Prior Authorization of Musculoskeletal Therapy & Chiropractic services for Blue Cross and Blue Shield Medicare and Medicaid Programs

Provider Orientation

Company Highlights

4K employees
including 1K clinicians

Headquartered in Bluffton, SC
Offices across the US including:

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

SHARING
A VISION
AT THE CORE OF CHANGE.

100M members
managed nationwide

NCQA Certification – Utilization Management

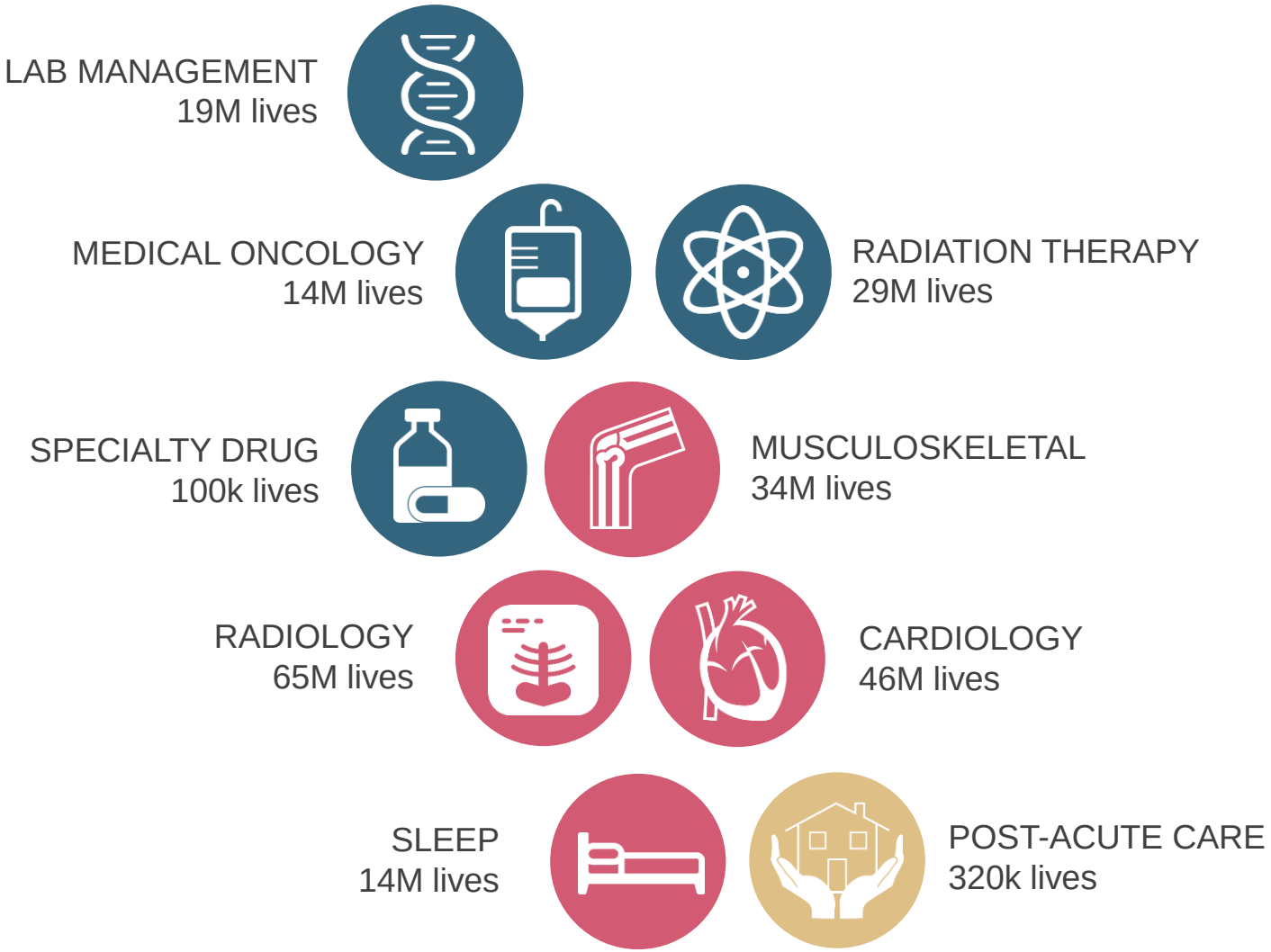
URAC – Accredited Health Utilization Management

Six Sigma

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

12M claims
processed annually

Integrated Solutions



Musculoskeletal Solution Experience

- 8 years' experience - since 2008
- 30+ regional and national clients
- 34M total membership
  - 25.5M Commercial membership
  - 2M Medicare membership
  - 6.5M Medicaid membership
- 3,120 average cases built per day

NCQA Certification Utilization Management

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT

Our Clinical Approach

Musculoskeletal by the Numbers

44

Musculoskeletal physicians on staff

66

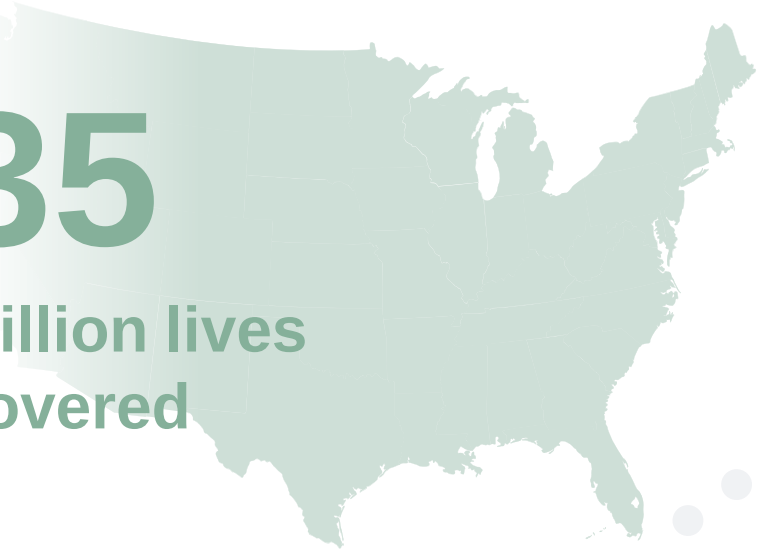
Musculoskeletal-trained nurses on staff

56

Musculoskeletal therapists
(PT/OT/ST/MT/CHIRO/ACU)

35

Million lives covered



Evidence-Based Guidelines

The foundation of our musculoskeletal solution:

Dedicated pediatric guidelines

Medicare LCDs & NCDs

Academic institutional experts and community physician panels

Current clinical literature

Aligned with National Societies

- American Academy of Neurology
- American College of Rheumatology
- American Association of Neurological Surgeons
- American Academy of Orthopedic Surgeons
- American Society of Interventional Pain Physicians
- North American Spine Society
- American College of Occupational and Environmental Medicine
- American Academy of Physical Medicine and Rehabilitation
- American Association of Hip and Knee Surgeons
- American Pain Society
- Official Disability Guidelines
- Medicare Guidelines
- Spine Intervention Society
- American Academy of Orthopedic Surgeons
- The American Orthopedic Society for Sports Medicine
- Cochrane Reviews
- American Physical Therapy Association
- American Chiropractic Association
- American Occupational Therapy Association
- American Speech Language Hearing Association
- American Society of Anesthesiologists

Service Model

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

Client Provider Representatives

Client Provider Representatives are cross-trained to investigate escalated provider and health plan issues.

Client Service Managers

Client Service Managers lead resolution of complex service issues and coordinate with partners for continuous improvement.

Regional Provider Engagement Managers

Regional Provider Engagement Managers are on-the-ground resources who serve as the voice of eviCore to the provider community.

Why Our Service Delivery Model Works

One centralized intake point allows for timely identification, tracking, trending, and reporting of all issues. It also enables eviCore to quickly identify and respond to systemic issues impacting multiple providers.

Complex issues are escalated to resources who are the subject matter experts and can quickly coordinate with matrix partners to address issues at a root-cause level.

Routine issues are handled by a team of representatives who are cross trained to respond to a variety of issues. There is no reliance on a single individual to respond to your needs.

Program Goals

- Authorize **medically necessary** services which require the skills of a licensed professional
- Promote **evidence-based practice**
- Identify and review treatment interventions where evidence is not present or does not support use
- Provide evidence-based guidelines to support authorization decisions and educate practitioners
- **Decrease or eliminate unexplained practice variation** and unnecessary visits
- Manage costs efficiently so members can **continue to receive quality care and skilled services**

Clinical Philosophy

- Support **patient-centered care** founded on best available evidence
- Promote **functionally oriented and measureable** treatment programs
- Focus on **skilled, medically necessary** treatment interventions
- Empower **patient independence**
- **Eliminate practice variation** that cannot be explained or justified

Medical Necessity

Medical Necessity

To be considered reasonable and necessary the following conditions must each be met:

- The services shall be considered under accepted standards of medical practice to be a **specific and effective** treatment for the patient's condition.
- There must be an **expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time**.
  - Exception – skilled maintenance therapy may be approved based on CMS definition
- The **amount, frequency, and duration** of the services must be reasonable under accepted standards of practice.

Medical Necessity

Additional Requirements for Therapy Services:

- Services shall be of **such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist**, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist.

- Services that do not require the performance or supervision of a therapist **are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.**

Medical Necessity

Accepted Standards of Medical Practice

- For these purposes, “accepted standards of medical practice” means standards that are based on **credible scientific evidence published in the peer-reviewed literature** generally recognized by the relevant healthcare community, **specialty society evidence-based guidelines or recommendation**, or **expert clinical consensus in the relevant clinical areas**.

Utilization Management

Clinical Case Managers review for:

- **Need for skilled services**
  - Level of complexity that requires the skills of a licensed practitioner
- The **frequency of care needed**
- **Initiation of home program**
  - Transition repetitive exercises (stretching and strengthening) from clinic to the home environment
- **The progress (or lack of progress) of the patient**
- **Patient compliance**

Prior Authorization Program for Blue Cross and Blue Shield Medicare and Medicaid Programs

Program Overview

eviCore began accepting requests on May 22, 2017 for dates of service June 1 , 2017 and beyond.

Prior authorization applies to services that are:

- Outpatient
- Elective/Non-Emergent

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

- Emergency room
- Inpatient
- Early Childhood Intervention (ECI) 3<

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

Applicable Membership

Authorization is required for Blue Cross and Blue Shield members enrolled in the following programs:

- **Blue Cross and Blue Shield of Illinois**
  - **Medicare and Medicaid members**
- **Blue Cross and Blue Shield of Montana**
  - **Medicare members**
- **Blue Cross and Blue Shield of New Mexico**
  - **Medicare members**
- **Blue Cross and Blue Shield of Oklahoma**
  - **Medicare members**
- **Blue Cross and Blue Shield of Texas**
  - **Medicare and Medicaid members**

Prior Authorization Required:

- **Physical Therapy**
- **Speech Therapy**
- **Occupational Therapy**
- **Chiropractic**

To find a list of CPT (Current Procedural Terminology) codes that require prior authorization through eviCore, please visit:

https://www.evicore.com/healthplan/bcbs

Prior Authorization Program

- Clinical reviewers evaluate clinical information to determine whether services are medically necessary.

- Providers must request authorization before care is administered to ensure payment for services rendered.

Prior Authorization Requests

How to request prior authorization:

www.evicore.com

Available 24/7 and the **quickest** way to create prior authorizations and check existing case status

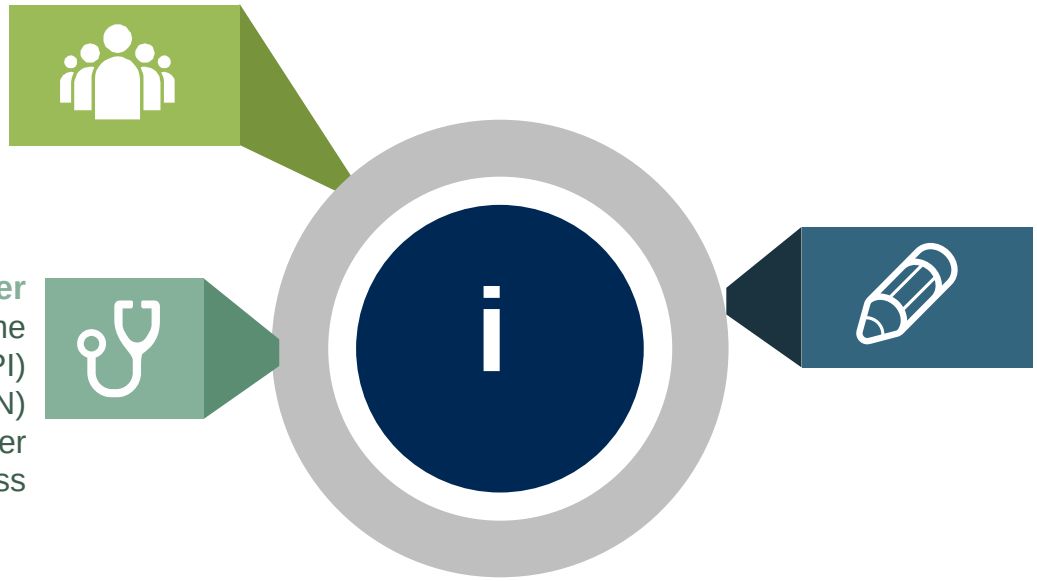
Or by phone:
855-252-1117
7:00 a.m. to 7:00 p.m. local time
Monday - Friday

Or Fax your request to 855-774-1319

Needed Information

Member
Member ID
Member name
Date of birth (DOB)

Performing Provider
Therapist name
National provider identifier (NPI)
Tax identification number (TIN)
Fax number
Street Address



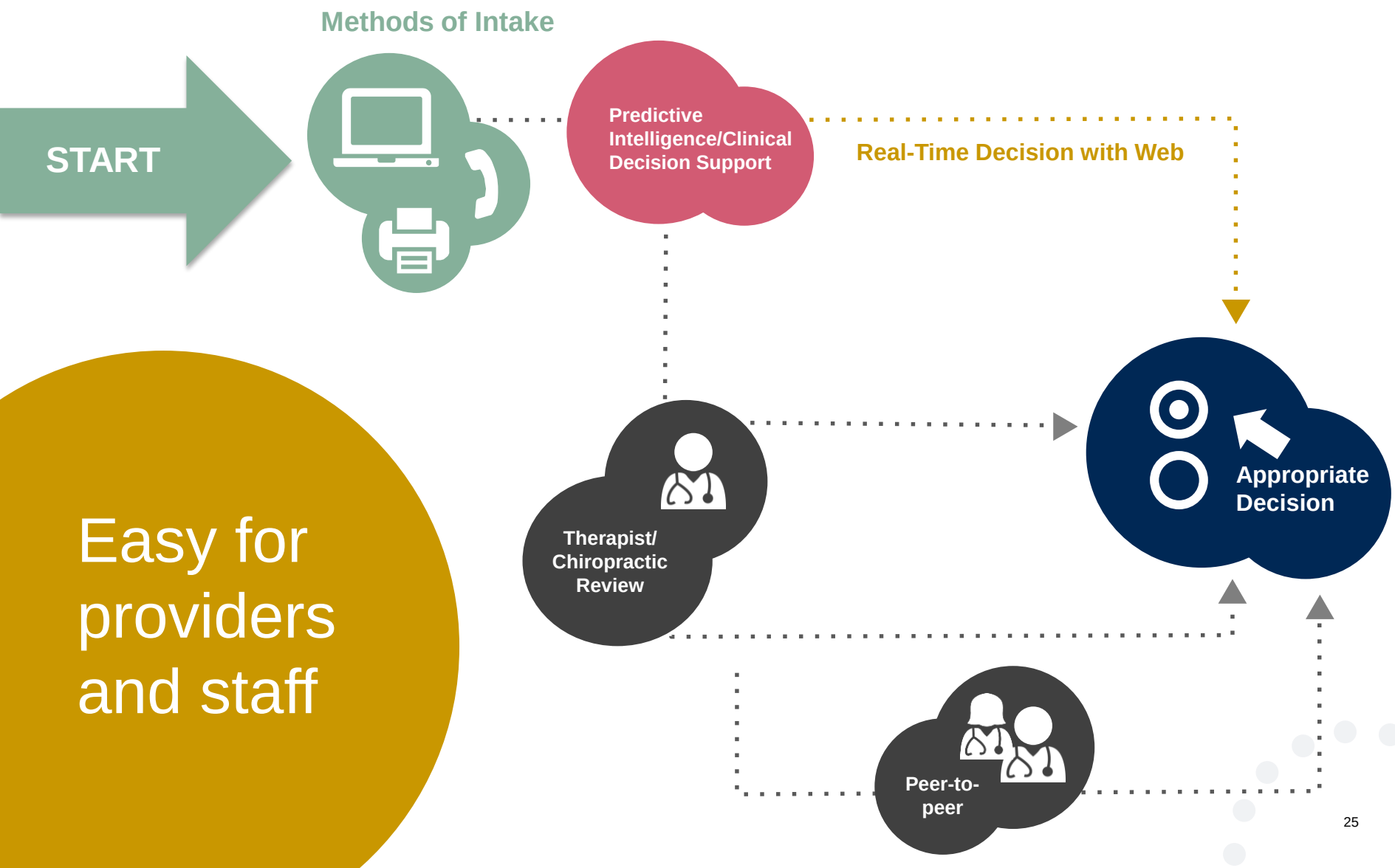
Requests
Select MSMPT, MSMOT, MSMST or Chiropractic for requested services

The appropriate diagnosis code for the working of differential diagnosis

If clinical information is needed, please be able to supply:

- Patient's subjective complaints, objective examination findings, and level of function
- Information from Treatment Request Clinical Worksheet
- Information should be current (collected within the past 10 days)
- Office notes will be requested as needed

Clinical Review Process



Prior Authorization Process

- **Complete your initial evaluation**
  - The initial evaluation does not require prior authorization.
- **Notify eviCore healthcare *within 7 days* of the initial visit.**
- **Start date should be the first day of treatment (Date of initial evaluation or visit following if treatment was not provided during the initial visit)**
- **You will be asked to include clinical information including but not limited to :**
  - Patient demographics
  - Provider demographics
  - Diagnosis
  - If this is a request for post-surgical care
  - Patient reported functional outcomes
  - Complexities
  - If there are existing authorizations within the system, questions will be asked to determine if this is a new condition

Prior Authorization Process

WHAT HAPPENS NEXT?

Your submission will receive **a real time decision** or be sent for **clinical review**

Real time decisions (applies to web and phone submissions ONLY)

- if the clinical information provided meets medical criteria, the case may be eligible for a real time decision.
- Decision is based on the information provided including the diagnosis and condition severity.
- The approved visits/units should be spread over the entire approved period to prevent a gap in care.
- If more care is required after the approval period ends, the provider may submit a new request with current clinical information.

Clinical Review (applies to fax submissions and requests for continuing care)

- Current clinical information will be requested
- Collected within the seven days prior
- Clinical worksheets available at www.evicore.com under the **Clinical Guidelines and Forms** section

Prior Authorization Program Process – Important Concepts

Overlapping Requests

- Request for more visits within the existing approved time period
- Information you provide should explain why the visits could not be spread over the approved period
- Review to determine if additional visits are medically necessary
    - **Approve**
    - **Deny** additional visits within the existing approved period
    - **Partially approve** – Visits will be approved with a new start date
        - Existing authorization end date plus one day
- 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.

Prior Authorization Process – Important Concepts

Authorization decisions include:

- **Visits**
- **Units** – These represent the total # of CPT codes that can be billed over the approved period
- **Approved Time Period**

Example – 1 visit, 4 units from 1/1/16 to 1/1/16

- Units example – 97110 x4 or 97110 x2, 97035 x1, 97112 x1

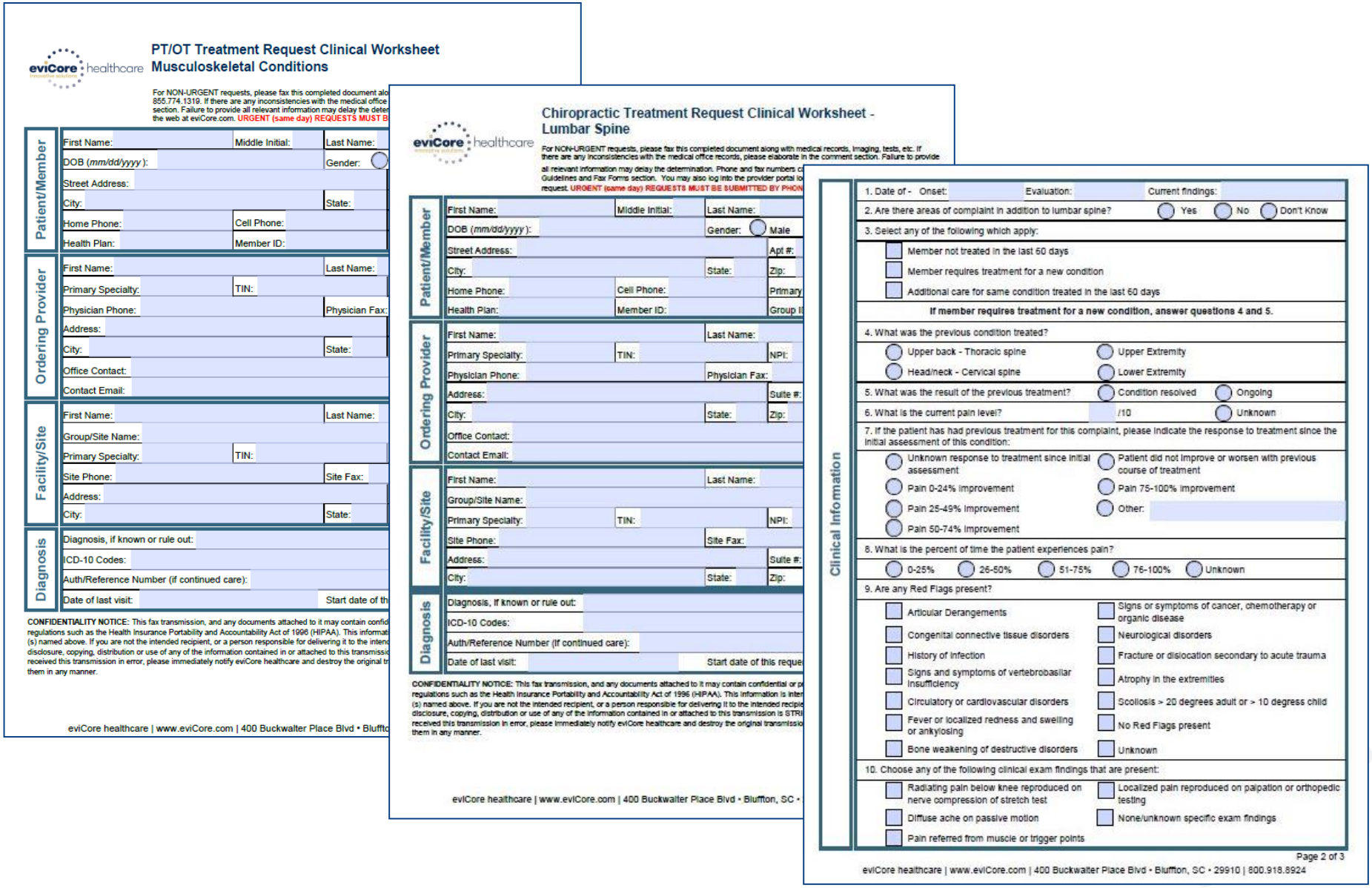
Spread the Visits/Units over the approved period to prevent a gap in care.

Clinical Information Worksheets

- The treatment request clinical worksheets are therapy specific and designed to assist with the submission of patient and provider information for medical necessity review.
- Worksheets should be used as a guide for questions the therapist will be prompted to answer when completing the online requests.
- These worksheets should be completed by the provider during the initial consultation and treatment planning, collecting the clinical information to allow for ease of submission.
- Worksheets are available through our web portal and are therapy-specific to the treatment request.

https://www.evicore.com/solution/pages/musculoskeletal.aspx

Examples of Clinical Worksheets



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PT/OT Treatment Request Clinical Worksheet
Musculoskeletal Conditions

For NON-URGENT requests, please fax this completed document alo
855.774.1319. If there are any inconsistencies with the medical office
section. Failure to provide all relevant information may delay the deter
the web at eviCore.com. URGENT (same day) REQUESTS MUST B

Patient/Member
First Name: Middle Initial: Last Name:
DOB (mm/dd/yyyy): Gender:
Street Address:
City: State:
Home Phone: Cell Phone:
Health Plan: Member ID:

Ordering Provider
First Name: Last Name:
Primary Specialty: TIN:
Physician Phone: Physician Fax:
Address:
City: State:
Office Contact:
Contact Email:

Facility/Site
First Name: Last Name:
Group/Site Name:
Primary Specialty: TIN:
Site Phone: Site Fax:
Address:
City: State:

Diagnosis
Diagnosis, if known or rule out:
ICD-10 Codes:
Auth/Reference Number (if continued care):
Date of last visit: Start date of th

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Chiropractic Treatment Request Clinical Worksheet -
Lumbar Spine

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Phone and fax numbers c
Guidelines and Fax Forms section. You may also log into the provider portal lo
request. URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHON

Patient/Member
First Name: Middle Initial: Last Name:
DOB (mm/dd/yyyy): Gender: Male
Street Address: Apt #:
City: State: Zip:
Home Phone: Cell Phone: Primary
Health Plan: Member ID: Group I

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

Facility/Site
First Name: Last Name:
Group/Site Name:
Primary Specialty: TIN: NPI:
Site Phone: Site Fax:
Address: Suite #:
City: State: Zip:

Diagnosis
Diagnosis, if known or rule out:
ICD-10 Codes:
Auth/Reference Number (If continued care):
Date of last visit: Start date of this reque

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Clinical Information

1. Date of - Onset: Evaluation: Current findings:
2. Are there areas of complaint in addition to lumbar spine? Yes No Don't Know
3. Select any of the following which apply:
- Member not treated in the last 60 days
- Member requires treatment for a new condition
- Additional care for same condition treated in the last 60 days

If member requires treatment for a new condition, answer questions 4 and 5.

4. What was the previous condition treated?
- Upper back - Thoracic spine
- Upper Extremity
- Head/neck - Cervical spine
- Lower Extremity

5. What was the result of the previous treatment? Condition resolved Ongoing
6. What is the current pain level? /10 Unknown
7. If the patient has had previous treatment for this complaint, please indicate the response to treatment since the initial assessment of this condition:
- Unknown response to treatment since initial assessment
- Patient did not improve or worsen with previous course of treatment
- Pain 0-24% improvement
- Pain 75-100% improvement
- Pain 25-49% improvement
- Other:
- Pain 50-74% improvement

8. What is the percent of time the patient experiences pain?
0-25% 26-50% 51-75% 76-100% Unknown
9. Are any Red Flags present?
- Articular Derangements
- Signs or symptoms of cancer, chemotherapy or organic disease
- Congenital connective tissue disorders
- Neurological disorders
- History of infection
- Fracture or dislocation secondary to acute trauma
- Signs and symptoms of vertebrobasilar insufficiency
- Atrophy in the extremities
- Circulatory or cardiovascular disorders
- Scoliosis > 20 degrees adult or > 10 degress child
- Fever or localized redness and swelling or ankylosing
- No Red Flags present
- Bone weakening of destructive disorders
- Unknown

10. Choose any of the following clinical exam findings that are present:
- Radiating pain below knee reproduced on nerve compression of stretch test
- Localized pain reproduced on palpation or orthopedic testing
- Diffuse ache on passive motion
- None/unknown specific exam findings
- Pain referred from muscle or trigger points

Page 2 of 3

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Prior Authorization Outcomes

Approved Requests:

- Medicare requests are processed within 14 calendar days
- IL Medicaid requests are processed within 4 calendar days
- TX Medicaid requests are processed within 3 business days
- Authorizations time frames will vary based on the members condition, generally it will be 30 calendar days from the date of determination

Delivery:

- Faxed to ordering provider and rendering facility. (verbal outreach for urgent requests)
- Mailed to the member, (verbal outreach for urgent requests)
- Information can be printed on demand from the eviCore healthcare Web Portal

Denied Requests:

- Communication of denial determination
- Communication of the rationale for the denial
- How to request a Peer Review

Delivery:

- Faxed to the ordering provider and rendering facility (verbal outreach for urgent requests)
- Mailed to the member (verbal outreach for urgent requests)

Prior Authorization Outcomes – Medicare

Pre-Decision Consultation

- If your case requires further clinical discussion for approval, we welcome requests for clinical determination discussions from rendering provider prior to a decision being made.
- In certain instances, additional information provided during the pre-decision consultation is sufficient to satisfy the medical necessity criteria for approval.

Prior Authorization Outcomes - Medicaid

Peer-to-Peer Review

- If a request is denied and requires further clinical discussion for approval, we welcome requests for clinical determination discussions from referring providers. In certain instances, additional information provided during the consultation is sufficient to satisfy the medical necessity criteria for approval.

- **Peer-to-Peer reviews** can be scheduled at a time convenient to your provider.

Special Circumstances

Appeals

- eviCore will manage first level appeals
- Appeals must be made in writing within 120 calendar days and 30 calendar days for IL Medicaid cases. eviCore will respond within 30 calendar days, and 15 business days for IL Medicaid requests.

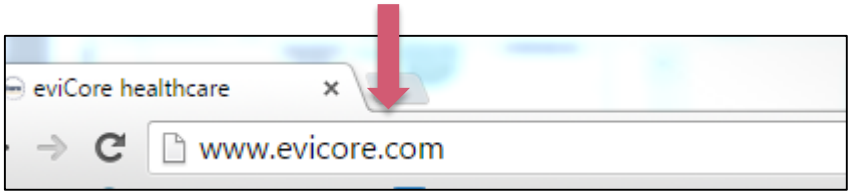
Outpatient Urgent Services:

- Contact eviCore by phone to request an expedited prior authorization review and provide clinical information
- Urgent Cases will be reviewed with 72 hours of the request.

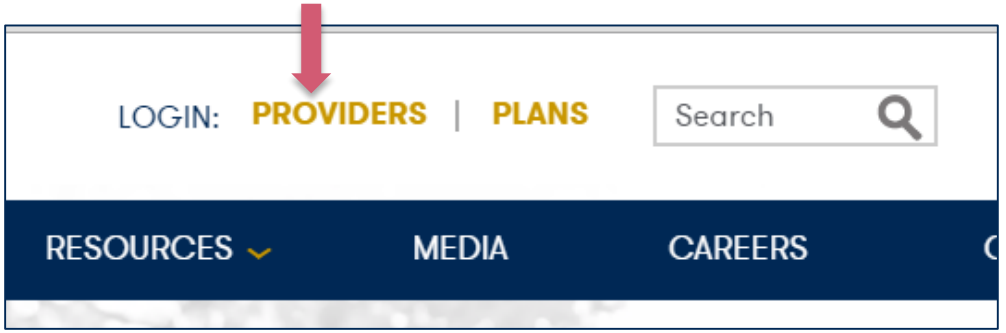
Web Portal Services

eviCore healthcare website

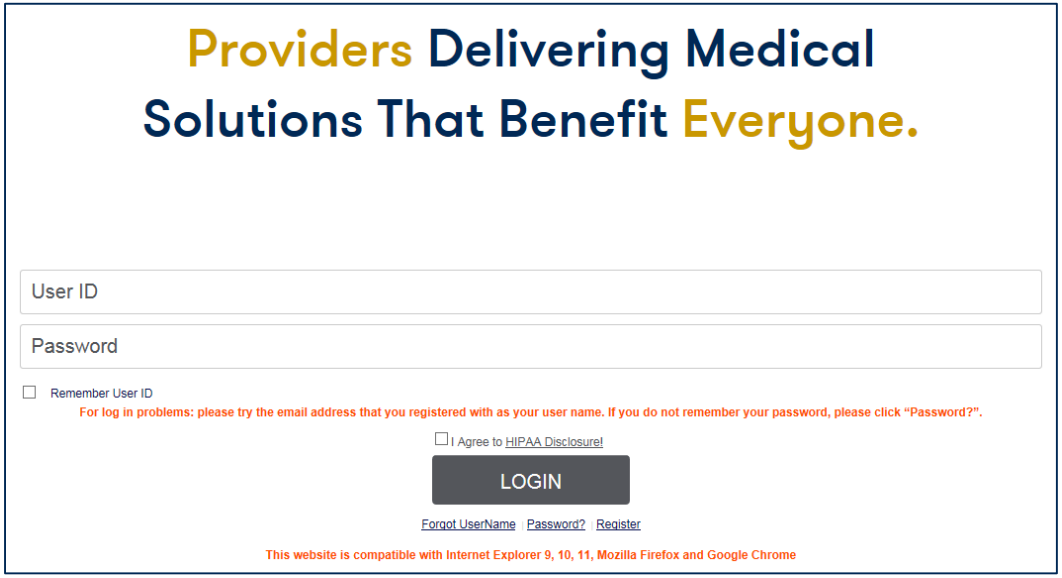
- Point web browser to evicore.com



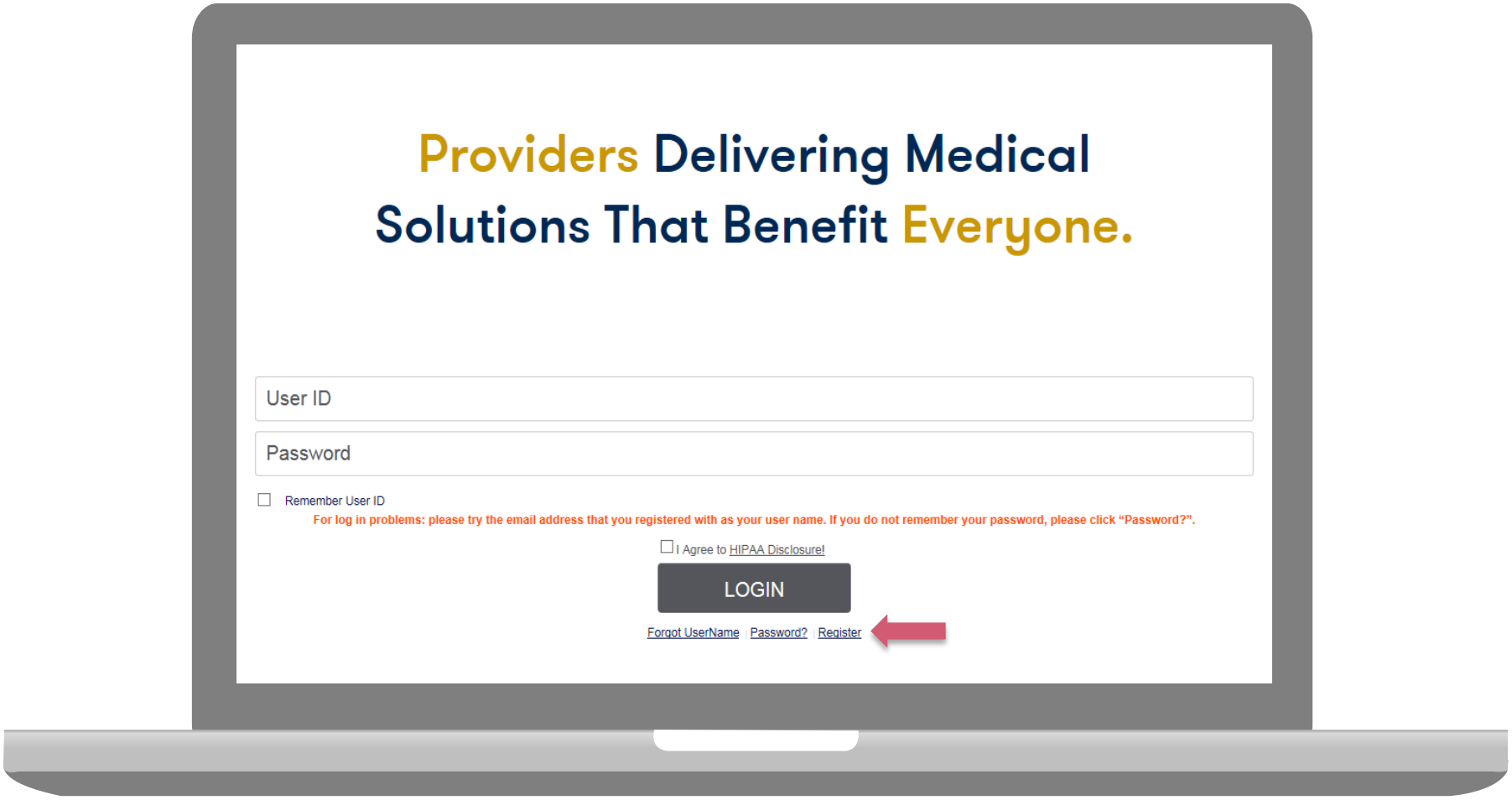
- Click on the “Providers” link



- Login or Register

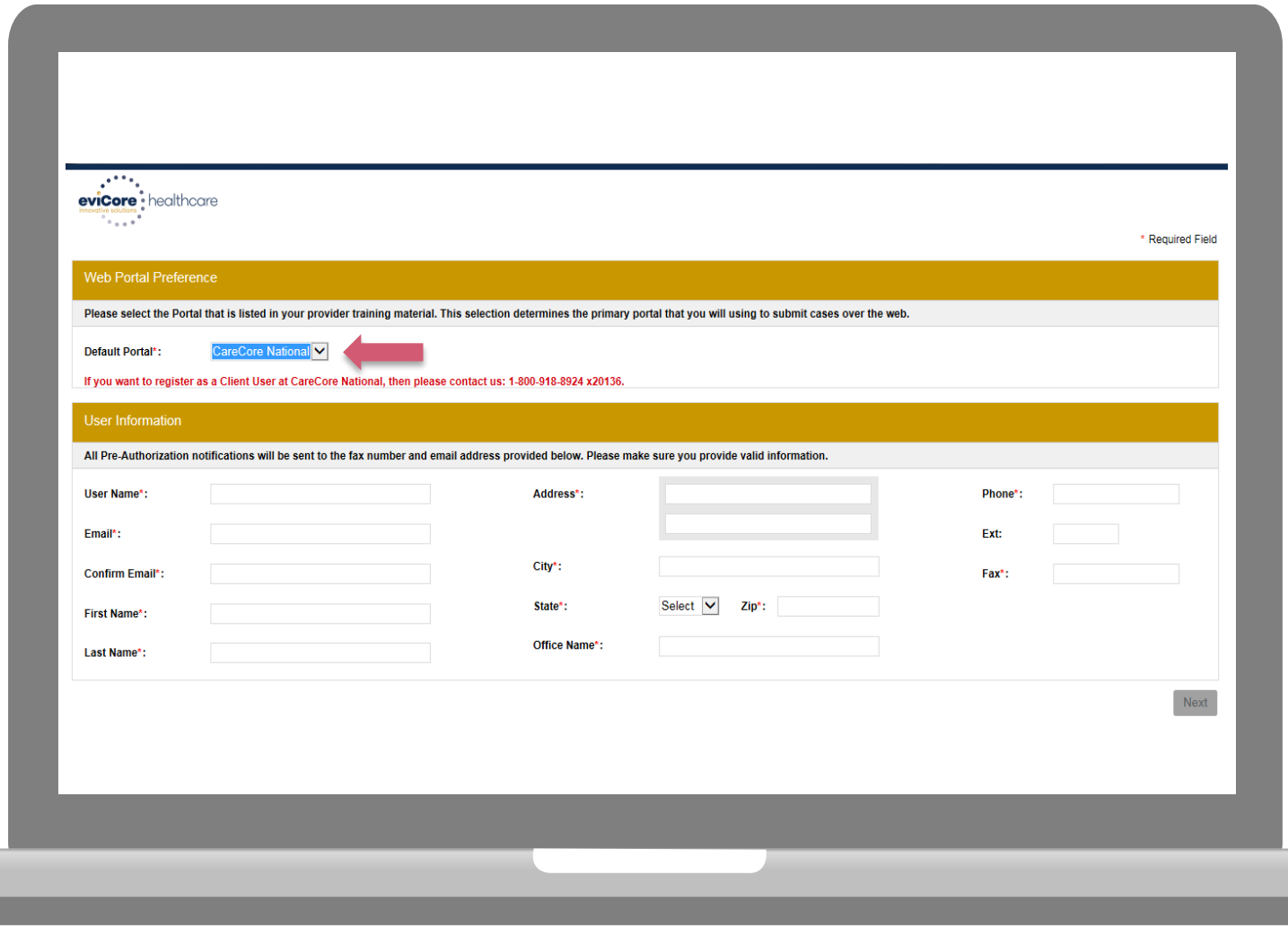


Creating An Account



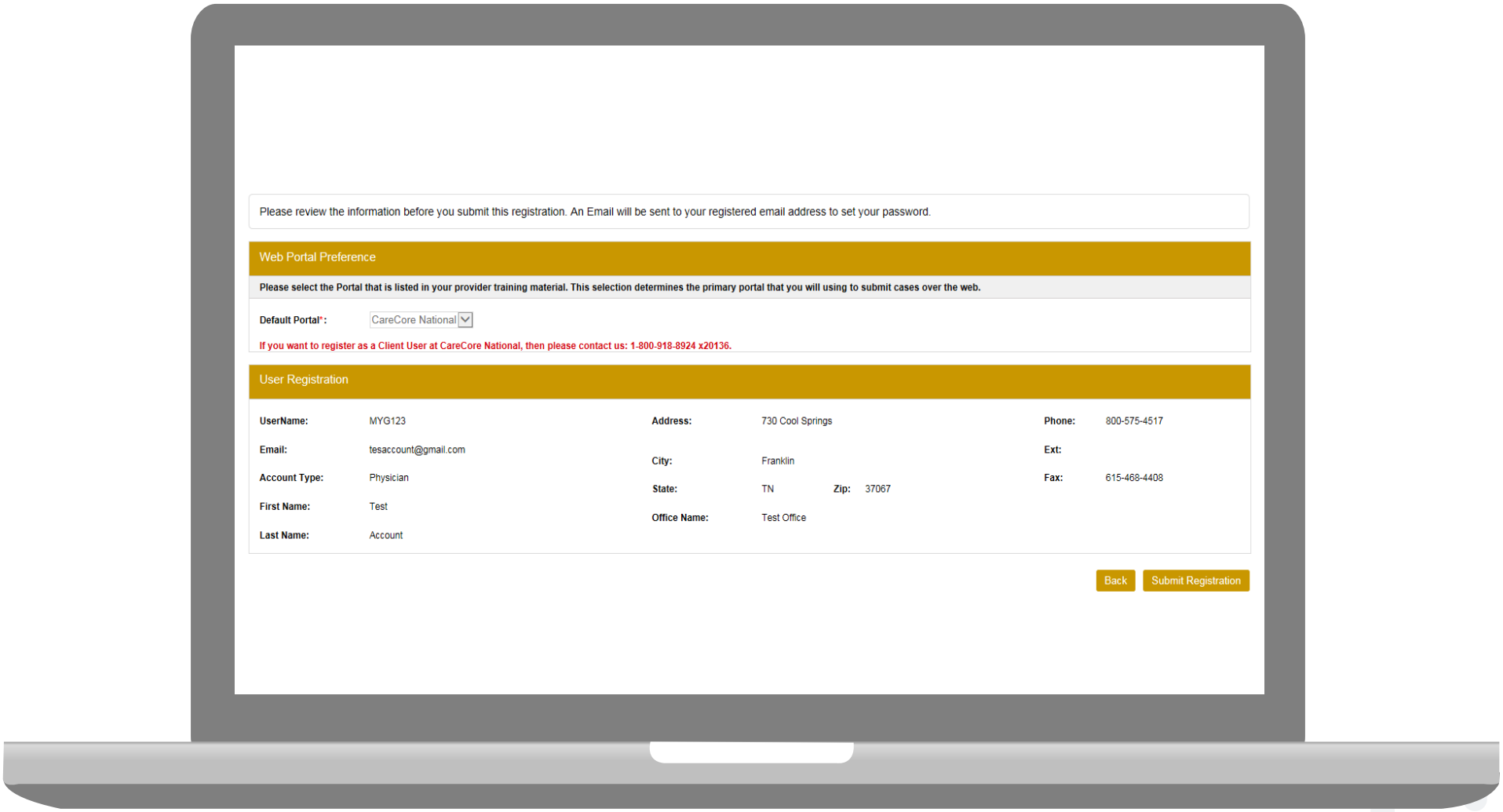
To create a new account, click **Register**.

Creating An Account



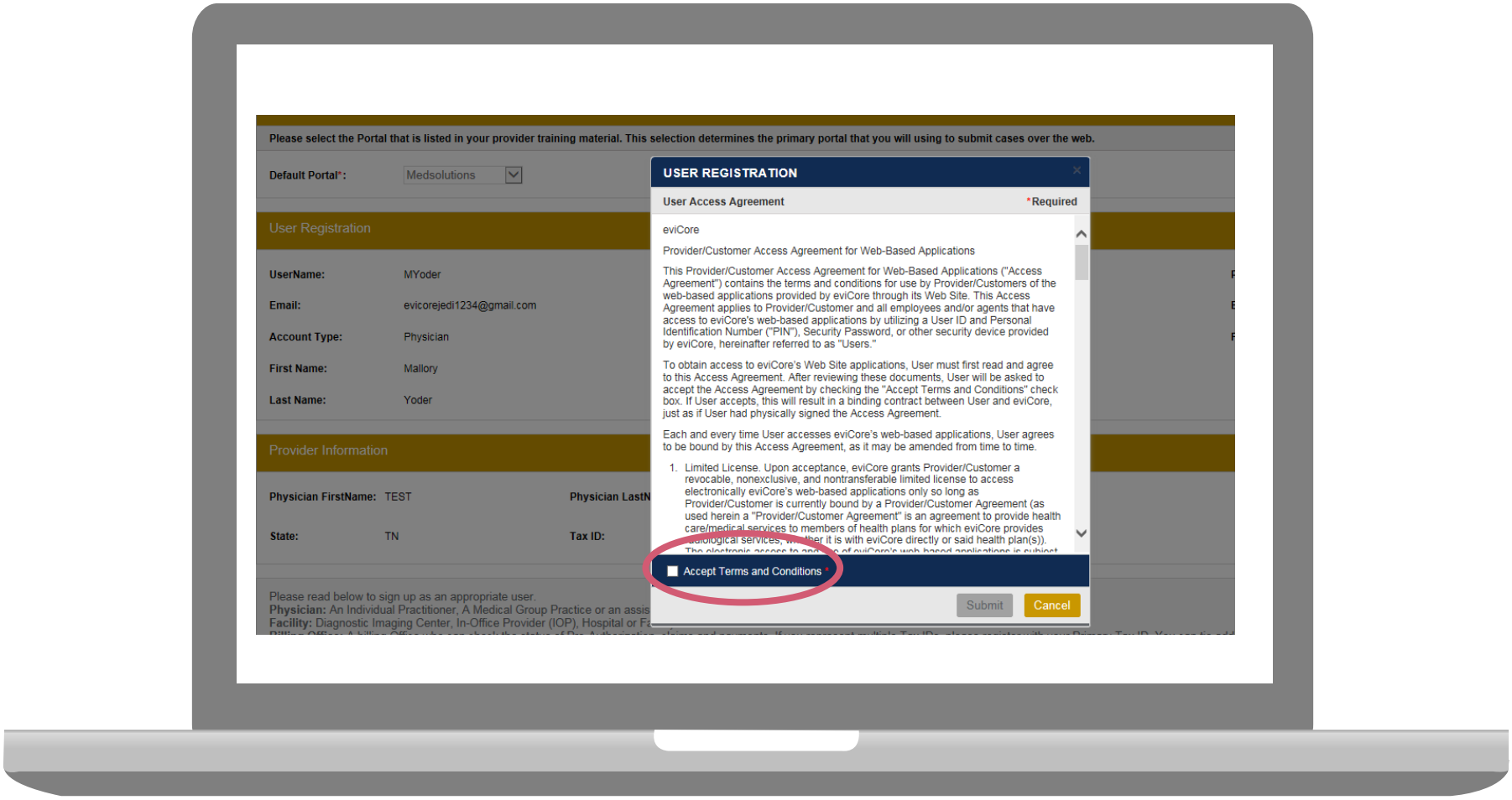
Select a **Default Portal**, and complete the registration form.

Creating An Account



Review information provided, and click "**Submit Registration.**"

User Registration-Continued



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

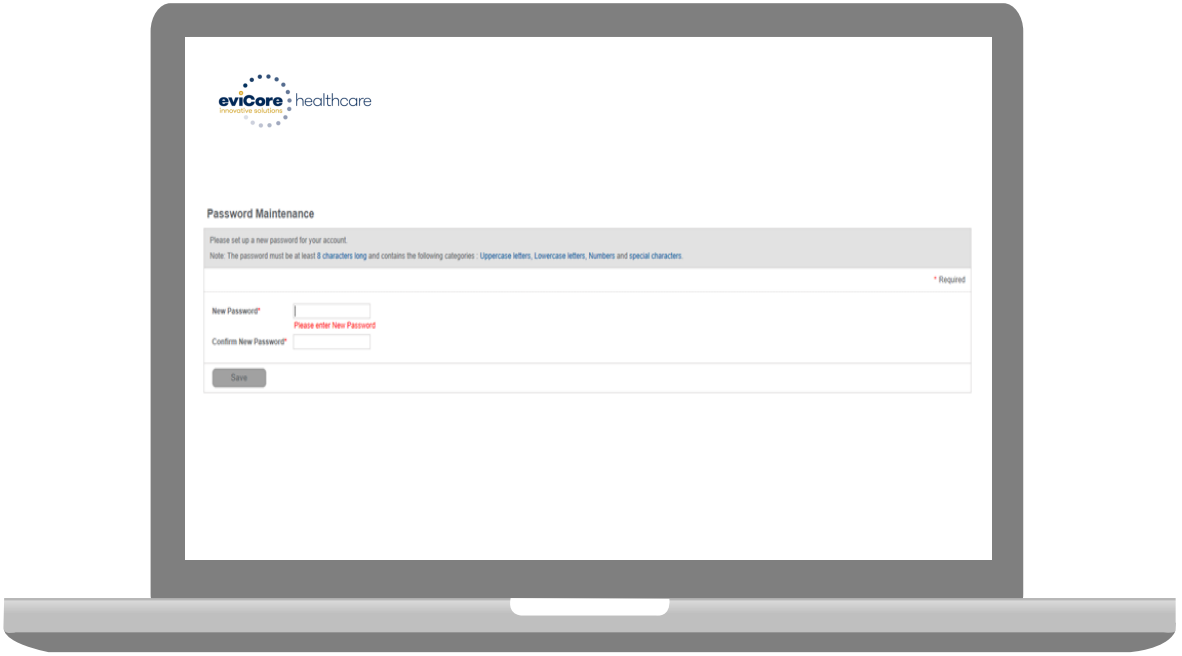
User Registration-Continued

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

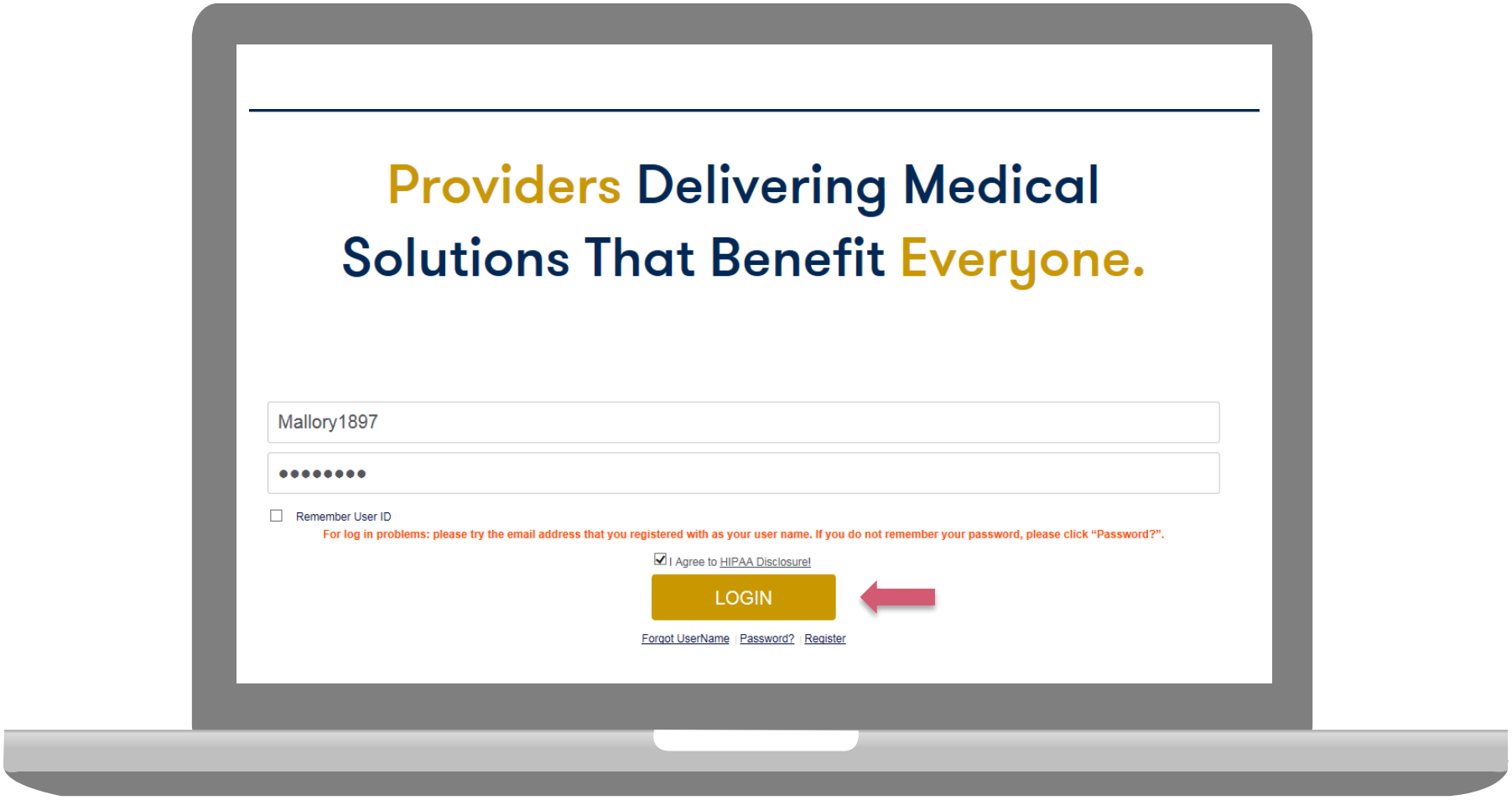
Create a Password

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

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



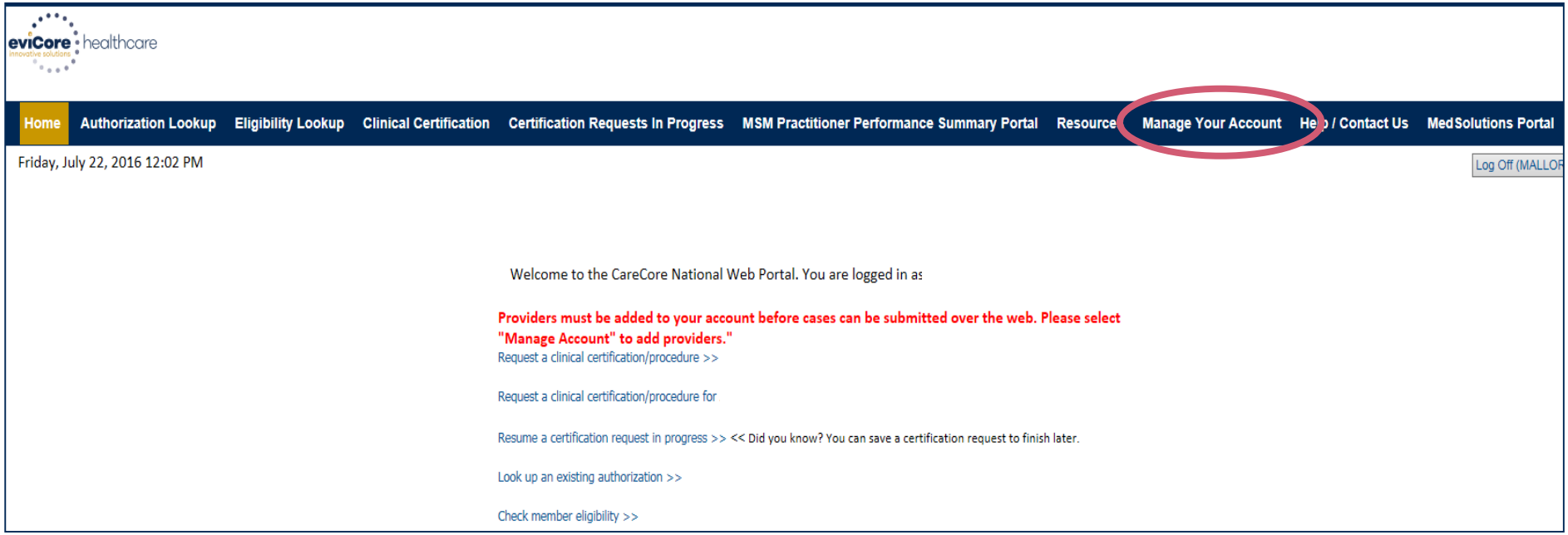
Account Log-In



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

Account Overview

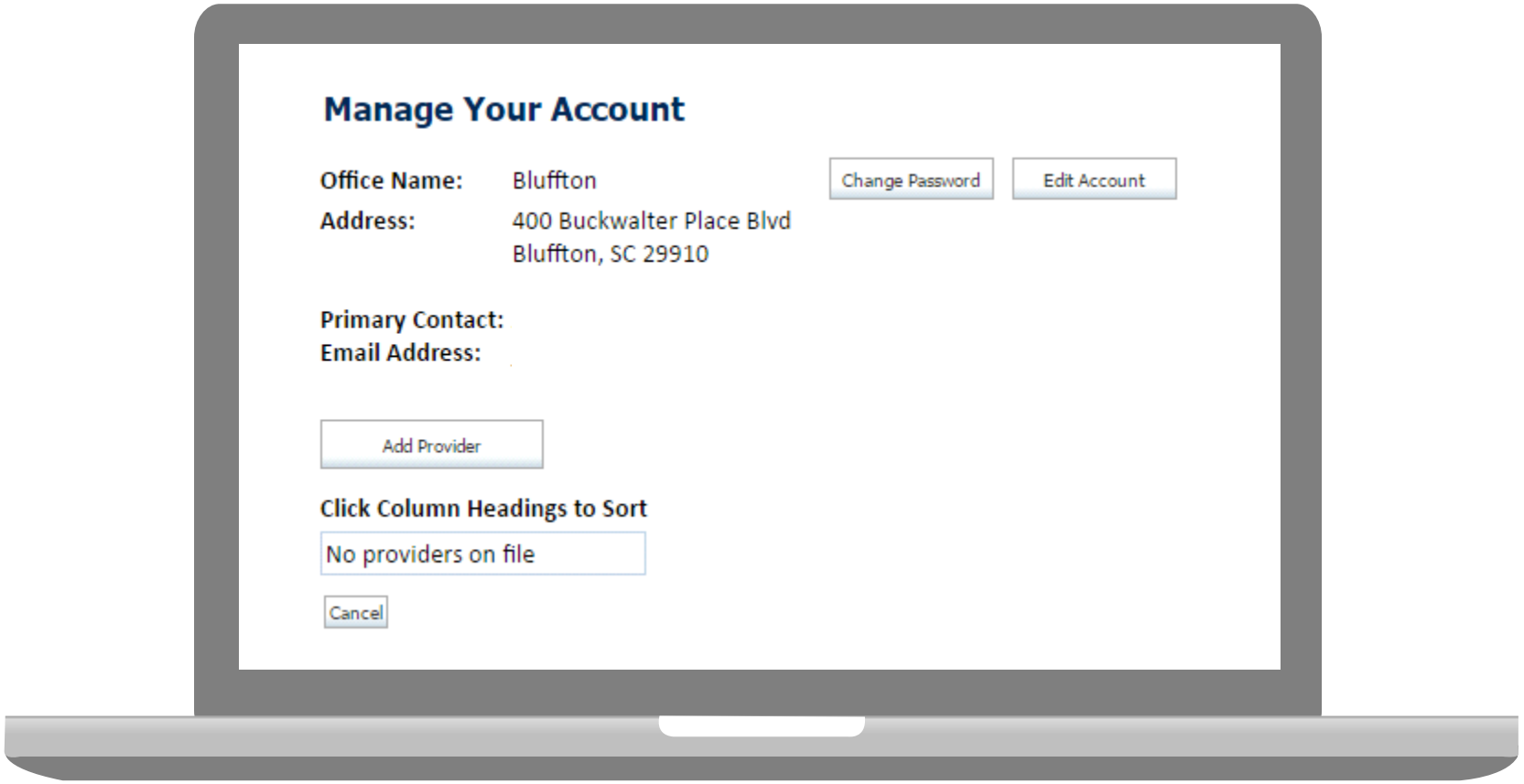
Welcome Screen



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

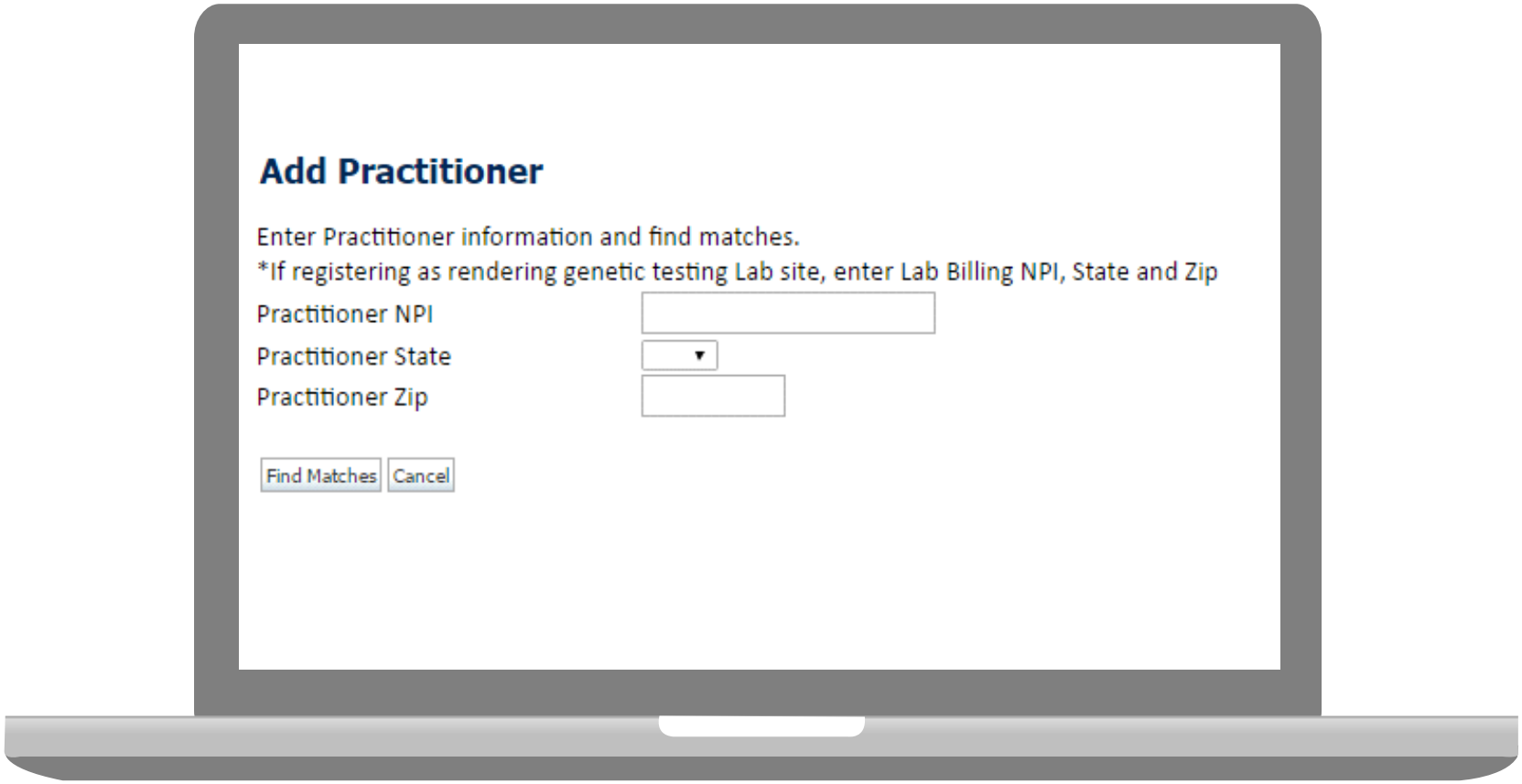
***Note:* You can access the MedSolutions Portal at any time if you are registered. Click the MedSolutions Portal button on the top right corner to seamlessly toggle back and forth between the two portals without having to log-in multiple accounts.**

Add Practitioners



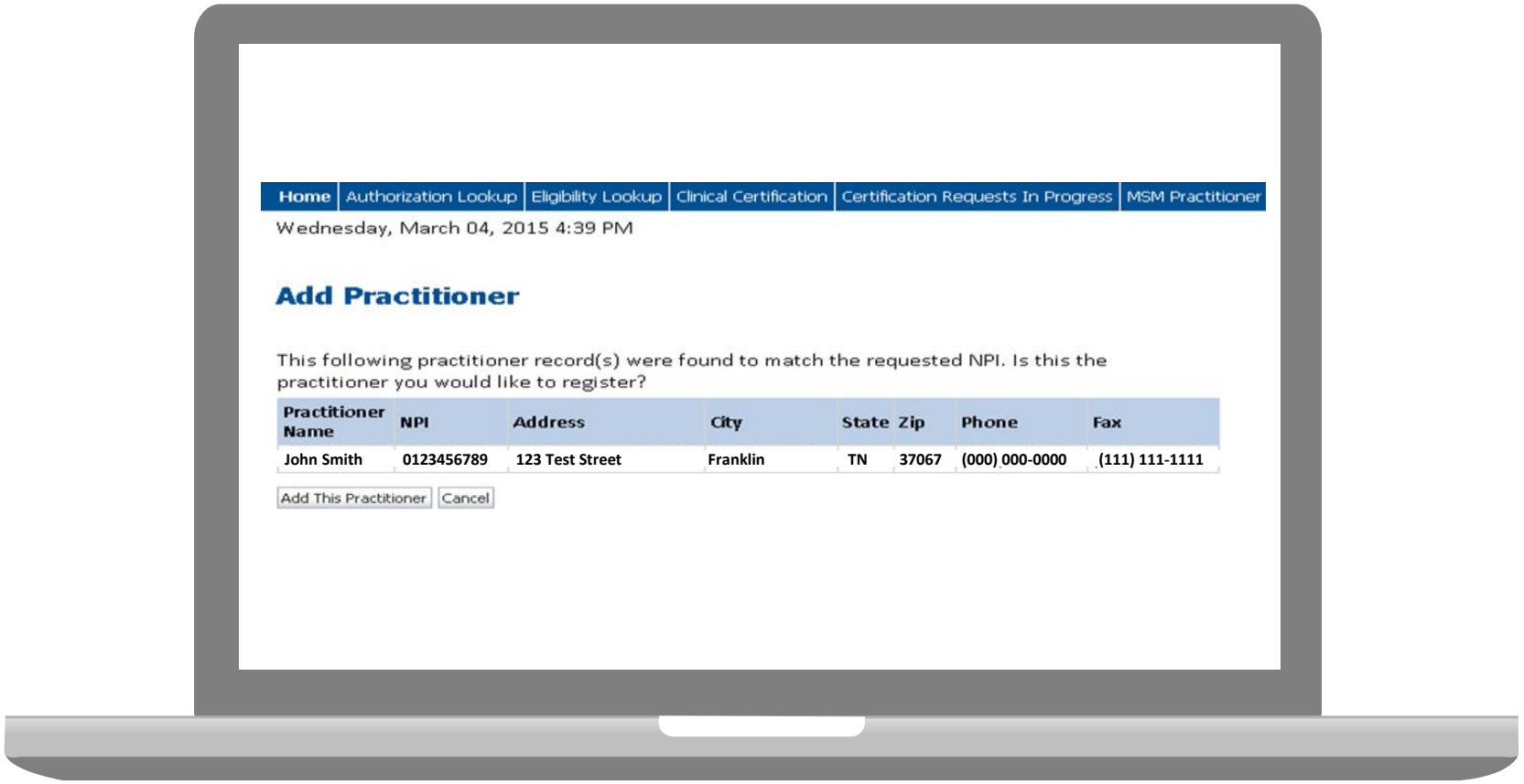
Click the "**Add Provider**" button.

Add Practitioners



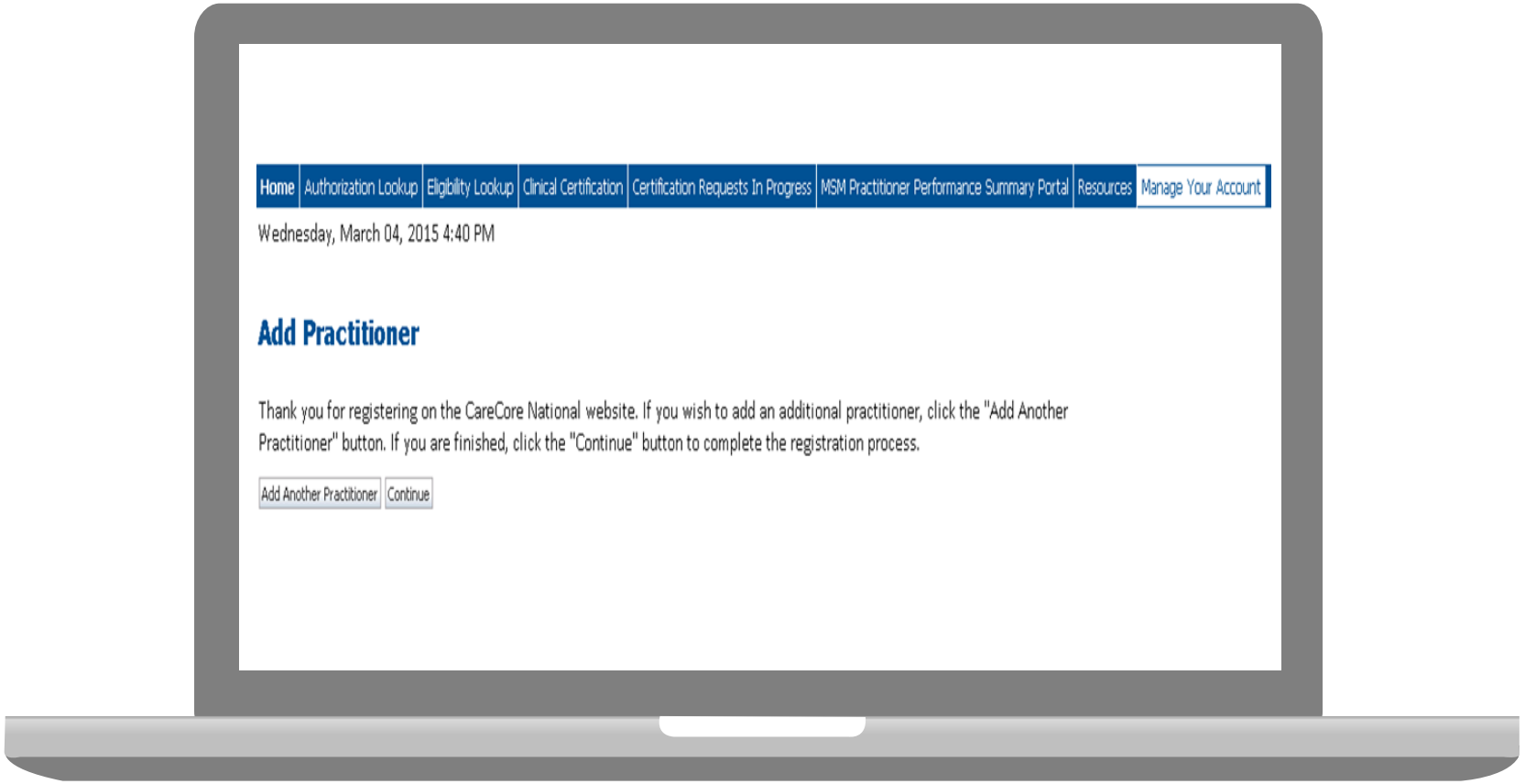
- Enter the **Provider's NPI**, **State**, and **Zip Code** to search for the provider record to add to your account. You are able to add multiple Providers to your account.

Adding Practitioners



Select the matching record based upon your search criteria

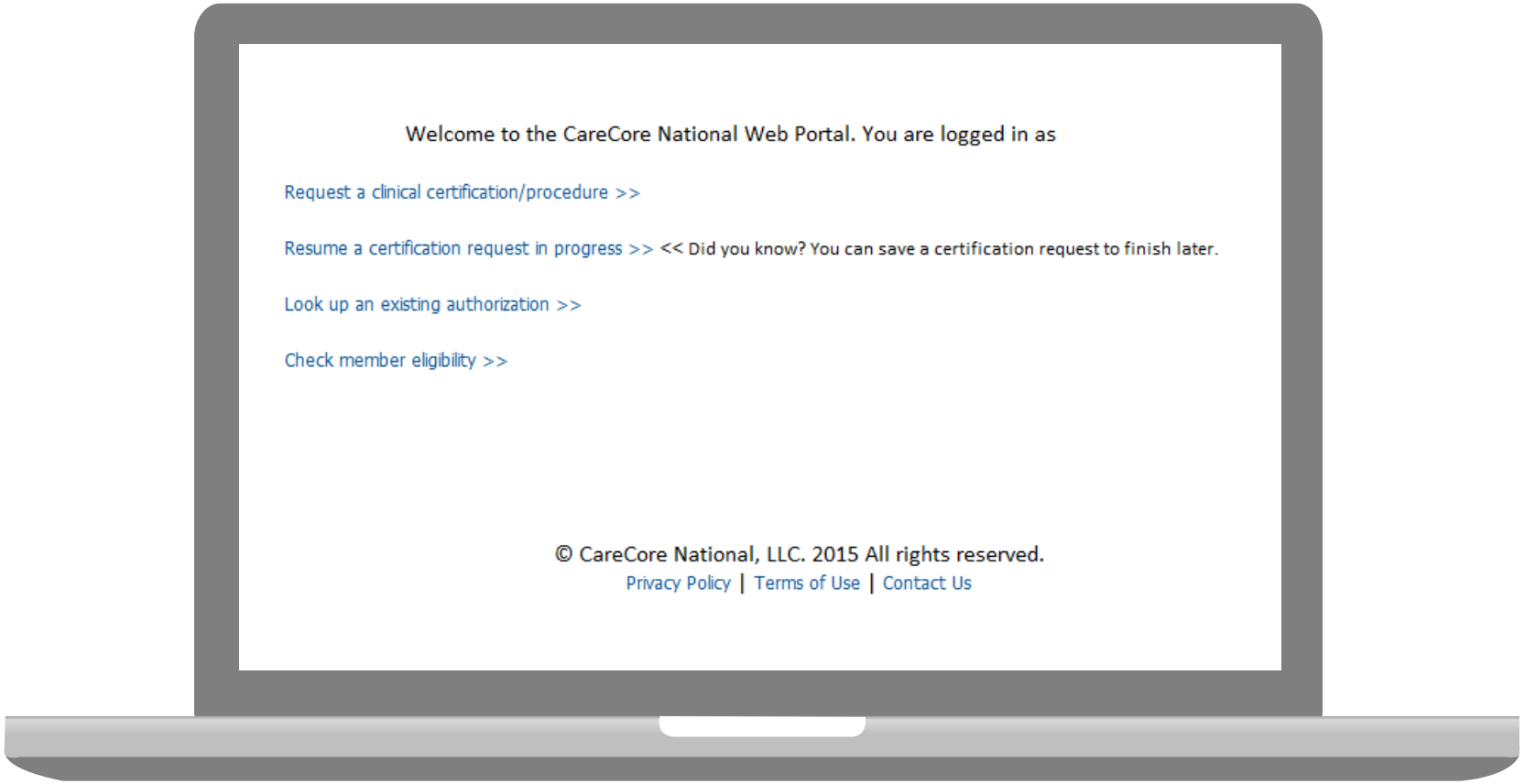
Manage Your Account



- 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.

Case Initiation

Initiating A Case

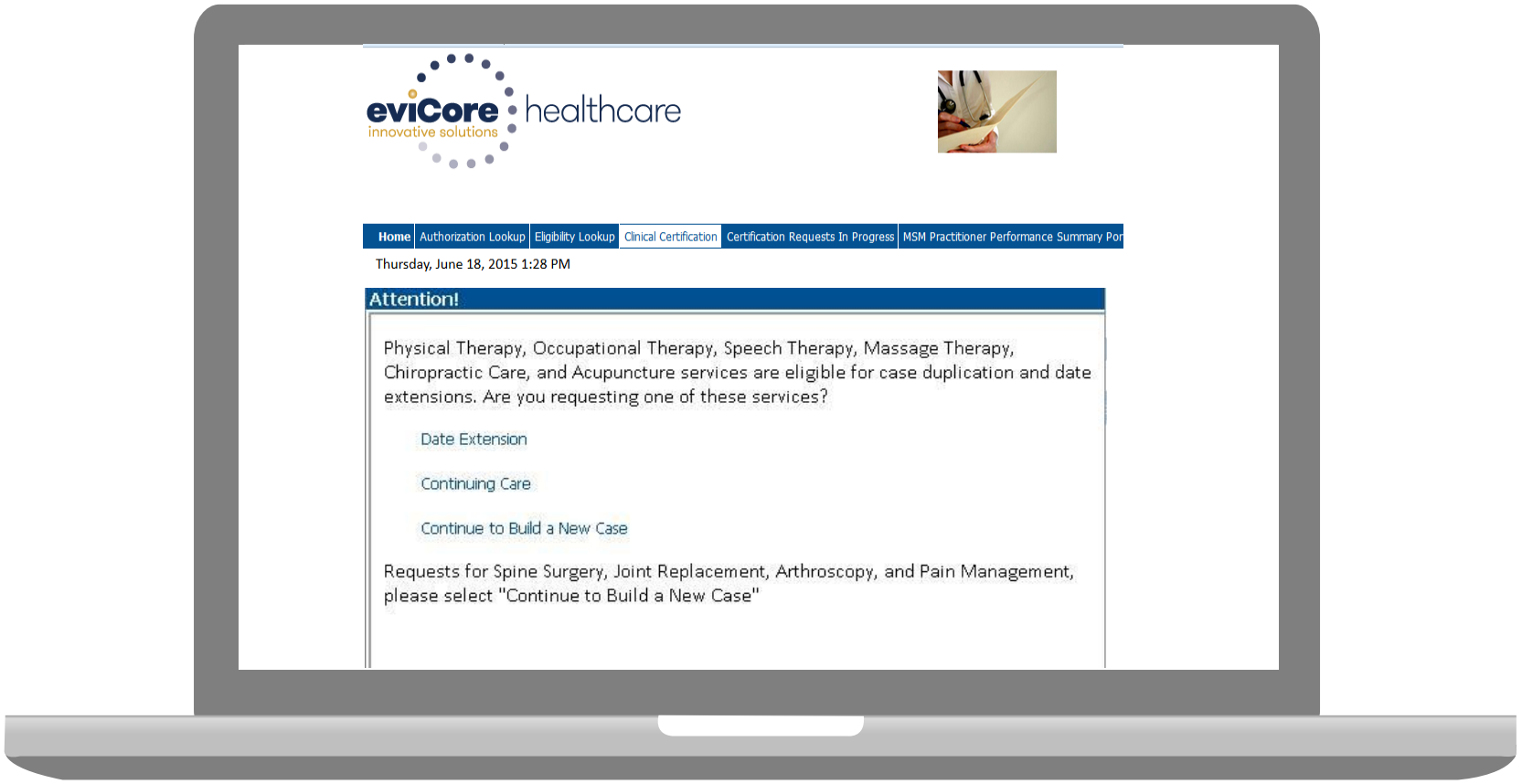


- Choose **"request a clinical certification/procedure"** to begin a new case request.

Select Program

Select the **Program** for your certification.

Service Options

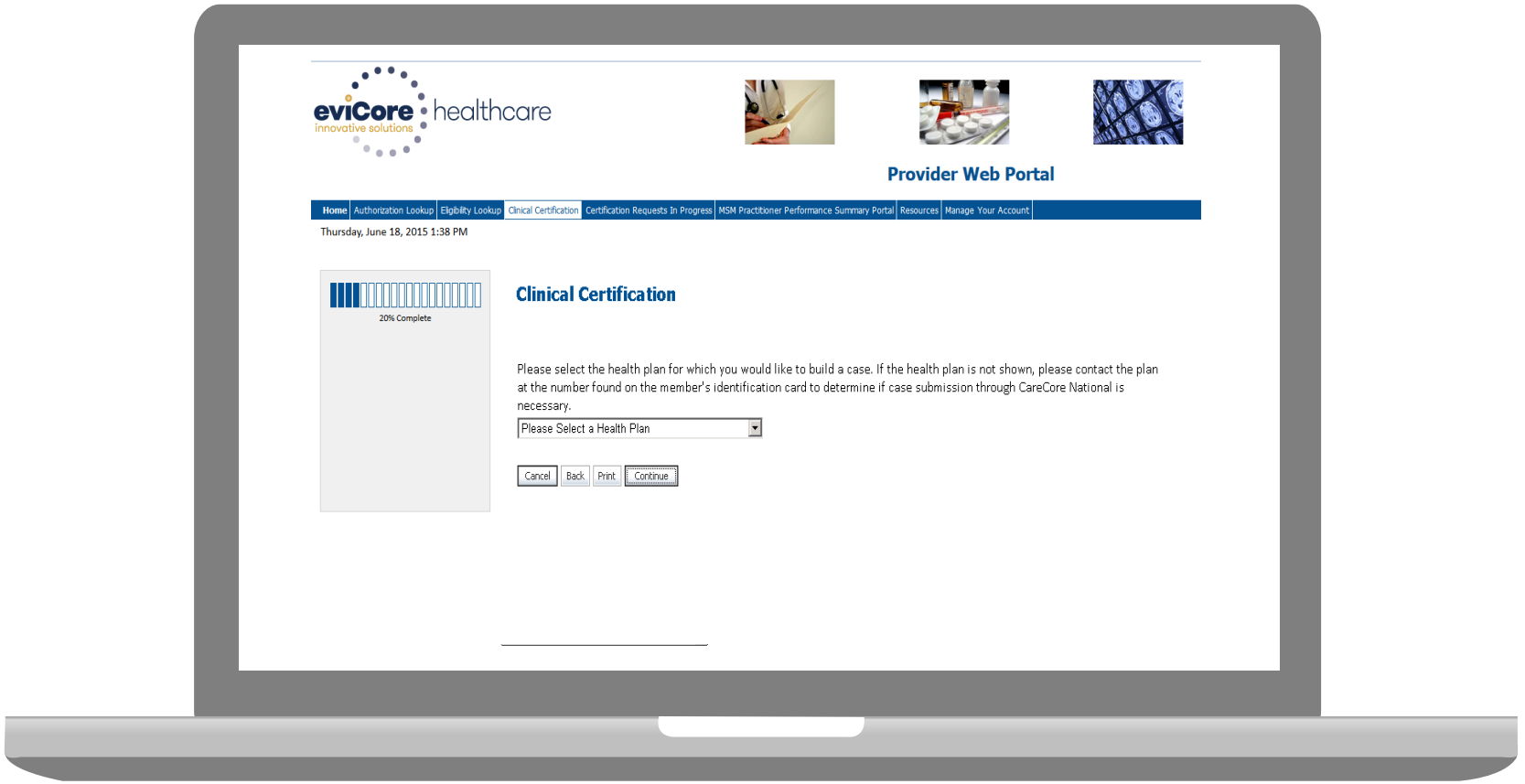


Select **Date Extension**, **Continuing Care**, or **Build a New Case**.

Select Provider

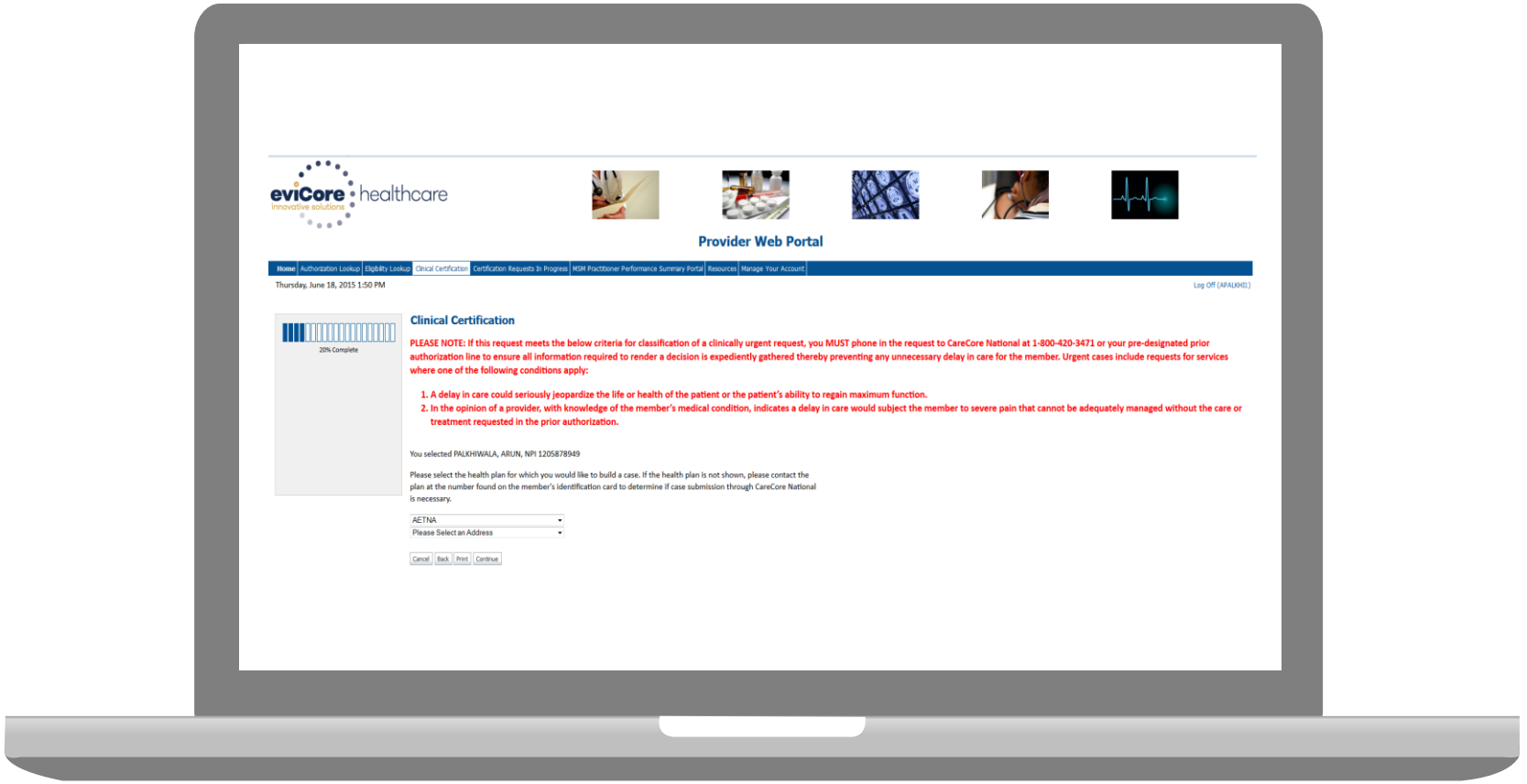
Select the **Practitioner/Group** for whom you want to build a case.

Select Health Plan



Choose the appropriate **Health Plan** for the case request.

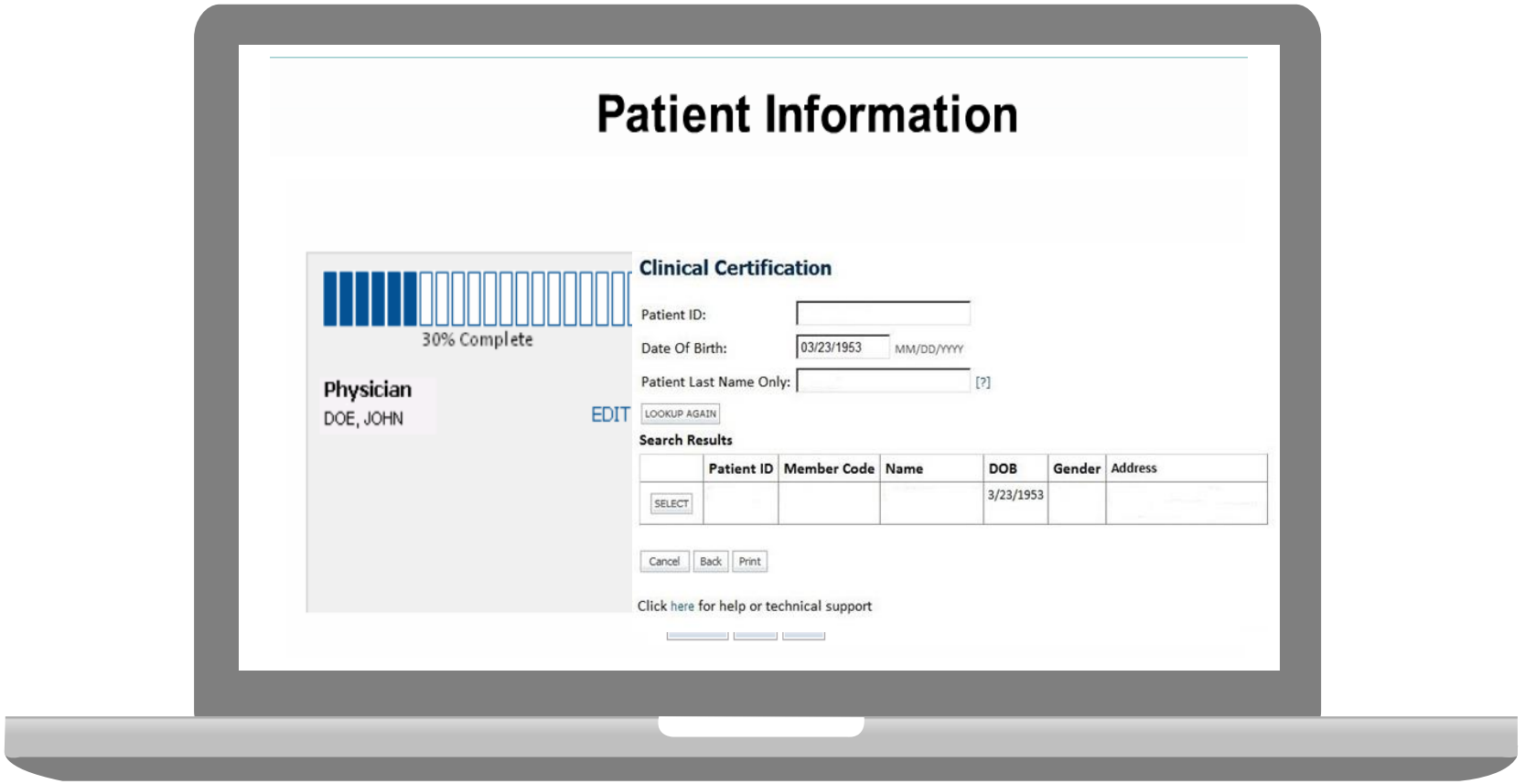
Select Address



Contact Information

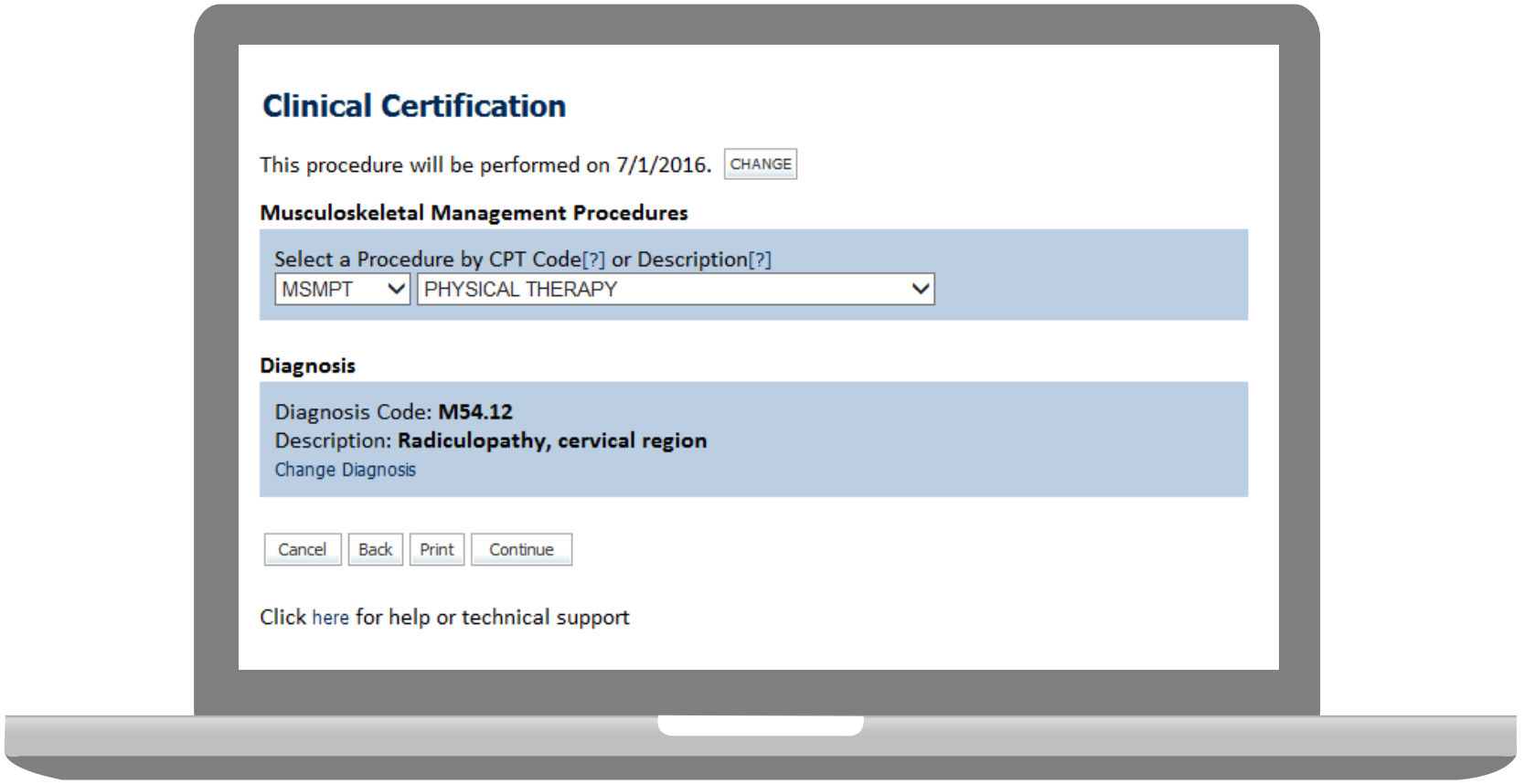
Enter the **Provider name** and appropriate information for the point of contact individual.

Member Information

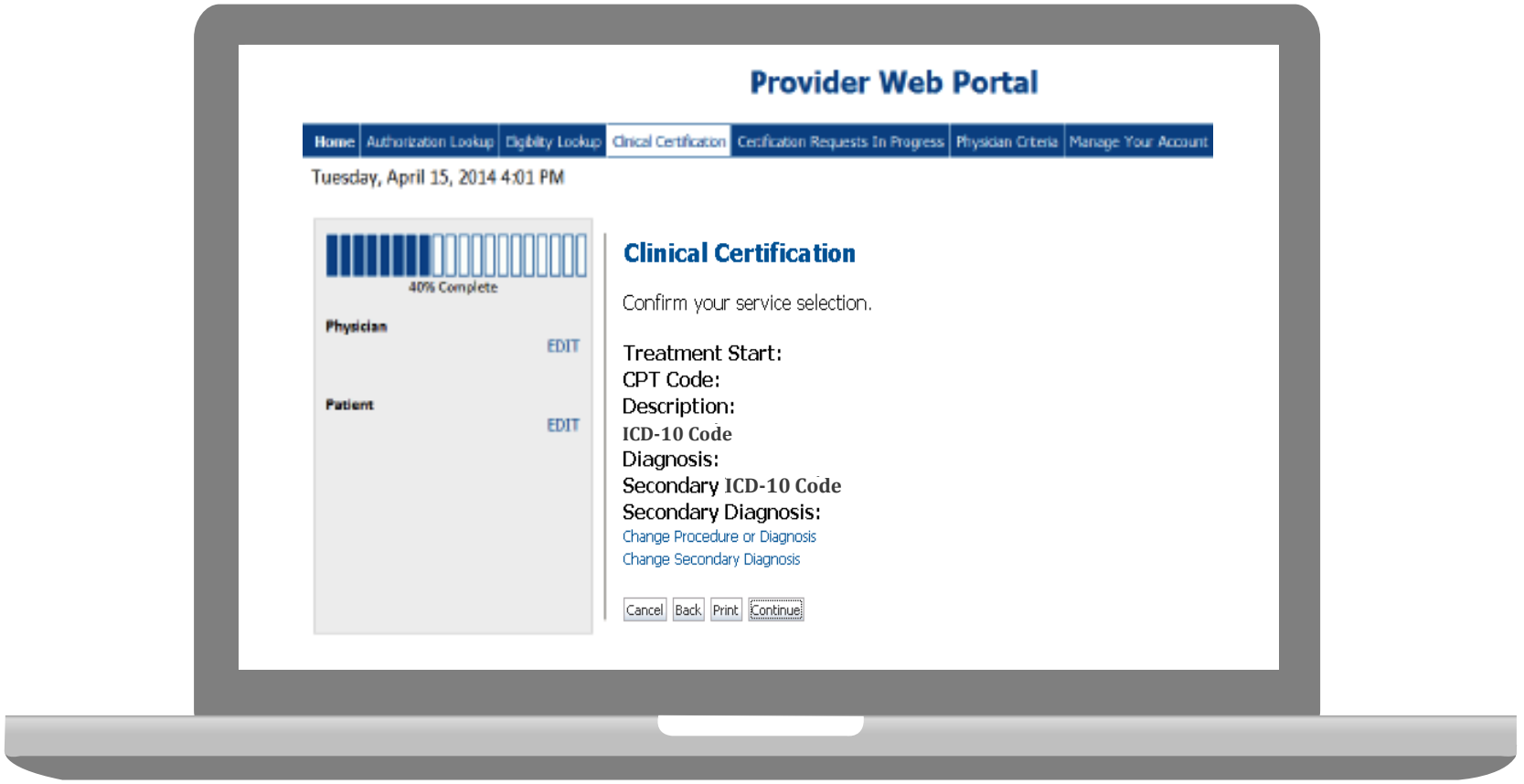


Enter the **member information** including the Patient ID number, date of birth, and patient's last name. Click **"Eligibility Lookup."**

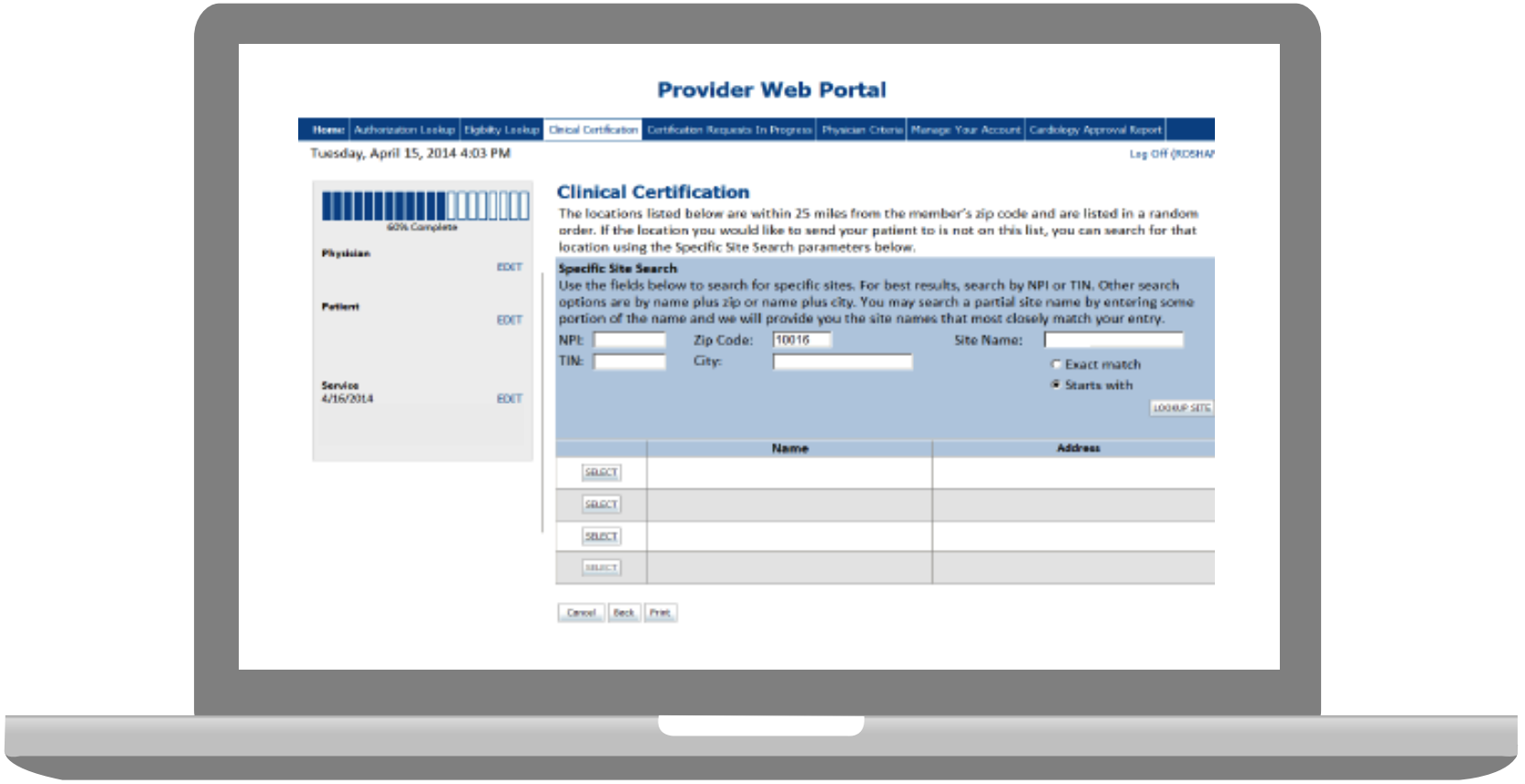
Clinical Details



Verify Service Selection



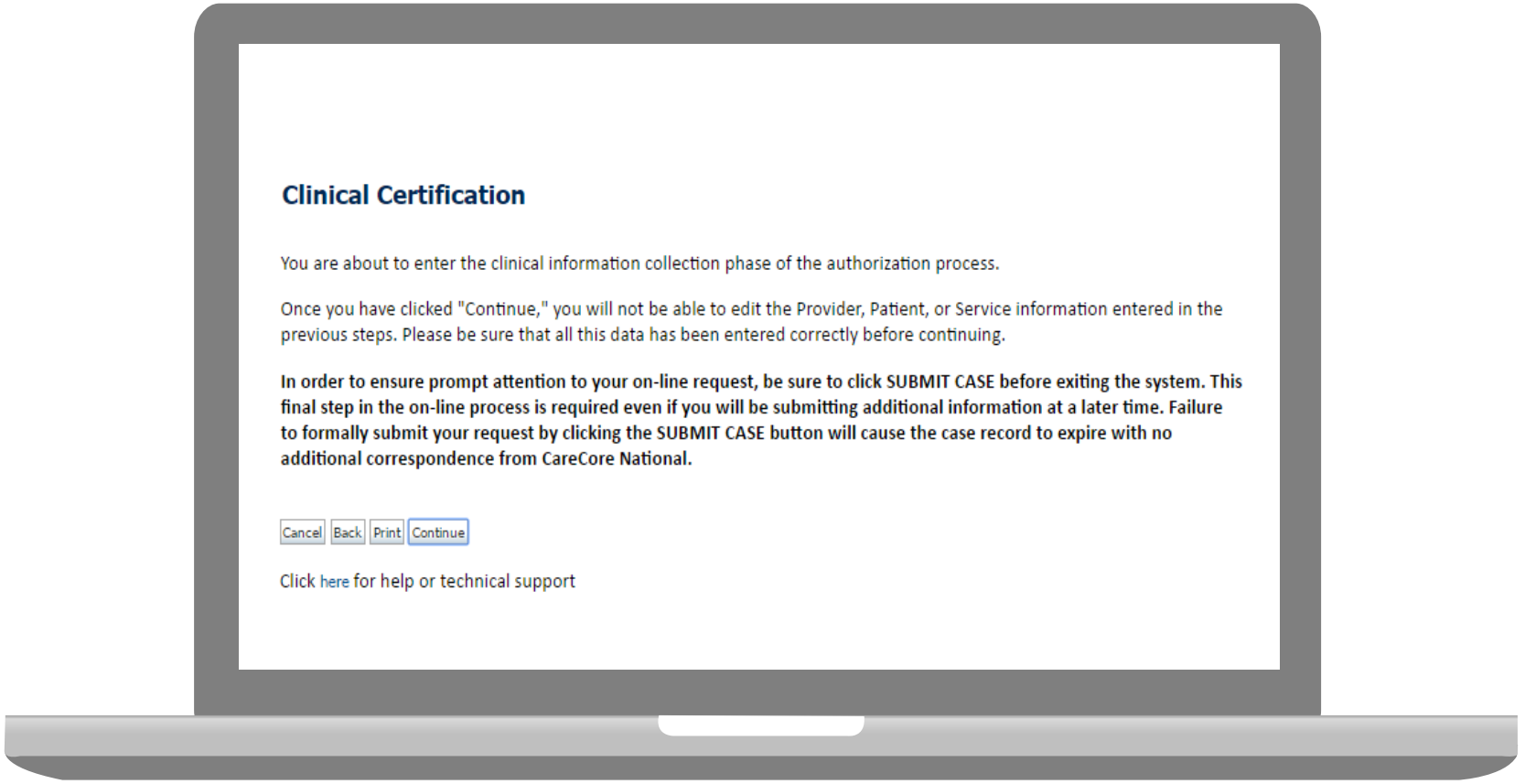
Site Selection



- **Verify all information entered and make any needed changes prior to moving into the clinical collection phase of the prior authorization process.**

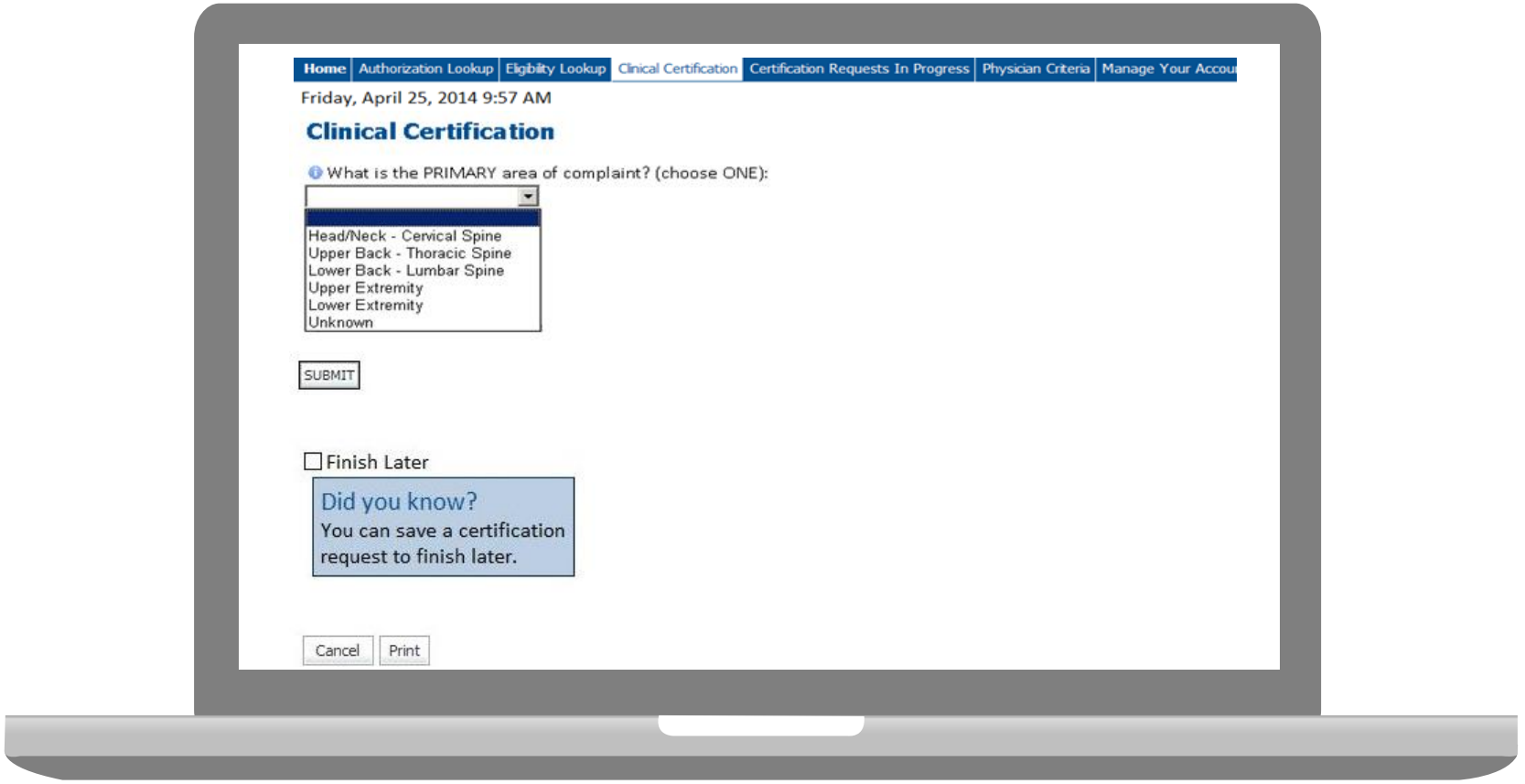
<u>You will not have the opportunity to make changes after that point.</u>

Clinical Certification



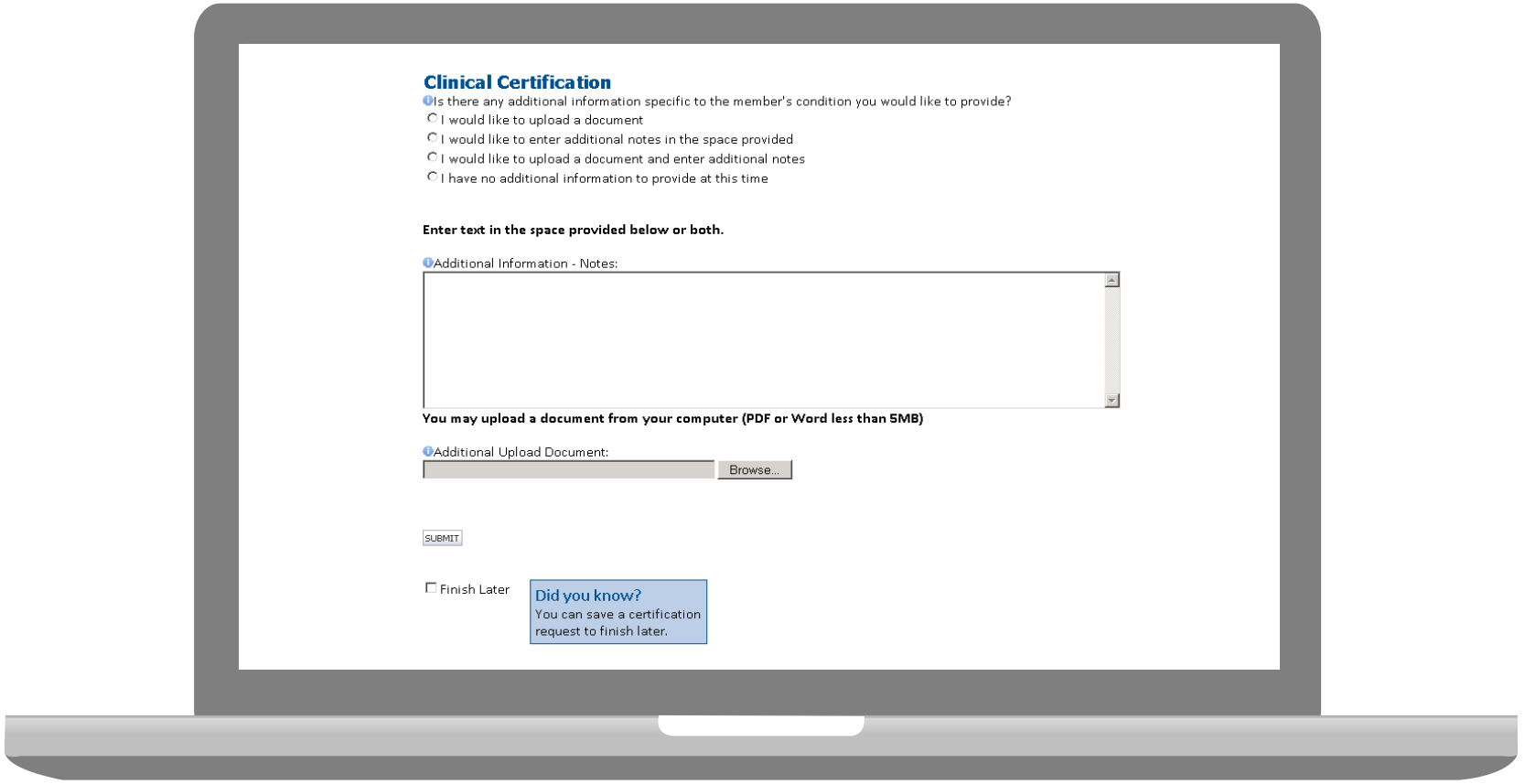
- Verify all information entered and make any needed changes prior to moving into the clinical collection phase of the prior authorization process.
- You will not have the opportunity to make changes after that point.

Pause/Save Option



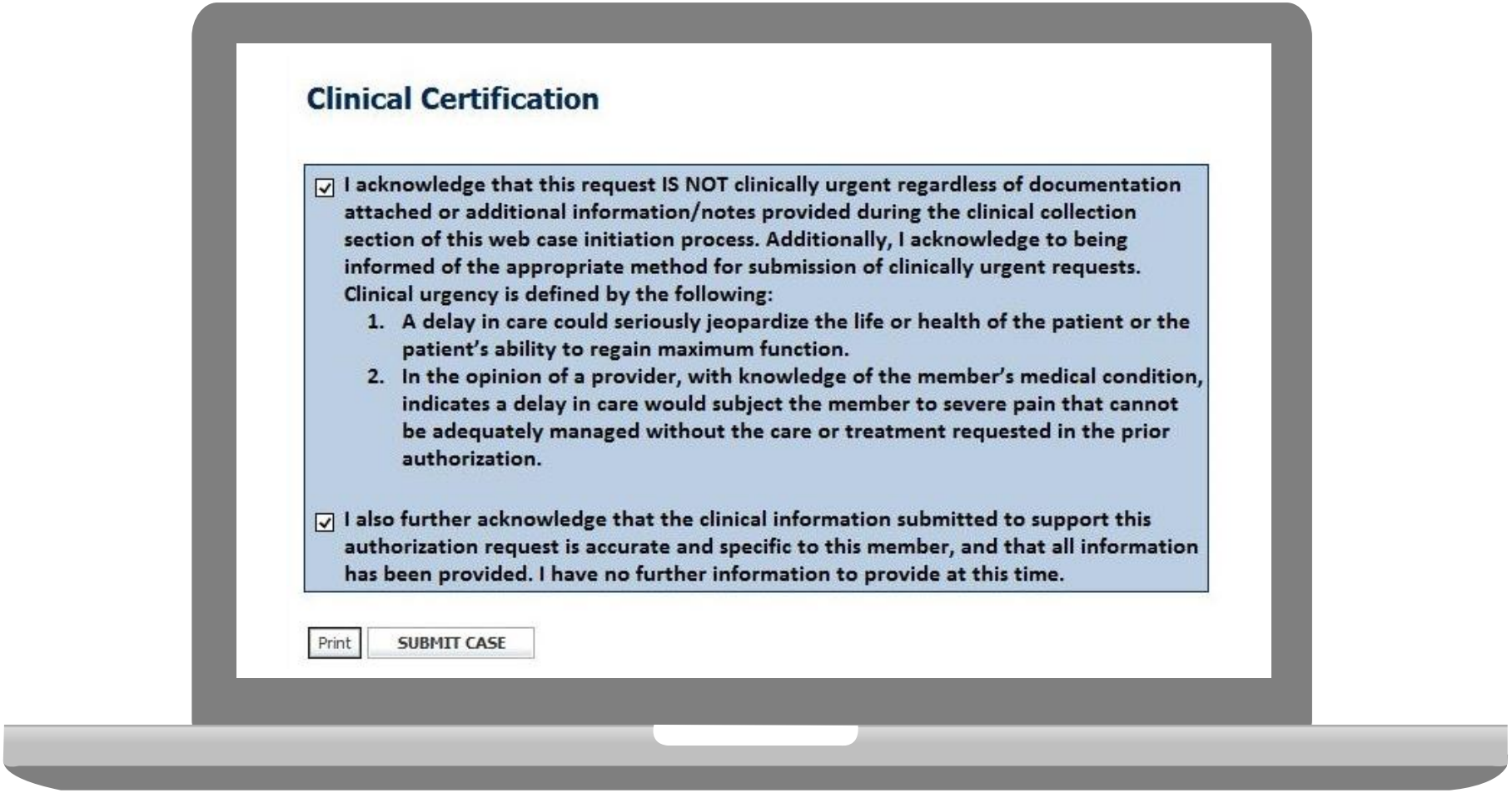
Once you have entered the clinical collection phase of the case process, you can save the information and return within (2) business days to complete.

Medical Review



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.

Medical Review



Acknowledge the Clinical Certification statements, and hit "**Submit Case**."

Approval

Clinical Certification

Your case has been Approved.

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

Patient Name:
Insurance Carrier:
Patient Id:

Site Name:
Site Address:
Site ID:

Primary Diagnosis Code:
Secondary Diagnosis Code:
CPT Code:
Description:
Description:
Description:

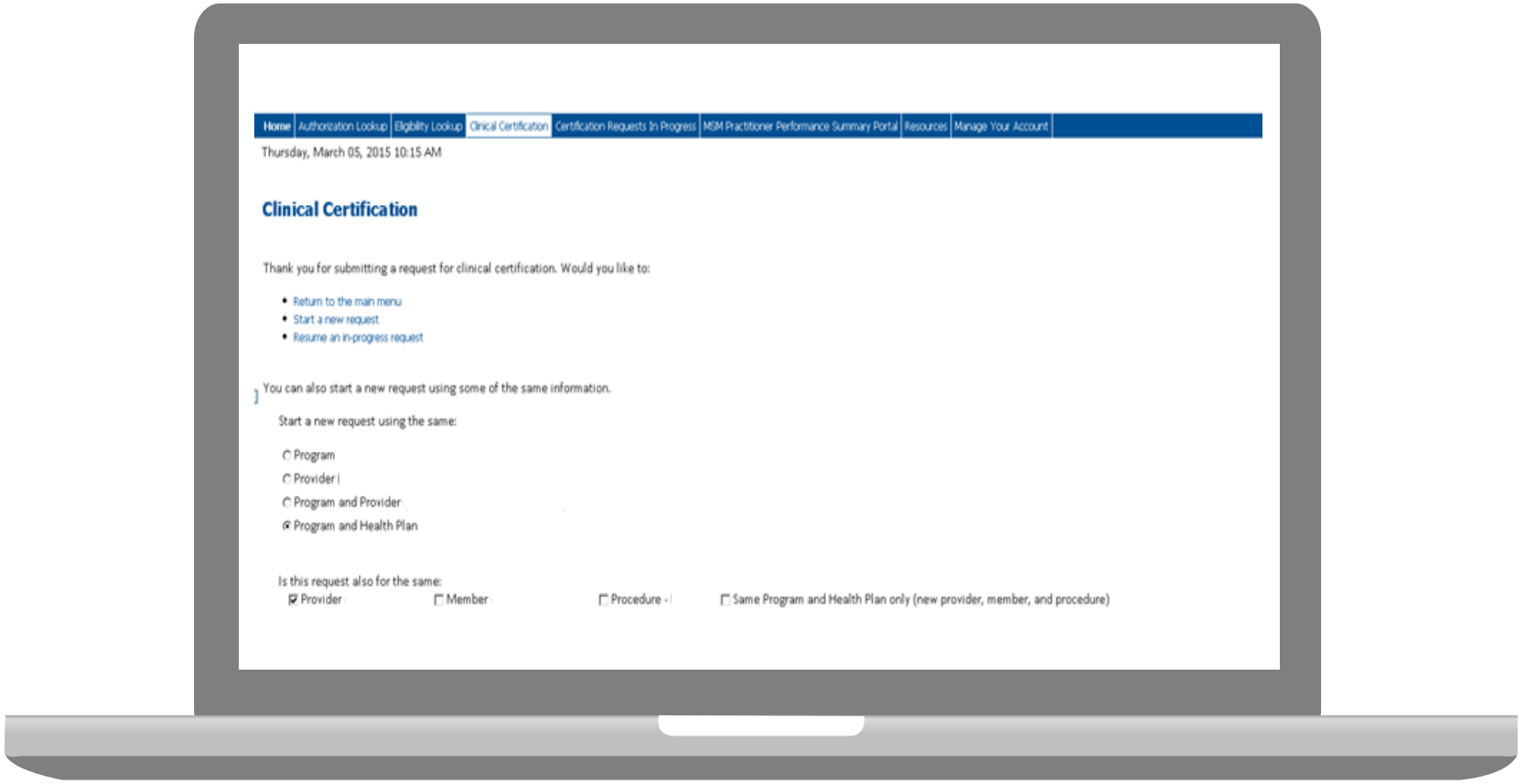
Modifier:
Authorization Number:
Review Date:
Expiration Date:
Status: Your case has been Approved.

Print | Continue

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

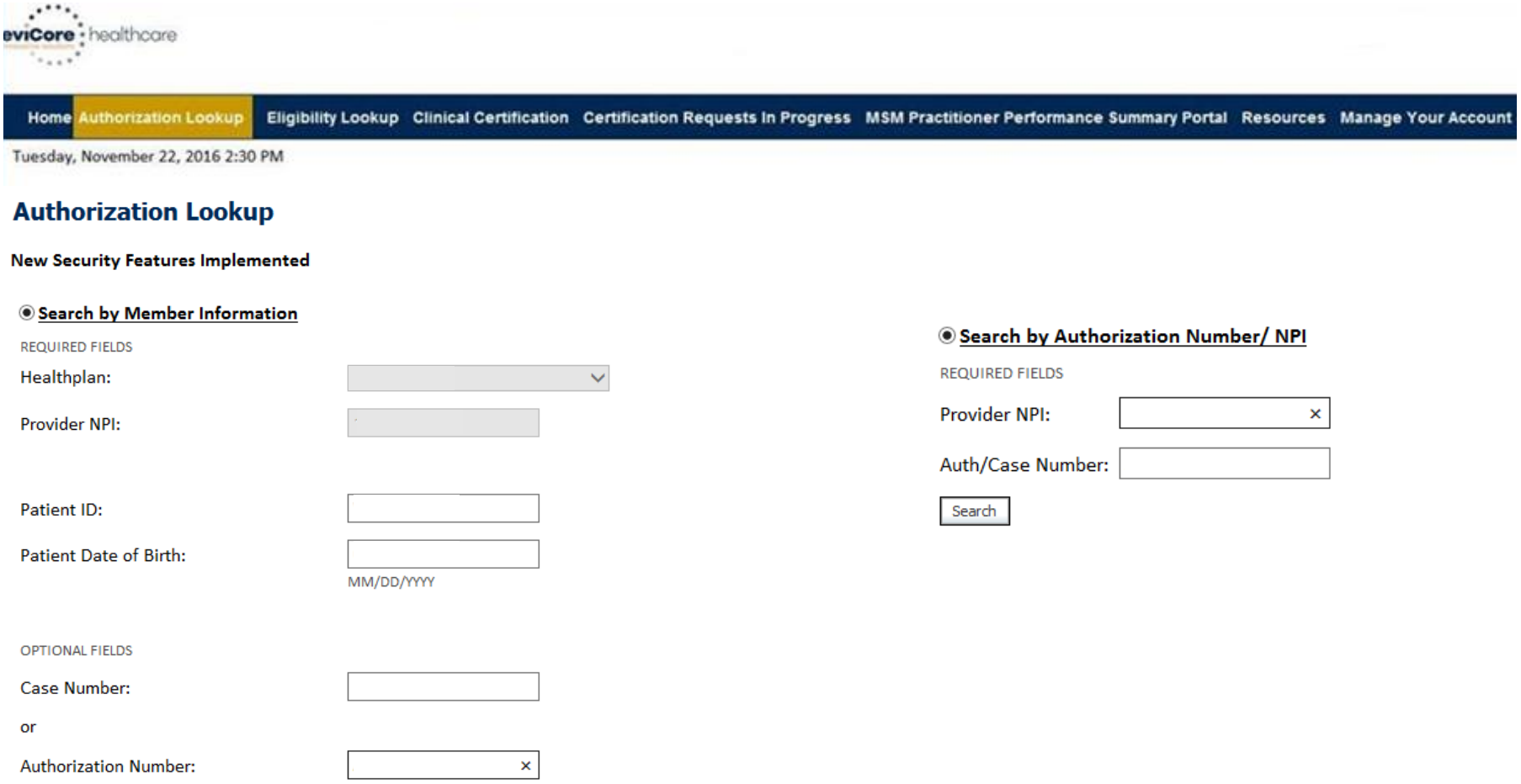
Print the screen and store in the patient's file.

Building Additional Cases



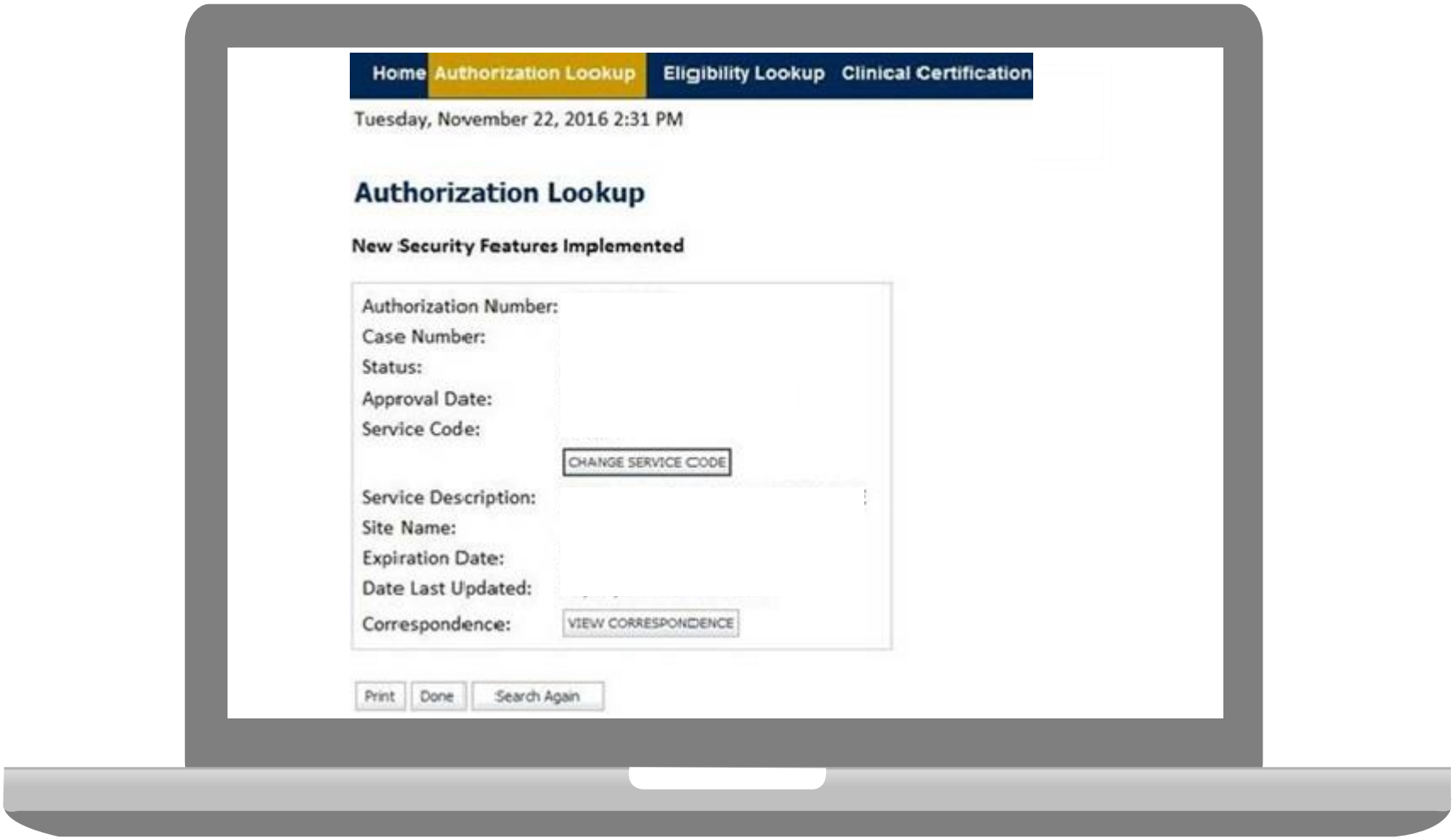
Once a case has been submitted for clinical certification, you can return to the **Main Menu**, **resume an in-progress request**, or **start a new request**. You can indicate if any of the previous case information will be needed for the new request.

Authorization look up



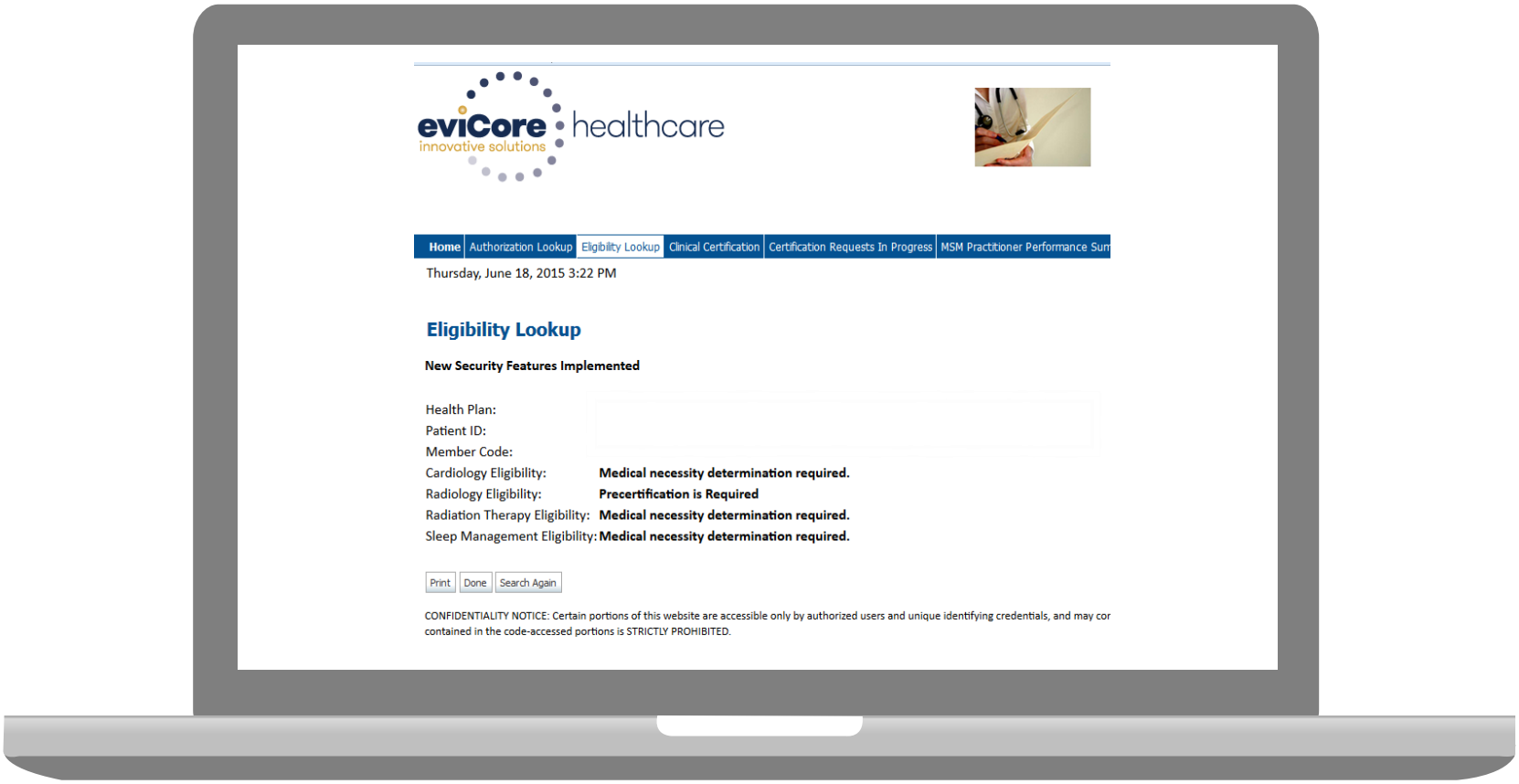
- Select Search by **Authorization Number/NPI**. Enter the provider's NPI and authorization or case number. Select **Search**.
- You can also search for an authorization by **Member Information**, and enter the health plan, Provider NPI, patient's ID number, and patient's date of birth.

Authorization Status



The authorization will then be accessible to review. To print authorization correspondence, select View Correspondence.

Eligibility Look Up

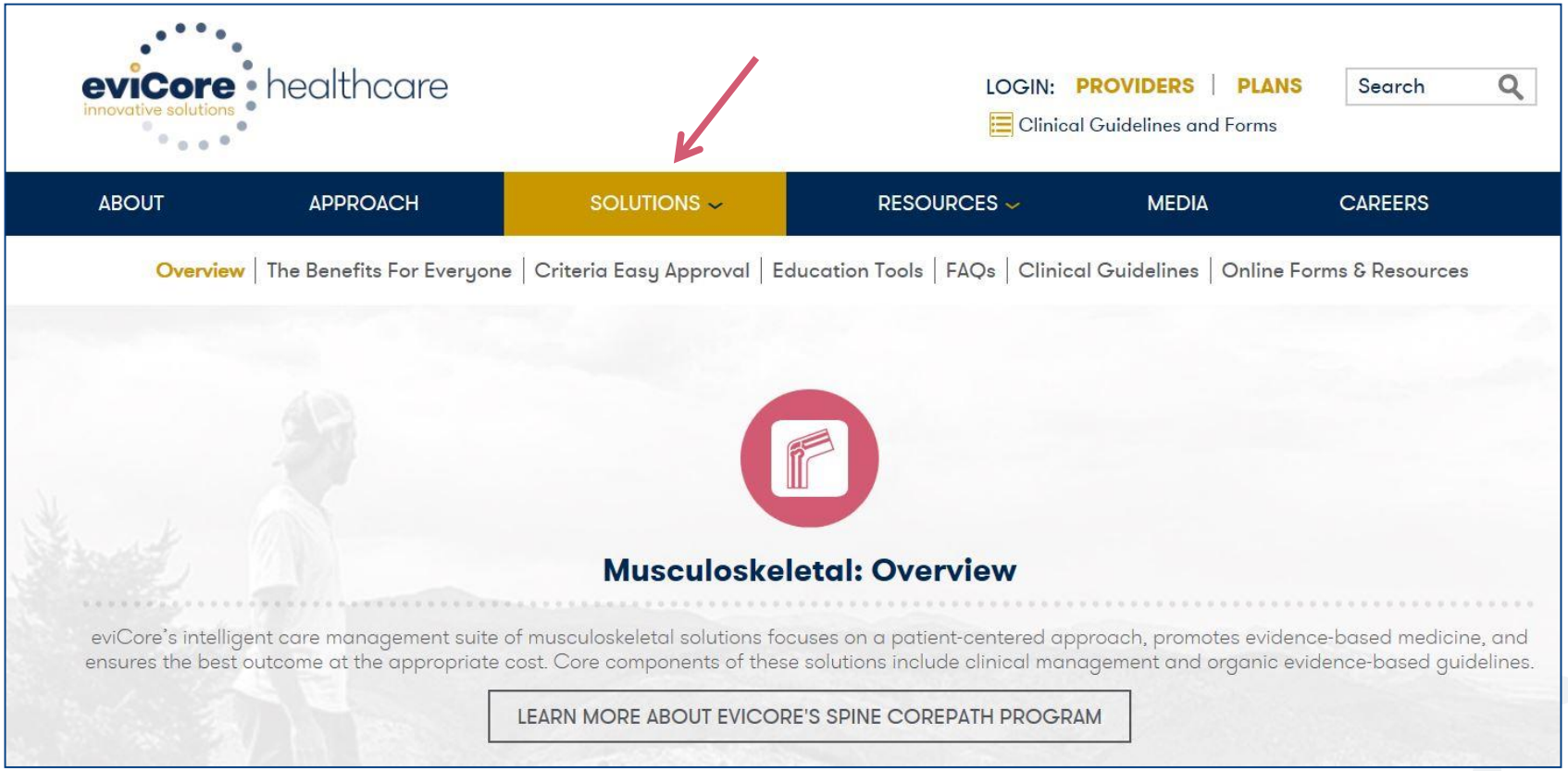


Provider Resources



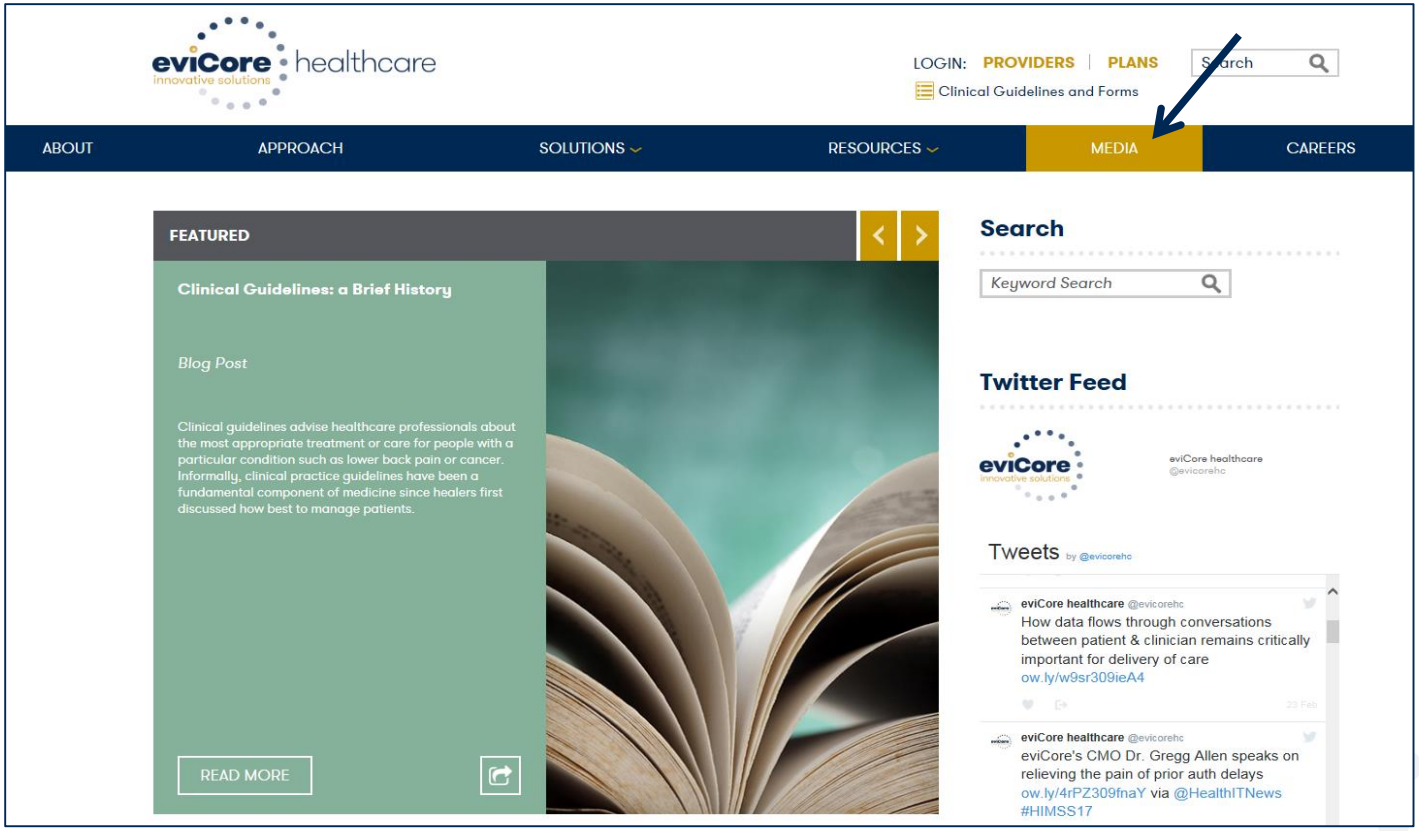

Musculoskeletal Online Resources

Clinical Guidelines, FAQ's, Online Forms, and other important resources can be accessed at www.evicore.com. Click "Solutions" from the menu bar, and select the specific program needed.

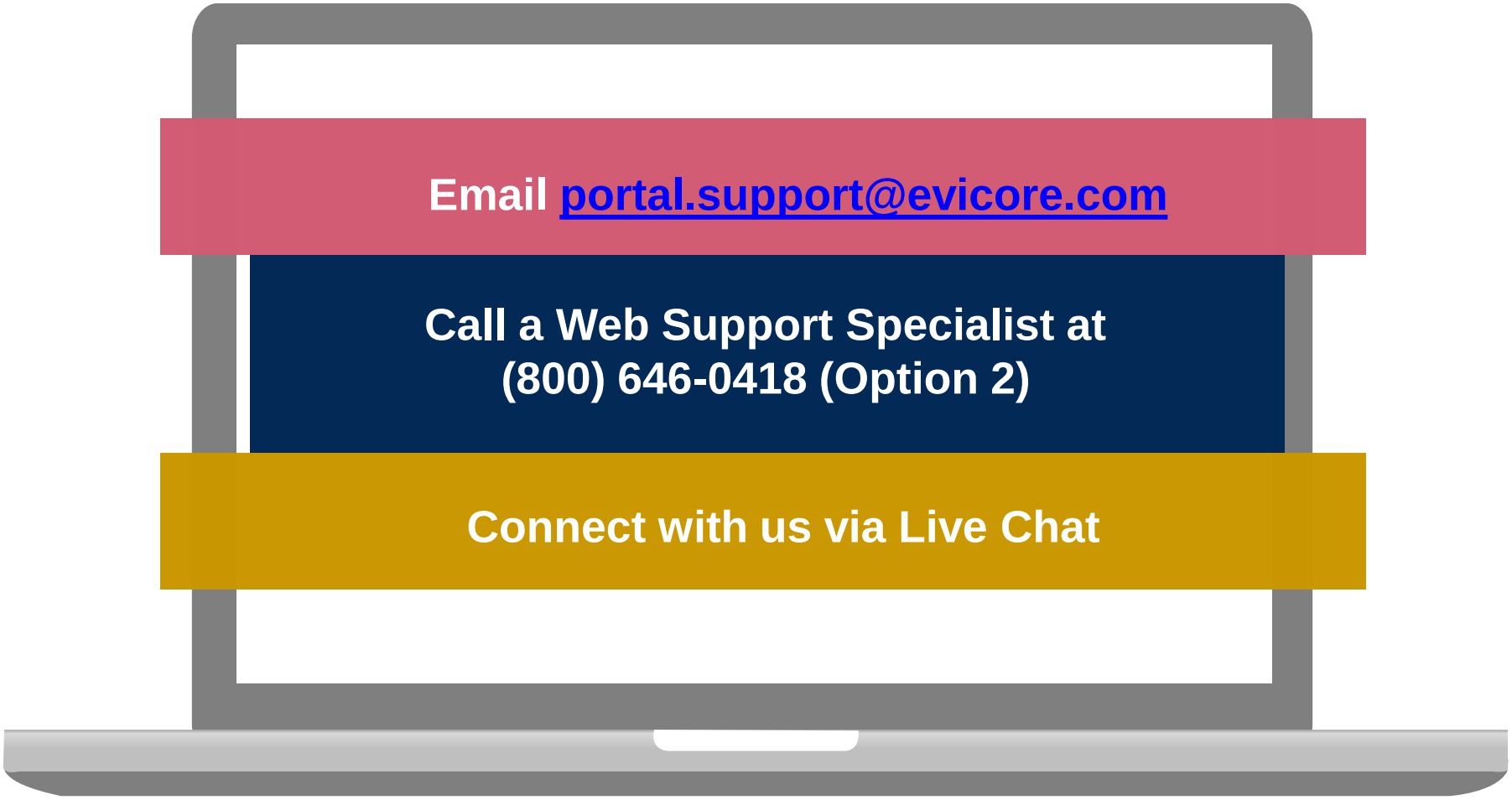


eviCore Provider Blog Series

- The eviCore blog series focuses on making processes more efficient and easier to understand by providing helpful tips on how to navigate prior authorizations, avoid peer-to-peer phone calls, and utilize our clinical guidelines.
- You can access the blog publications from the **Media** tab or via the direct link at https://www.evicore.com/pages/media.aspx.



Web Portal Services-Assistance



Web Portal Services-Available 24/7

Provider Resources: Pre-Certification Call Center

Pre-Certification Call Center

Web-Based Services

Client Provider Operations

Documents

7:00 AM - 7:00 PM (Local Time): 855-252-1117

- Obtain pre-certification or check the status of an existing case
- Discuss questions regarding authorizations and case decisions
- Change facility or CPT Code(s) on an existing case

Provider Resources: Client Provider Operations

Pre-Certification Call Center

Web-Based Services

Client Provider Operations

Documents

clientservices@evicore.com

- Eligibility issues (member, rendering facility, and/or ordering physician)
- Questions regarding accuracy assessment, accreditation, and/or credentialing
- Issues experienced during case creation
- Request for an authorization to be resent to the health plan

Provider Resources: Implementation Document

Pre-Certification Call Center

Web-Based Services

Client Provider Operations

Documents

Provider Enrollment Questions
Contact your Provider Network Consultant for more information

Blue Cross and Blue Shield Implementation site - includes all implementation documents:

https://www.evicore.com/healthplan/bcbs

- **Provider Orientation Presentation**
- **CPT code list of the procedures that require prior authorization**
- **Quick Reference Guide**
- **eviCore clinical guidelines**
- **FAQ documents and announcement letters**

You can obtain a copy of this presentation on the implementation site listed above. If you are unable to locate a copy of the presentation, please contact the Client Provider Operations team at ClientServices@evicore.com

Thank You!