

# Prior Authorization of Musculoskeletal Therapies for WellCare



## Therapy corePath<sup>SM</sup> Migration



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# Corporate Overview

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100M Members  
Managed  
Nationwide

**Headquartered in Bluffton, SC  
Offices across the US including:**

- Lexington, MA
- Colorado Springs, CO
- Franklin, TN
- Greenwich, CT
- Melbourne, FL
- Plainville, CT
- Sacramento, CA



# 9 Comprehensive Solutions



The industry's most **comprehensive clinical evidence-based guidelines**



4k+ employees including **1k clinicians**

Engaging with 570k+ providers



Advanced, innovative, and intelligent technology

# 9 | Comprehensive Solutions

End-to-End Solution on a single integrated platform

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-  Radiology
-  Cardiology
-  Musculoskeletal
-  Sleep Management
-  Medical Oncology
-  Specialty Drug
-  Radiation Therapy
-  Lab Management
-  Post-Acute Care

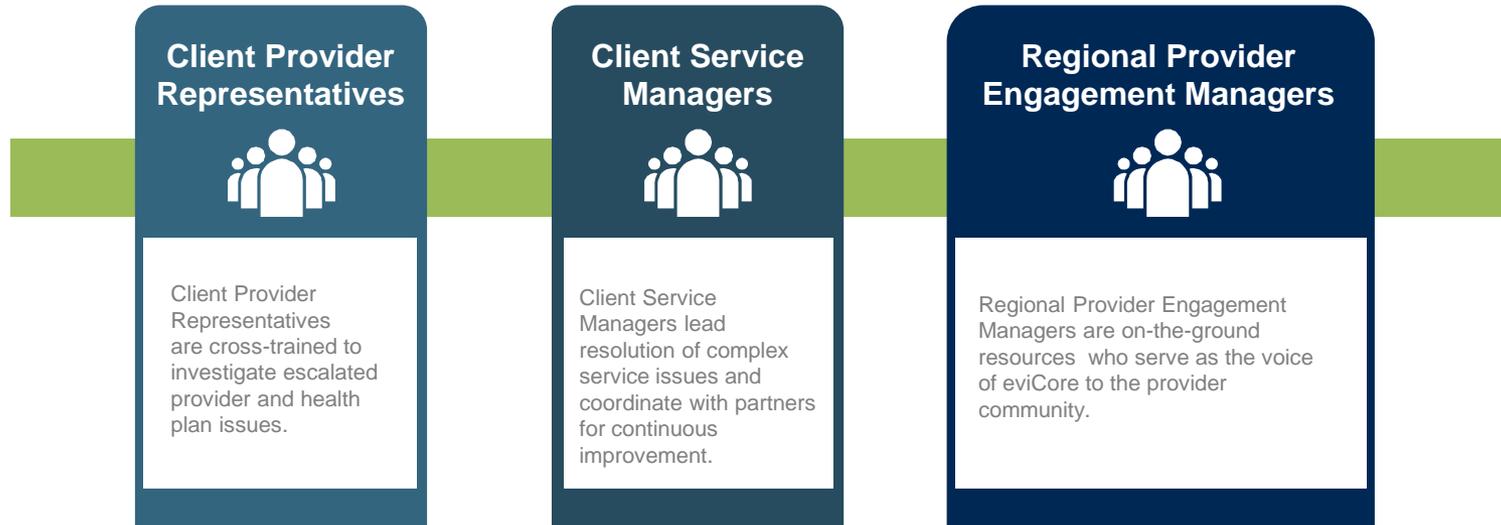
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# Service Model

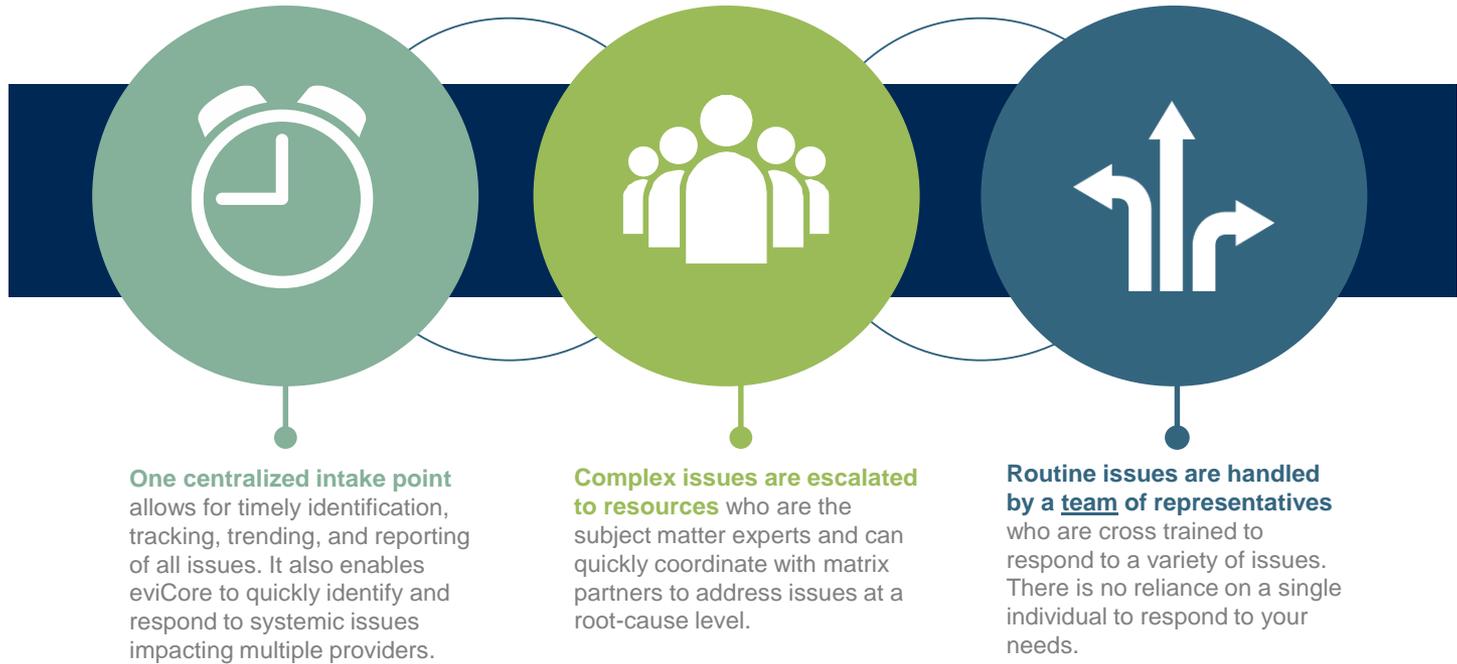
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# Client Provider Operations

The Client Provider Operations team is responsible for high-level service delivery to our health plan clients as well as ordering and rendering providers nationwide



# Why Our Service Delivery Model Works



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# MSK Specialized Therapy Program

eviCore's new strategy:

Therapy corePath<sup>SM</sup>

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# Program Overview

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**eviCore will begin accepting requests on December 17, 2018 for dates of service January 1, 2019 and beyond.**

**Prior authorization applies to services that are:**

- Outpatient
- Elective / Non-emergent
- Diagnostic

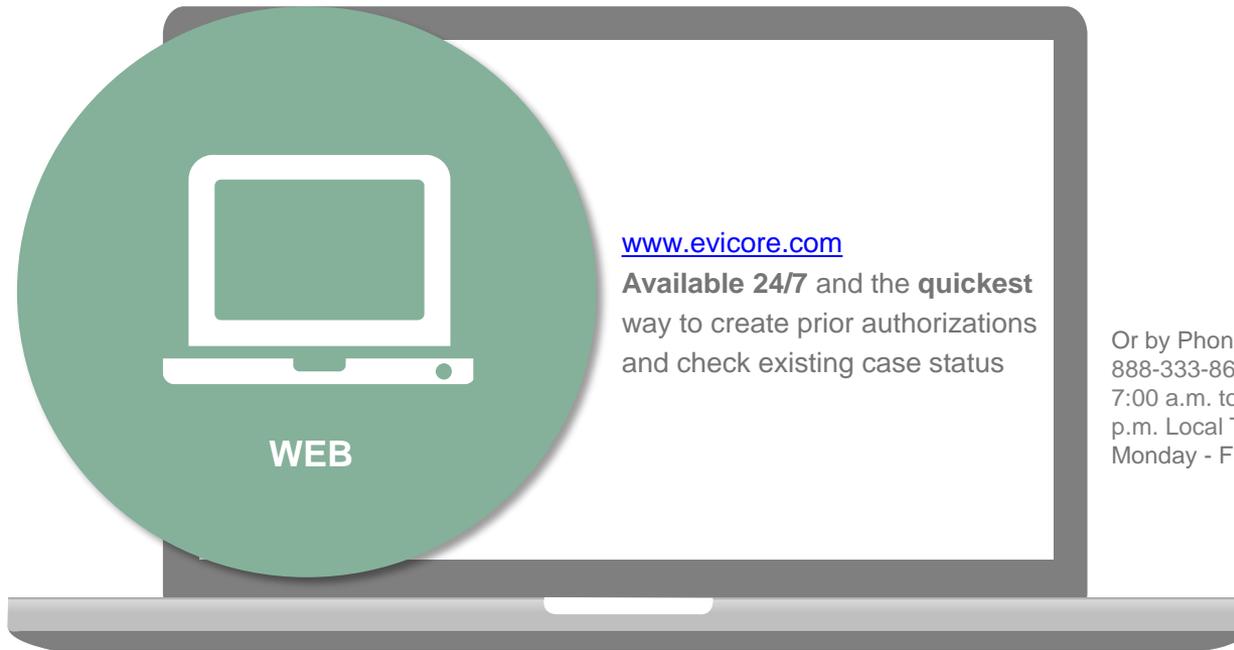
**Prior authorization **does not apply** to services that are performed in:**

- Emergency room
- Inpatient
- Observation

**It is the responsibility of the ordering provider to request prior authorization approval for services.**

# Prior Authorization Requests

## How to request prior authorization:



Fax option: 888.693.3210 Fax forms available at: [www.evicore.com](http://www.evicore.com)

# What is Therapy corePath<sup>SM</sup>?

We've Received Your Feedback and Modified Our Approach



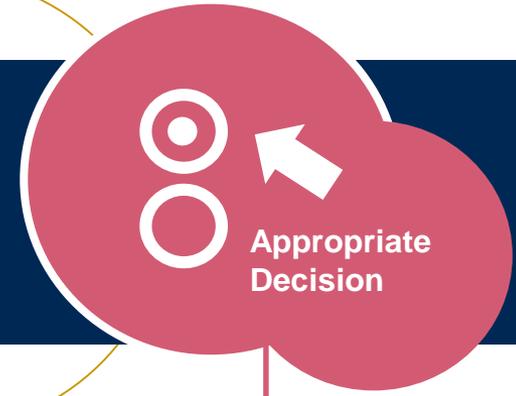
## Focused on the Member

Authorization strategy emphasizes the unique attributes of a specific member's condition and any associated complexities.



## Streamlined for Providers

Providers will experience a simplified and consistent prior authorization process that requires only key clinical information.

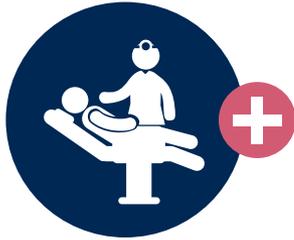


## Condition-Specific Approvals

Visits allocated in accordance with condition severity/complexity, functional loss and confirmation that patient is responding to care as planned.

# Therapy corePath<sup>SM</sup>: How it Works...

1



## Initial visit allocation

Based on each patient's needs

2



## Additional visits authorized

Based on each patient's response to previous treatment

## Getting to the Right Yes vs the Wrong No

- ✓ Collects only key clinical information
- ✓ Uses validated measurement tools
- ✓ Considers complexities

- ✓ Focuses on patient response to care
- ✓ Captures lack of response reasons
- ✓ Confirms effectiveness of treatment

*Ongoing care requires more detailed review to identify the individual patient's special need*

# Sample Therapy corePath<sup>SM</sup> Pathway

## Initial Requests

1

This request is for treatment of:

- New condition that has not had previous treatment
- An existing condition that has had previous treatment
- Unknown

2

Please indicate the primary area of treatment (Choose only one):

Lumbar / Lower Thoracic Spine / Pelvis / Sacrum

Is there a second area being treated? If so, please indicate below.

No second area being treated

Dates:

You requested a treatment start date of 06/13/2017

3

Date of initial evaluation

06/13/2017

Date of onset of treatment:

06/13/2017

Enter date of current findings:

06/13/2017

## Case Related Questions:

- Identify new care vs. continuing care based on treatment area, not time
- Identify primary area of treatment
- First indicator of complexity – second unrelated treatment area

# Sample Therapy corePath<sup>SM</sup> Pathway

## Initial Requests, continued....

4 Please enter the Oswestry Disability Index score (in %)  
46

5 Does your patient have radiating pain below the knee?  
 Yes  No  Unknown

6 How many occurrences of low back pain has your patient had in the past 3 years?  
 1  2  3  4 or more

Submit

High Potential for Immediate  
Approval When Pathway is  
Completed!

## Initial Clinical Questions:

- Enter functional score, if available
  - Oswestry Index
  - Neck Disability Index
  - LEFS
  - HOOS Jr./ KOOS Jr
  - Dash / QuickDASH
- Incorporates ROM, Strength, Pain, etc.
- Complexity:
  - Neural signs
  - Chronicity

# Sample Therapy corePath<sup>SM</sup> Pathway

## Follow-Up Clinical Questions:

- Current and Previous Functional Score
- Complexity Question – Neural Signs
- Patient response to care
  - Validated scores have MCD (minimal clinical difference) as response indicator
  - Clinical Assessment

## Follow-Up Request



**i** Please enter the Oswestry Disability Index score (in %)

41



**i** Please enter the previous ODI score

46



**i** Does your patient have radiating pain below the knee?

Yes  No

**i** Has your patient responded as expected?

Yes  No

Submit

High Potential for Immediate  
Approval When Pathway is  
Completed!

# Sample Therapy corePath<sup>SM</sup> Pathway

## Follow-Up Request – Lack of Response Identified

**i** You indicated that your patient is NOT responding as expected. Please indicate if any of the following occurred:

- Patient "overdid" activities or exercise resulting in temporary increase in symptoms  New injury resulting in significant change  
 Symptoms progressed despite treatment  Patient did not participate in clinical visits or home program

**i** Please indicate the nature of the new injury OR overuse incident.

N/A

### Lack of Response to Treatment:

- Categories of explanations
- Used in algorithm to determine care
- Future, additional pathway to identify details

# Therapy corePath<sup>SM</sup> Results

- ✓ Submit request for authorization upon start of care
- ✓ Still given visits/units
- ✓ Still given date span for authorization
- ✓ Elimination of pre-set waivers
- ✓ Increased provider satisfaction
- ✓ Reduced administrative burden for providers
- ✓ Increased opportunity for real-time decisions
- ✓ Expanded, member-focused decisions
- ✓ Decreased case review turn-around-times
- ✓ Patients able to receive the right amount of care in a timely manner



# Clinical Collection for Pediatric Neurodevelopmental Cases

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- Collect recommended Plan of Care
  - Visits
  - Units
  - Duration
- General Clinical Conditions/Problems
- Standardize Test Results
- Clinical Observations
- Short Term Goals
  - Progress Towards Goals
- Additional Clinical Information



# Clinical Collection for Pediatric Neurodevelopmental Cases - OT

CLINICAL OBSERVATION RESULTS	<b>General Assessment</b>				
	<b>SENSORY PROFILE Complete Sensory Profile, if completed.</b>				
	<input type="checkbox"/> Not Tested	Date Performed: _____			
	<input type="checkbox"/> Sensory Processing Measure (SPM)	<input type="checkbox"/> Sensory Profile-2 (SP2)	<input type="checkbox"/> Sensory Profile (SP)	<input type="checkbox"/> Other:	
	Number of Sections completed: _____	Number of tests: _____	<input type="checkbox"/> >1 s.d. below mean	<input type="checkbox"/> >2 s.d. below mean	
		At or above the mean _____			
		Modulation: _____	<input type="checkbox"/> Typical Performance	<input type="checkbox"/> Probable Difference	<input type="checkbox"/> Definite Difference
		Behavioral _____	<input type="checkbox"/> Typical Performance	<input type="checkbox"/> Probable Difference	<input type="checkbox"/> Definite Difference
	<b>SELF CARE ASSESSMENT</b>				
	Complete if Self-Care is indicated as a treatment focus – Please enter the age appropriate skills that require treatment/ instruction.				
	<input type="checkbox"/> Dressing	<input type="checkbox"/> Toileting	<input type="checkbox"/> Bathing	<input type="checkbox"/> Grooming	<input type="checkbox"/> Eating / using utensils
	<b>FEEDING / ORAL- MOTOR ASSESSMENT</b> Complete if Oral-Motor is indicated as a treatment focus				
	<input type="checkbox"/> Sensory Food Aversion	<input type="checkbox"/> Dysphagia or Aspiration/Choking Risk	<input type="checkbox"/> Oral motor weakness		
	<input type="checkbox"/> Behavioral Issue (picky eater)	<input type="checkbox"/> Inadequate food / caloric intake combined with low weight percentile			
<b>FINE MOTOR ASSESSMENT</b> Complete if Fine-Motor is indicated as a treatment focus – Please enter the age appropriate skills that require treatment/ instruction.					
<input type="checkbox"/> Writing	<input type="checkbox"/> Reaching/Grasping/ Holding	<input type="checkbox"/> Manual Dexterity	<input type="checkbox"/> Other:		
<b>Please indicate if any of the following are present:</b>					
<input type="checkbox"/> N/A	<input type="checkbox"/> Language Barrier	<input type="checkbox"/> Impulsive/Aggressive Behavior that interferes with regulation			
<input type="checkbox"/> Severe attention deficit disorder or intellectual disability		<input type="checkbox"/> Lack or consistent caregiver at home			

# Clinical Collection for Pediatric Neurodevelopmental Cases - PT

**CLINICAL OBSERVATION RESULTS - Gross Motor Function Assessment. Please select the description that best fits. See appendix 2 for explanation of levels, if needed**

**Age 0 – 1 (before 2<sup>nd</sup> birthday):**  No limitations

- Able to sit, creep, crawl. May pull to standing and cruise.
- May need back support in sitting. Able to roll and creep.
- Requires trunk support to sit. May be able to roll to prone.
- Unable to control head and trunk in prone and sitting. Requires assistance to roll.

**Age 2 - 3 (before 4<sup>th</sup> birthday):**  No assistance required.

- Generally sit without support. May use assistive device for walking
- Sitting generally requires some assistance. Creeping/Crawling is preferred means of mobility.
- Hand or device support required for sitting. Unable to walk.
- All motor function is limited, including head and trunk control.

**Age 4 - 5 (before 6<sup>th</sup> birthday):**  Able to sit, stand, walk. Run and jump emerging.

- Sit without support. Capable of walking, some limit with long distances, stairs, balance, running/jumping.
- Little or no assistance needed for sitting. Generally walk with a hand-held mobility device.
- Require support for sitting. Walk with hand held device, may use wheeled mobility.
- All motor function is limited.

Member Name:

Member ID:

Provider Name:

**Age 6 - 11 (before 12<sup>th</sup> birthday):**  Walk at home, school, outdoors. May have limits with speed, balance, coordination.

- Walk in most settings. Run/jump is limited. May use hand-held device or wheeled mobility.
- Usually walk with hand-held device. May need support in sitting.
- Mobility requires assistance or wheeled device. Adaptive seating is required.
- Wheeled mobility required. Unable to fully maintain head/trunk posture or control limb movements.

**Age 12 and up:**  Walk in all settings. May have limits with speed, balance, coordination.

- Walk in most settings, may use assistive device. Negotiates stairs with railing or assistance.
- Able to walk with hand-held device, may use wheelchair for distances. Transfer to standing may require assistance.
- Wheeled mobility used in most settings. Adaptive seating required.
- Wheeled mobility required. Unable to fully maintain head/trunk posture or control limb movements.

# Clinical Collection for Pediatric Neurodevelopmental Cases - PT

Please indicate if any of the following are present:

- N/A       Language Barrier       Impulsive/Aggressive Behavior that interferes with regulation  
 Severe attention deficit disorder or intellectual disability       Lack of consistent caregiver at home

## CLINICAL OBSERVATION RESULTS - Torticollis

Degree of Limitation in Cervical Rotation\*  Enter patient age (IN MONTHS) when treatment started

(\*Example: if the patient is lacking 12 degrees of rotation, enter 12)

# Prior Authorization Requests

**Friendly Reminder: Submit Online using the same Web Portal/Login!**



[www.evicore.com](http://www.evicore.com)

**Available 24/7** and the **quickest, most efficient** way to create prior authorizations and check existing case status. Web submissions also have a high potential for immediate approval!

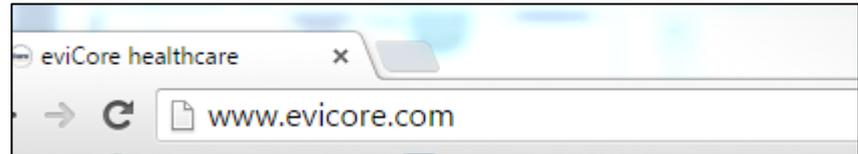
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# Web Portal Services

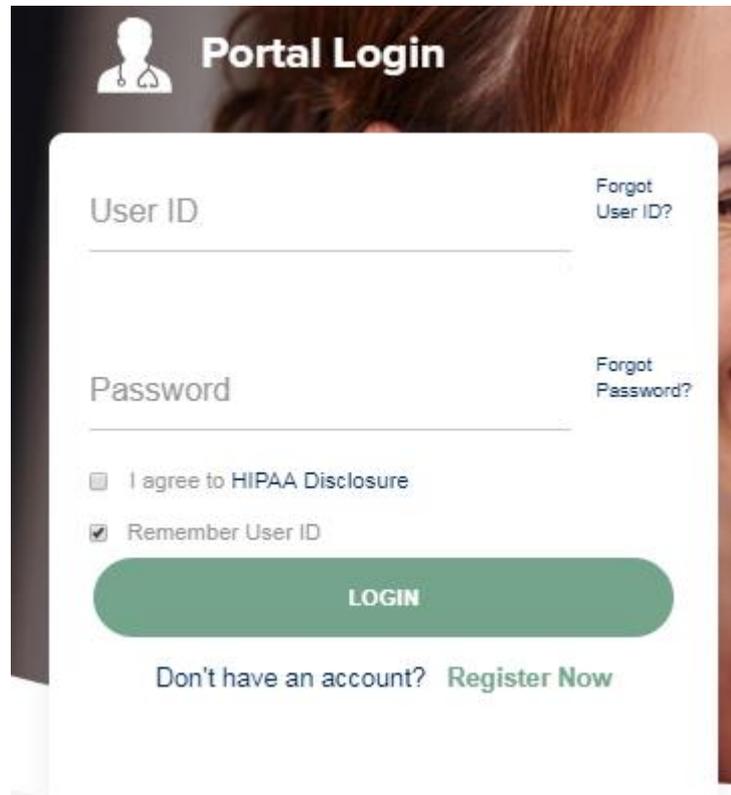
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# eviCore healthcare website

- Point web browser to evicore.com



- Login or Register

A screenshot of the 'Portal Login' form on the eviCore healthcare website. The form is white with a green 'LOGIN' button. It includes fields for 'User ID' and 'Password', each with a 'Forgot' link. There are two checkboxes: 'I agree to HIPAA Disclosure' and 'Remember User ID'. Below the form is a link for 'Don't have an account? Register Now'. The background of the form is a blurred image of a person's face.

**Portal Login**

User ID [Forgot User ID?](#)

Password [Forgot Password?](#)

I agree to HIPAA Disclosure

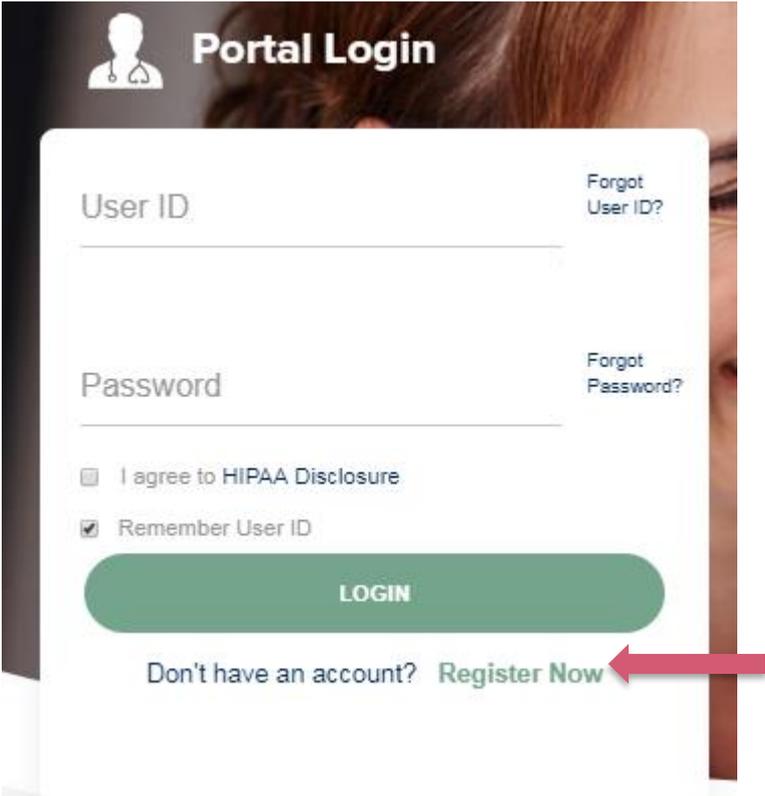
Remember User ID

**LOGIN**

Don't have an account? [Register Now](#)



# Creating An Account



To create a new account, click **Register**.



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## Portal Compatibility

The eviCore.com website is compatible with the following web browsers:

- Google Chrome
- Mozilla Firefox
- Internet Explorer 9, 10, and 11

You may need to disable pop-up blockers to access the site. For information on how to disable pop-up blockers for any of these web browsers, please refer to our [Disabling Pop-Up Blockers guide](#).



# Creating An Account

**eviCore** healthcare  
INNOVATIVE SOLUTIONS

\* Required Field

### Web Portal Preference

Please select the Portal that is listed in your provider training material. This selection determines the primary portal that you will using to submit cases over the web.

Default Portal\*: **CareCore National** ▼

If you want to register as a Client User at CareCore National, then please contact us: 1-800-918-8924 x20136.

### User Information

All Pre-Authorization notifications will be sent to the fax number and email address provided below. Please make sure you provide valid information.

User Name*:	<input type="text"/>	Address*:	<input type="text"/> <input type="text"/>	Phone*:	<input type="text"/>
Email*:	<input type="text"/>	City*:	<input type="text"/>	Ext:	<input type="text"/>
Confirm Email*:	<input type="text"/>	State*:	Select ▼	Zip*:	<input type="text"/>
First Name*:	<input type="text"/>	Office Name*:	<input type="text"/>	Fax*:	<input type="text"/>
Last Name*:	<input type="text"/>				

Next

➔ Select a **Default Portal**, and complete the registration form.

# Creating An Account

Please review the information before you submit this registration. An Email will be sent to your registered email address to set your password.

**Web Portal Preference**

Please select the Portal that is listed in your provider training material. This selection determines the primary portal that you will using to submit cases over the web.

Default Portal\*:

If you want to register as a Client User at CareCore National, then please contact us: 1-800-918-8924 x20136.

**User Registration**

<b>UserName:</b>	MYG123	<b>Address:</b>	730 Cool Springs	<b>Phone:</b>	800-575-4517
<b>Email:</b>	tesaccount@gmail.com	<b>City:</b>	Franklin	<b>Ext:</b>	
<b>Account Type:</b>	Physician	<b>State:</b>	TN	<b>Zip:</b>	37067
<b>First Name:</b>	Test	<b>Office Name:</b>	Test Office	<b>Fax:</b>	615-468-4408
<b>Last Name:</b>	Account				



Review information provided, and click “**Submit Registration.**”

# User Registration-Continued

Please select the Portal that is listed in your provider training material. This selection determines the primary portal that you will using to submit cases over the web.

Default Portal\*: Medsolutions

### User Registration

UserName: MYoder  
Email: evicorejedi1234@gmail.com  
Account Type: Physician  
First Name: Mallory  
Last Name: Yoder

### Provider Information

Physician FirstName: TEST      Physician Last Name: Yoder  
State: TN      Tax ID:

Please read below to sign up as an appropriate user.  
Physician: An Individual Practitioner, A Medical Group Practice or an assistant  
Facility: Diagnostic Imaging Center, In-Office Provider (IOP), Hospital or Facility

#### USER REGISTRATION

User Access Agreement \*Required

eviCore  
Provider/Customer Access Agreement for Web-Based Applications

This Provider/Customer Access Agreement for Web-Based Applications ("Access Agreement") contains the terms and conditions for use by Provider/Customers of the web-based applications provided by eviCore through its Web Site. This Access Agreement applies to Provider/Customer and all employees and/or agents that have access to eviCore's web-based applications by utilizing a User ID and Personal Identification Number ("PIN"), Security Password, or other security device provided by eviCore, hereinafter referred to as "Users."

To obtain access to eviCore's Web Site applications, User must first read and agree to this Access Agreement. After reviewing these documents, User will be asked to accept the Access Agreement by checking the "Accept Terms and Conditions" check box. If User accepts, this will result in a binding contract between User and eviCore, just as if User had physically signed the Access Agreement.

Each and every time User accesses eviCore's web-based applications, User agrees to be bound by this Access Agreement, as it may be amended from time to time.

1. Limited License. Upon acceptance, eviCore grants Provider/Customer a revocable, nonexclusive, and nontransferable limited license to access electronically eviCore's web-based applications only so long as Provider/Customer is currently bound by a Provider/Customer Agreement (as used herein a "Provider/Customer Agreement" is an agreement to provide health care/medical services to members of health plans for which eviCore provides radiological services, whether it is with eviCore directly or said health plan(s)).  
The electronic access to applications of eviCore's web-based applications is subject to the terms and conditions of the Provider/Customer Agreement.

Accept Terms and Conditions \*

Submit Cancel

Accept the **Terms and Conditions**, and click **"Submit."**

# User Registration-Continued

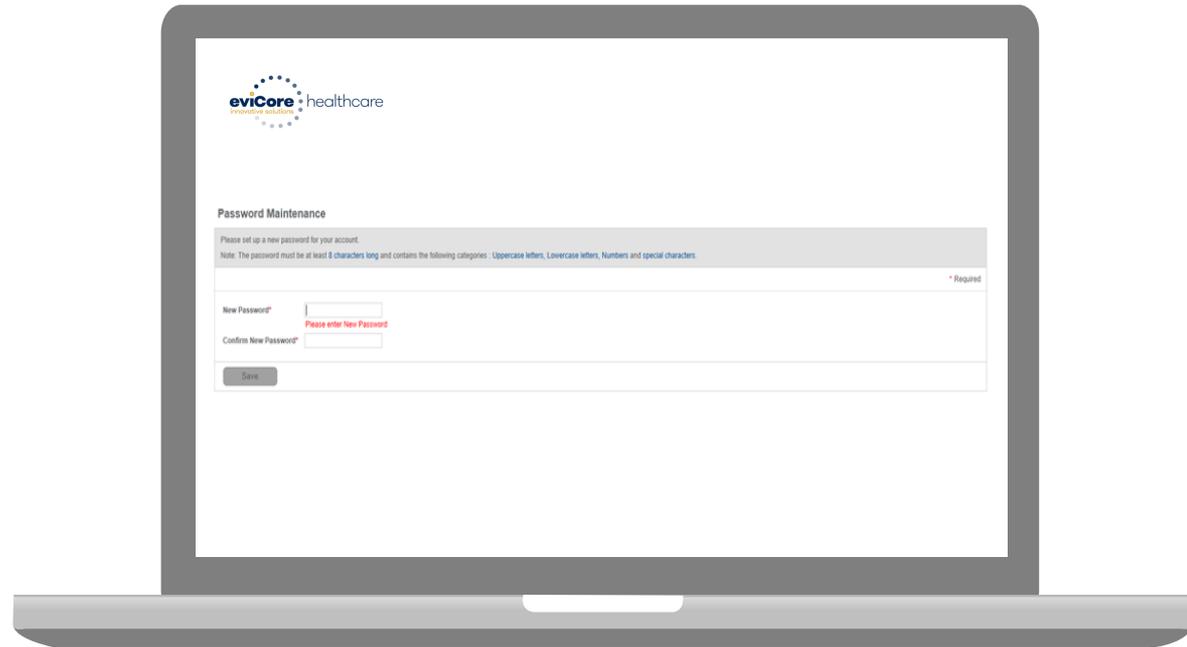


You will receive a message on the screen confirming your registration is successful. You will be sent an email to create your password.

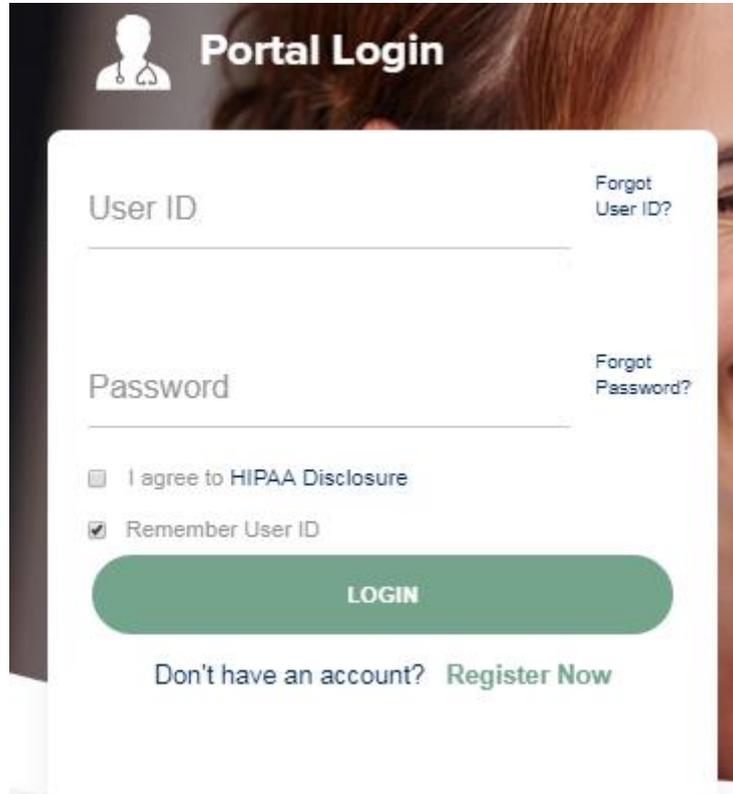
# Create a Password

Your password must be at least (8) characters long and contain the following:

- ✓ Uppercase letters
- ✓ Lowercase letters
- ✓ Numbers
- ✓ Characters (e.g., ! ? \*)



# Account Log-In



The image shows a 'Portal Login' form. At the top left is a white icon of a person with a stethoscope. To its right is the text 'Portal Login'. Below this is a white form box with a rounded bottom. Inside the form box, there are two input fields: 'User ID' and 'Password'. To the right of the 'User ID' field is a link 'Forgot User ID?'. To the right of the 'Password' field is a link 'Forgot Password?'. Below the input fields are two checkboxes: the first is 'I agree to HIPAA Disclosure' with an unchecked box, and the second is 'Remember User ID' with a checked box. Below the checkboxes is a green rounded button with the text 'LOGIN'. At the bottom of the form box is the text 'Don't have an account? Register Now'.



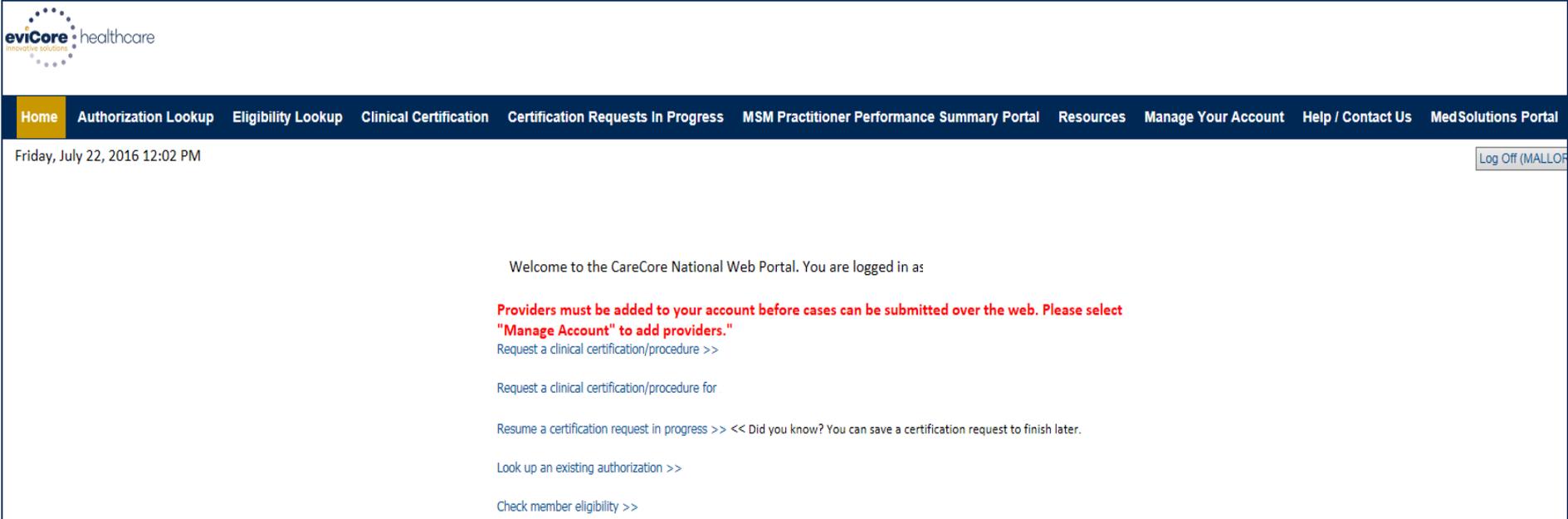
To log-in to your account, enter your **User ID** and **Password**. Agree to the HIPAA Disclosure, and click “**Login**.”

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# Account Overview

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# Welcome Screen

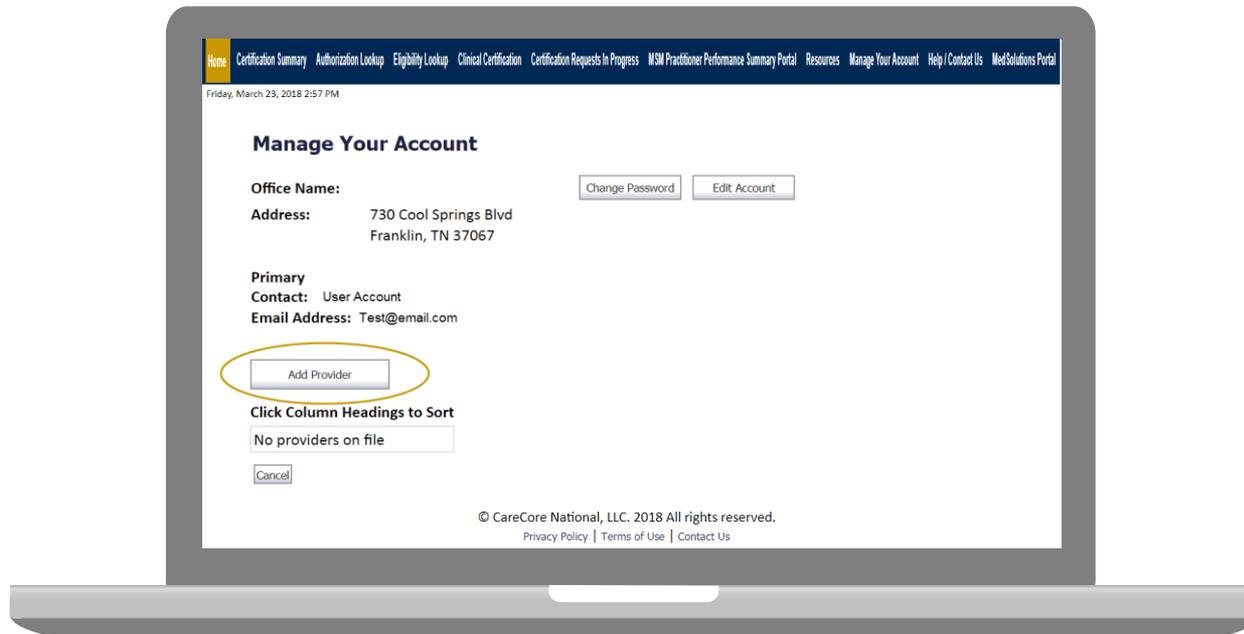


The screenshot shows the CareCore National Web Portal welcome screen. At the top left is the eviCore healthcare logo with the tagline 'innovative solutions'. Below the logo is a dark blue navigation bar with white text for various menu items: Home, Authorization Lookup, Eligibility Lookup, Clinical Certification, Certification Requests In Progress, MSM Practitioner Performance Summary Portal, Resources, Manage Your Account, Help / Contact Us, and MedSolutions Portal. The 'Home' tab is highlighted in yellow. Below the navigation bar, the date and time 'Friday, July 22, 2016 12:02 PM' are displayed on the left, and a 'Log Off (MALLOR)' button is on the right. The main content area contains a welcome message: 'Welcome to the CareCore National Web Portal. You are logged in as'. Below this is a red warning message: 'Providers must be added to your account before cases can be submitted over the web. Please select "Manage Account" to add providers.' followed by several links: 'Request a clinical certification/procedure >>', 'Request a clinical certification/procedure for', 'Resume a certification request in progress >> << Did you know? You can save a certification request to finish later.', 'Look up an existing authorization >>', and 'Check member eligibility >>'.

Providers will need to be added to your account prior to case submission. Click the “**Manage Account**” tab to add provider information.

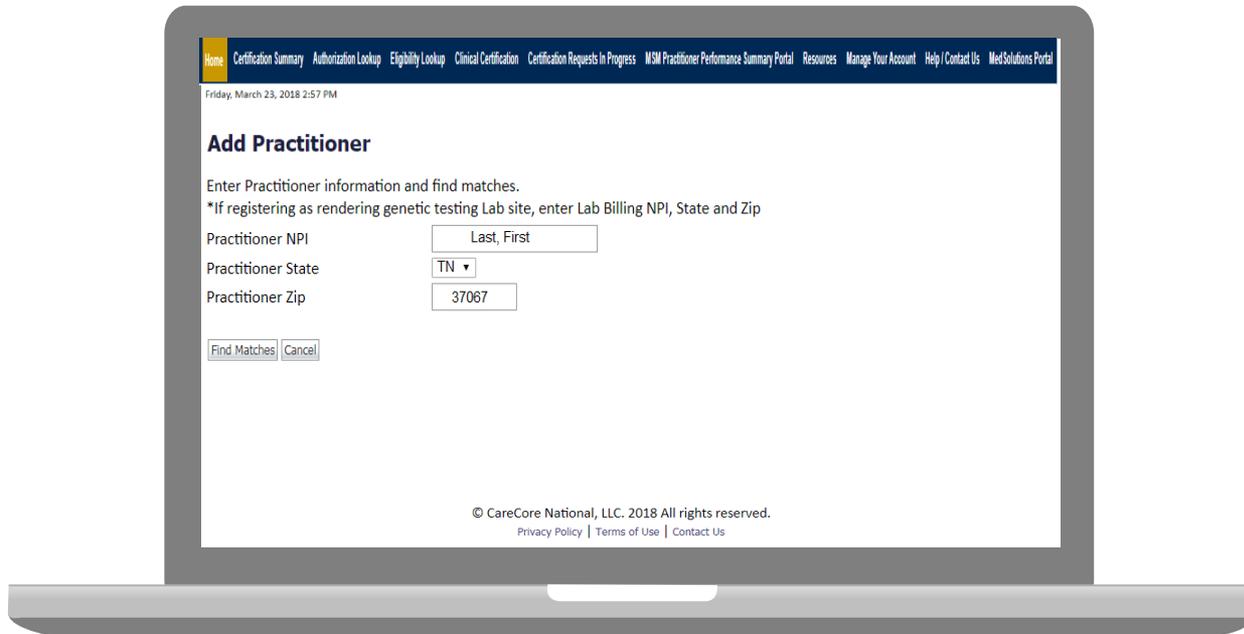
**Note:** You can access the MedSolutions Portal at any time if you are registered. Click the MedSolutions Portal button on the top right corner to seamlessly toggle back and forth between the two portals without having to log-in multiple accounts.

# Add Practitioners



Click the “Add Provider” button.

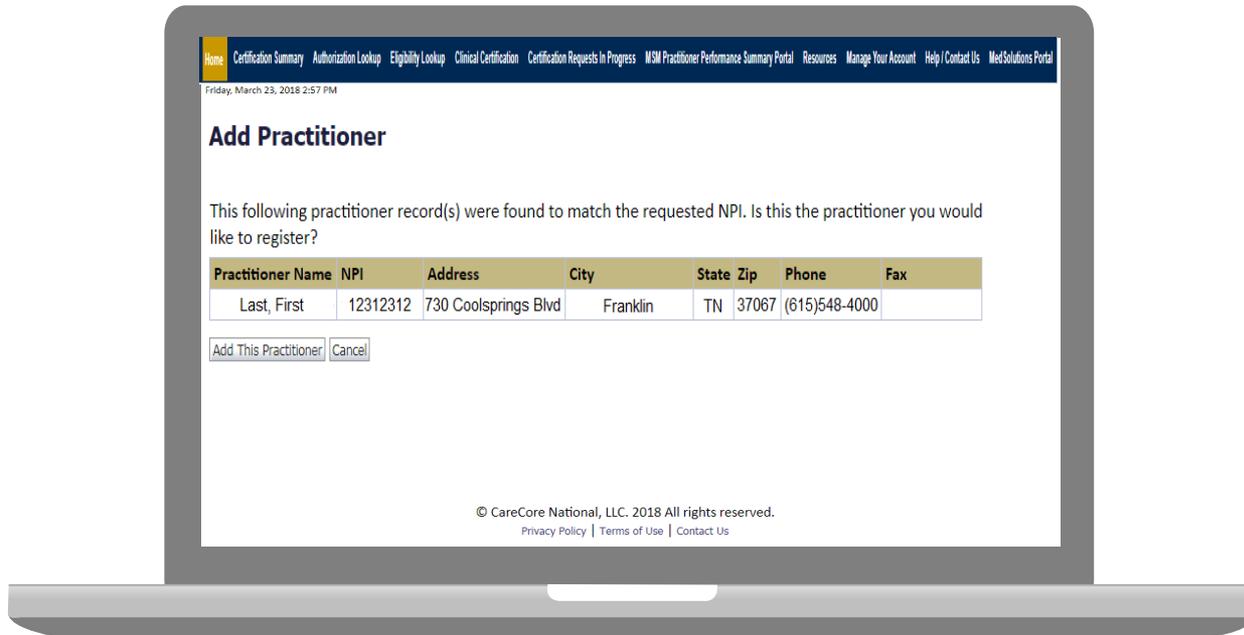
## Add Practitioners



The screenshot shows a web application interface for adding practitioners. At the top, there is a navigation menu with links: Home, Certification Summary, Authorization Lookup, Eligibility Lookup, Clinical Certification, Certification Requests In Progress, MSM Practitioner Performance Summary Portal, Resources, Manage Your Account, Help / Contact Us, and Med Solutions Portal. Below the menu, the date and time are displayed as "Friday, March 23, 2018 2:57 PM". The main heading is "Add Practitioner". Below the heading, there is a prompt: "Enter Practitioner information and find matches." followed by a note: "\*If registering as rendering genetic testing Lab site, enter Lab Billing NPI, State and Zip". The form contains three input fields: "Practitioner NPI" with a text box containing "Last, First"; "Practitioner State" with a dropdown menu showing "TN"; and "Practitioner Zip" with a text box containing "37067". At the bottom of the form, there are two buttons: "Find Matches" and "Cancel". At the very bottom of the page, there is a copyright notice: "© CareCore National, LLC. 2018 All rights reserved." and links for "Privacy Policy", "Terms of Use", and "Contact Us".

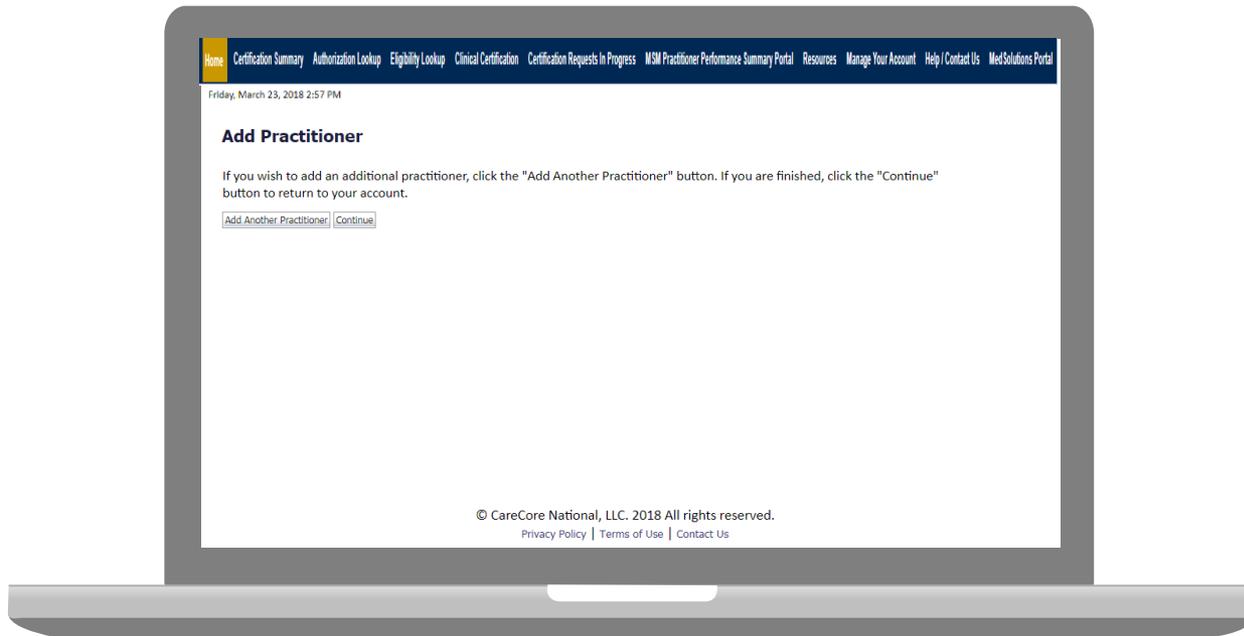
Enter the **Provider's NPI**, **State**, and **Zip Code** to search for the provider record to add to your account. You are able to add multiple Providers to your account.

## Adding Practitioners



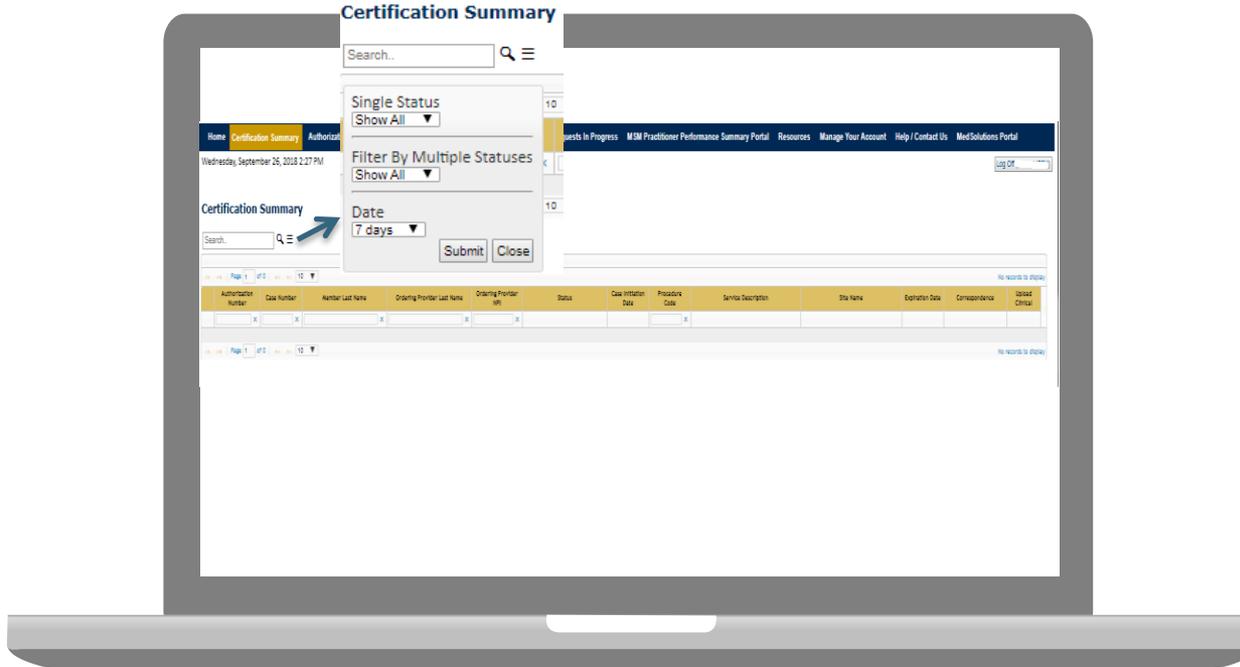
Select the matching record based upon your search criteria

## Manage Your Account



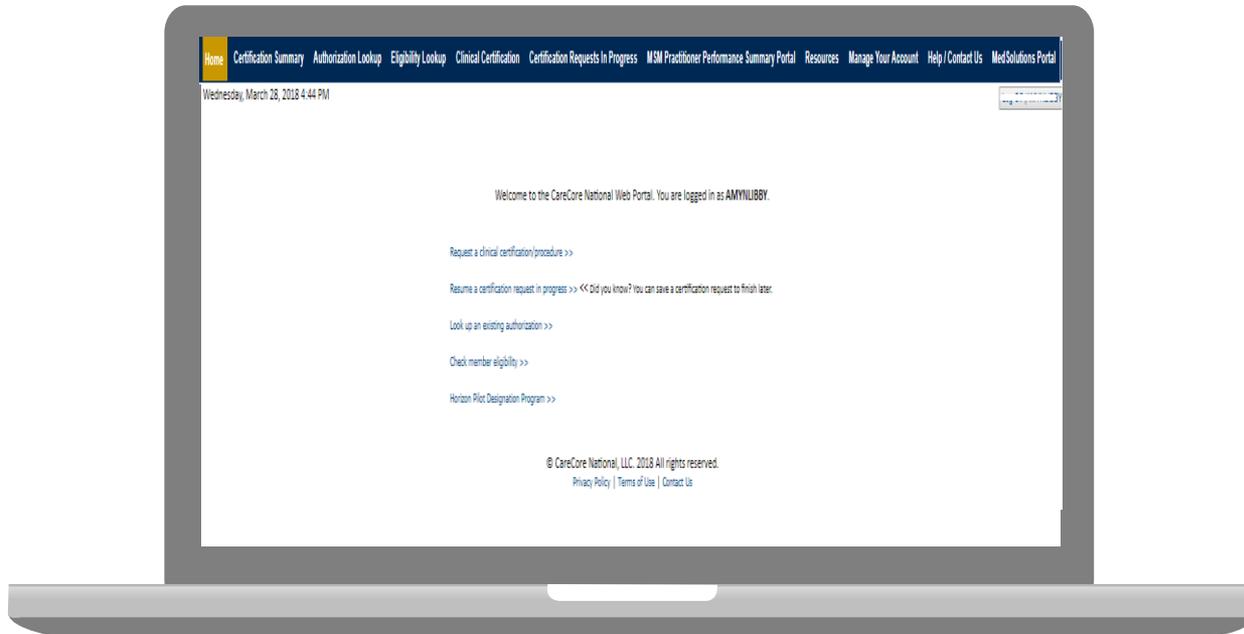
- Once you have selected a practitioner, your registration will be completed. You can then access the **“Manage Your Account”** tab to make any necessary updates or changes.
- You can also click **“Add Another Practitioner”** to add another provider to your account.

# \*New\* Certification Summary



- CareCore National Portal now includes a Certification Summary tab, to better track your recently submitted cases.
- The work list can also be filtered - as seen above.

## Initiating A Case



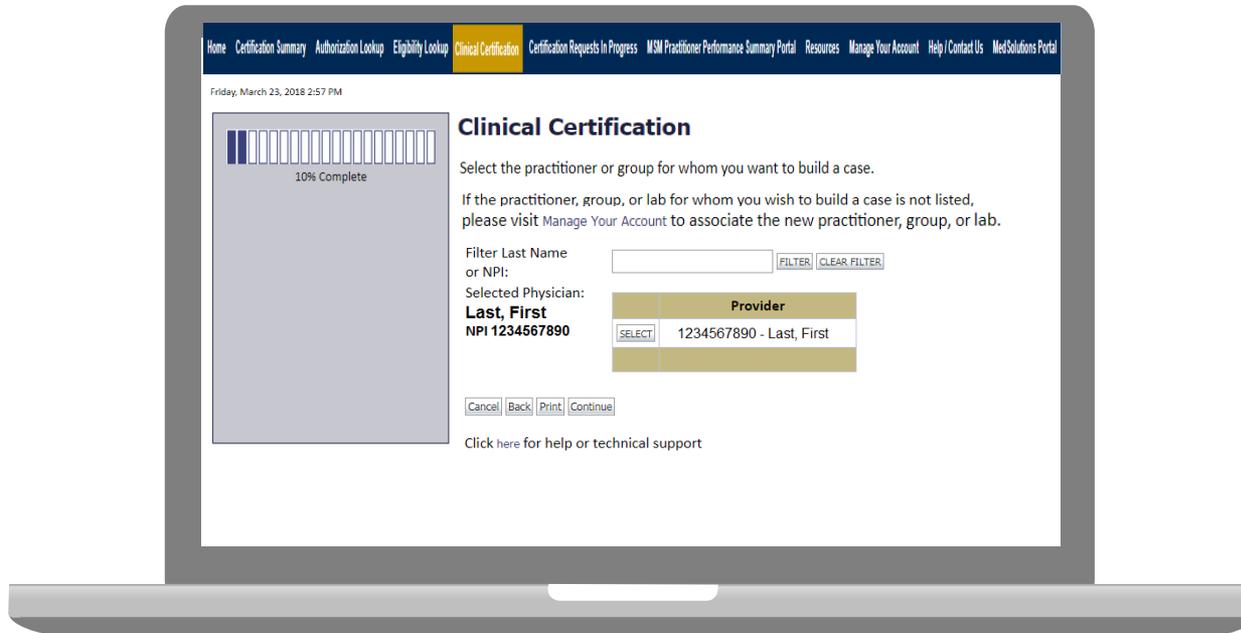
Choose **“request a clinical certification/procedure”** to begin a new case request.

## Select Program



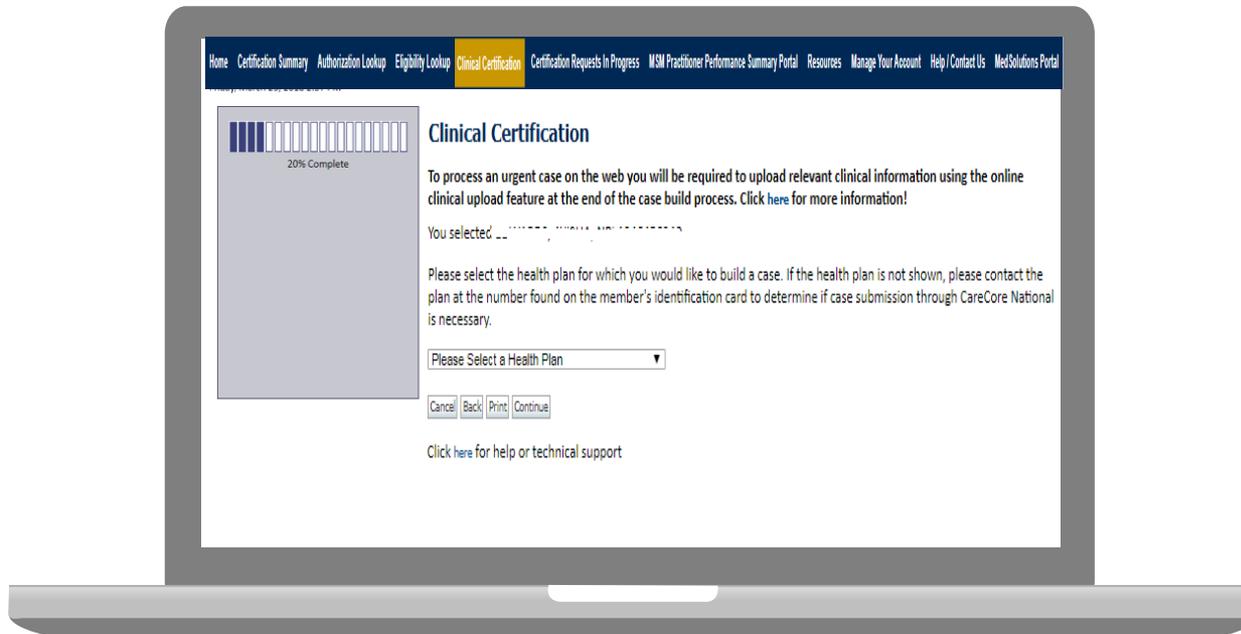
Select the **Program** for your certification.

# Select Provider



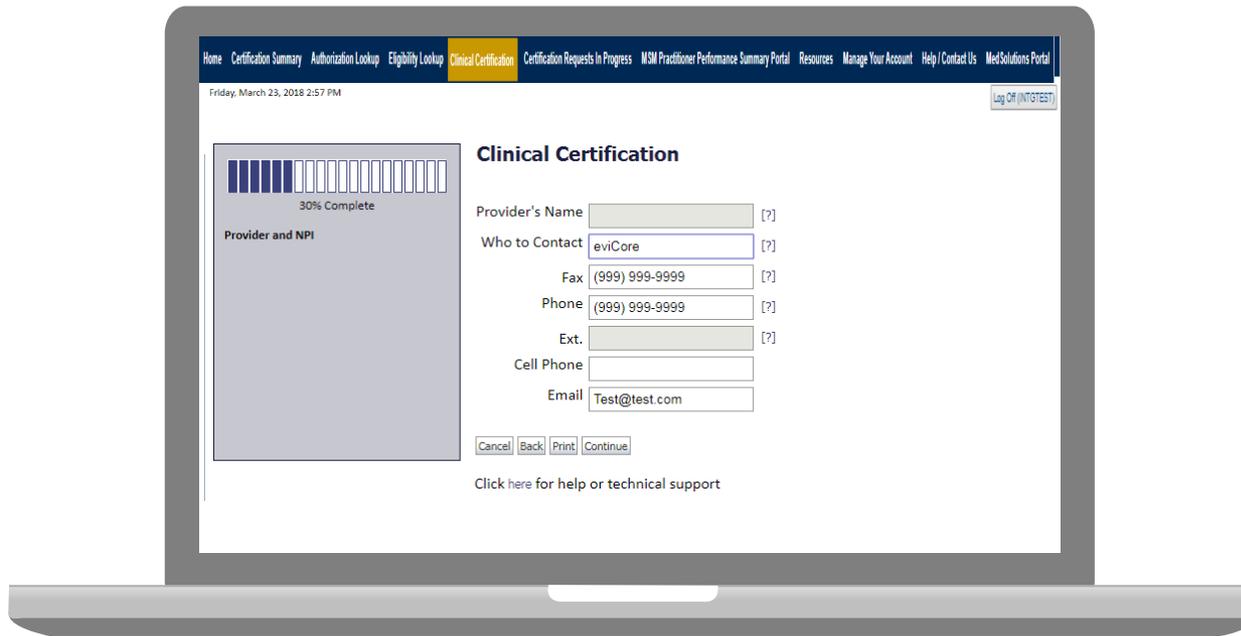
Select the **Practitioner/Group** for whom you want to build a case.

## Select Health Plan



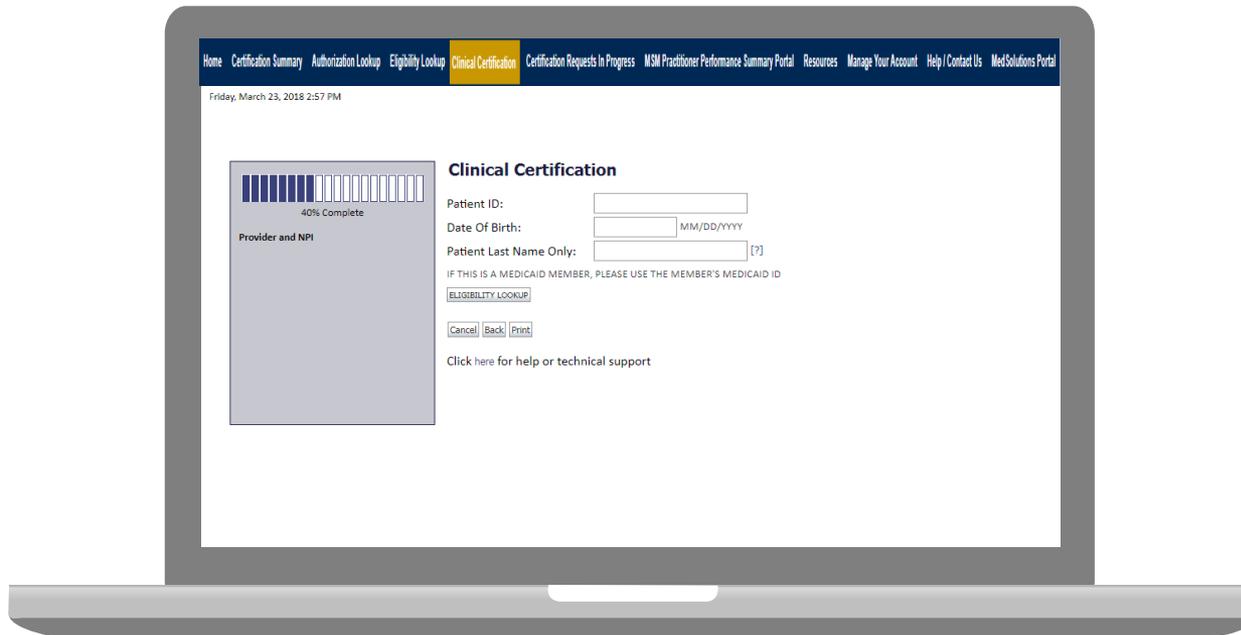
Choose the appropriate **Health Plan** for the case request. If the health plan does not populate, please contact the plan at the number found on the member's identification card. Once the plan is chosen, please select the provider address in the next drop down box.

# Contact Information



Enter the **Provider's name** and appropriate information for the point of contact individual.

## Member Information



The screenshot shows a web application interface for Clinical Certification. At the top, there is a navigation menu with links: Home, Certification Summary, Authorization Lookup, Eligibility Lookup, Clinical Certification (highlighted), Certification Requests In Progress, MSM Practitioner Performance Summary Portal, Resources, Manage Your Account, Help / Contact Us, and Med Solutions Portal. Below the navigation menu, the date and time are displayed: Friday, March 23, 2018 2:57 PM.

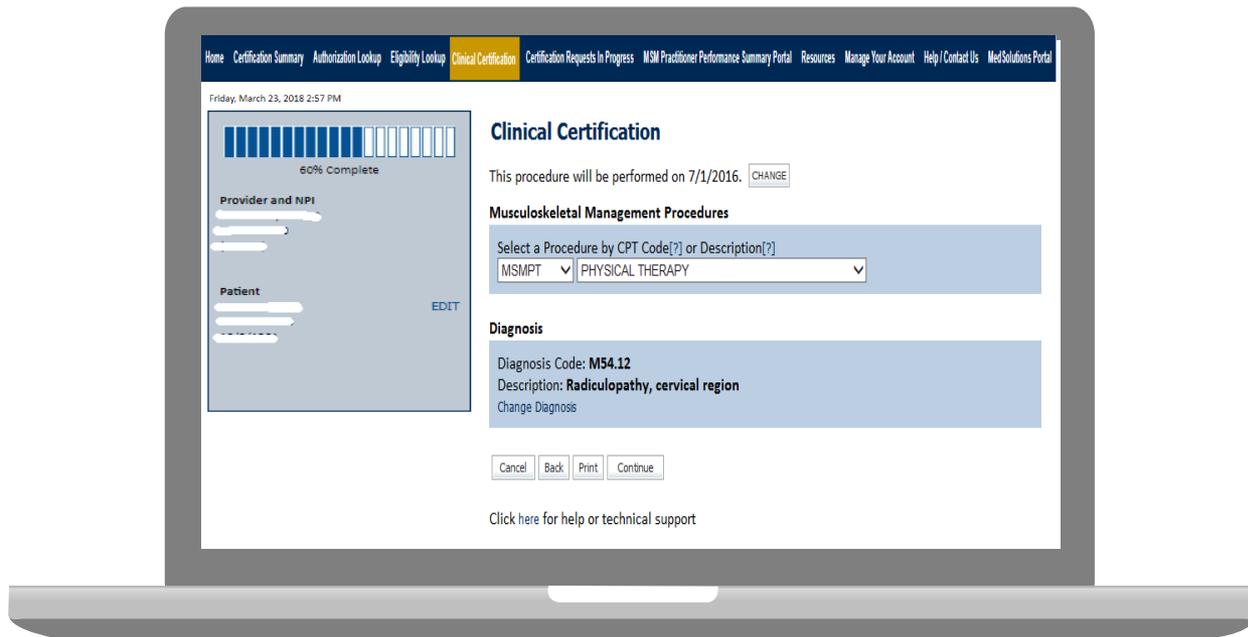
The main content area is divided into two sections. On the left, there is a progress indicator consisting of 10 vertical bars, with 4 bars filled in blue, indicating 40% completion. Below the progress indicator, the text "40% Complete" is displayed. Underneath, there is a section titled "Provider and NPI" with a large grey rectangular area below it.

On the right, the section is titled "Clinical Certification". It contains the following fields and controls:

- Patient ID:
- Date Of Birth:  M/M/DD/YYYY
- Patient Last Name Only:  [?]
- IF THIS IS A MEDICAID MEMBER, PLEASE USE THE MEMBER'S MEDICAID ID
- [ELIGIBILITY LOOKUP](#)
- [Cancel](#) [Back](#) [Print](#)
- [Click here for help or technical support](#)

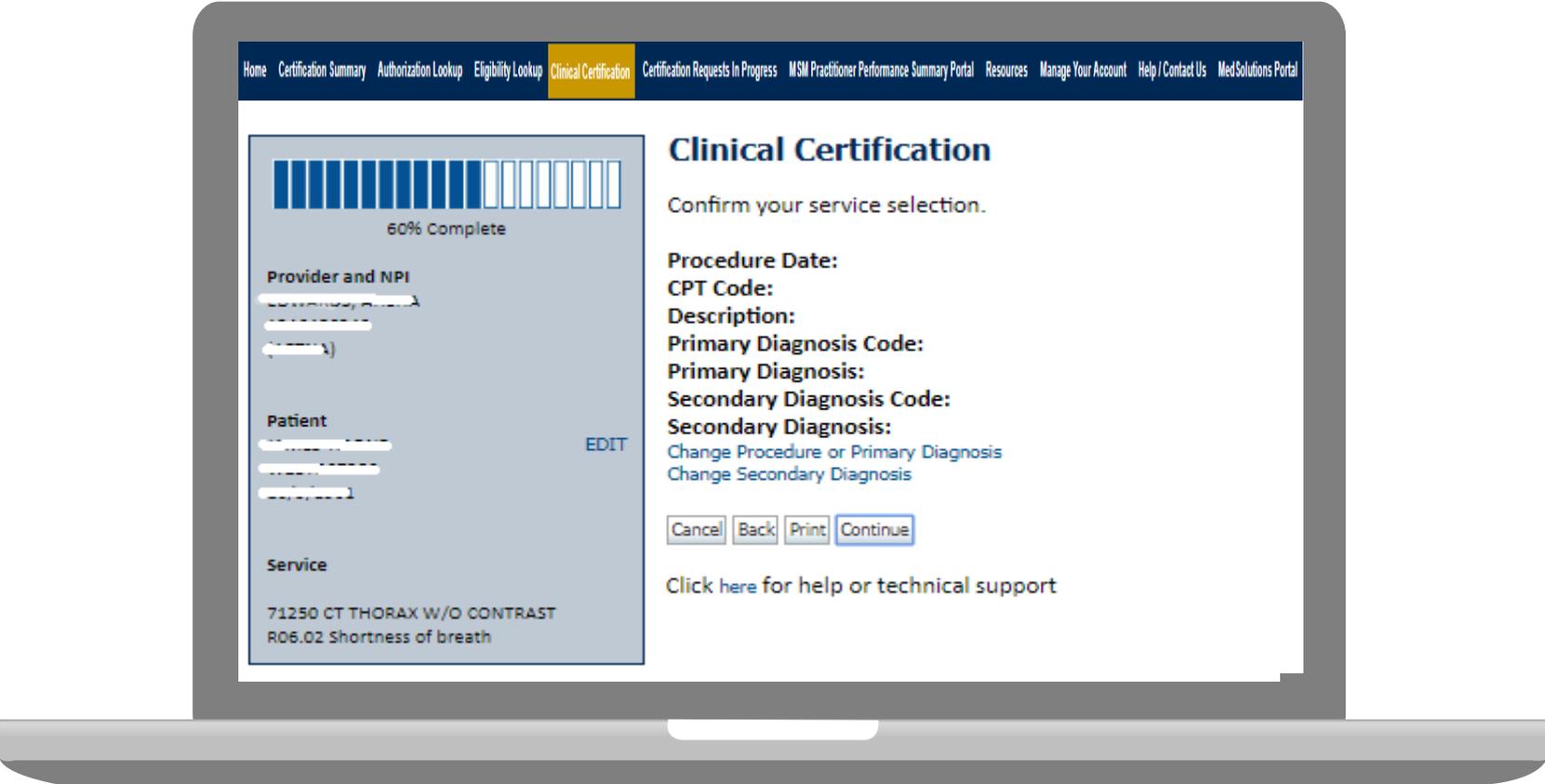
Enter the **member information** including the Patient ID number, date of birth, and patient's last name. Click **"Eligibility Lookup."**

# Clinical Details

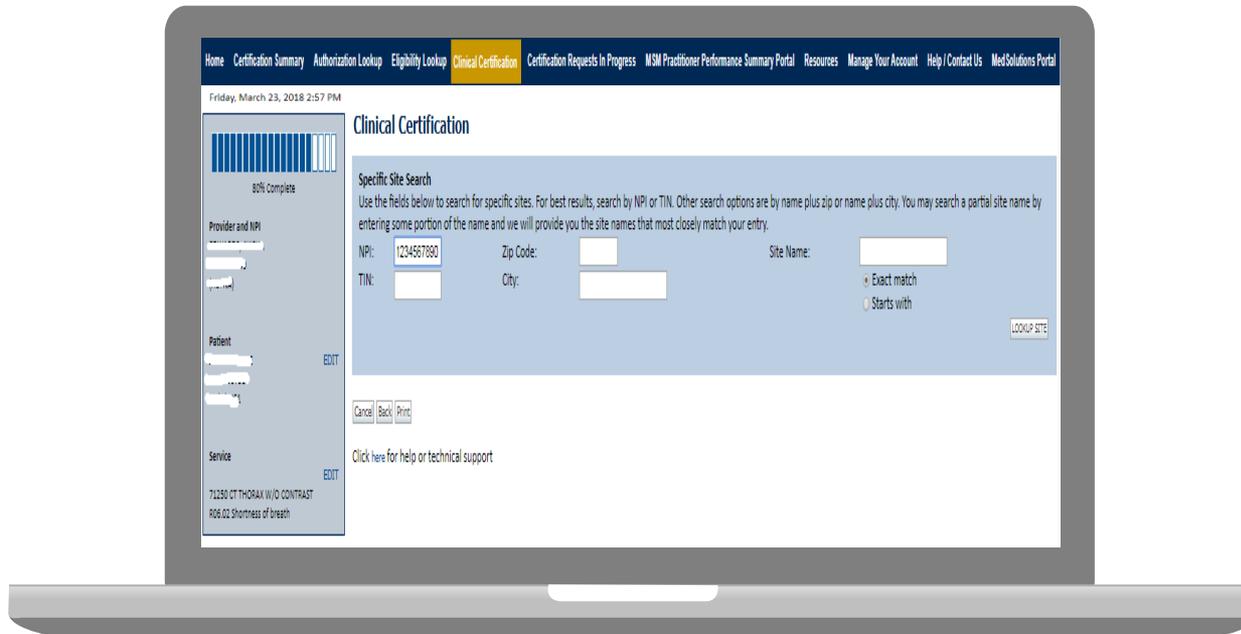


Select the **CPT** and **Diagnosis** codes.

# Verify Service Selection

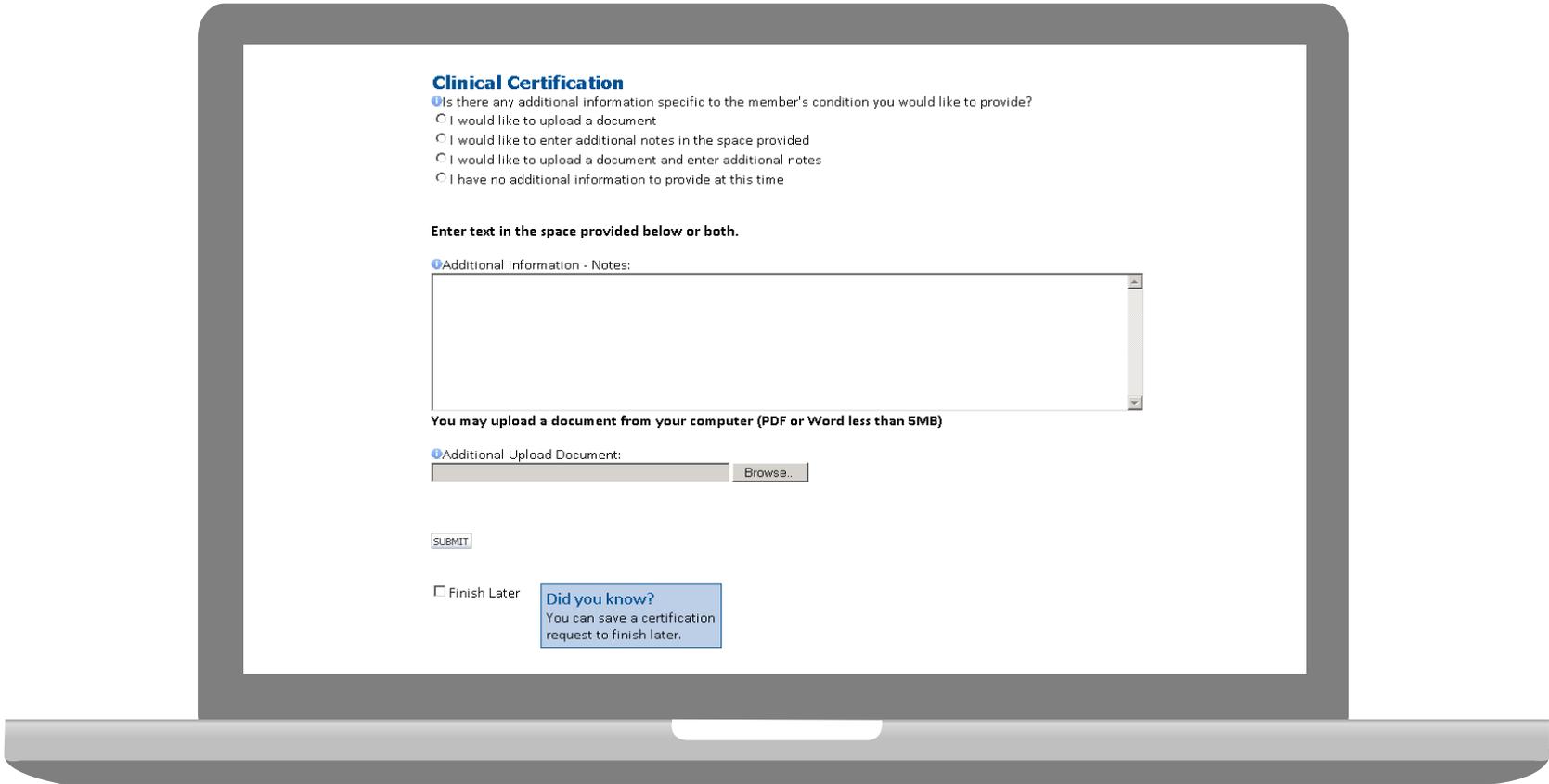


## Site Selection



Select the **specific site** where the testing/treatment will be performed.

# Medical Review



**Clinical Certification**

Is there any additional information specific to the member's condition you would like to provide?

- I would like to upload a document
- I would like to enter additional notes in the space provided
- I would like to upload a document and enter additional notes
- I have no additional information to provide at this time

Enter text in the space provided below or both.

Additional Information - Notes:

You may upload a document from your computer (PDF or Word less than 5MB)

Additional Upload Document:

Finish Later

**Did you know?**  
You can save a certification request to finish later.

➔ If **additional information** is required, you will have the option to either upload documentation, enter information into the text field, or contact us via phone.

# Approval

**Clinical Certification**

Your case has been Approved.

Provider Name: \_\_\_\_\_ Contact: \_\_\_\_\_  
Provider Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

---

Patient Name: \_\_\_\_\_ Patient Id: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_

---

Site Name: \_\_\_\_\_ Site ID: \_\_\_\_\_  
Site Address: \_\_\_\_\_

---

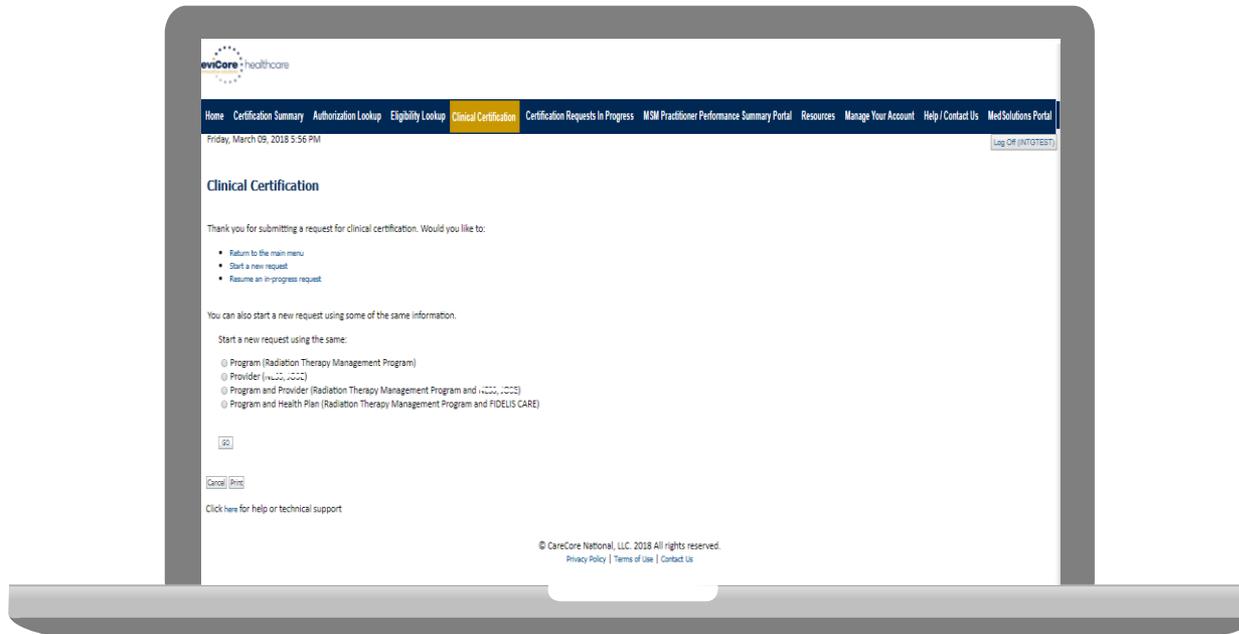
Primary Diagnosis Code: \_\_\_\_\_ Description: \_\_\_\_\_  
Secondary Diagnosis Code: \_\_\_\_\_ Description: \_\_\_\_\_  
CPT Code: \_\_\_\_\_ Description: \_\_\_\_\_

Modifier: \_\_\_\_\_  
Authorization Number: \_\_\_\_\_  
Review Date: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Status: Your case has been Approved.

Once the clinical pathway questions are completed and if the answers have met the clinical criteria, an **approval** will be issued.

Print the screen and store in the patient's file.

## Building Additional Cases

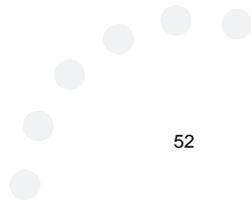


Once a case has been submitted for clinical certification, you can return to the **Main Menu**, **resume an in-progress request**, or **start a new request**. You can indicate if any of the previous case information will be needed for the new request.

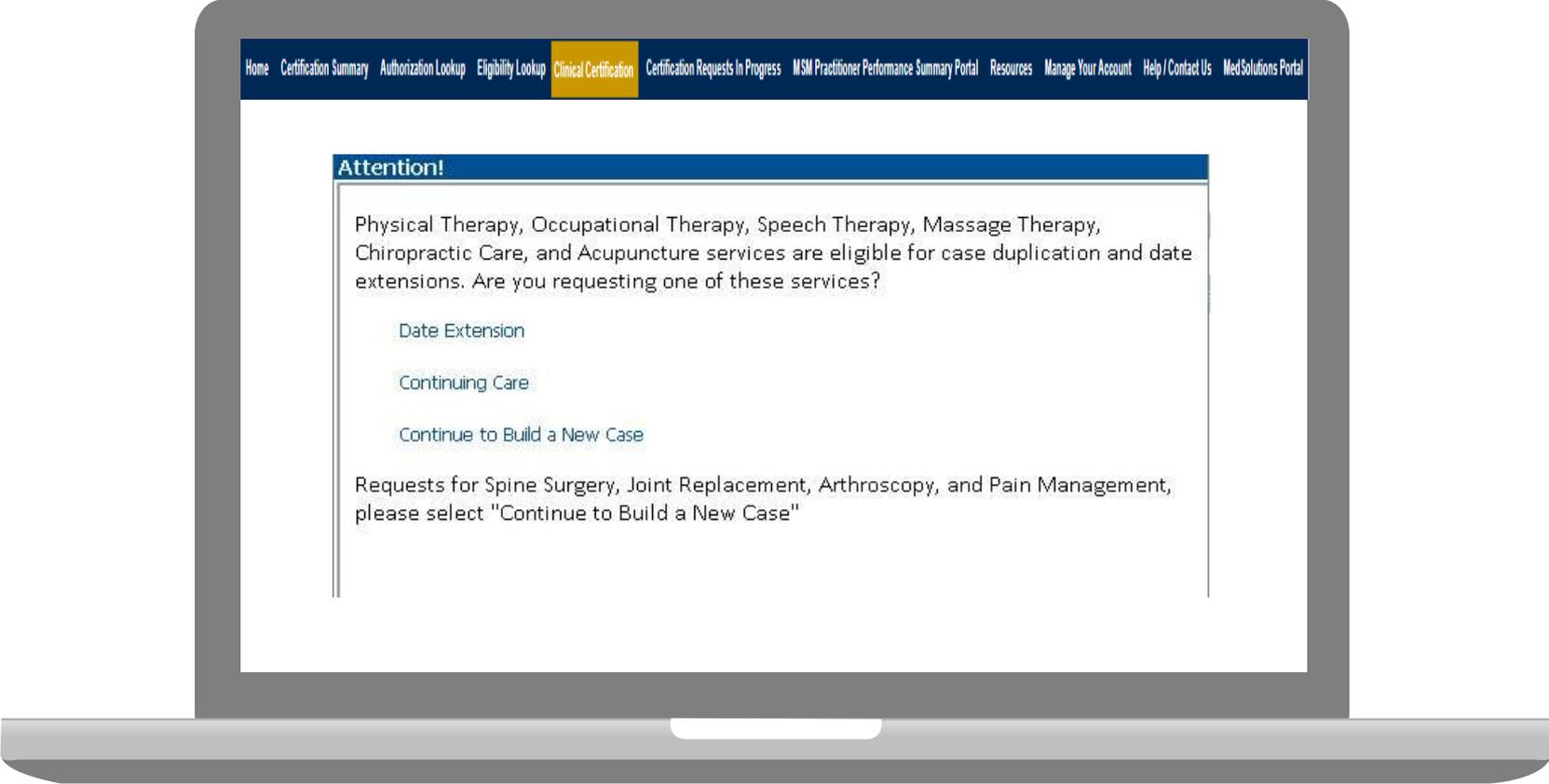
# Date Extensions

---

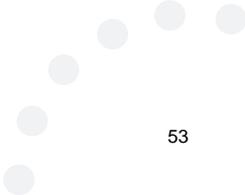
- The authorization can be extended if all the approved visits have not been used.
- eviCore healthcare will approve one date extension per Approved Time Period up to 30 days as long as the authorization has not expired.
- Date extension can be requested via the online portal.



# Service Options



Select **Date Extension**



# Authorization look up



## Authorization Lookup

### New Security Features Implemented

**Search by Member Information**

REQUIRED FIELDS

Healthplan:

Provider NPI:

Patient ID:

Patient Date of Birth:   
MM/DD/YYYY

OPTIONAL FIELDS

Case Number:

or

Authorization Number:

**Search by Authorization Number/ NPI**

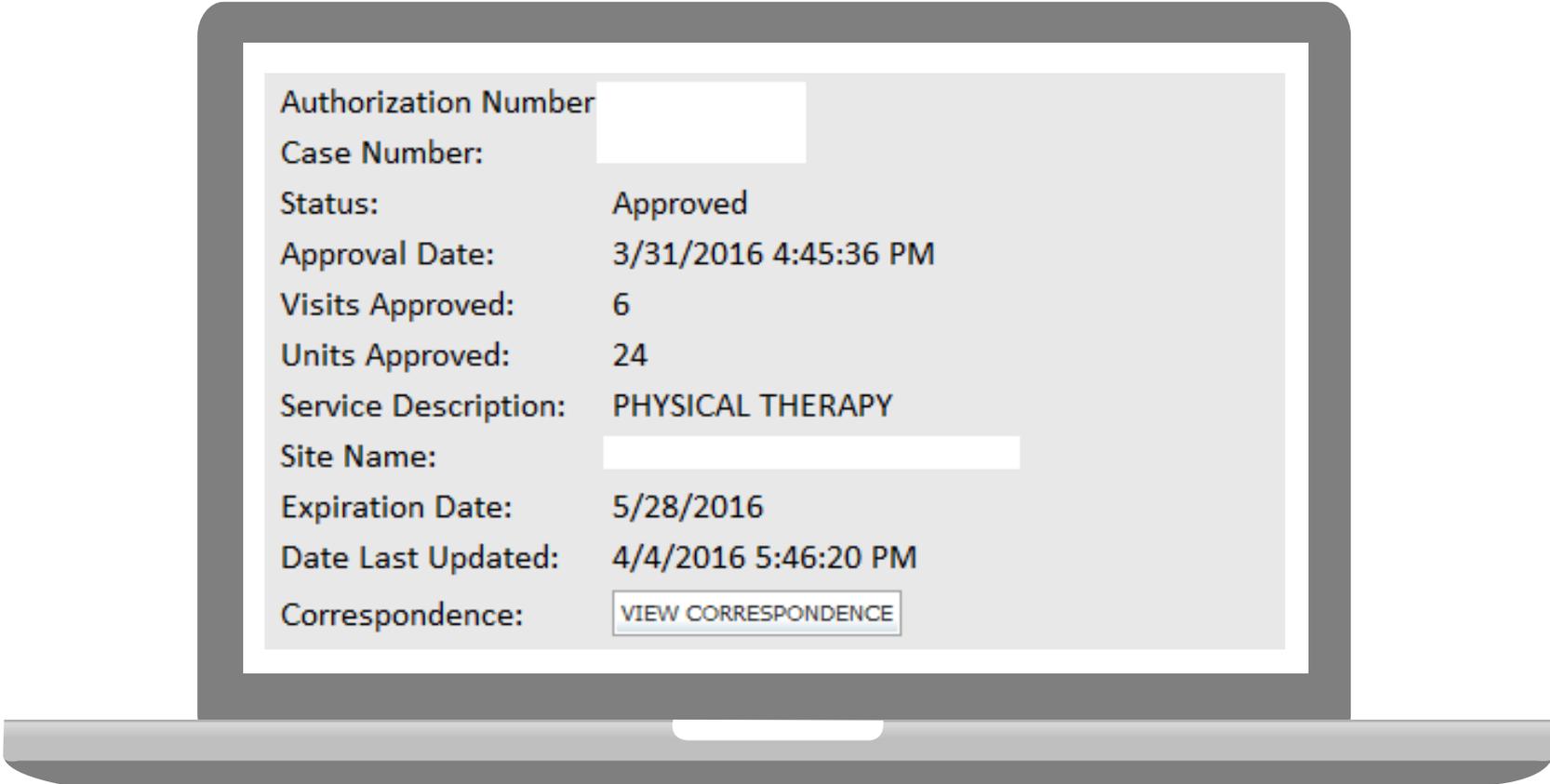
REQUIRED FIELDS

Provider NPI:

Auth/Case Number:

- Select Search by **Authorization Number/NPI**. Enter the provider's NPI and authorization or case number. Select **Search**.
- You can also search for an authorization by **Member Information**, and enter the health plan, Provider NPI, patient's ID number, and patient's date of birth.

# Authorization Status



# Eligibility Look Up



[Home](#) [Authorization Lookup](#) **[Eligibility Lookup](#)** [Clinical Certification](#) [Certification Requests In Progress](#) [MSM Practitioner Performance Summary Portal](#) [Resources](#) [Manage Your Account](#) [Help / Contact Us](#)

Thursday, March 15, 2018 4:43 PM

[Log Off \(INTGTEST\)](#)

## Eligibility Lookup

### New Security Features Implemented

Health Plan:

Patient ID:

Member Code:

Cardiology Eligibility: **Medical necessity determination required.**

Radiology Eligibility: **Precertification is Required**

Radiation Therapy Eligibility: **Medical necessity determination required.**

MSM Pain Mgt Eligibility: **Precertification is Required**

Sleep Management Eligibility: **Medical necessity determination required.**

[Print](#) [Done](#) [Search Again](#)

[Click here for help or technical support](#)

CONFIDENTIALITY NOTICE: Certain portions of this website are accessible only by authorized users and unique identifying credentials, and may contain confidential or privileged information. If you are not an authorized recipient of the information, you are hereby notified that any access, disclosure, copying, distribution, or use of any of the information contained in the code-accessed portions is STRICTLY PROHIBITED.

You may also confirm the patient's eligibility by selecting the **Eligibility Lookup** tab.

---

# Provider Resources





# Sample MSK Therapy corePath<sup>SM</sup> Worksheet

Worksheets for the following conditions are already available using the Therapy corePath approach:

- PT/OT MSK Conditions – Includes:
  - Hand
  - Pelvic Health
- PT/OT Lymphedema
- PT/OT Vestibular
- Developmental Pediatrics



### Musculoskeletal Program: PT/OT Therapy Intake Form

*Required for all MSK Conditions (Including Hand)*

Please use this fax form for NON-URGENT requests only. Failure to provide all relevant information may delay the determination. Phone and fax numbers may be found on eviCore.com under the Guidelines and Forms section. You may also log into the provider portal located on the site to submit an authorization request.

URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE

---

Previous Reference/Auth Number (If Continued Care): \_\_\_\_\_

Date of Submission: \_\_\_\_\_

Service Type Requested:  Physical Therapy  Occupational Therapy

---

PATIENT

First Name:	MI:	Last Name:	
Member ID:	DOB (mm/dd/yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address:		Apt #:	
City:	State:	Zip:	
Home Phone:	Cell Phone:	Primary: <input type="checkbox"/> Home <input type="checkbox"/> Cell	
Member Health Plan/Insurer:			

---

PROVIDER

First Name:	Last Name:		
Primary Specialty:	TIN:	NPI:	
Physician Phone:	Physician Fax:		
Address:	Suite #:		
City:	State:	Zip:	
Office Contact:	Ext:	Email:	

---

ADMINISTRATIVE

Diagnoses:			
Code	Description	Code	Description

Start Date for this Request: \_\_\_\_\_

This is a (select the most appropriate):  New condition not previously treated  Same/previous condition

Date of initial evaluation: \_\_\_\_\_ Date of onset of condition: \_\_\_\_\_ Date of current findings: \_\_\_\_\_

**Primary Treatment Area:**

Spine:	<input type="checkbox"/> Cervical / Upper Thoracic	<input type="checkbox"/> Lower Thoracic / Lumbar / Pelvis
Upper Extremity:	<input type="checkbox"/> Shoulder / Arm	<input type="checkbox"/> Elbow / Wrist / Forearm <input type="checkbox"/> Hand
Lower Extremity:	<input type="checkbox"/> Hip / Thigh	<input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot
Other:	<input type="checkbox"/> Pelvic Pain / Incontinence	

**Secondary Treatment Area:**

Spine:	<input type="checkbox"/> Cervical / Upper Thoracic	<input type="checkbox"/> Lower Thoracic / Lumbar / Pelvis
Upper Extremity:	<input type="checkbox"/> Shoulder / Arm	<input type="checkbox"/> Elbow / Wrist / Forearm <input type="checkbox"/> Hand
Lower Extremity:	<input type="checkbox"/> Hip / Thigh	<input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot
Other:	<input type="checkbox"/> Pelvic Pain / Incontinence	

**Previous Treatment – Leave Blank if N/A:**

If the member requires treatment for a new condition, what was the previous condition?  N/A

Cervical / Upper Thoracic  Lower Thoracic / Lumbar / Pelvis  UE - Shoulder/Arm  UE - Hand

UE - Elbow/Wrist/Forearm  LE - Hip/Thigh  LE - Knee  LE - Ankle/Foot

Pelvic Pain / Incontinence

What is the status of the previous treatment?  Condition Resolved  Ongoing Treatment  N/A

Is this request for fabricating a splint/orthotic or developing a home exercise program only?  Yes  No

# Clinical Worksheet Example – cont...

<b>CERVICAL / UPPER THORACIC</b>	<b>TREATMENT AREA: Cervical / Upper Thoracic</b>		Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-Up		
	Post-Surgical Care: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, Date of Surgery:</i>				
	Surgery Type: <input type="checkbox"/> Decompression <input type="checkbox"/> Discectomy <input type="checkbox"/> Fusion <input type="checkbox"/> Total Disc Replacement <input type="checkbox"/> Scoliosis/Deformity/Fracture Levels of Surgery:				
<i>Complete the following section for initial OR follow-up care as appropriate</i>					
		Initial	Follow-Up		
Neck Disability Index score (NDI):		% <input type="checkbox"/> Not performed			
Radiating pain below elbow:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of episodes in past 3 yrs:		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> ≥4			
Change from previous NDI:		N/A – Leave Blank for Initial Request			
Has pt. responded as expected?		N/A – Leave Blank for Initial Request			
If patient has not responded, lack of patient progress due to: (select the most appropriate)		N/A – Leave Blank for Initial Request			
<b>LOWER THORACIC / LUMBAR / PELVIS</b>	<b>TREATMENT AREA: Lower Thoracic / Lumbar / Pelvis</b>		Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-Up		
	Post-Surgical Care: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, Date of Surgery:</i>				
	Surgery Type: <input type="checkbox"/> Decompression <input type="checkbox"/> Discectomy <input type="checkbox"/> Fusion <input type="checkbox"/> Total Disc Replacement <input type="checkbox"/> Scoliosis/Deformity/Fracture Levels of Surgery:				
<i>Complete the following section for initial OR follow-up care as appropriate</i>					
		Initial	Follow-Up		
Oswestry Disability Index Score:		% <input type="checkbox"/> Not performed		% <input type="checkbox"/> Not performed	
Radiating Pain to Knee or Below:		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of episodes in past 3 yrs:		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> ≥4			
Change from Previous ODI:		N/A – Leave Blank for Initial Request			
Has pt. responded as expected?		N/A – Leave Blank for Initial Request			
If patient has not responded, lack of patient progress due to: (select the most appropriate)		N/A – Leave Blank for Initial Request			
<b>UPPER EXTREMITY (ALL CONDITIONS)</b>	<b>TREATMENT AREA: Upper Extremity (All Conditions)</b>		Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-Up		
	Post-Surgical Care: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, Date of Sur</i>				
	<i>If yes, Indicate Type of Surgery from Selection Below:</i> Shoulder: <input type="checkbox"/> Rotator Cuff <input type="checkbox"/> Total Shoulder <input type="checkbox"/> Biceps/Si <input type="checkbox"/> Sub-Acromial Decompression <input type="checkbox"/> MUA Elbow: <input type="checkbox"/> Tendon Repair/Debridement <input type="checkbox"/> Total Elbow <input type="checkbox"/> <input type="checkbox"/> Nerve Release <input type="checkbox"/> MUA Wrist: <input type="checkbox"/> Tendon Repair/Debridement <input type="checkbox"/> Carpal Tunnel Rele <input type="checkbox"/> Ligament Repair <input type="checkbox"/> Nerve Release Hand: <input type="checkbox"/> Nerve Release (Hand) <input type="checkbox"/> Ligament Reconstruction <input type="checkbox"/> Finger Joint Replacement <input type="checkbox"/> Debridement/Infection				
<i>Complete the following section below for initi</i>					
		Initial			
Assessment Measure Used:		<input type="checkbox"/> DASH <input type="checkbox"/> QuickDASH			
Function/Symptom Score:		<input type="checkbox"/> Not performed			
More than 3 blank answers?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Optional module included?		<input type="checkbox"/> No <input type="checkbox"/> Work <input type="checkbox"/> Sports/ Mus			
Optional Module Score:					
<b>Shoulder / Elbow:</b>		<input type="checkbox"/> Loss of 15 degrees or more of elb			
Does your patient demonstrate (choose all that apply)		<input type="checkbox"/> Recurrent subluxation/dislocation			
		<input type="checkbox"/> Measurable (less than 4/5) weakn (Abduction, Flexion, External Rota			
		<input type="checkbox"/> Fracture of humeral head, greater			
<b>HAND ONLY:</b>		<input type="checkbox"/> Crush injury OR fracture of distal i			
Does your patient demonstrate (choose all that apply)		<input type="checkbox"/> Total active range of motion of the			
		<input type="checkbox"/> Total active range of motion of an			
		<input type="checkbox"/> Post-surgical or post-traumatic sw			
Change from previous DASH:		N/A – Leave Blank for Initial Request			
Patient responded as expected?		N/A – Leave Blank for Initial Request			
If patient has not responded as expected, lack of patient progress due to: (select the most appropriate)		N/A – Leave Blank for Initial Request			
<b>LOWER EXTREMITY (ALL CONDITIONS)</b>	<b>TREATMENT AREA: Lower Extremity (All Conditions)</b>		Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-Up		
	Post-Surgical Care: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, Date of Sur</i>				
	<i>Indicate Type of Surgery from Selection Below:</i> Knee: <input type="checkbox"/> Total/ Partial Arthroplasty <input type="checkbox"/> Ligament Reconstruction <input type="checkbox"/> Osteochondral/Microfracture <input type="checkbox"/> Tendon Repair Hip: <input type="checkbox"/> Total/Partial Arthroplasty <input type="checkbox"/> Total/Partial Hip Resurfac <input type="checkbox"/> Bursectomy Ankle/Foot: <input type="checkbox"/> Total Ankle Replac <input type="checkbox"/> Achilles/Other Tendon Repair <input type="checkbox"/> Ligament Reconstruction <input type="checkbox"/> Osteochondral/ Microfract				
<i>Complete the following section for initial or foll</i>					
		Initial			
Identify Functional Test Performed:		<input type="checkbox"/> LEFS (0-80 score range)			
		<input type="checkbox"/> HOOS Jr (0-100 score range)			
		<input type="checkbox"/> KOOS Jr (0-100 score range)			
		<input type="checkbox"/> None of the Above			
Functional Score:		<input type="checkbox"/> N/A			
Does your patient demonstrate:		<input type="checkbox"/> Loss of 10 degrees or more of knee			
		<input type="checkbox"/> Grade 3 or 4 laxity of the ankle or d			
		<input type="checkbox"/> Tinetti Gait/Balance score < 24 OR			
		<input type="checkbox"/> Measurable (less than 4/5) weakne (Abduction, Flexion, External Rotati			
Change from Previous Score:		N/A – Leave Blank for Initial Request			
Has pt. responded as expected?		N/A – Leave Blank for Initial Request			
If patient has not responded, lack of patient progress due to: (select the most appropriate)		N/A – Leave Blank for Initial Request			
<b>PELVIC PAIN / INCONTINENCE</b>	<b>TREATMENT AREA: Pelvic Pain / Incontinence</b>		Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-Up		
	<i>Complete the following section for initial or follow-up care as appropriate.</i>				
	Indicate which patient reported outcome score was used from the selection below. If no score, select "None Used": <input type="checkbox"/> None used				
<b>Please enter all component scores</b>		Initial	Follow-Up		
<input type="checkbox"/> Pelvic Floor Distress Inventory – 20 (PFDI-20).		Summary score (0-300)			Summary score (0-300)
<input type="checkbox"/> Pelvic Floor Impact Questionnaire – short form 7 (PFIQ-7).		Summary score (0-300)			Summary score (0-300)
<input type="checkbox"/> NIH – Chronic Prostatitis Symptom Index (NIH-CPSI).		Summary score (0-43)			Summary score (0-43)
<input type="checkbox"/> Oswestry Disability Index		%			%
Does your patient demonstrate:		<input type="checkbox"/> Iliac crest height OR Pubic symphysis asymmetry			
		<input type="checkbox"/> Positive provocative S.I. test OR Sacral torsion			
		<input type="checkbox"/> INABILITY to perform repetitive contractions of the pelvic floor muscles			
		<input type="checkbox"/> INABILITY to relax the pelvic floor muscles			
Incontinence (if applicable):		Number of leakage events per day:			(Enter 0 if not applicable)
Has pt. responded as expected?		N/A – Leave Blank for Initial Request		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If patient has not responded, lack of patient progress due to: (select the most appropriate)		N/A – Leave Blank for Initial Request		<input type="checkbox"/> "Overdid" activities/exercise causing increase in symptoms	
				<input type="checkbox"/> Progression of symptoms despite treatment	
				<input type="checkbox"/> Suffered a new injury resulting in significant change	
				<input type="checkbox"/> Unable to complete clinical visits/home program	
<b>Additional Clinical Information:</b>					

# Provider Resources: Pre-Certification Call Center



Pre-Certification  
Call Center



Web-Based  
Services



Provider Relations  
Department



Documents

**7:00 AM - 7:00 PM (Local Time): 888-333-8641**

- Obtain pre-certification for Urgent requests
- Check the status of an existing case when unable to access web
- Discuss questions regarding authorizations and case decisions
- Change facility or CPT Code(s) on an existing case

# Provider Resources: Web-Based Services



Pre-Certification  
Call Center



Web-Based  
Services



Client Provider  
Operations



Documents

[www.evicore.com](http://www.evicore.com)

*To speak with a Web Specialist, call (800) 646-0418 (Option #2) or email [portal.support@evicore.com](mailto:portal.support@evicore.com).*

- Request authorizations and check case status online – 24/7
- Pause/Start feature to complete initiated cases
- Upload electronic PDF/word clinical documents

# Provider Resources: Client Provider Operations



Pre-Certification  
Call Center



Web-Based  
Services



Client Provider  
Operations



Documents

[clientservices@evicore.com](mailto:clientservices@evicore.com)

*To speak with a Client Services representative, call 800-646-0418 (Option #4)*

- Eligibility issues (member, rendering facility, and/or ordering physician)
- Issues experienced during case creation
- Request for an authorization to be resent to the health plan
- Request for education/training on program processes

# Provider Resources: Implementation Document

Provider Enrollment Questions Contact WellCare



Pre-Certification  
Call Center



Web-Based  
Services



Provider Relations  
Department



Documents

## WellCare Implementation Site:

[https://www.evicore.com/healthplan/WellCare\\_corePath](https://www.evicore.com/healthplan/WellCare_corePath)

- Worksheets
- Quick reference guide links
- FAQ documents
- eviCore clinical guidelines
- A copy of this presentation

## Coding Guidelines & Program Criteria:

<https://www.evicore.com/>

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# Thank You!

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