Creating a Prior Authorization Request

What are Specialized Therapies?

Specialized Therapies are Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)

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

- **Saves time:** The process is faster than submitting authorization requests over the phone.
- **Potential for a real-time decision**.
- **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 in 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.
    - The case duplication feature provides several options. When creating a case via eviCore's web portal, the following options are presented:

- **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.

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Frequently Asked Questions

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

When multiple provider types provide a physical medicine benefit, eviCore currently allows providers to create a request using the MSMPT code. Entering the provider specialty type (discipline) ensures that the request will route to the correct specialty reviewer (e.g., PT, OT, ST) for review.

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

Depending on 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 will be able to move backward to correct errors. However, once you begin answering clinical questions, you will be unable to go back to change your answers. This limitation is intentional. It prevents providers from modifying answers if they are not satisfied with the determination they obtain.

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

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

This question helps identify requests that are urgent, to ensure that each request is processed correctly. To be considered urgent, the need for the requested service must be such that adherence to the standard timeframe could seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function. The following will be presented when creating a request on the web:

Proceed to Clinical Information

Is this case Routine/Standard?

[YES] [NO]

- If your request is urgent select **No**
- When a request is submitted as Urgent, you will be <u>required</u> 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 urgent as defined above, answer "Yes" to the question "Is this case Routine/Standard?" to continue to create your request.

What 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 to submit a request via web or phone. 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 is collected via routine assessment. (The exception is updated patient-reported outcome scores.) There is <u>no need to perform a formal re-evaluation or progress report.</u>

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 Disabilities of Arm, Shoulder and Hand (DASH) 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 <u>not</u> 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.

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When can I expect a review to be completed?

eviCore strives to complete reviews within 2 business days of receipt. NC Medicaid allows up to 14 days to communicate a routine decision and 72 hours to communicate an urgent decision.

- **TIP:** Submitting requests by web or phone increases the likelihood you'll receive a real time decision with reduced care delays.

How long will an authorization remain valid?

Authorization durations vary based on state requirements, health plan rules, or type of condition. Typically, the authorization duration will range from 30 days to 180 days.

- **TIP:** Specialized Therapy services that require prior authorization are those that require prior approval in the NC Clinical Coverage Policies located at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies. The NC Clinical Coverage Policies also provide guidelines for duration of authorizations.

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

Requests for additional visits may be submitted as early as 7 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 about Appeals is included in the letter you receive when a request is denied or partially approved.

Peer-to-Peer/Clinical Consultation

To schedule a peer-to-peer conversation via the web, log in to 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:

Public Information

If your case is eligible for a Peer-to-Peer Consultation, a link will display allowing you to proceed to scheduling without any additional messaging.
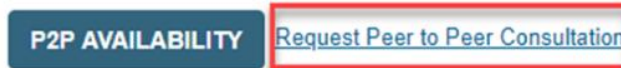
Pay attention to any messaging that displays. In some instances, a Peer-to-Peer conversation is allowed, but the case decision cannot be changed. When this happens, you can still request a Consultative-Only Peer-to-Peer. You may also click on the "All Post-Decision Options" button to learn what other action may be taken.
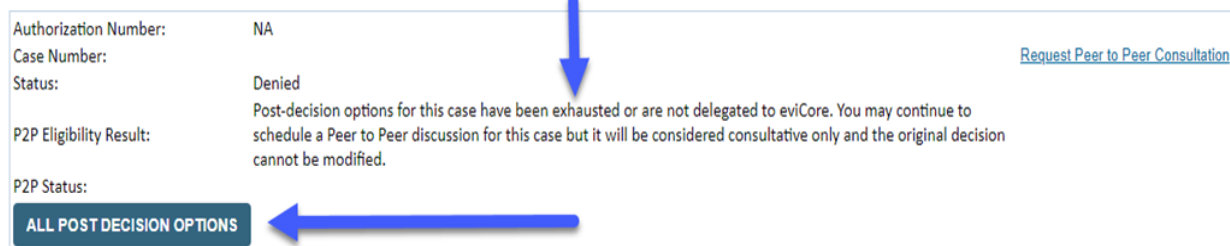
Once the "Request Peer-to-Peer Consultation" link is selected, you will be transferred to eviCore's scheduling software via a new browser window.

- **TIP:** A Peer-to-Peer must be conducted by a clinician, for example, 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 conversation, new information (not previously presented) must be provided.

Can I request an extension of an authorization date?

Date extensions are available if you are unable to use all visits within the approved period. You may request an extension for the period that is 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 at www.eviCore.com
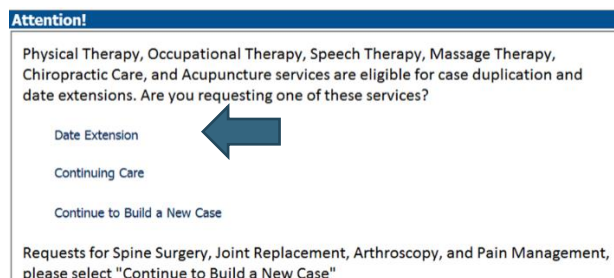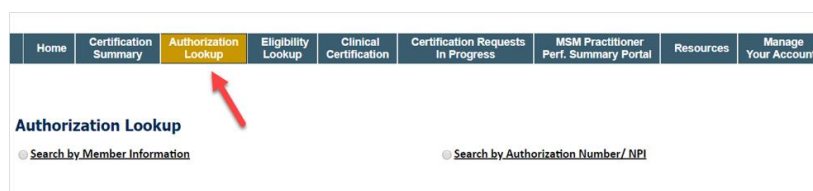
- **TIP:** If your patient experiences a gap in care due to vacation, illness, etc., requesting a date extension will allow you to use approved visits without the need to provide additional clinical information. Once the approved visits have been used, you can submit a request for additional care if necessary. Updated clinical information must be submitted with that new request.

Checking Authorization Status

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

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account

Authorization Lookup

○ **Search by Member Information**   ○ **Search by Authorization Number/ NPI**

Resources available to Providers

Prior Authorization (PA) Call Center: 855-754-5527

Call centers are open from 7 a.m. to 7 p.m. (local time). Providers can contact our 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 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** 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 https://evicore.webex.com/webappng/sites/evicore/dashboard?siteurl=evicore by selecting Webex Training, and searching "upcoming" for an "eviCore Portal Training" or "Provider Resource Review Forum".
- 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 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.**

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Frequently Asked Questions

Client and Provider Services

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

- Questions regarding existing prior authorization, 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 request creation

The team can be reached via email at **ClientServices@evicore.com (preferred), or phone by calling 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, and member/provider/case details when applicable.

A review of our TIPS for improving your experience:

Specialized Therapy services that require prior authorization are those that require prior approval in the NC Clinical Coverage Policies located at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

- 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 will enable eviCore to assess the patient's functional change.
- Once you enter the clinical portion of the pathway, review your answer before submitting and moving to the next page.
- Unless the request meets the definition of Urgent which is the need for a requested service must be such that adherence to the standard timeframe could seriously jeopardize a member's life, health or the ability

to attain, maintain or regain maximum function, answer Yes to the question ("Is this case Routine/Standard?") to continue to create your request. If it meets the Urgent definition, answer No.

- If additional care is required, do not wait until all approved visits have been 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 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 have been used, you can submit a request for additional care if necessary. Updated clinical information must be submitted with that new request.