Specialized Musculoskeletal Therapies

Frequently Asked Questions

Who is eviCore healthcare?

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for The Health Plan

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

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

- **Medicare**
- **Medicaid**
- **Commercial**

What is the relationship between eviCore and The Health Plan?

Beginning on 12/13/2021, eviCore will manage outpatient physical and occupational therapy services, as well as chiropractic care for dates of service 1/01/2022 and beyond.

Which Specialized Therapies require prior authorization for The Health Plan?

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

- Physical Therapy
- Occupational Therapy
- Chiropractic Care

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

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

Member eligibility and benefits should be verified on The Health Plan's Provider Portal at https://myplan.healthplan.org/Account/Login or by calling 877-791-4101 before requesting prior authorization through eviCore.

Who needs to request prior authorization through eviCore?

All requesting (treating) therapists are required to obtain a prior authorization for services prior to the service being rendered in an office or outpatient setting.

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

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.

How do I request a prior authorization through eviCore healthcare?

Practitioners 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.Practitioners can request authorization by visiting https://myplan.healthplan.org/Account/Login

Call Center

eviCore's call center is open from 7 a.m. to 7 p.m. local time. Practitioners and/or staff can request prior authorization and make revisions to existing cases by calling 877-791-4101

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

The number of visits and units approved will vary based on the condition/complexity/response to care. 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.

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. **Efficiency** – Medical documentation can be attached to the case upon initial submission, reducing follow-up calls and consultation.
- **Real-Time Access** – Web users are able to see real-time status of a request.
- **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 practitioners to your account once you have registered. You would do this by choosing the Manage Your Account and providing the information for the practitioner you want to add.

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).

When should a pre-service authorization request be submitted for therapy services?

Pre-service authorization is not required for the initial evaluation and treatment provided at that initial evaluation visit. However, pre-authorization is required for all treatment provided after the initial evaluation visit. When submitting your initial request for authorization, the clinical information obtained from the initial evaluation will help you create your authorization request. If additional therapy is required after the initial request, requests for ongoing care may be submitted as early as seven (7) days prior to the requested start date. The current findings date on your pre-service authorization request should be within fourteen days of your requested start date. Delays may occur if the request is made too far in advance and/or if the clinical information is incomplete or too old.

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, see Check Prior Authorization Status.

What is the difference between the "ordering" and the "rendering" provider?

When requesting a pre-service authorization for Physical Therapy or Occupational Therapy, the "ordering" and "rendering" provider is the therapist who is submitting the request. Note: There is no need to enter information about the provider that referred the member for therapy.

I practice within a group practice. Should the pre-service authorization request be created under my individual NPI or under the group's NPI?

The way claims are submitted to The Health Plan should inform the way you create your pre-service authorization request. If claims are billed under a group NPI, the pre-service authorization request should use the group's NPI, address, etc. Using the group NPI allows providers practicing within a group to share the same authorization if coverage is necessary.

If claims are billed to The Health Plan using individual provider NPI's, the pre-service authorization request should also be created using the individual provider's NPI.

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 therapy requests, the ordering/rendering provider are the same.

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

Rendering (Performing) Provider

- Facility Name
- National Provider Identification (NPI) Number
- Tax Identification Number (TIN)
- Street Address

Clinical(s) Pediatric Neurodevelopmental

- Diagnosis/ICD10
- Date of current objective findings
- Date of initial evaluation
- Date of onset
- Standardized test scores collected within one year of the requested start date
- Plan of care – planned frequency/intensity/duration of care
- Clinical observations

Clinical(s) Adult

- Diagnosis/ICD-10
- Date of current objective findings
- Date of the initial evaluation
- Date of onset
- Co-morbidities/Complexities
- Functional Assessment (using Patient Reported outcomes including the NDI, ODI, Roland Morris Disability Score, DASH/Quick DASH, LEFS, HOOS JR, KOOS JR, etc. See clinical worksheets for details.)

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.

Do services provided in an emergency room setting require an authorization?

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

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 eviCore at 877-791-4104.

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

All requests are processed within 2-3 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 practitioner for services, will a new pre-service authorization request be required?

Yes. When a member changes to a treating practitioner 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 practitioner 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, authorization timeframe, or waiver visits. 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?

Generally, eviCore will approve services for a period of 90 days from the start date identified on your authorization request. The authorization period may differ based on the member's condition.

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

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 requesting practitioner 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 practitioner.
Practitioners may also visit www.evicore.com to view the authorization determination.

Note: The authorization number will begin with the letter 'A' followed by a nine-digit number. (example: A123456789).

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

Yes, the authorization will include 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.

What does units mean?

For Physical and Occupational therapies units are 15 minute increments. 1 visit and 4 units equates to a one hour visit.

Can I request additional visits beyond what was already approved?

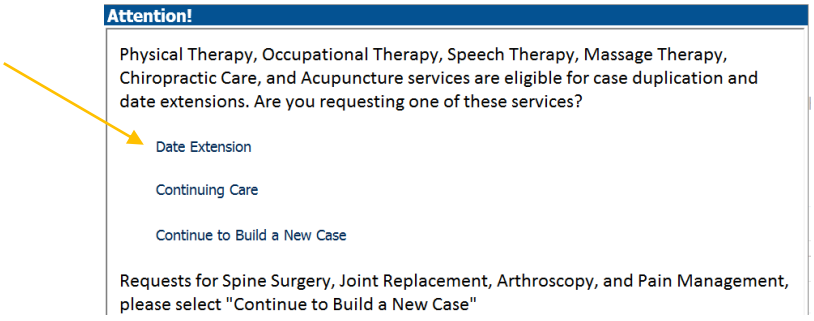
Yes. eviCore will review and approve services in accordance with what is required for the member to demonstrate progress over a specific period of time. Upon expiration of an approved authorization, you may request additional visits as early as seven (7) days prior to the requested start date by submitting another authorization request via web or phone. The request should include current clinical information (collected within the prior 14 days prior for adult and pediatric non-neurodevelopmental conditions; 20 days for pediatric neuro developmental conditions), including the patient's response to any treatment already approved and rendered.

If denied, what follow-up information will the requesting therapist receive?

The requesting therapist will receive a denial letter that contains the reason for denial as well as Appeal rights and processes.

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 877-791-4101



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 AND units must still be available. Note: If visits are available but the approved units have been used, submit a request for continuing care instead of requesting a date extension.
- 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; the extension is required for a shorter period, specify the duration as long as it is less than 30 days..
- An extension should not overlap with another request for the same specialty.

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

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

Does eviCore review cases retrospectively if no authorization was obtained?

Retrospective requests are not in scope for The Health Plan members.

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 888-333-8641 to speak with a customer service specialist.

How do I determine if a practitioner is in network?

Participation status can be verified by https://myplan.healthplan.org/Account/Login. Practitioners may also contact eviCore healthcare at 877-791-4104.

eviCore receives a provider file from The Health Plan with all independently contracted participating and non-participating practitioners.

Where do I submit my claims?

All claims will continue to be filed directly to The Health Plan.

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/thp