Health Alliance

eviCore healthcare
innovative solutions

MSK Specialized Therapy Program

Frequently Asked Questions

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Who is eviCore healthcare?

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for **Health Alliance Medical Plan**.

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What services are managed through eviCore's Musculoskeletal (MSK) Specialized Therapy Program?

Beginning **8/1/2017**, eviCore will manage the following specialized therapy services for **Health Alliance Medical Plan**:

✓ Physical Therapy	✓ Occupational Therapy	✓ Speech Therapy	✓ Chiropractic

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Which patients require prior authorization and when?

For the **Health Alliance Medical Plan** program, the following patients require prior authorization:

✓ Commercial Members	✓ Medicare Advantage Members

Please see below for additional details:

Services	Patient Type	When is PA through eviCore required?
Physical Therapy Occupational Therapy Speech Therapy Chiropractic	Patients currently in treatment plans that began prior to 8/1/17	PA is not required through eviCore though 2017 **UNLESS** there is a change in diagnosis. PA must be obtained for continuing treatment prior to 1/1/18.
	Patients who began treatment on or after 8/1/17	PA is required for all dates of service 8/1/17 and after

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How do I verify patient eligibility?

Follow your routine **Health Alliance Medical Plan** process for eligibility verification. For more information please visit YourHealthAlliance.org.

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Who needs to request prior authorization?

Prior authorization requests should be submitted by the healthcare provider who will be treating the patient. eviCore does not manage PCP referrals and, as such, a PCP does not need to initiate the prior authorization request.

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How do I request prior authorization?

Providers in the Health Alliance network may submit a prior authorization ***online*** by accessing eviCore through YourHealthAlliance.org. Online submissions are the ***quickest*** and most ***efficient*** way to request prior authorization and have the highest potential of returning an automatic approval!

You may also request authorization telephonically by calling eviCore at **1-844-303-8452**. eviCore is available for telephonic case initiation Monday through Friday between 7 AM and 7 PM local time.

Fax submissions may be submitted to **1-855-774-1319**, using the applicable clinical worksheet available at https://www.evicore.com/healthplan/health_alliance. You may include additional clinical information with your fax request if desired. **Note!** Prior authorization requests submitted by fax have a higher likelihood of requiring full clinical review. To avoid delays, we encourage web submission.

Note! Out-of-network providers **must** call **1-844-303-8452** or fax **1-855-774-1319** to request prior authorization.

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Does the patient's initial evaluation require prior authorization?

No. The patient's initial evaluation does not require prior authorization; **however**, if treatment is also performed the same day, authorization will be required for those services. You have 7 calendar days from the initial date of service to request retrospective review for any treatment performed during the patient's initial visit.

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What clinical information is collected during the prior authorization process?

The clinical information requested by eviCore during prior authorization will differ per each specialized service, patient age and condition, and request type (i.e., initial request, second or more).

Baseline clinical information should be included when submitting an initial request. This typically includes:

- Diagnostic information
- History of surgery, as applicable
- Complexities and additional information about recent surgery (i.e., type and date)
- Primary area of complaint; pain distribution
- Select examination findings, i.e. range of motion and strength
- Outcome Measurement Test scores
  Note! Refer to "***What Outcomes Measurement Tests are commonly used by eviCore?***"
- Standardized test scores, as applicable

The following may be collected during a request for prior authorization of continuing care:

- Patient response to treatment
- Updated Outcome Measurement Test scoring, including change from previously reported score
- Identification of reasons associated to lack of progress from treatment provided

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Can I attach additional clinical information when requesting prior authorization?

You may be able to submit additional clinical information in limited scenarios.

Web initiated cases for initial and second requests may restrict your ability to include attachments or notes for review. This is intentional. Our clinical pathways have been specifically designed to collect all clinical information we need to make a decision for a patient's condition during these intervals of treatment. Completed pathways will likely yield an instant approval of services.

You may include additional clinical information that you would like to be considered during the prior authorization process for a fax initiated case; ***however***, submissions that include journal notes or attachments **will** require additional clinical review and are less likely to yield an immediate approval. **Note!** Compliance/Statutory guidelines require that eviCore respond to any and all requests for care (visits, units, frequency) that may be contained within the attachment provided.

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What Outcome Measurement Tests are commonly used by eviCore?

eviCore uses the following Outcome Assessment tests during its prior authorization review processes based on the patient's region of complaint:

✓ Neck Disability Index (NDI)	✓ Oswestry Disability Index (ODI)
✓ Lower Extremity Functional Scale (LEFS)	✓ Disabilities of Arm, Shoulder and Hand (DASH/QuickDASH)

Note! eviCore has carefully selected the above Outcome Measurement Tests based on a number of factors, including consideration of tests that have broad application, validated and consistent scoring methodology, defined clinimetrics and ease of use. eviCore closely monitors the evolution of standard practices and may expand upon this list over time, as appropriate.

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What Standardized Test Scores does eviCore consider?

eviCore considers Standardized Test Scores for Pediatric cases. Please see Appendix for full list.

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Will separate authorizations be required for a patient with two concurrent diagnoses?
No. eviCore considers all diagnoses reported during the prior authorization process and allows for collection of additional information specific to secondary treatment areas, as applicable. **Note!** Separate requests for prior authorization are required if the patient is receiving care from multiple healthcare providers or specialties.

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How long do I have to submit a request for prior authorization?
Prior authorization must be submitted before treating your patient. **Note!** Refer to **Initial Visit question** for exception to this rule when treatment is performed same day as the patient's initial evaluation.

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How far in advance can I submit a request for prior authorization?
Requests for authorization must be submitted no more than **seven (7)** days prior to the requested start date. Requesting care too far in advance does not allow you to report current examination findings and clinical information.

Clinical information must be less than **ten (10)** days old to be considered current. Prior authorization requests with out-of-date clinical information may be placed on hold awaiting current clinical information.

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How can I initiate prior authorization for a medically urgent request?
Medically urgent requests – defined as conditions that are a risk to the patient's life, health, ability to regain maximum function or cause severe pain that may require a medically urgent procedure – must be initiated by phone. All web and fax cases will be considered standard. **Note!** Cases should not be classified as medically urgent solely for convenience of the patient or healthcare provider.

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Do services provided in an inpatient setting at a hospital or in an emergency room require prior authorization?
No. Services performed during in inpatient stay or in an emergency room setting do not require prior authorization.

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What do I enter as the start date on my prior authorization request?
The Start Date should reflect the date you want the authorization to begin.

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Are retrospective review requests allowed?
No. Retrospective reviews are not allowed for this program. **Note!** Refer to **Initial Visit question** for exception to this rule when treatment is performed same day as the patient's initial evaluation.

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How long is an approved coverage period?
Approved coverage periods may vary based on patient age, condition, surgical history and request type (initial or subsequent).

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How many visits are generally approved?
Approved visits will vary based on each individual patient's condition, severity and complexity and response to treatment received once provided.

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Can additional visits be requested?
Yes. If you believe a patient will require more visits after the approved coverage period expires, submit an updated prior authorization request for continuing care. The request should include current clinical information. Keep in mind that prior authorization requests should not overlap. The start date of your request for continuing care should be after the expiration of your previous authorization.

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Can I extend the approved timeframe if I have not used all approved visits?

Yes. eviCore will allow up to one (1) extension per approved coverage period. The extension must be requested online or telephonically before the approved coverage period expires. Date extensions cannot be requested via fax.

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Can I include Durable Medical Equipment (DME) supplies on an authorization request?

This is not required. eviCore does not review for medical necessity of DME supplies.

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How long will it take for a determination to be rendered?

Completed cases that were initiated online have the highest potential to receive an instant approval; however, if your request required additional clinical review, eviCore will follow the contractual and/or compliance and regulatory turn-around-times as stipulated below:

- Medicare Urgent – Within 72 hours
- Medicare Non-Urgent – Within 14 calendar days
- Non-Medicare – Within 2 business days of receipt of **sufficient clinical information** needed to render a decision.

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Is the clinical criteria available for review?

Yes. Our clinical criteria are available online at **http://www.evicore.com/solution/Pages/Musculoskeletal.aspx**.

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How can I track the status of my prior authorization request?

You may track the status of your prior authorization request online by accessing eviCore through **YourHealthAlliance.org**. Once logged in, select "Authorization Lookup" to view the current status of your request.

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What authorization information will be visible on the eviCore website?

The authorization status function on our website will provide the following information:

✓ Auth/Case Number	✓ Status of Request	✓ CPT Codes/Quantity
✓ Procedure Name	✓ Site Name and Location	✓ Authorization Date
	✓ Expiration Date	

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Will eviCore's medical necessity decision specify the number of services and/or units approved?

Yes. Our decision will include the total number of visits and units approved over a specific coverage period duration. **Note!** eviCore's decision is based solely on medical necessity of the requested services and does not guarantee payment. Payment may be subject to further eligibility and benefit checks.

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What is the format of the eviCore Authorization Number?

An authorization number is one (1) alpha character followed by nine (9) numeric values: i.e., A123456789.

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Can I speak to a reviewer regarding a denied request?

Yes. You may request a Peer-to-Peer discussion online or telephonically by calling eviCore at **1-844-303-8452**.
Note! eviCore cannot overturn any denials issued for Medicare requests via a peer-to-peer conversation.

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Can I file an appeal for requests that have been fully or partially denied?

It is recommended that you utilize reconsiderations processes before submitting requests for formal appeal. Reconsiderations may be initiated telephonically or through a peer-to-peer conversation. **Note!** Denied Medicare requests can only be overturned via formal appeal processes.

Requests upheld via reconsideration processes may be appealed further. Determination letters associated to the denied service(s) will contain additional information specific to applicable appeal processes.

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Where do I submit claims?

Follow your routine **Health Alliance Medical Plan** process for claims submission. For more information, you may also visit **YourHealthAlliance.org**.

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Appendix

✓ **Standardized Test List – Pediatric (Full List):**

Bayley – III *Bayley Scale of Infant and Toddler Development*	**BDI** *Batelle Development Inventory*
Beery VMI *Beery-Buktenica: Developmental Test of Visual- Motor Integration*	**BOT-2** *Bruininks - Oseretsky Test of Motor Proficiency*
DAYC *Developmental Assessment of Young Children*	**DP-3** *Developmental Profile -3*
DTVP *Developmental Test of Visual Perception*	**M-FUN** *Miller Function and Participation Scales*
Movement ABC *Movement Assessment Battery for Children*	**MVPT** *Motor Visual Perception Test*
PDMS-2 *Peabody Developmental Motor Scales -2*	**PEDI-CAT** *Pediatric Evaluation of Disability Inventory*
REAL *Roll Evaluation of Activities of Life*	**TVMS-3** *Test of Visual Motor Skills*
TVPS *Test of Visual Perceptual Skills*	**WRAVMA** *Wide Range Assessment of Visual Motor Ability*