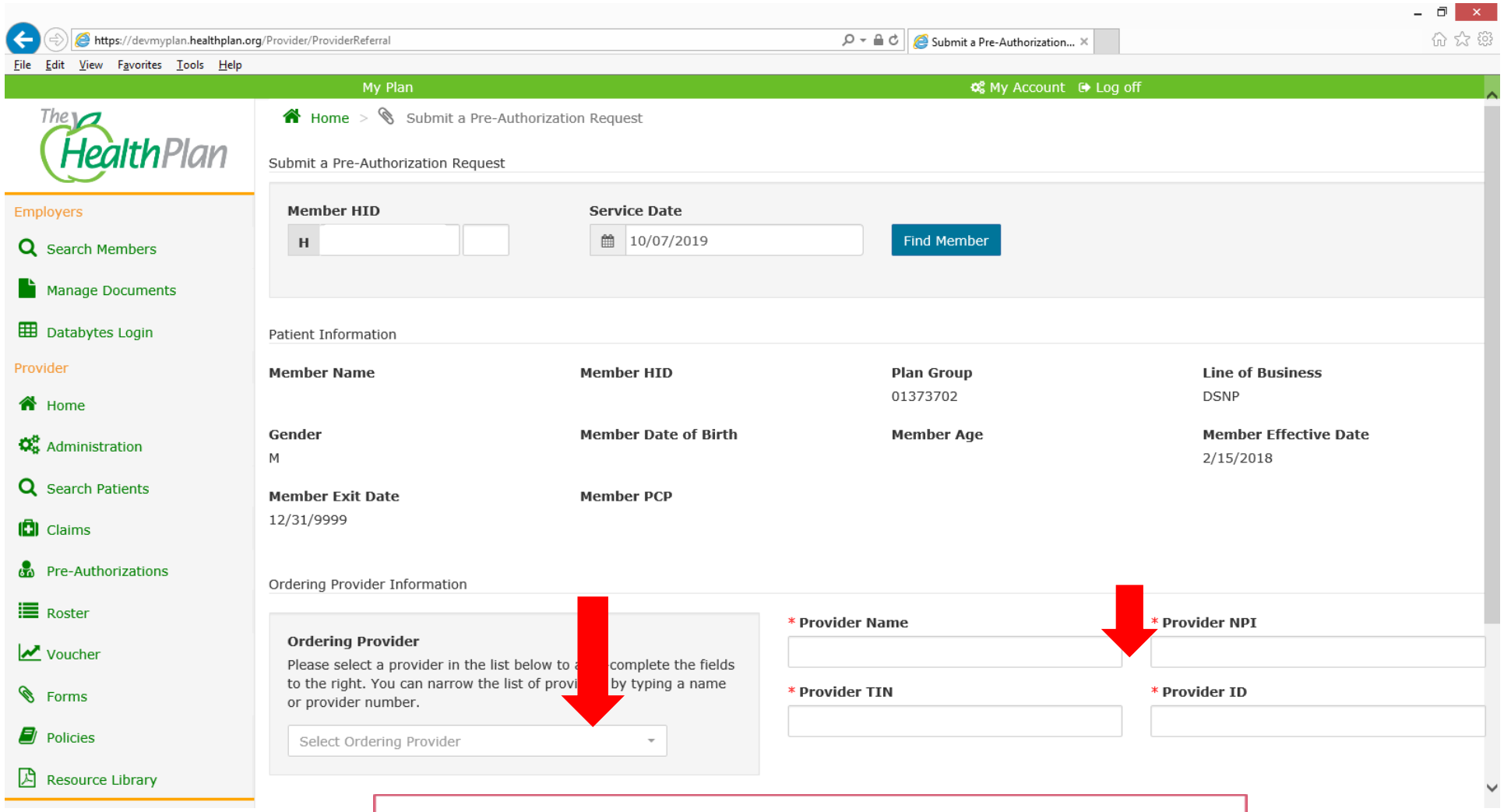




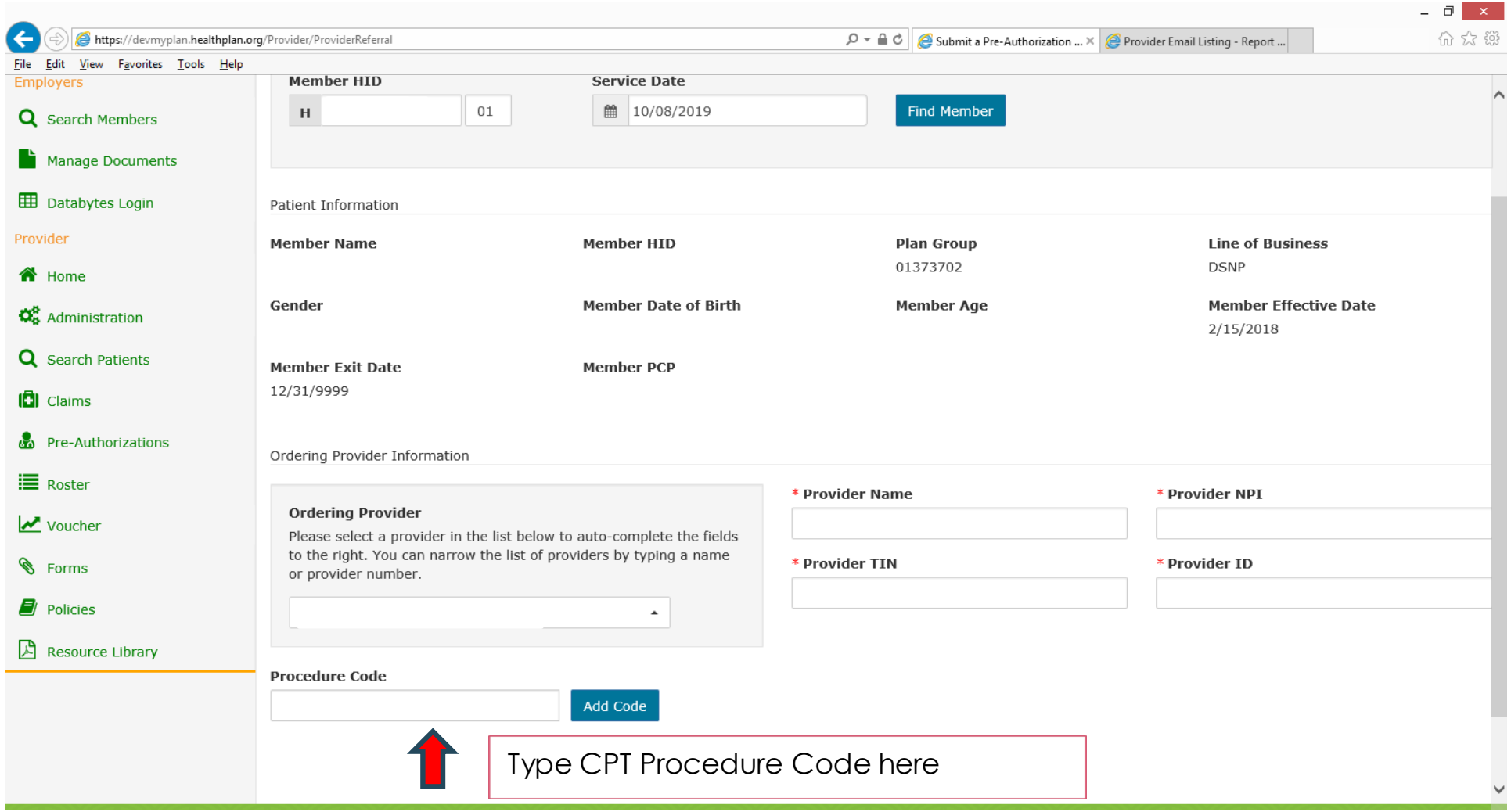


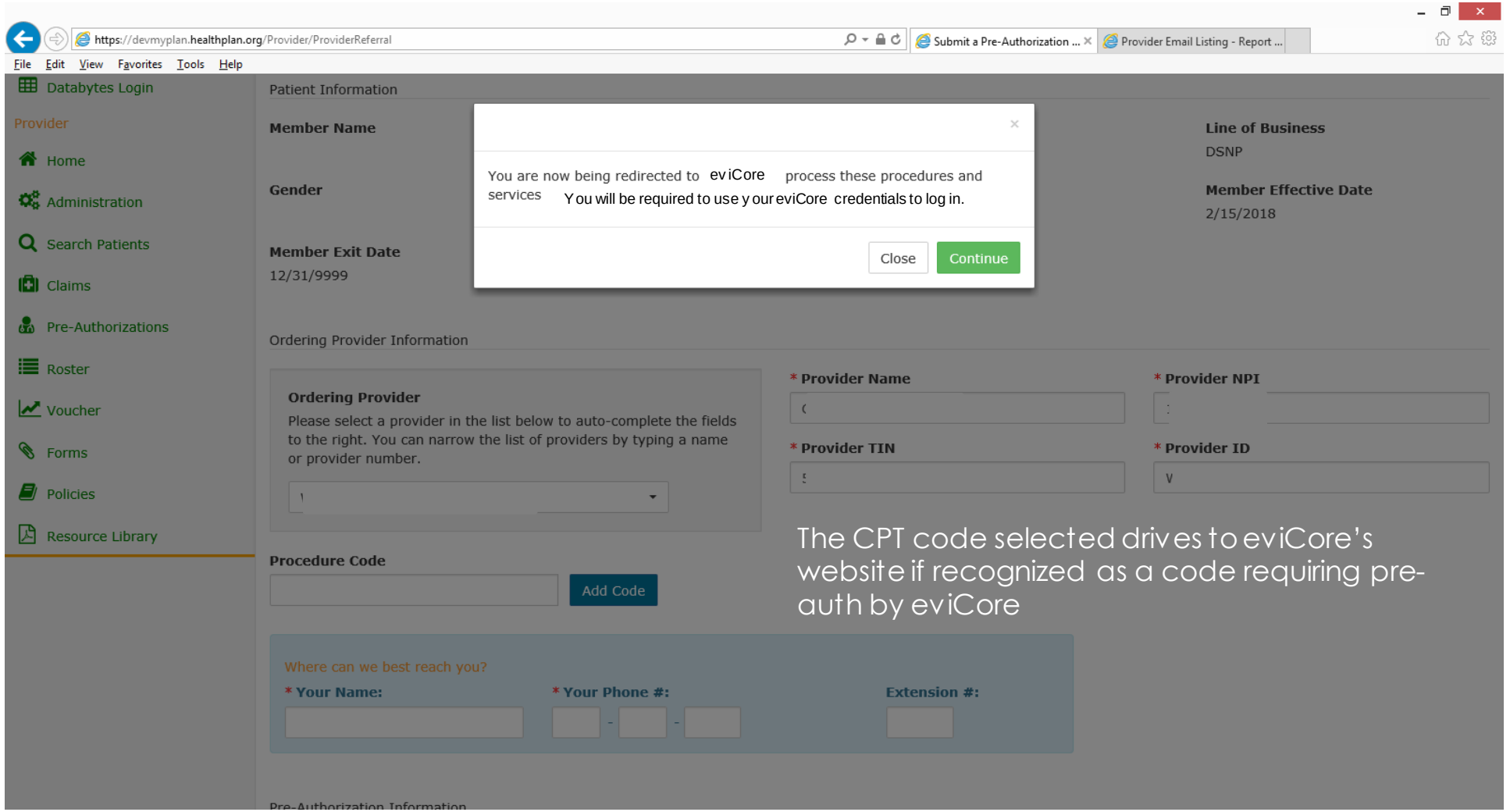




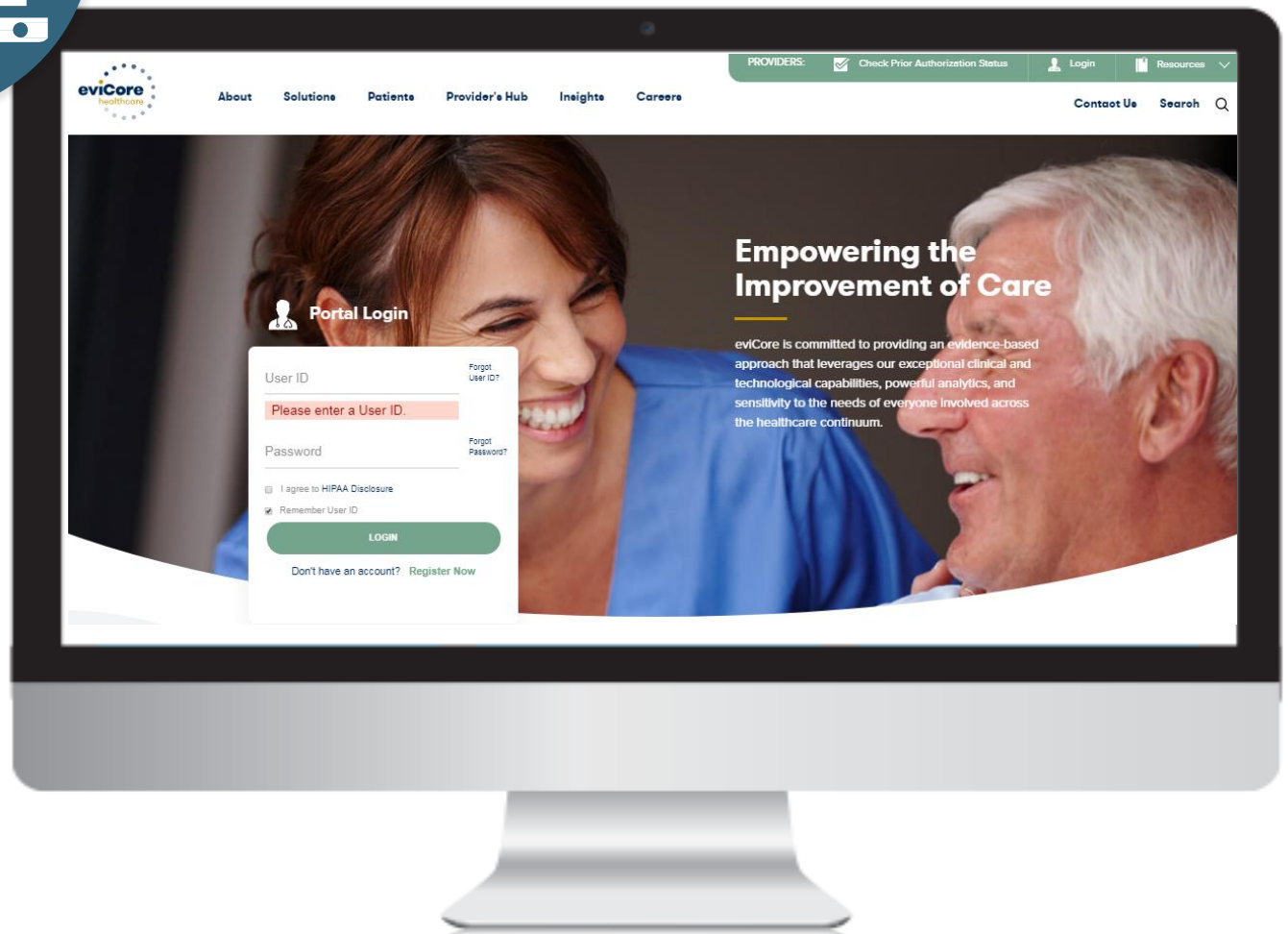


Provider demographics pre-populates upon selecting the Ordering Provider from the drop down box





Redirection to eviCore's Provider Web Portal – You will need to log in using your eviCore User ID and Password



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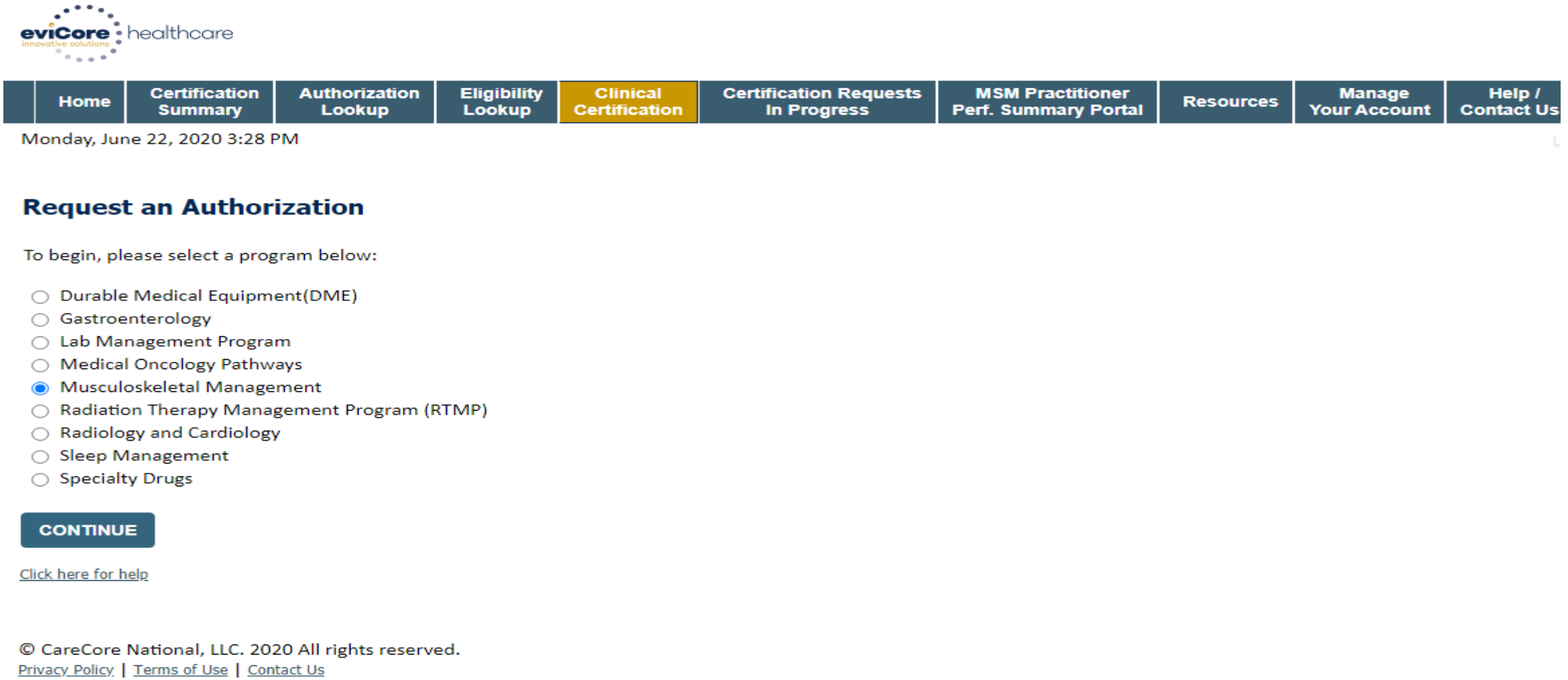
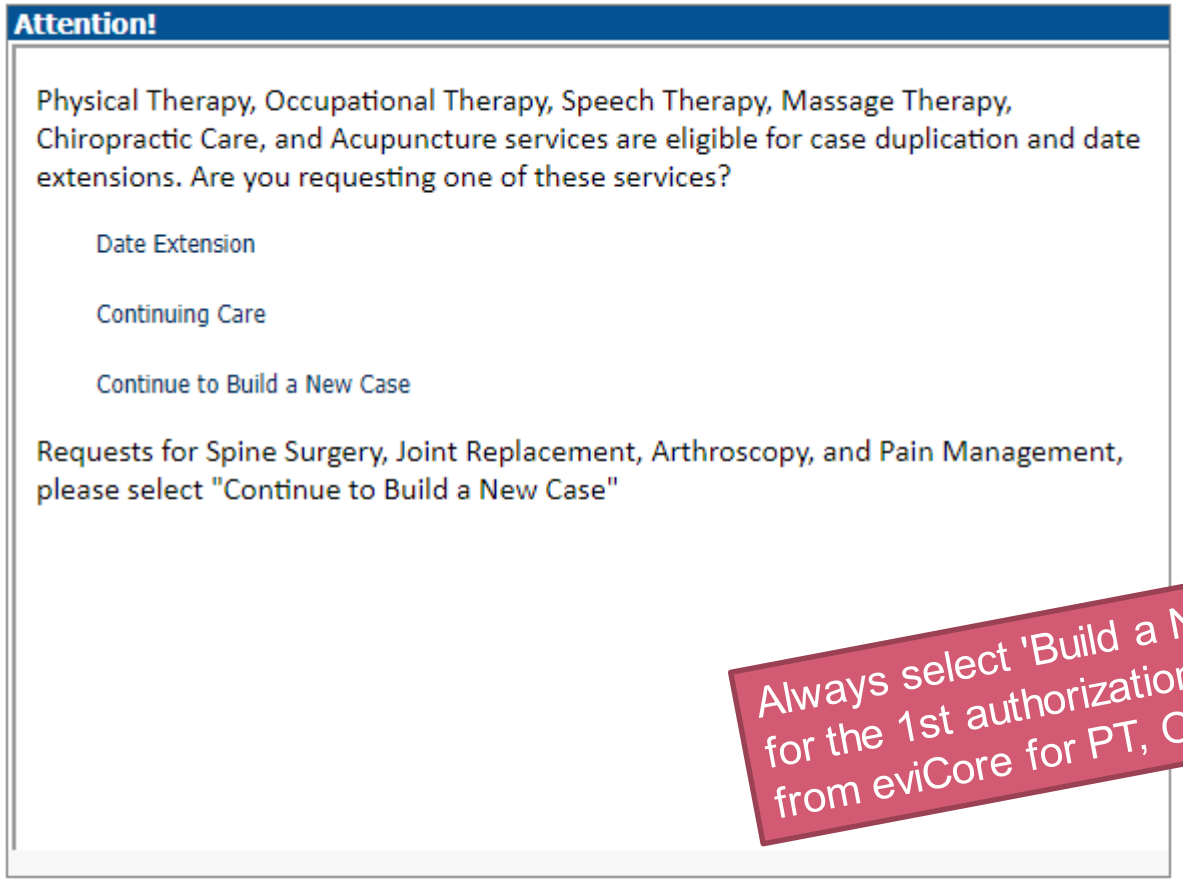
Select Program

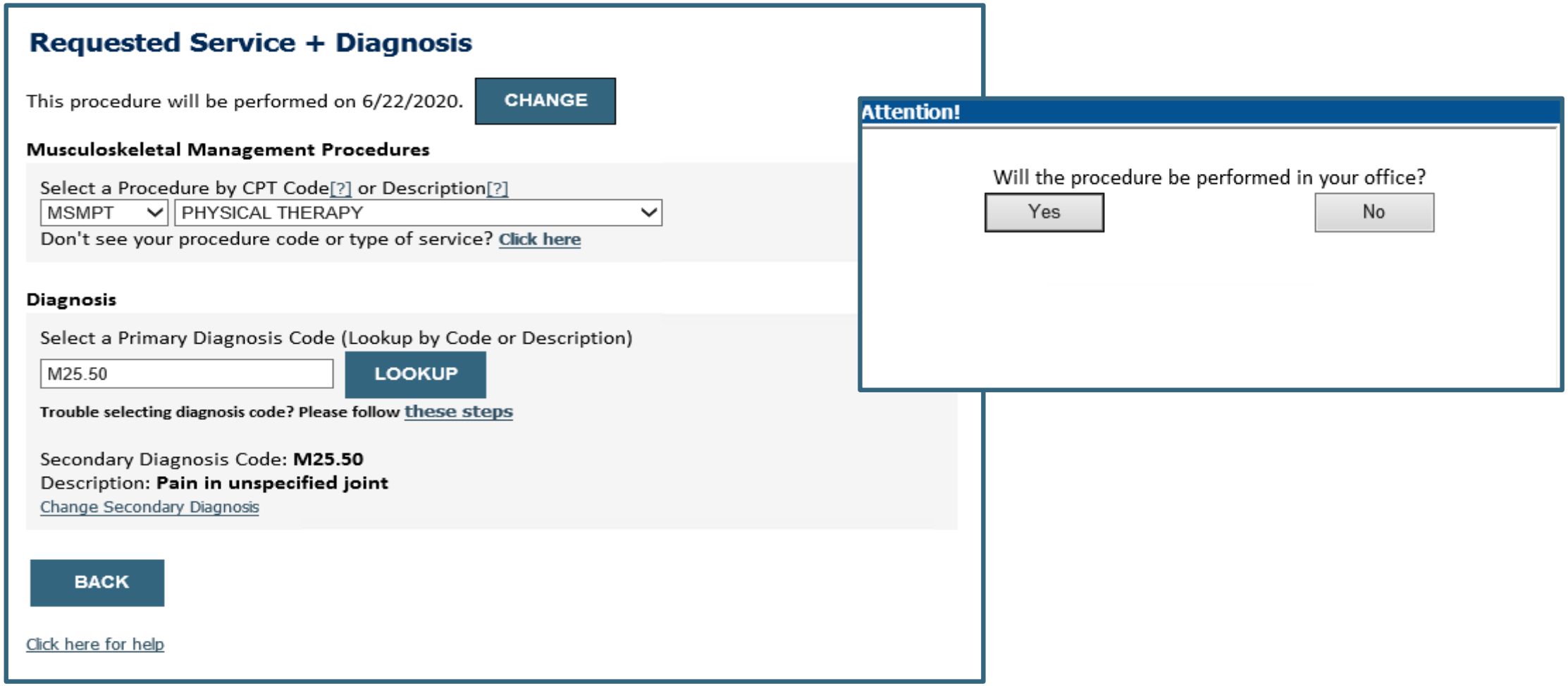


Type of Request



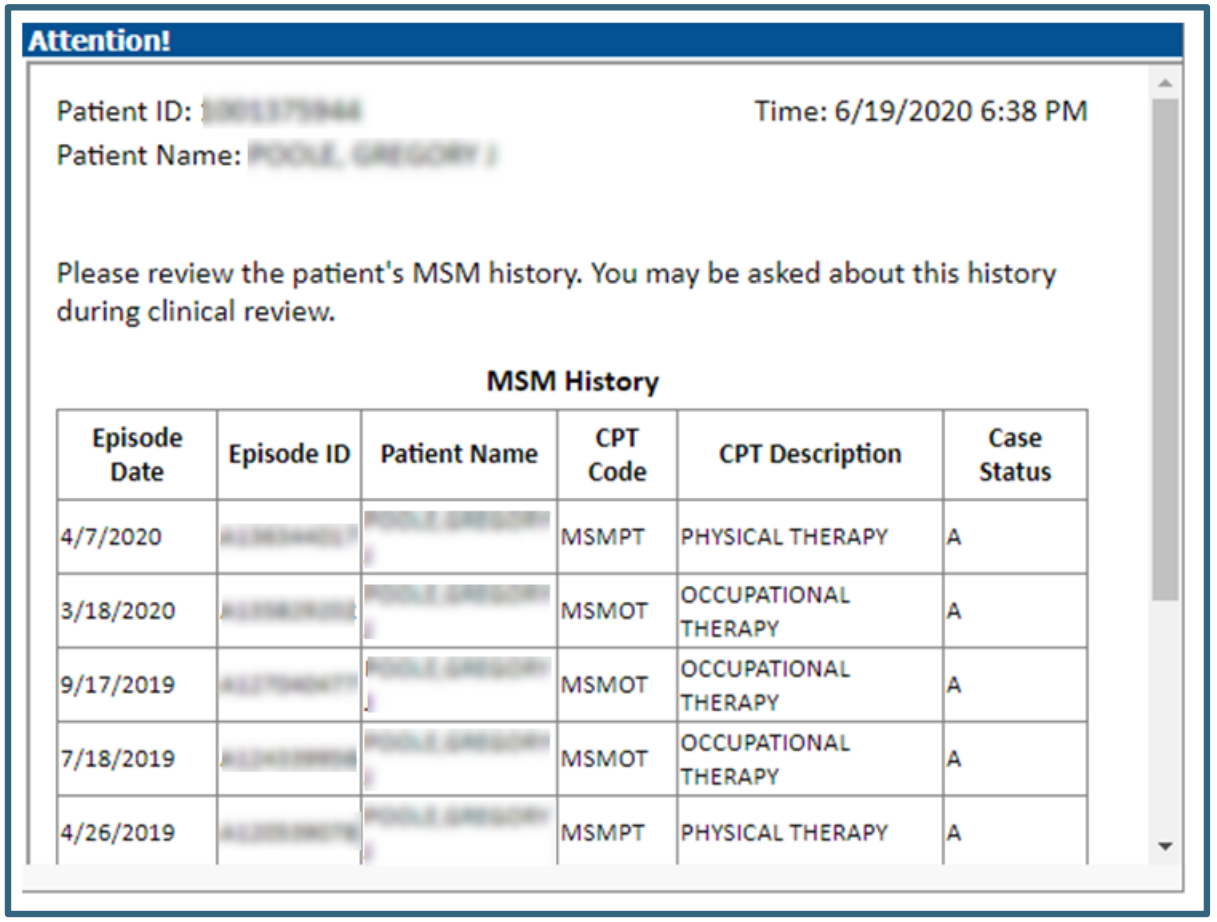
Always select 'Build a New Case' for the 1st authorization request from eviCore for PT, OT or Chiro

Request Information



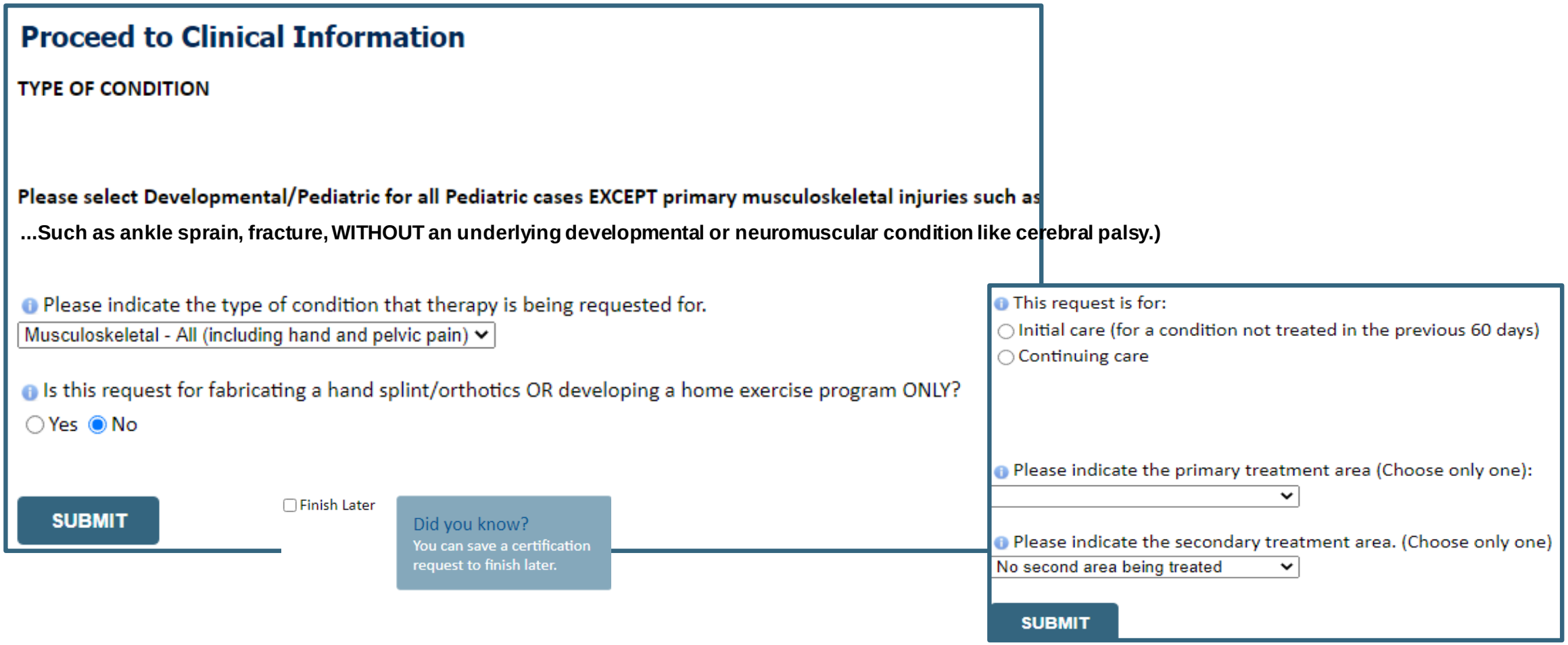
- Next you can enter CPT code (MSMPT, MSMOT, or CHIRO)
- Also add diagnosis code(s)
- Note: Place of service vary depending on health plan rules.

Verify Service Selection



- 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

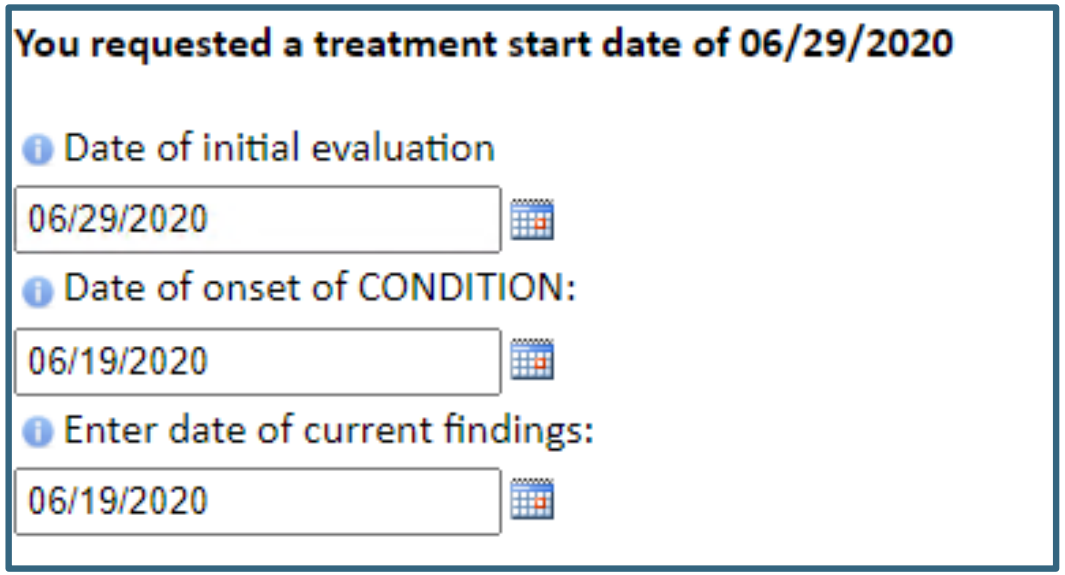
Clinical Information – Example of Questions



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

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.

Clinical Certification – Case Summary – Medical Review

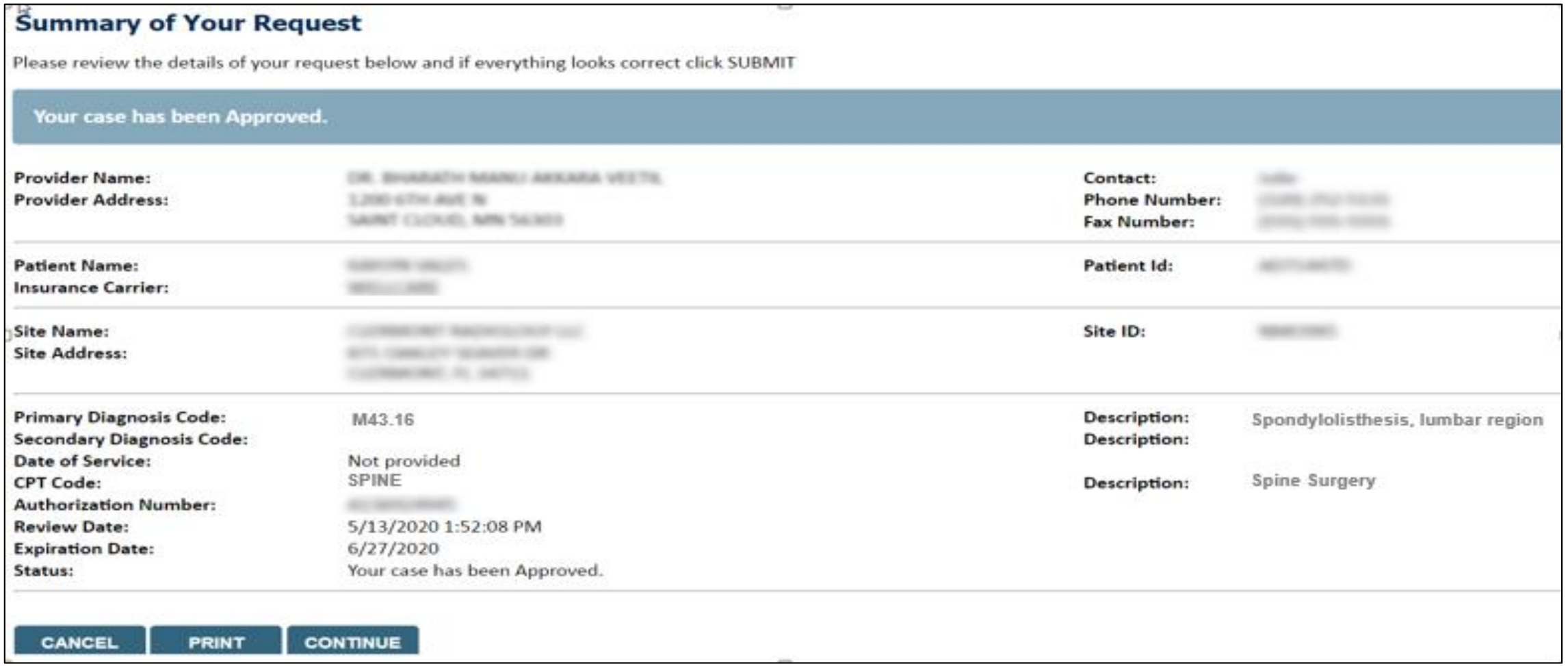
Summary of Your Request

Please review the details of your request below and if everything looks correct click SUBMIT

Your case has been sent to clinical review. You will be notified via fax within 2 business days if additional clinical information is needed. If you wish to speak with eviCore at anytime, please call 1-888-333-8641.

Provider Name:	[redacted]	**Contact:**	[redacted]
Provider Address:	[redacted]	**Phone Number:**	[redacted]
		Fax Number:	[redacted]
Patient Name:	[redacted]	**Patient Id:**	[redacted]
Insurance Carrier:	[redacted]		
Site Name:	[redacted]	**Site ID:**	[redacted]
Site Address:	[redacted]		
Primary Diagnosis Code:	[redacted]	**Description:**	Other cervical disc displacement, unspecified cervical region
Secondary Diagnosis Code:		**Description:**	
Date of Service:	[redacted]		
CPT Code:	[redacted]	**Description:**	Spine Surgery
Case Number:	[redacted]		
Review Date:	5/13/2020 2:36:00 PM		
Expiration Date:	N/A		
Status:	Your case has been sent to clinical review. You will be notified via fax within 2 business days if additional clinical information is needed. If you wish to speak with eviCore at anytime, please call 1-888-333-8641.		

Clinical Certification – Case Summary - Approval



Summary of Your Request

Please review the details of your request below and if everything looks correct click SUBMIT

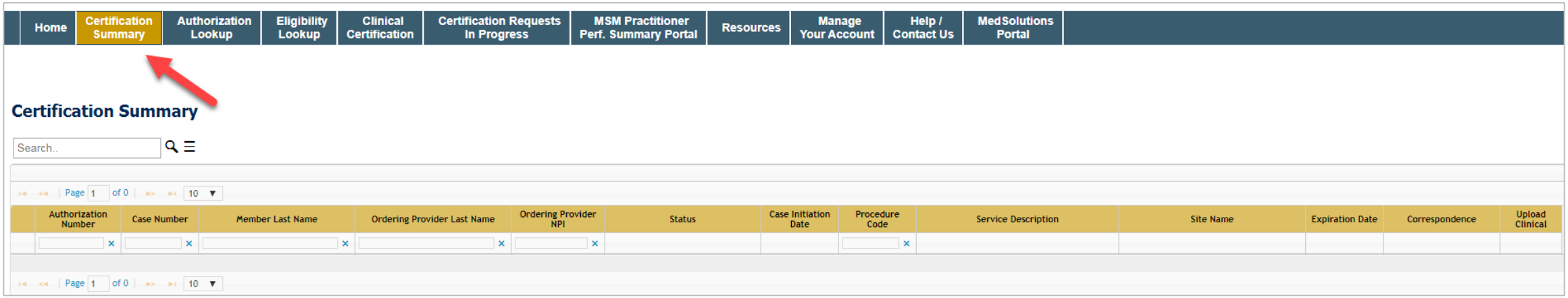
Your case has been Approved.

Provider Name:	[redacted]	**Contact:**	[redacted]
Provider Address:	[redacted]	**Phone Number:**	[redacted]
		Fax Number:	[redacted]
Patient Name:	[redacted]	**Patient Id:**	[redacted]
Insurance Carrier:	[redacted]		
Site Name:	[redacted]	**Site ID:**	[redacted]
Site Address:	[redacted]		
Primary Diagnosis Code:	M43.16	**Description:**	Spondylolisthesis, lumbar region
Secondary Diagnosis Code:		**Description:**	
Date of Service:	Not provided		
CPT Code:	SPINE	**Description:**	Spine Surgery
Authorization Number:	[redacted]		
Review Date:	5/13/2020 1:52:08 PM		
Expiration Date:	6/27/2020		
Status:	Your case has been Approved.		

CANCEL PRINT CONTINUE

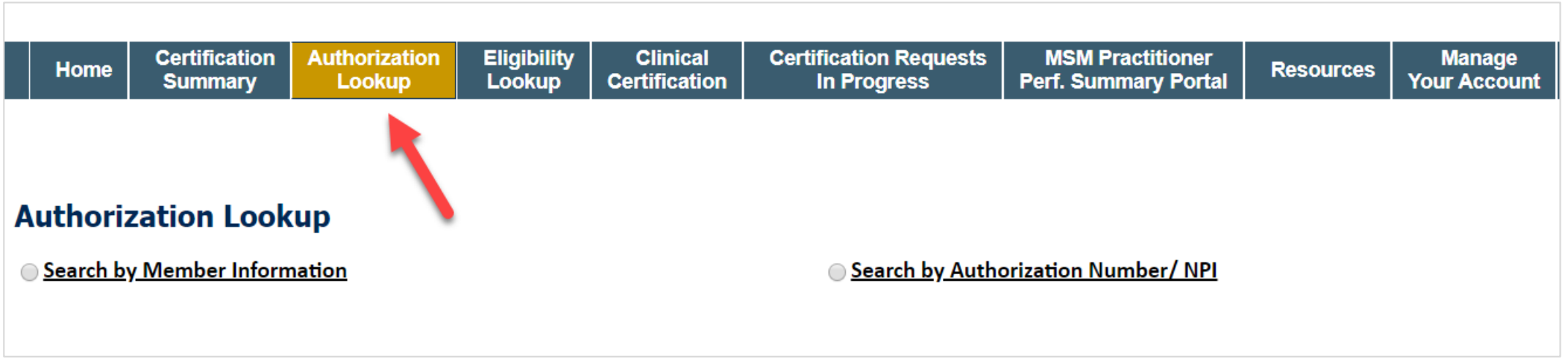
Additional Provider Portal Features

Certification Summary



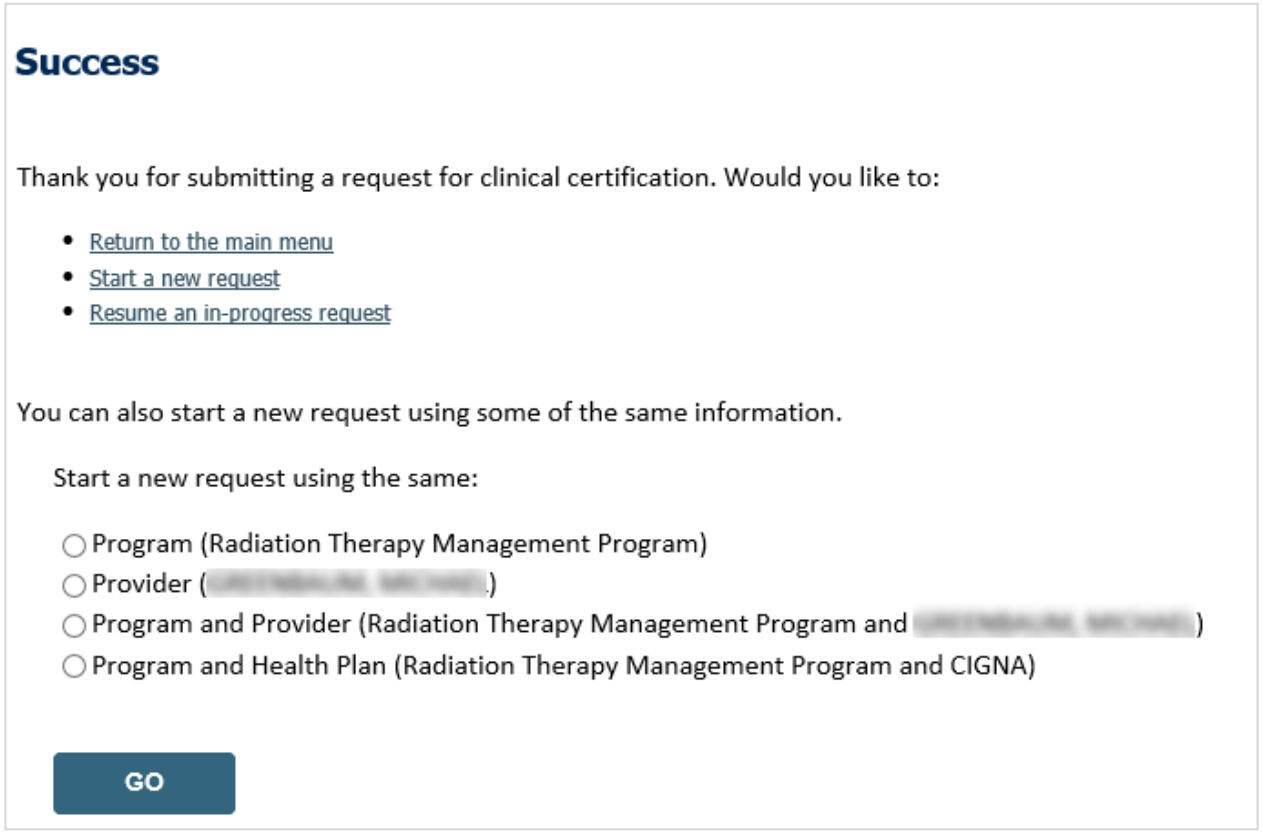
- Certification Summary tab allows you to track recently submitted cases
- The work list can also be filtered

Authorization Lookup



- You can look-up authorization status on the portal
- Search by member information OR
- Search by authorization number with ordering NPI
- View and print any correspondence

Duplication Feature



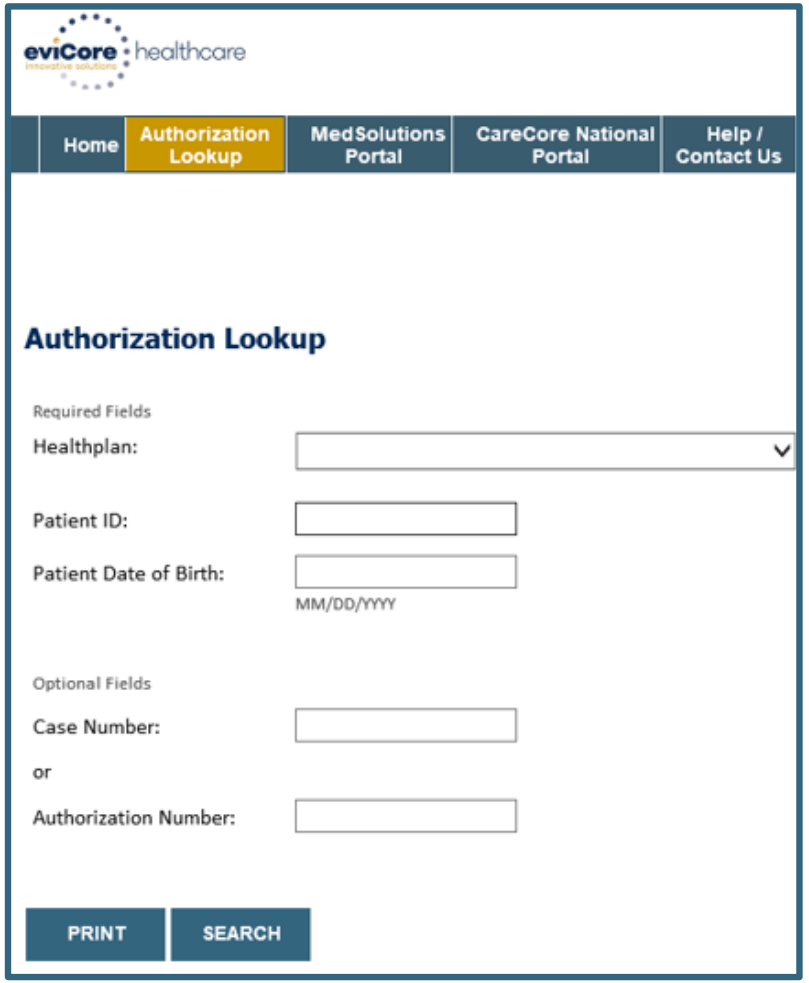
- Duplicate feature allows you to start a new request using same information
- Eliminates entering duplicate information
- Time saver!

Additional Provider Portal Features

Reconsideration Process and How to Schedule a Peer to Peer using the Online Self-Scheduling Tool

eviCore Reconsideration Review Process on the Web

- Select “Auth Lookup”, health plan and enter the patient information



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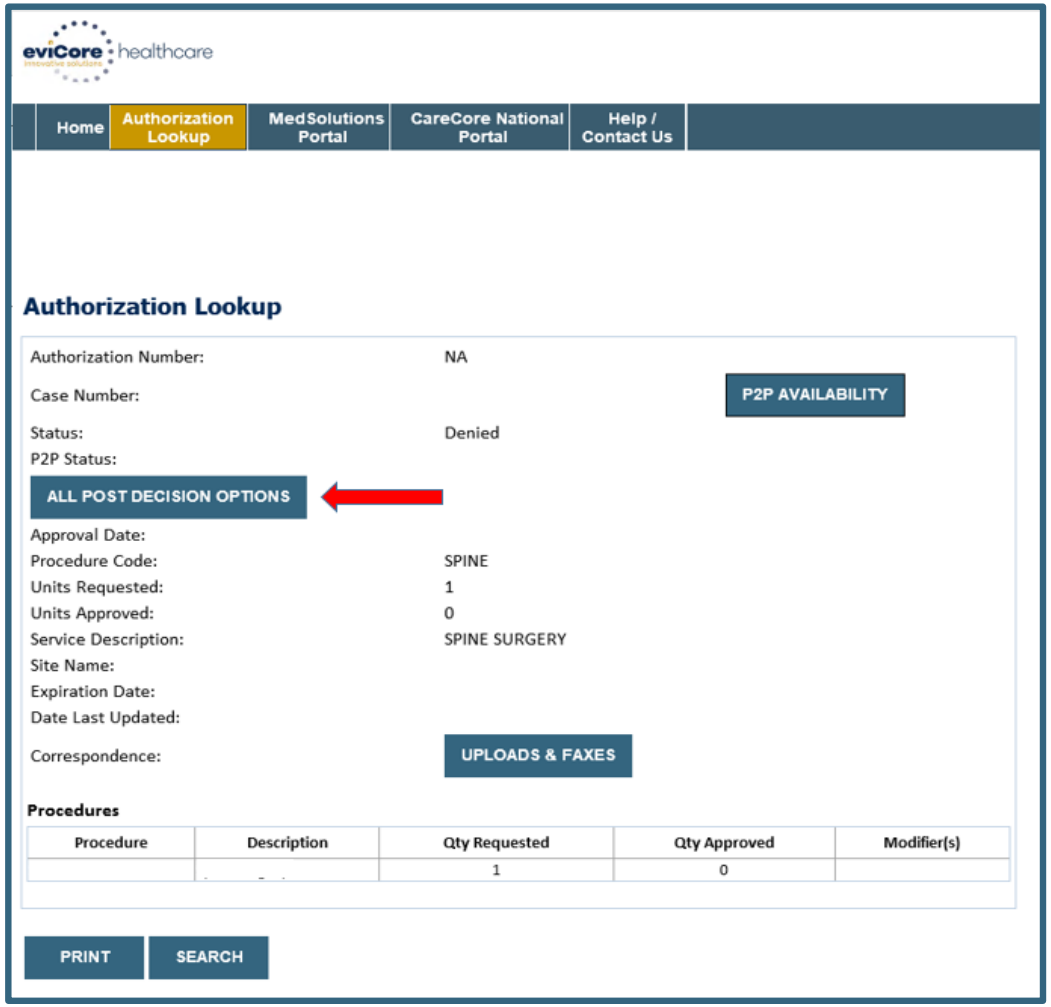
eviCore Reconsideration Review Process on the Web (cont.)

- Select “All Post Decision Options” to view available options



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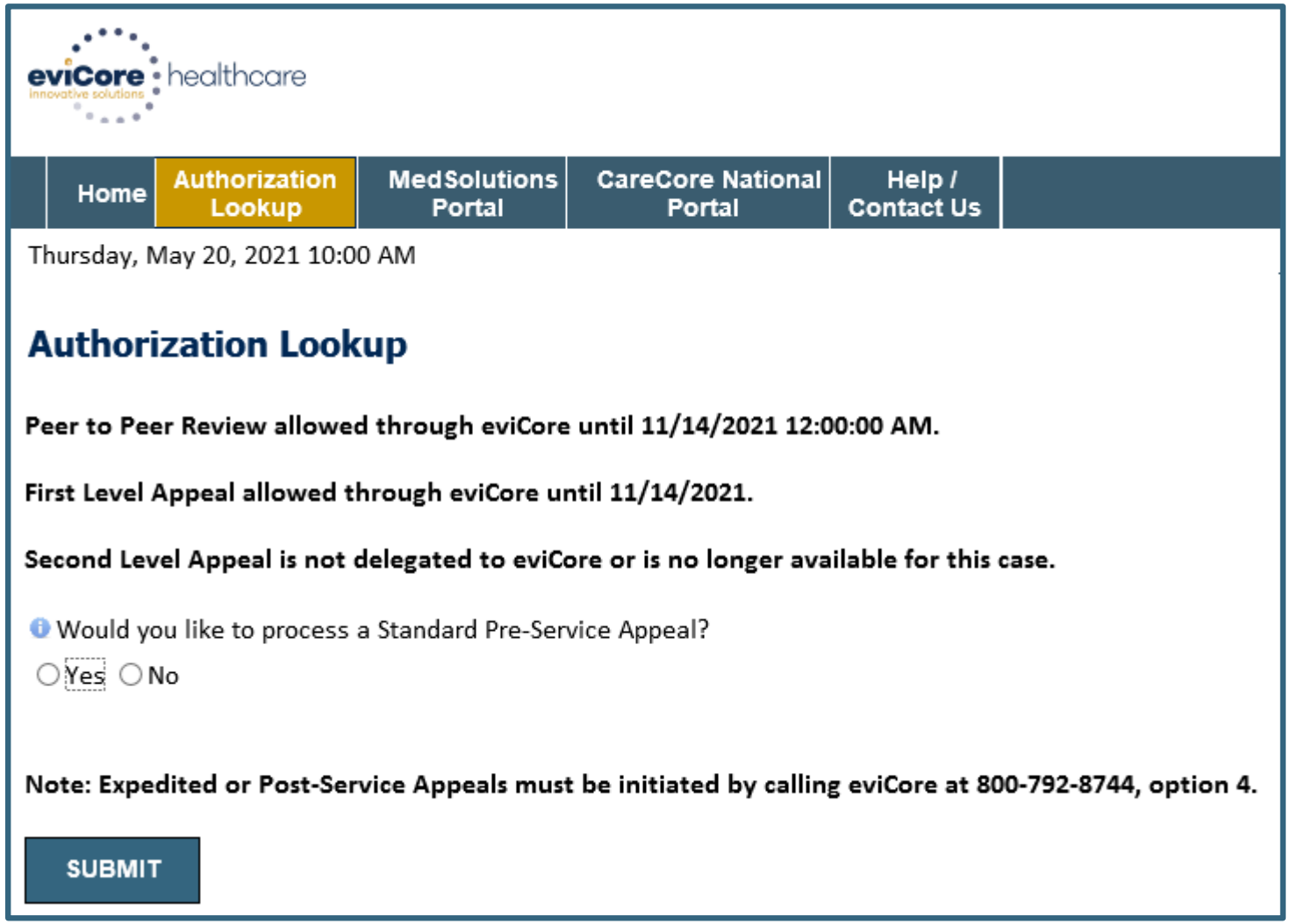
eviCore Reconsideration Review Process on the Web (cont.)

- If a reconsideration or first level appeal is delegated through eviCore, the user will see the following question at the bottom of available appeal options
- User can answer “Yes” to move forward
- If the user answers “No” an appeal or reconsideration will not be started and the following notation will be placed on the case: **Post Decision Review process opened and abandoned by Web User. Case will not proceed to Reconsideration or Appeal review at this time.**
- **Note:** Select ‘No’ to go back to schedule a Peer-to-Peer



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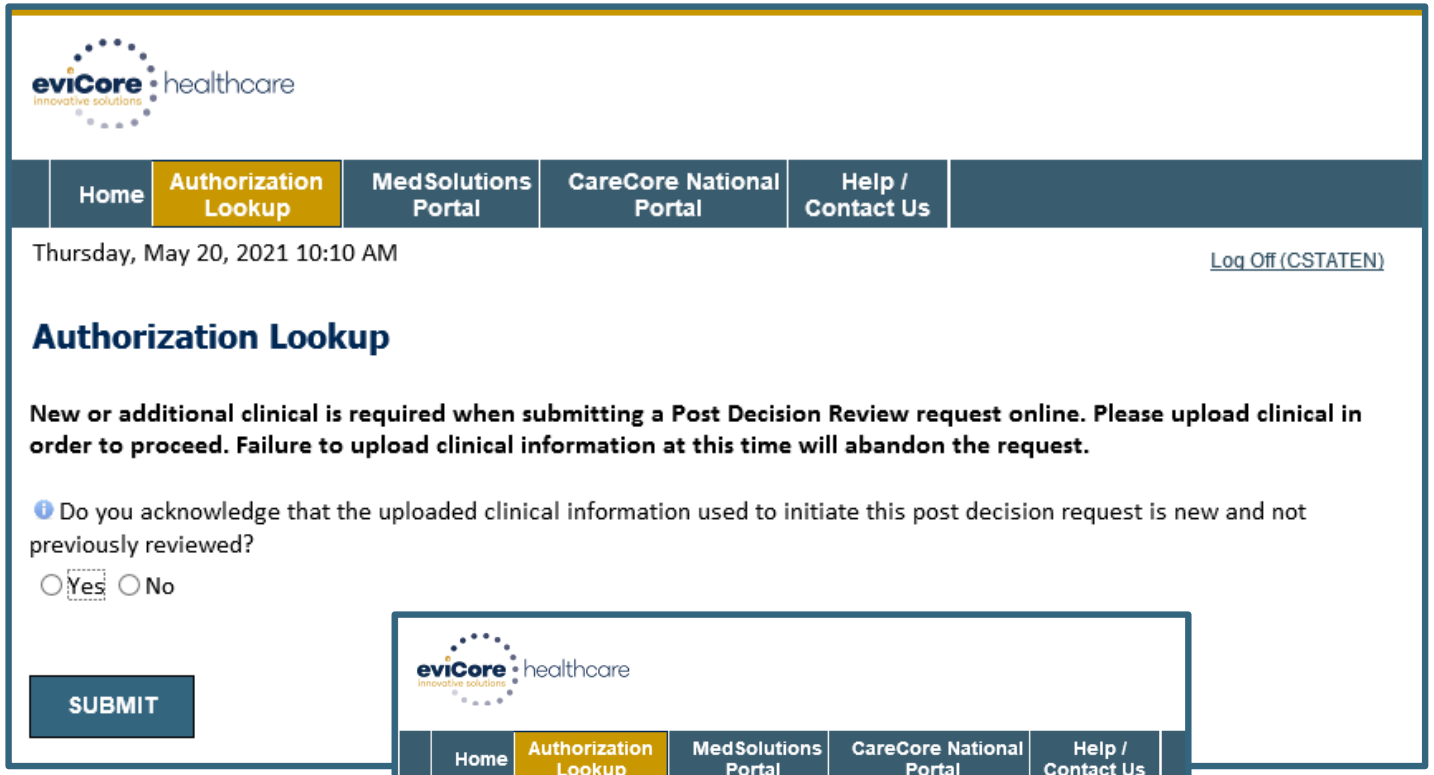
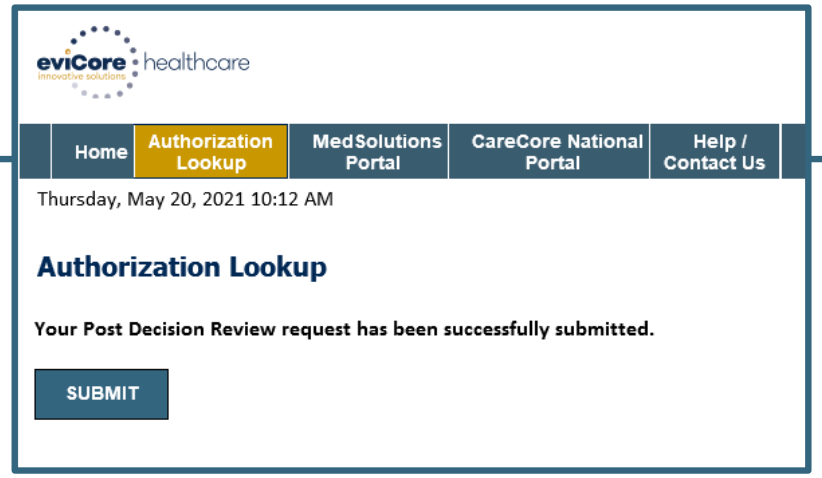
eviCore Reconsideration Process on the Web (cont.)

- New or additional clinical documentation is required
- Failure to upload new or additional clinical documentation will cancel the request
- Once the clinical information is uploaded, the user will receive message “Your Post Decision Review request has been successfully submitted”
- Select ‘Submit’ to initiate the request





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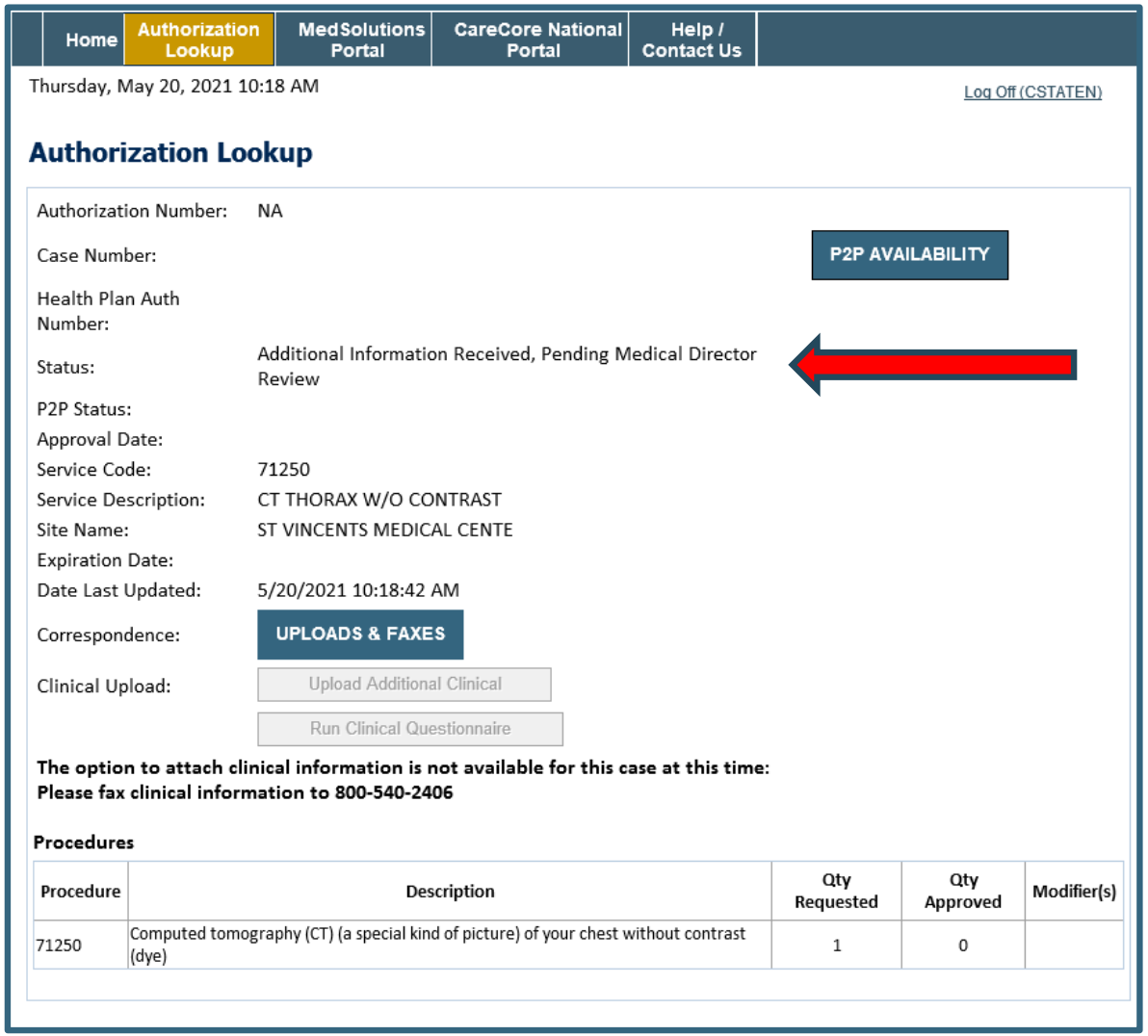
eviCore Reconsideration Review Process on the Web (cont.)

- After the post decision review is initiated, the user will return to the authorization lookup
- Status will be updated to show additional information was submitted and pending review
- A determination will be faxed to the provider



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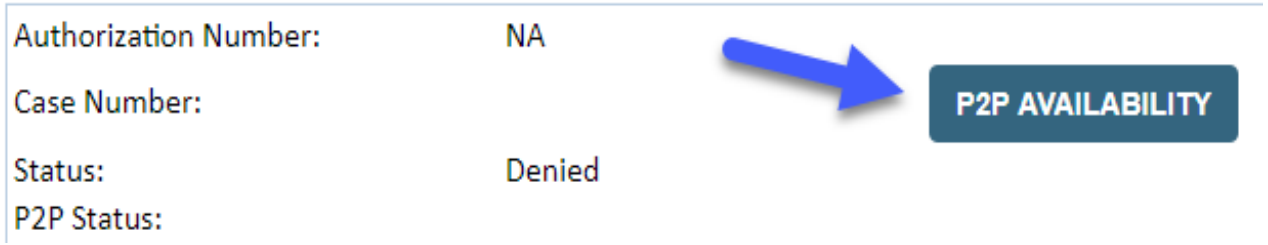
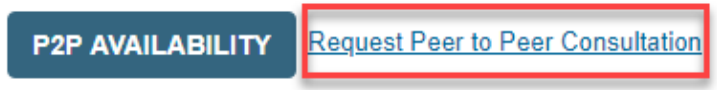
How to schedule a Peer to Peer Request

- 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:

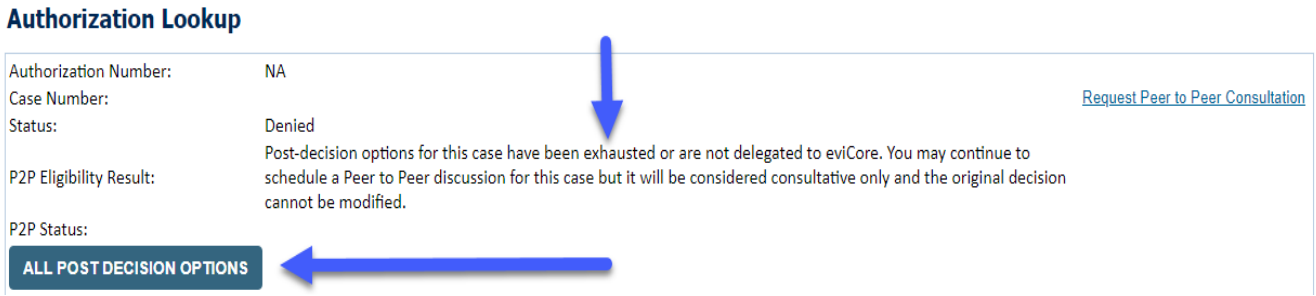


- If your case is eligible for a Peer to Peer conversation, a link will display allowing you to proceed to scheduling without any additional messaging.



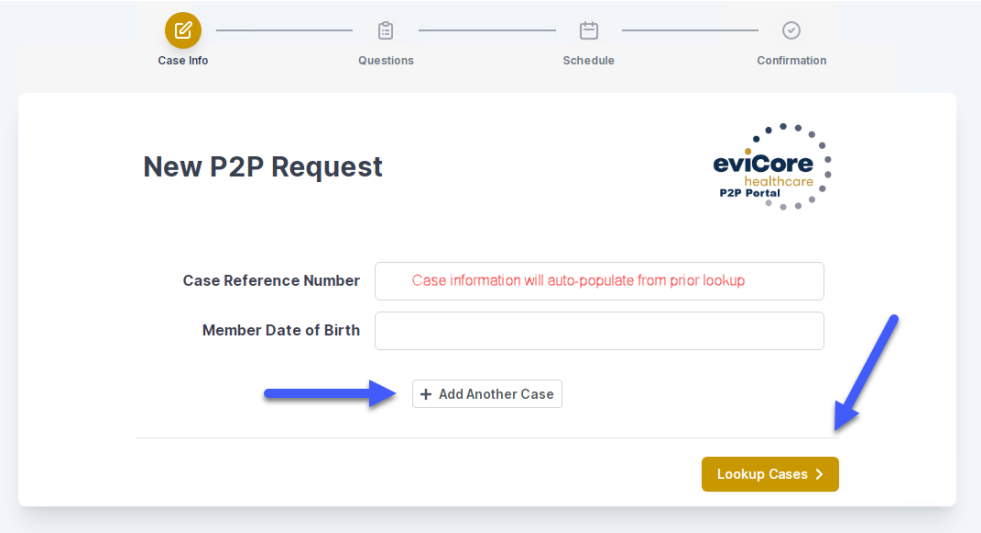
How to schedule a Peer to Peer Request

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.

How to Schedule a Peer to Peer Request



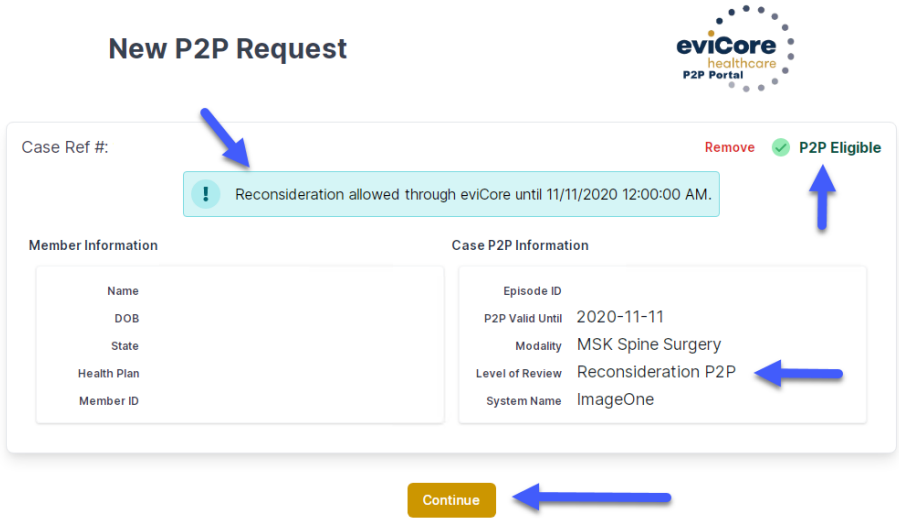
Upon first login, you will be asked to confirm your default time zone.

You will be presented with the Case Number and Member Date of Birth (DOB) for the case you just looked up.

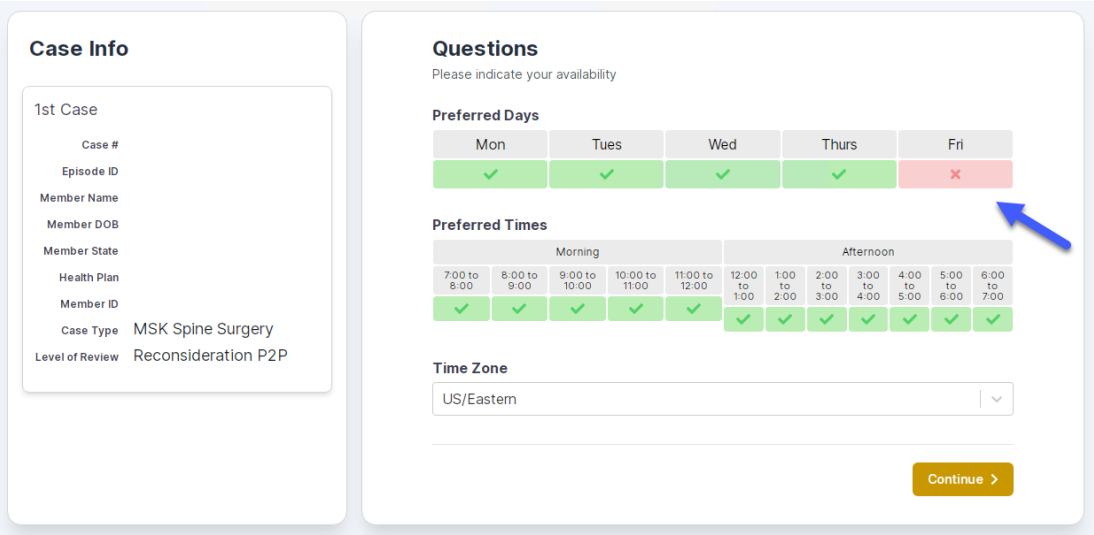
You can add another case for the same Peer to Peer appointment request by selecting “Add Another Case”

To proceed, select “Lookup Cases”

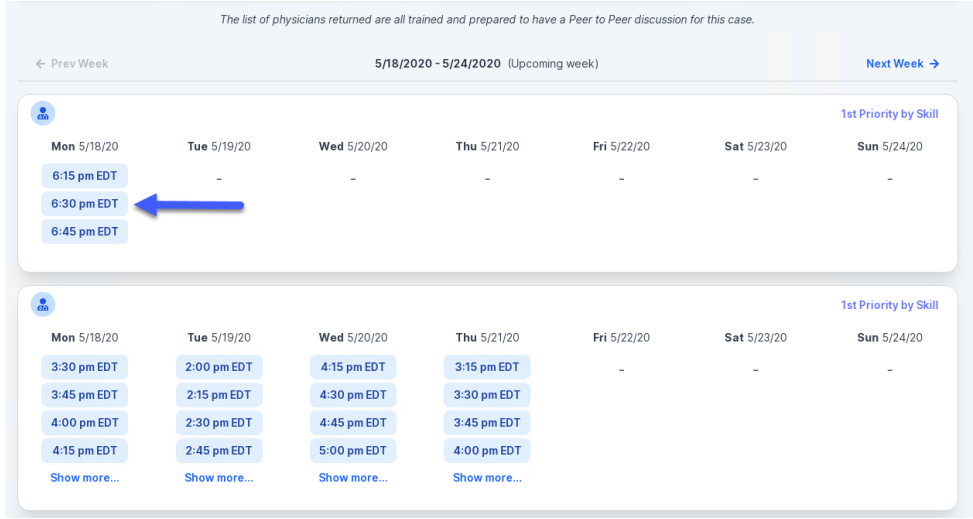
You will receive a confirmation screen with member and case information, including the Level of Review for the case in question. Click Continue to proceed.



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.

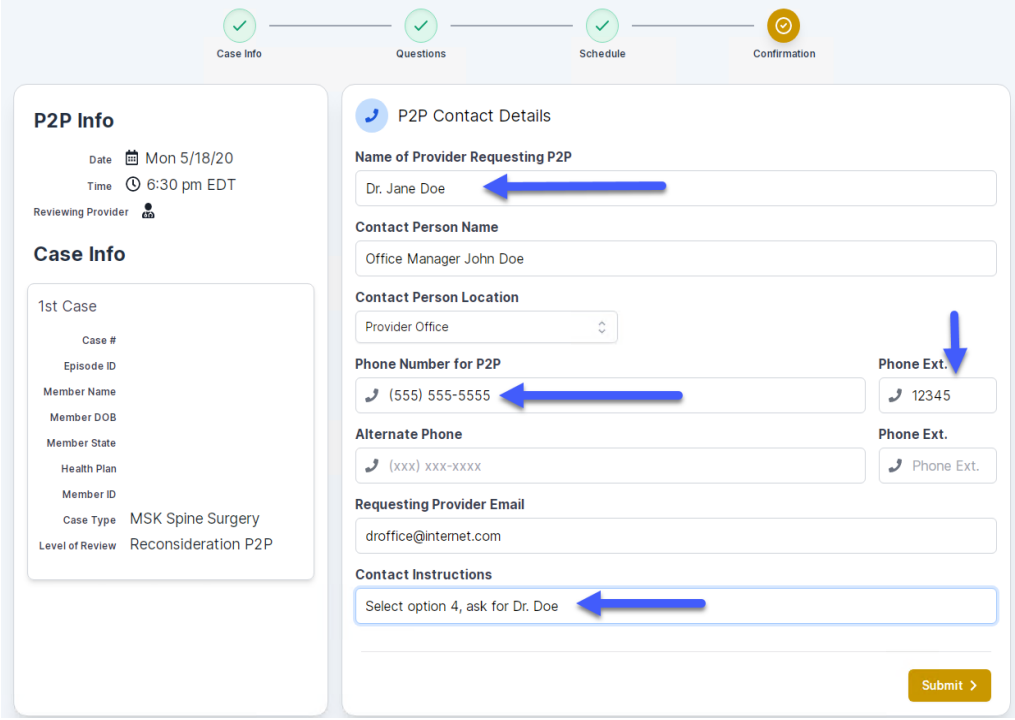


You will be prompted to identify your preferred Days and Times for a Peer to Peer conversation. All opportunities will automatically present. Click on any green check mark to deselect the option and then click Continue.

How to Schedule a Peer to Peer

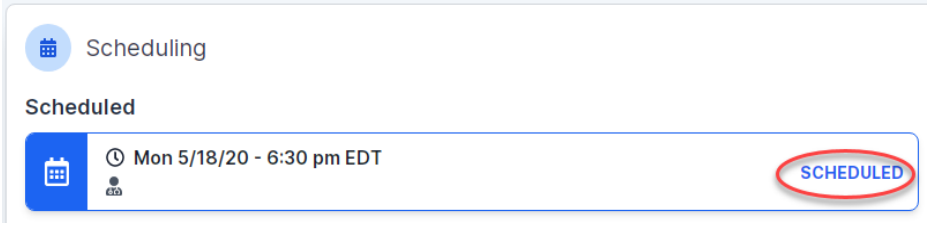
Confirm Contact Details

- 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.



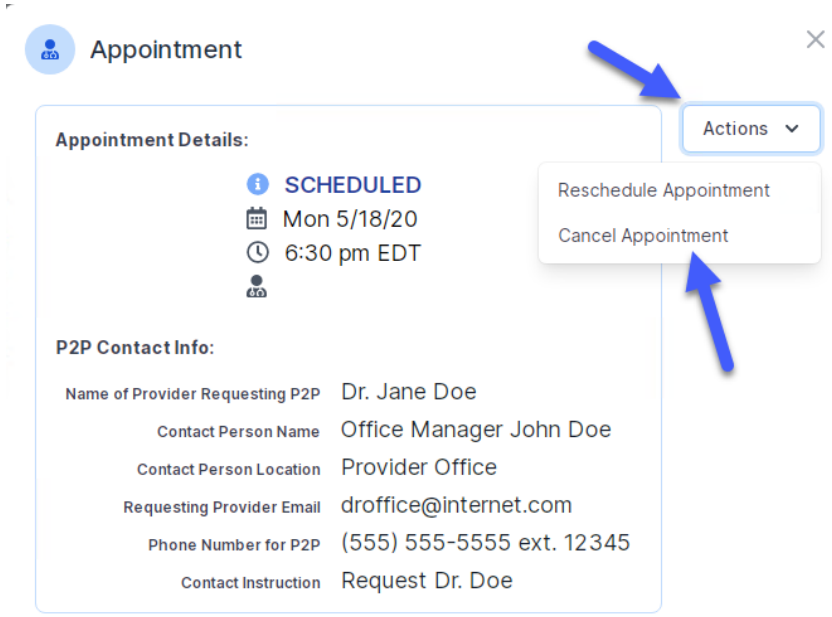
Canceling or Rescheduling a Peer to Peer Appointment

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

Provider Resources

Dedicated Call Center

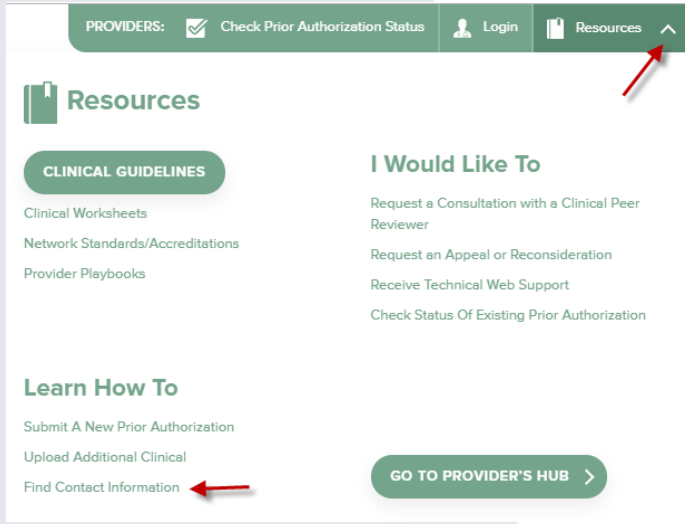
Prior Authorization Call Center – 877.791.4104

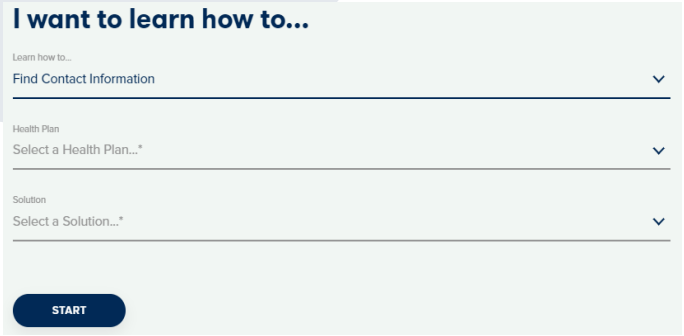
Our call centers are open from 7AM to 7 PM (local time).

Providers can contact our 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 CPT Code(s) on an existing case
- Request to speak to a clinical reviewer
- Schedule a clinical consultation with an eviCore Medical Director

Online 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.**
- Provider's Hub section includes many resources
- Provider forums and portal training are offered weekly, you can find a session on www.eviCore.WebEx.com, select WebEx Training, and search upcoming for a "eviCore Portal Training" or "Provider Resource Review Forum"
- The quickest, 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 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

Client & Provider Operations Team

Client and Provider Services

Dedicated team to address provider-related requests and concerns including:

- 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

Email: ClientServices@evicore.com (preferred)

Phone: 1 (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 with a description of the issue, with member/provider/case details when applicable.

Provider Engagement Team

Provider Engagement team

Regional team that on-boards providers for new solutions and provides continued support to the provider community. How can the provider engagement team help?

- Partner with the health plan to create a market-readiness strategy for a new and/or existing program
- Conduct onsite and WebEx provider-orientation sessions
- Provide education to supporting staff to improve overall experience and efficiency
- Create training materials
- Monitor and review metrics and overall activity
- Conduct provider-outreach activities when opportunities for improvement have been identified
- Generate and review provider profile reports specific to a TIN or NPI
- Facilitate clinical discussions with ordering providers and eviCore medical directors

How to contact the Provider Engagement team?

You can find a list of Regional Provider Engagement Managers at evicore.com → Provider's Hub → Training Resources

Provider Resource Website

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
- Provider Training
- CPT code list

To access these helpful resources, please visit

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

The Health Plan Provider Services: 1.877.847.7901 or email providersupport@healthplan.org

Provider Newsletter

Stay Updated With Our Free Provider Newsletter

eviCore's provider newsletter is sent out to the provider community with important updates and tips. If you are interested in staying current, feel free to subscribe:

- Go to eviCore.com
- Scroll down and add a valid email to subscribe
- You will begin receiving email provider newsletters with updates

Provider Resource Review Forums

The eviCore website contains multiple tools and resources to assist providers and their staff during the prior authorization process.

We invite you to attend a Provider Resource Review Forum, to navigate www.eviCore.com and understand all the resources available on the Provider's Hub. Learn how to access:

- eviCore's evidence-based clinical guidelines
- Clinical worksheets
- Check-status function of existing prior authorization
- Search for contact information
- Podcasts & Insights
- Training resources

How to register for a Provider Resource Review Forum?

You can find a list of scheduled **Provider Resource Review Forums** on www.eviCore.com → Provider's Hub → Scroll down to eviCore Provider Orientation Session Registrations → Upcoming

Thank You!