**eviCore healthcare Musculoskeletal Therapies Program**
**Frequently Asked Questions**

## Who is eviCore healthcare?

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma, and Texas.

## Which BCBS members will eviCore healthcare manage?

eviCore will manage services for:

- Blue Cross and Blue Shield (BCBS) Medicare members located in the states listed above.
- BCBS Medicaid members located in Illinois and Texas

## What is the relationship between BCBS and eviCore healthcare?

Beginning on June 1, 2017, eviCore will manage select outpatient Musculoskeletal Therapy services for BCBS.

## What services are managed through the Musculoskeletal Therapies Program?

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

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Chiropractic

*Please note: Massage Therapy & Acupuncture services are not covered under the current governmental programs. Pediatric PT/OT developmental and pediatric ST are included in the program.

The list of codes that require prior authorization can be viewed on the provider resource website at: www.evicore.com/healthplan/bcbs.

## Will eviCore be processing claims for BCBS?

No, eviCore will only manage prior authorization requests. Pre-Certification and Pre-Service approval is not a guarantee of payment of benefits.

Medicare: Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions of your Certificate of Benefits booklet and/or Summary of Benefits.

Medicaid: For services to be paid by Blue Cross and Blue Shield, members must be eligible for Medicaid at the time of treatment. Payment depends on the amount allowed for the treatment. It also depends on a review of supporting records. Other terms and limits of your plan may also apply.

### How many visits will eviCore approve when I submit a prior authorization request?

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. The number of visits approved for the initial course of care will vary based on the diagnosis and treatment type of service being requested.

### How do I submit a prior authorization request?

There are three ways to submit requests to eviCore healthcare for outpatient member therapy services:

**Web Portal:** The web portal is the quickest, most efficient way to submit authorizations and check case status. The web portal is available 24 hours a day, 7 days a week. By utilizing the web portal, you have real-time access to patient authorization and eligibility information as well as the ability to submit requests at a time that best fits your schedule. The web portal can be accessed online at www.evicore.com.

**Phone:** eviCore healthcare's prior authorization call center is available from 7:00 a.m. to 7:00 p.m, Monday through Friday local time. For auth requests originating from Texas hours of operation are 6 am to 6 pm central time Monday through Friday and between 9 am-noon central time on Saturdays, Sundays, and legal holidays.

### 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. They can often be processed immediately.
- 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 prior authorization requests on the web. If you have an existing account, a new account is not necessary.

### Can one user submit prior authorization requests for multiple providers with different Tax ID numbers on the portal?

Yes, you can add the providers to your account once you have registered. In the Options Tool section at the top right of the portal, choose "Preferences" from the drop-down menu to set preferred Tax IDs for a physician or facility. By adding the preferred Tax IDs for a physician or facility to your account, you will be able to view the summary of cases submitted for those providers and facilities.

### Who do I contact for online support/questions?

Web portal inquiries can be emailed to portal.support@evicore.com.

### Why is prior authorization required if the member has not reached their benefit limit?

Medical necessity is included in all provider and member contracts. eviCore's role is to monitor the use of the member's benefit and review requests in accordance with what is needed for the member to return to basic function.

> ***Important!*** Authorization from eviCore healthcare does not guarantee claim payment. Services must be covered by the health plan and the member must be eligible at the time in which services are rendered. Claims submitted for unauthorized services are subject to denial and the member must be held harmless. You may verify member eligibility via eviCore's web portal or by calling the health plan directly.

### What clinical information will a provider need to initiate a prior authorization request?

The clinical information required to initiate a prior authorization request may vary based upon the type of service requested and the member's specific condition. When using eviCore's web portal, users will be prompted to answer specific questions based upon these factors. Prior authorization requests submitted via fax, using the appropriate eviCore Clinical Worksheet, may require more clinical information. Generally, any of the following clinical information may be required:

- Diagnosis/ICD-10
- Date of the current objective findings
- Date of the initial evaluation
- Date of onset
- Mechanism of onset
- Date and type of surgery, if applicable
- Restrictions
- Co-morbidities/complexities
- Conditions that would prohibit the safe delivery of care
- Pain level and duration/percent of time a member has pain
- Range of motion and strength findings
- Gait assessment/special tests
- Functional assessment (using the Patient Specific Functional Scale)
- For Pediatric PT/OT Developmental or Pediatric ST requests:
    - Standardized test scores and behaviors
    - Plan of care with short term goals and baseline measures for each
- Additional information that supports the need for therapy

### Where can I find the Clinical Worksheets needed to initiate prior authorization via fax?

Clinical worksheets may be found online at www.eviCore.com, under the "Resources" section. Please note, if electing to submit prior authorization requests via fax, the appropriate eviCore clinical worksheet should be completed in its entirety and submitted to 855-774-1319.

When submitting by fax, please ensure all fields are completed in entirety to avoid delays in processing. eviCore's Clinical Worksheets were designed to collect all clinical information needed to perform a

thorough medical necessity review. As such, additional information beyond the Clinical Worksheet is not necessary, but may be submitted if desired.

### Can I use my own forms when requesting authorizations?

**No.** To ensure that clinical peer reviewers receive necessary and complete information, and to make consistent clinical determinations, **eviCore' s Clinical Worksheets** are required for fax submission.

### When should a prior authorization request be submitted for therapy services?

Initial prior authorization requests should be requested through eviCore (by web, phone or fax) within seven days of the member's initial evaluation. Requests for ongoing care may be submitted as early as 7 days prior to the requested start date. The current findings date on your prior authorization request should be within ten 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.

### Will separate prior 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.

### Who should submit a prior authorization request?

The rendering (treating) provider should submit the prior authorization request. Services should always be requested and performed by appropriately licensed providers, practicing within the scope of their licensure and using their credentials.

### Can an Athletic Trainer initiate an authorization for physical therapy?

No, an Athletic Trainer may not initiate a case for Physical Therapy.

### If a member goes to a new provider for services, will a new prior authorization request be required?

Yes. When a member changes to a treating provider who is not within the same practice, a new prior authorization request is required. If the member has discontinued care with the original provider, please include the discharge date with the original provider 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 prior authorization request?

The start date of each prior 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 or authorization timeframe. 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 30 days from the start date identified on your prior authorization request. The authorization period; however, may differ based on the member's condition. For instance, pediatric therapy requests are often approved for a longer duration to allow sufficient time for the member to demonstrate progress.

### What is the turn-around time for a determination on a prior authorization request?

eviCore healthcare is committed to reviewing all requests and giving case decisions within fourteen (14) calendar days of receiving all necessary clinical information with an exception of Texas Medicaid that will be processed within 3 calendars days.

### How do I request an urgent procedure?

All urgent requests must meet the NCQA medically urgent criteria which are defined as conditions that are a risk to the patient's life, health, ability to regain maximum function, or the patient is having severe pain that required a medically urgent procedure. All urgent requests must be initiated telephonically. Most requests will receive a real-time approval, however if clinical documentation is requested, then a determination will be processed within 72 hours of receiving all clinical information.

> **Important!** Requests submitted by web portal and fax are treated as standard requests. ***Urgent requests should be initiated telephonically only.***

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

Yes, the authorization will included 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.

### How will I be notified of a determination?

Ordering and rendering providers will receive written notification via fax and urgent requests via phone. You can also validate the status using the eviCore provider portal at www.evicore.com or by calling eviCore healthcare at 855.252.1117. Members will be notified in writing by mail and urgent requests via phone.

### 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 7 days prior to the requested start date by submitting another prior authorization request via web, phone or fax. The request should include current clinical information (collected within the prior 10 days), including the patient's response to any treatment already approved and rendered. Authorizations cannot overlap. As such, be sure that the start date for a continuing care request is after the expiration of your previous authorization.

### 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 855-252-1117

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.
- An extension can only be requested during an open coverage period. If the coverage period has already expired, a new prior authorization request is required.
- Only one (1) extension is allowed per authorization.
- Authorizations can only be extended for up to an additional 30 days.
- An extension cannot 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.

### What clinical guidelines will be used to make a determination of medical necessity?

eviCore clinical guidelines will be followed. These are available at www.evicore.com.

### What are my options when there is an adverse determination on my request?

For Medicaid BCBS IL & TX members, the referring provider will receive a denial letter that contains the reason for denial as well as Reconsideration and Appeal rights and processes. A reconsideration allows providers the chance to provider additional information to support the request and includes the opportunity to request a Peer-to-Peer discussion with an eviCore Medical Director to review the decision.

For Medicare BCBS members, the referring provider will receive a denial letter that contains the reason for denial as well as Appeal rights and processes. Please note that after a denial has been issued for a Medicare member, no changes to the case decision, such as a reconsideration, can be made. Speaking with an eviCore Medical Director is for educational purposes only

### Who should I contact with questions?

If you have additional questions about the medical necessity review program, please contact the Client Provider department at eviCore healthcare via the following email address: clientservices@evicore.com

### What are the parameters of an appeals request?

eviCore will manage 1st level appeals. An authorized representative, including a provider, acting on behalf of a member, with the member's written consent may file an appeal on behalf of a member. A member patient authorization form must be completed for all first level appeals. Appeal rights are detailed in coverage determination letters sent to the providers with each adverse determination. Appeals must be made in writing within 120 calendar days and 30 calendar days for IL Medicaid unless the request involves urgent care, in which case the request may be made verbally. eviCore will respond within 30 calendar days, and 15 business days for IL Medicaid requests.

### Where should first-level appeals be sent?

Appeals must be submitted by mail, fax or email to:

Mail: eviCore healthcare
Attn: Clinical Appeal Dept
400 Buckwalter Place Blvd,
Bluffton, SC 29910

Fax: 866-699-8128

E-mail: Appealsfax@evicore.com

Toll Free Phone: (800)792-8744 ext 49100 or
(800)918-8924 ext 49100