Physical and Occupational Therapy Management

Provider Orientation Session for Network Health Wisconsin

Medical Benefits Management (MBM)

Addressing the complexity of the healthcare system

10
Comprehensive
solutions

Evidence-based
clinical guidelines

5k+ employees,
including
1k+ clinicians

Advanced, innovative,
and intelligent
technology

Program Overview

Network Health Wisconsin Prior Authorization Services

eviCore healthcare (eviCore) will begin accepting prior authorization requests for Physical Therapy and Occupational Therapy services on May 24, 2021 for dates of service June 1, 2021 and after.

Prior Authorization is required for members who are enrolled in Medicare and Commercial (Self Insured & Fully Insured) lines of business/programs.

Prior authorization applies to the following services:

- Outpatient only Physical and Occupational Therapy
- Telehealth/home Physical and Occupational Therapy
- Elective / Non-emergent Therapy

Providers should verify member eligibility and benefits on the secured provider log-in section at: https://networkhealth.com/

Prior Authorization Process – Specialty Therapies

corePath

- Simplified approach to clinical collection attempting to reduce administrative efforts for providers.
- Improves the ability to receive a real time decision when submitting a request via the web or phone.
- “Gets out of the way” of providers who are practicing efficiently and effectively.
- Adds quality measures via inclusion of patient reported functional outcomes.
- Uses data collected over the years from claims data (managed and unmanaged) to set the average # of visits for a condition.
- Acknowledges complexities that may require a greater frequency or intensity of care.
- Allows therapists to provide additional information for cases that are not “average”.

Therapy corePath: How it Works

1

Initial Visit Allocation

Based on each patient's needs

2

Authorization of Additional Visits

Based on each patient's confirmed progress

Getting to the Right Yes vs the Wrong No

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

- Focuses on progress
- Captures reasons for lack of progress
- Confirms effectiveness of treatment

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

Prior Authorization Process

Clinical Information – What eviCore needs and why we need it

- Clinical information is required to determine whether the services requested are medically necessary.
- Use clinical worksheets located at eviCore.com as a guide to determine what clinical information is required.
- Be prepared to provide patient reported functional outcome measures with your submission (for example: ODI, NDI, DASH/QuickDASH, LEFS, HOOS JR, KOOS JR).
- Clinical information should be current – typically something collected within 14 days prior to the request.
  - Exception – for peds neurodevelopmental, information may be up to 20 days old and the standardized testing should have been completed within up to one year prior to the requested start date.
- **Missing or incomplete clinical information will delay case processing.**
- **Medicare cases with incomplete or missing information will receive special handling. CMS allows eviCore to reach out multiple times over a 14 day period to obtain the information required to complete our review.**

Prior Authorization Process

Extended PT/OT Authorization

- Providers should base the frequency and intensity of care on the patient's condition, complexities, functional status, and response to care.
- Avoid creating a plan of care based on historical or business practice. Providers will be expected to only use the visits (and units) that are medically necessary.
- Provider behavior will be monitored and if there is a pattern of unnecessary utilization, future cases will not be eligible for expanded authorizations in the future.

Pathway Questions

- Questions are included in the pathway to help eviCore create a case correctly.

- For example, you may be asked questions about the site (location) of the service.
  - Reason – Prior authorization may not be required for some sites of service.
  - Example – Emergency Department, Inpatient Services.

- Is the care requested following a mastectomy?
  - Should present only when the request is for a cervical or upper extremity condition.
  - Presents for both males and females since mastectomy applies to both.
  - There is a federal mandate related to post-mastectomy care.

Insufficient Clinical – Additional Documentation Needed

Additional Documentation to Support Medical Necessity

If all required pieces of documentation are not received, or are insufficient for eviCore to reach a determination, the following will occur:

A Hold Letter will be faxed to the Requesting Provider inviting additional documentation

To ensure that a determination is completed within the designated timeframe for each LOB, the case will remain on hold as follows:

- Medicare: 1 calendar day
- Commercial: 10 calendar days

The Provider will need to submit the additional information to eviCore

Requested information must be received within the timeframe as specified in the Hold Letter.

eviCore will review the additional documentation and reach a determination

Determination will be completed within 14 calendar days

Prior Authorization Process

Requesting Authorization

- For the first request
  - Evaluate the member before you request prior authorization.
  - Network Health allows providers to evaluate and treat at the initial visit.
  - The evaluation code does not require prior authorization, but treatment does.
  - If treatment is provided during the evaluation visit, you have 7 days from the date of service to submit your request for authorization for the initial treatment.
- If additional care is needed:
  - You may submit your request as early as 7 days prior to the requested start date.
  - This allows time for the request to be reviewed and prevents a gap in care.
  - Remember to provide complete, current clinical information including patient reported functional outcome measures.
- **Retrospective** requests will be accepted up to 7 business days. Please note that any cases after 7 business days will be expired.

- Notes: Requests with a start date of > than 7 days in the future will not be accepted. If the member is away from therapy, reassess the condition once therapy has resumed. This allows you to provide current information to allow eviCore to determine medical necessity of ongoing therapy.

Treating Multiple conditions

Treating Multiple Conditions Within The Same Authorization Period

- If you are treating multiple conditions within the same period, there is no need to request authorization for treatment for each condition.

- The authorization covers all conditions treated within the same period of time.

- If you are treating more than 1 condition, advise eviCore to ensure adequate units are approved.
  - When submitting by the web, you will be asked if you are treating a second condition.
    - Answer = Yes; report information specific to the second condition
  - When requesting authorization over the phone, inform the agent that you are requesting authorization for two conditions
  - If submitting by fax, complete clinical worksheets for both conditions

Duplicate Care

- eviCore will approve care by two different providers within the same period only when it is medically necessary.
- Examples – PT and OT for therapy following a CVA; PT treating a knee condition and PT treating a vestibular condition.
- eviCore will not approve care by two providers within the same period if the care is duplicative.
- If a provider submits a request for authorization and there is an existing authorization for the same condition with a different provider, eviCore will reach out to the second provider to ask if the member has discontinued care with their original therapist. If this has occurred, please provide the date of discharge from the original therapist.
- If the condition being treated is the same and the member has not discontinued care with their original provider, the request for duplicate care will be denied.

Date Extensions

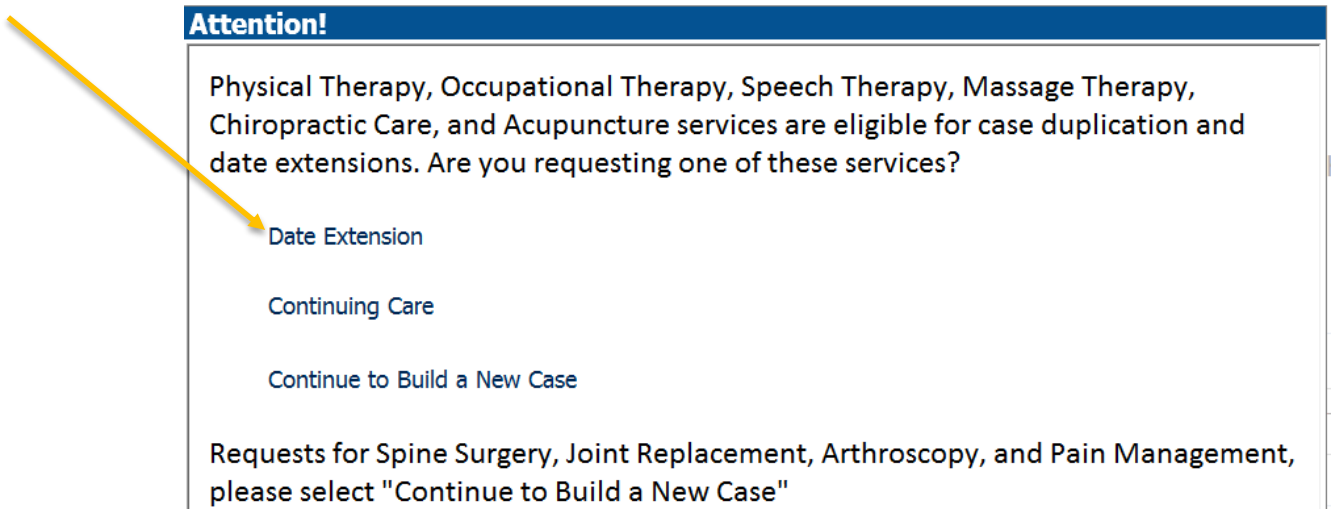
Date extensions are available if you are unable to use all units within the approved period

- Extend for the period that is needed, up to a maximum of 30 days
- One date extension is available per case
- **Must be requested prior to the expiration of the authorization**

Available

- By phone 855-727-7444
- Online

https://carriers.carecorenational.com/PreAuthorization/screens/CreateCase.aspx



Prior Authorization Outcomes & Special Considerations

Prior Authorization Approval

Approved Requests

- Standard requests are processed within14 calendar days after receipt of all necessary clinical information
- The time frames for which authorizations are valid vary, but often are valid for up to 90 days
- Authorization letters will be faxed to the ordering physician & rendering facility
- When initiating a case on the web you may receive e-notifications when a determination is made, if you have provided your email address
- Members will receive a letter by mail
- Approval information can be printed on demand from the eviCore portal: www.eviCore.com

Special Circumstances

Retrospective (Retro) Authorization Requests

- Must be submitted within 7 business days from the date of services
- Retro requests submitted beyond this timeframe will be expired
- Reviewed for clinical urgency and medical necessity
- Retro requests are processed within 14 calendar days
- When authorized, the start date will be the submitted date of service

Urgent Prior Authorization Requests

- eviCore uses the NCQA/URAC definition of **urgent**: when a delay in decision-making may seriously jeopardize the life or health of the member
- Can be initiated on provider portal or by phone
- Urgent request will be reviewed within 72 hours
- Reviewed for clinical urgency and medical necessity

When a Request is Determined as Inappropriate

Based on evidence-based guidelines, request is determined as **inappropriate**.

A denial letter with the rationale for the decision and the appeal rights will be issued to both the provider and member.

Post-Decision Options: Commercial

My case has been denied. What's next?

Your determination letter is the best immediate source of information to assess what options exist on a case that has been denied. You can also call us at 855-727-7444 to speak to an agent who can provide available option(s) and instruction on how to proceed.

Reconsiderations (for Commercial cases only)

- Providers and/or staff can request a reconsideration review
- Reconsiderations must be requested within 14 calendar days days after the determination date
- Reconsiderations can be requested in writing or verbally via a Clinical Consultation with an eviCore physician

Appeals

- eviCore is not delegated to manage appeals
- Please refer to the determination letter for instruction on how to file any appeal.

Pre-Decision Options: Medicare Members

I’ve received a request for additional clinical information. What’s next?

Submission of Additional Clinical Information

- eviCore will notify providers telephonically and in writing before a denial decision is issued on Medicare cases
- You can submit additional clinical information to eviCore for consideration per the instructions received
- Additional clinical information must be submitted to eviCore in advance of the due date referenced

Pre-Decision Clinical Consultation

- Providers can choose to request a Pre-Decision Clinical Consultation instead of submitting additional clinical information
- The Pre-Decision Clinical Consultation must occur prior to the due date referenced
- If additional information was submitted, we proceed with our determination and are not obligated to hold the case for a Pre-Decision Clinical Consultation, even if the due date has not yet lapsed

Post-Decision Options: Medicare Members

My Medicare case has been denied. What are my options?

Clinical Consultation

- Providers can request a Clinical Consultation with an eviCore physician to better understand the reason for denial
- Once a denial decision has been made, however, the decision cannot be overturned via Clinical Consultation

Reconsideration

- Medicare cases do not include a Reconsideration option

Appeals

- eviCore will not process first-level appeals
- Appeal requests must be submitted to Network Health Wisconsin within 60 calendar days from the initial determination
- Appeal requests can be submitted to NH: Please refer to the denial letter for how to file an appeal or grievance

Submitting Requests

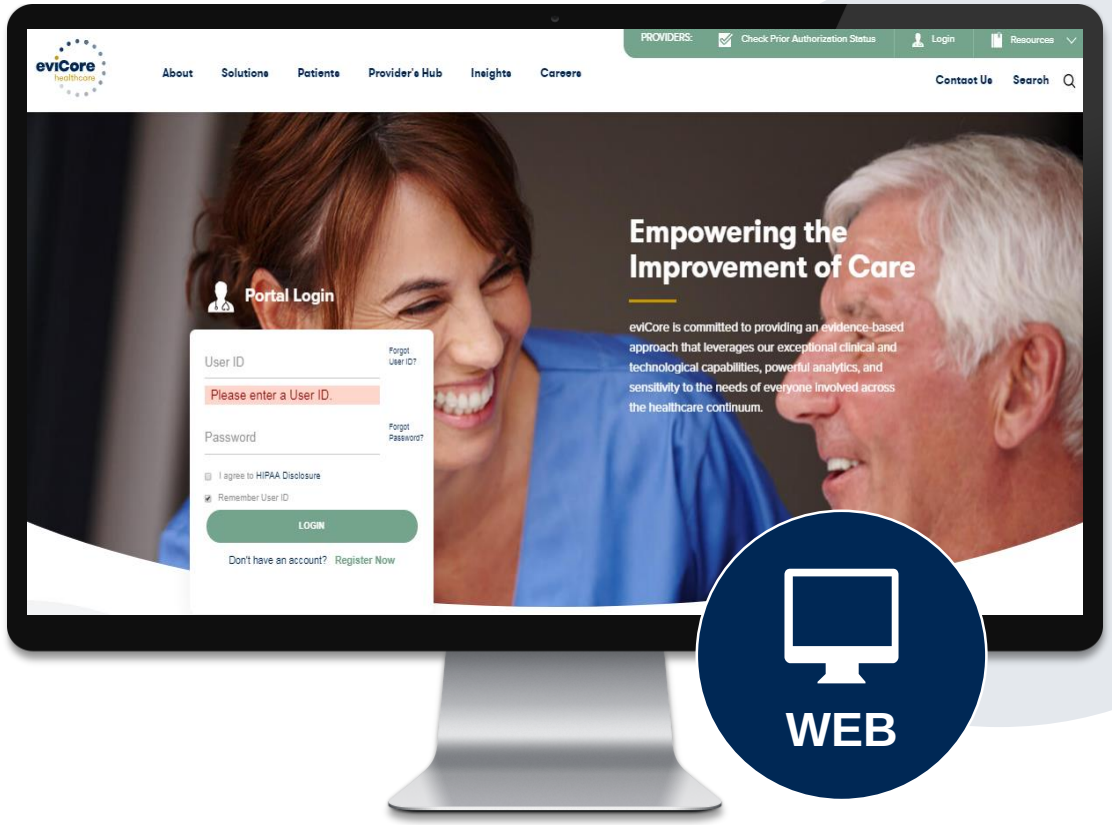
Methods to Submit Prior Authorization Requests

eviCore Provider Portal (preferred)

The eviCore online portal www.eviCore.com is the quickest, most efficient way to request prior authorization and check authorization status, and it's available 24/7

Phone Number:
855-727-7444
Monday through Friday:
7 am – 7 pm central time

Fax Number:
855-774-1319
PA requests are accepted via fax and can be used to submit additional clinical information



Benefits of Provider Portal

Did you know that most providers are already saving time submitting prior authorization requests online? The provider portal allows you to go from request to approval faster. Following are some benefits & features:

- Saves time: Quicker process than phone authorization requests
- Potential for Real Time Decision
- Available 24/7: You can access the portal any time and any day
- Save your progress: If you need to step away, you can save your progress and resume later
- Upload additional clinical information: No need to fax in supporting clinical documentation, it can be uploaded on the portal to support a new request or when additional information is requested
- View and print determination information: Check case status in real-time
- Dashboard: View all recently submitted cases
- Duplication feature: If you are submitting more than one prior authorization request, you can duplicate information to expedite submittals

Keys to Successful Prior Authorizations

To obtain prior authorization on the very first submission, the provider submitting the request will need to gather four categories of information:

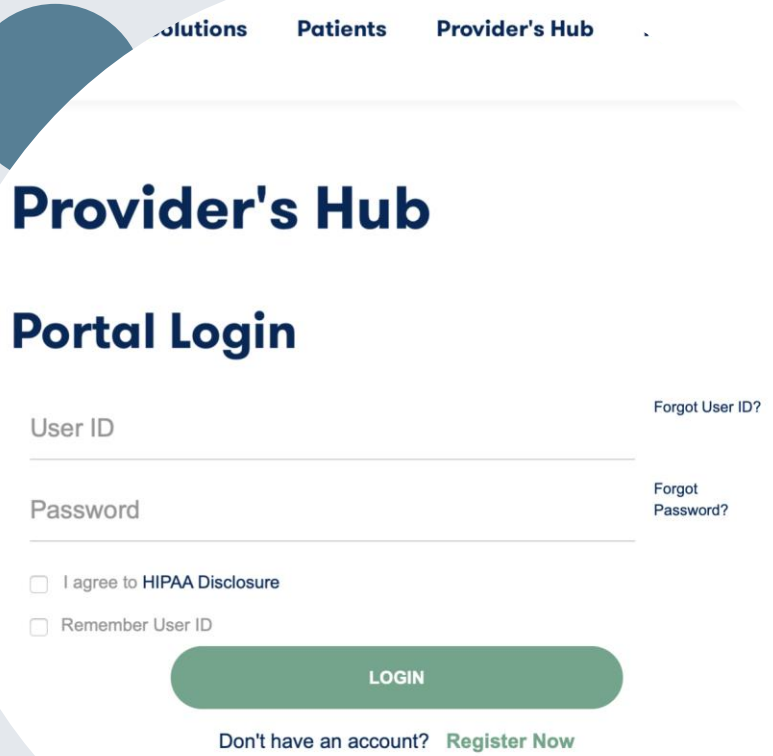
1. Member
- ID
- Member name
- Date of birth (DOB)

2. Referring (Ordering) Physician
- Physician name
- National provider identifier (NPI)
- Phone & fax number

3. Rendering Facility
- Facility name
- Address
- National provider identifier (NPI)
- Tax identification number (TIN)
- Phone & fax number

4. Supporting Clinical
- Pertinent clinical information to substantiate medical necessity for the requested service
- CPT/HCPCS Code(s)
- Diagnosis Code(s)
- Previous test results

Provider Portal Overview



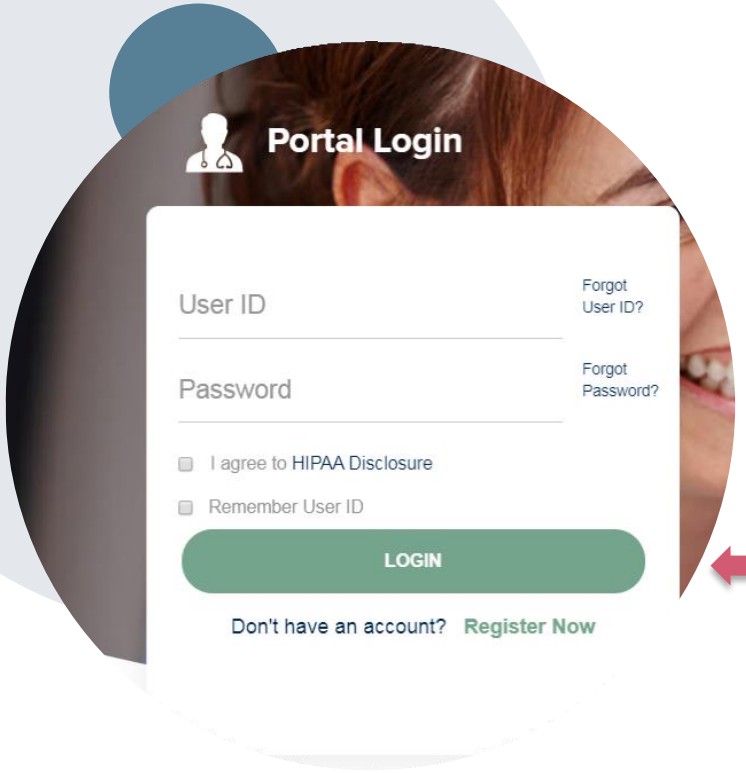
Portal Compatibility

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.

eviCore healthcare Website



Visit www.evicore.com

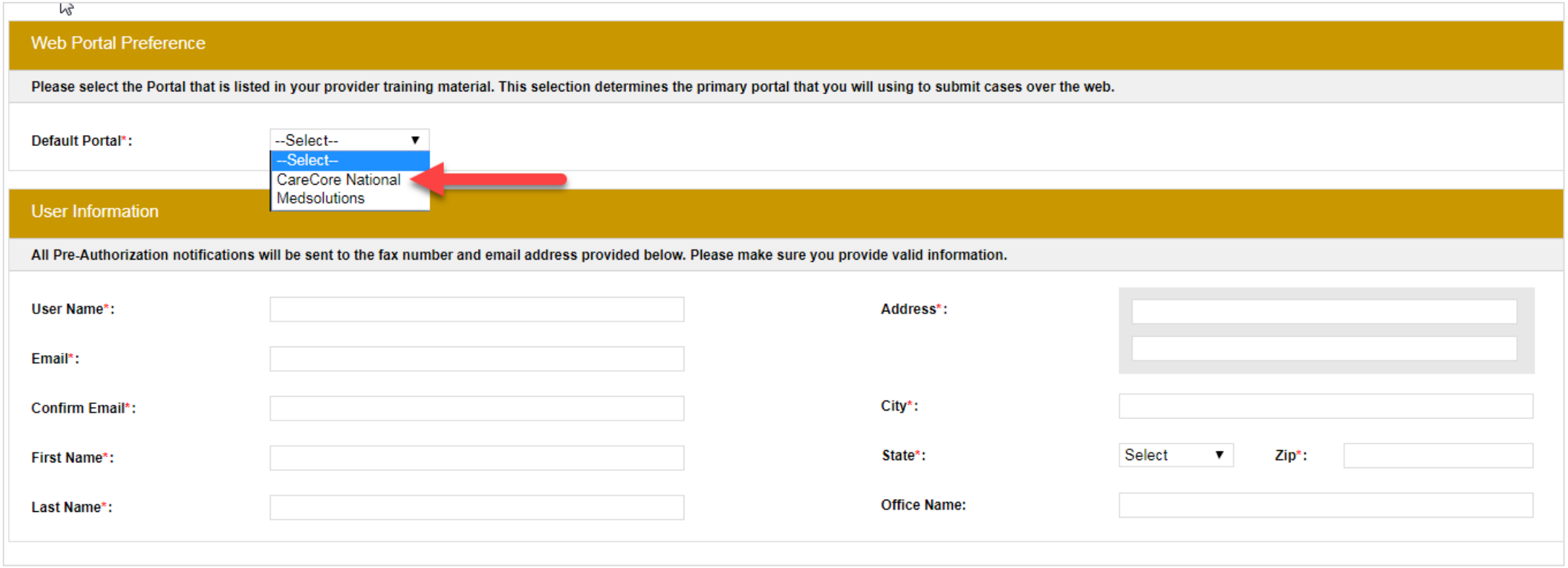
Already a user?

If you already have access to eviCore's online portal, simply log-in with your User ID and Password and begin submitting requests in real-time!

Don't have an account?

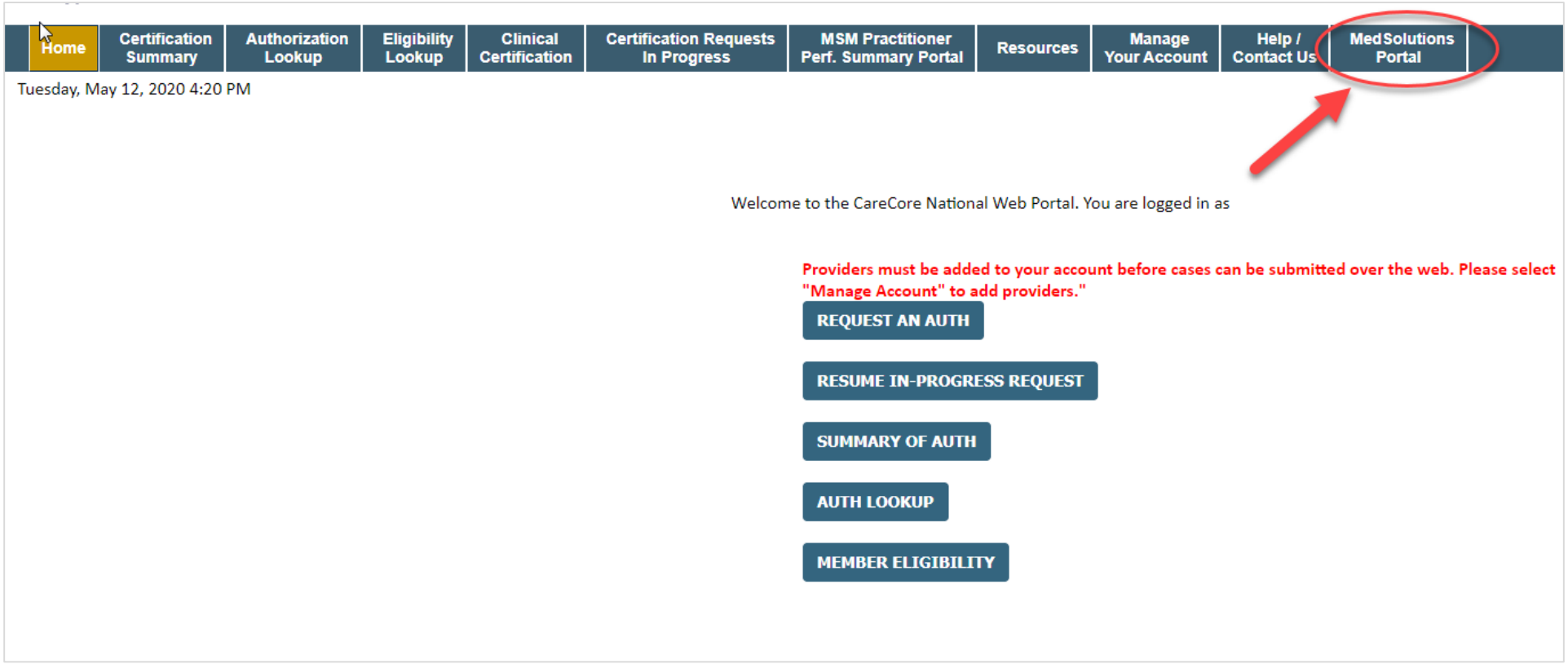
Click "Register Now" and provide the necessary information to receive access today!

Creating An Account



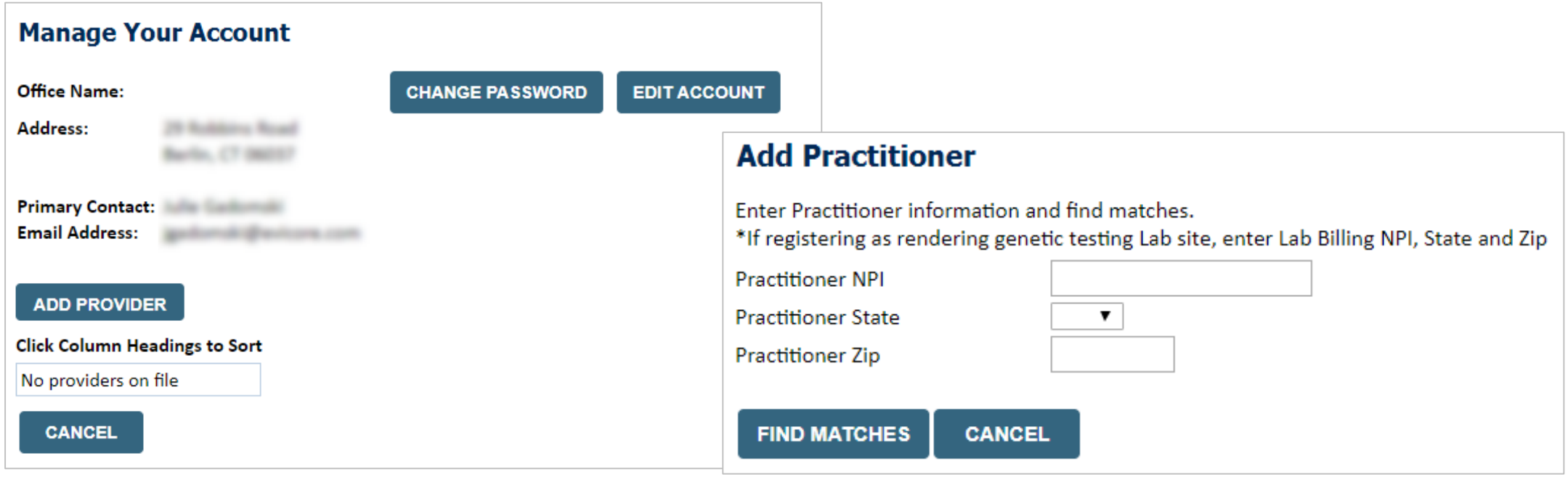
- Select CareCore National as the Default Portal, complete the User Information section in full, and Submit Registration.
- You will immediately be sent an email with a link to create a password. Once you have created a password, you will be redirected to the log-in page.

Welcome Screen



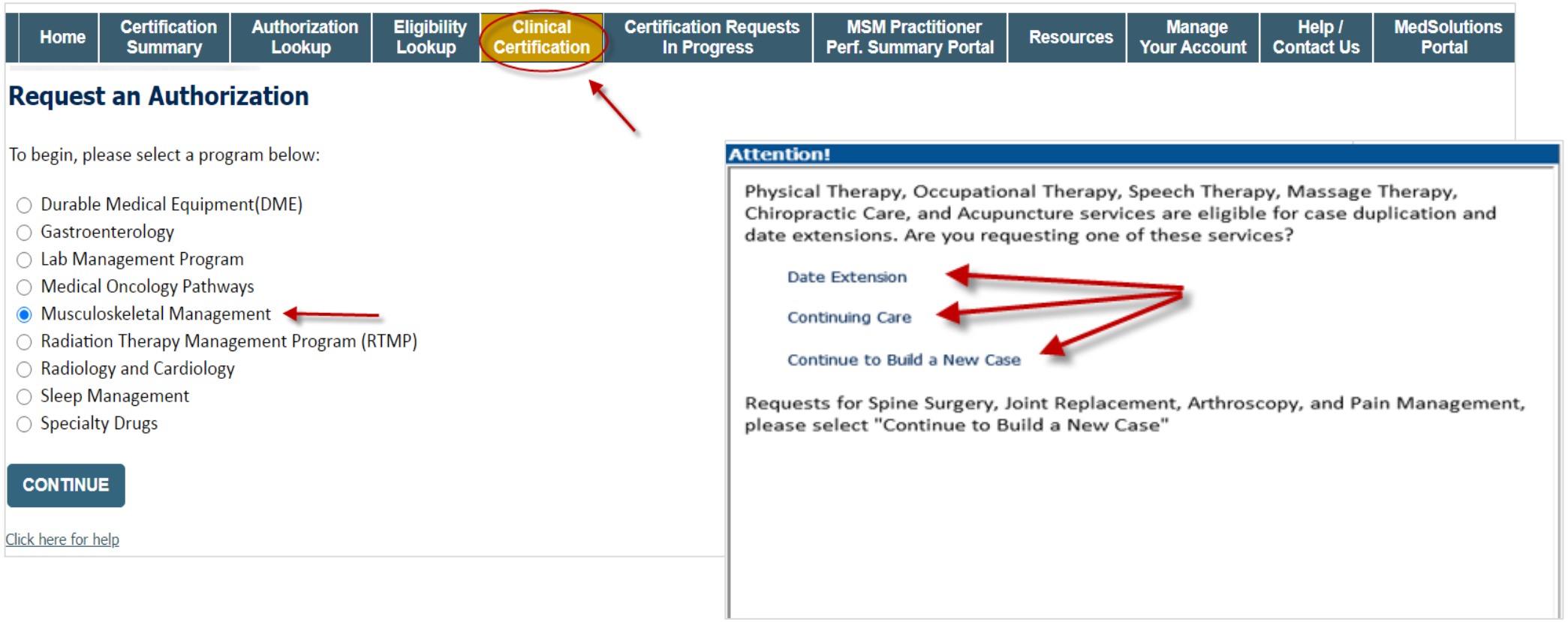
Note: You can access the MedSolutions Portal at any time without having to provide additional log-in information. Click the MedSolutions Portal on the top-right corner to seamlessly toggle back and forth between the two portals.

Add Practitioners



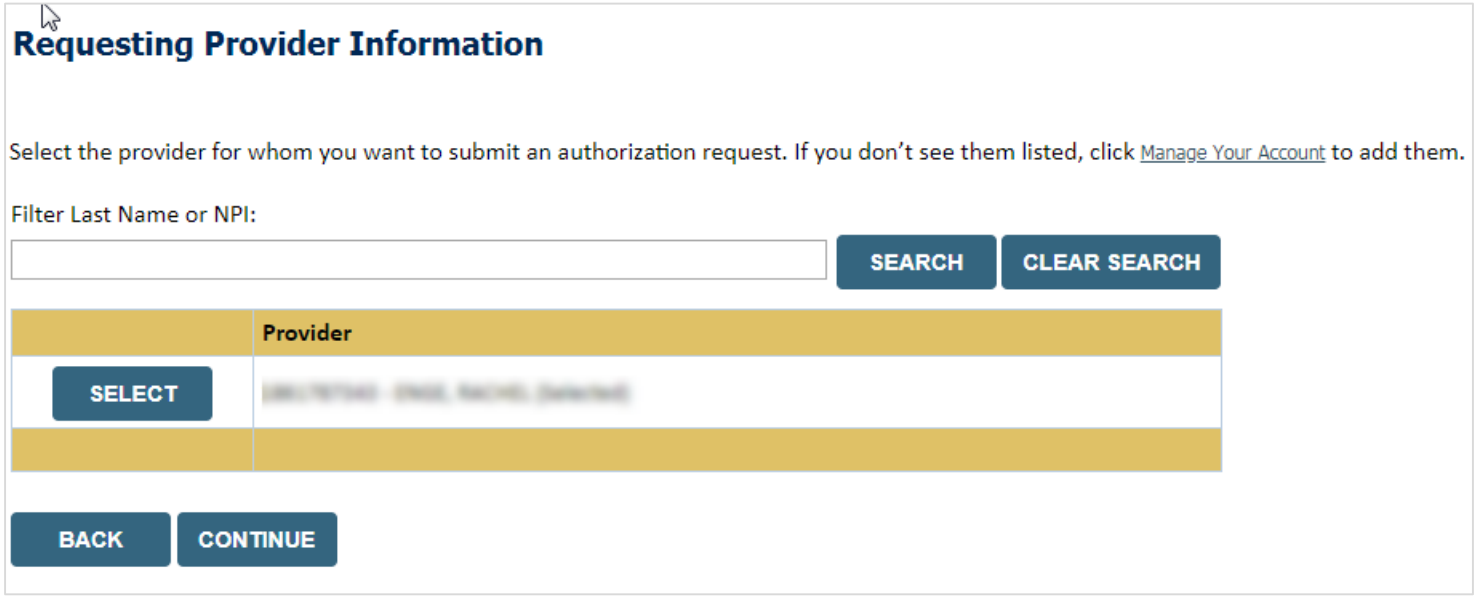
- Select the "**Manage Your Account**" tab, then the **Add Provider**
- Enter the NPI, state, and zip code to search for the provider
- Select the matching record based upon your search criteria
- Once you have selected a practitioner, your registration will be complete
- You can also click "**Add Another Practitioner**" to add another provider to your account
- You can access the "**Manage Your Account**" at any time to make any necessary updates or changes

Initiating A Case



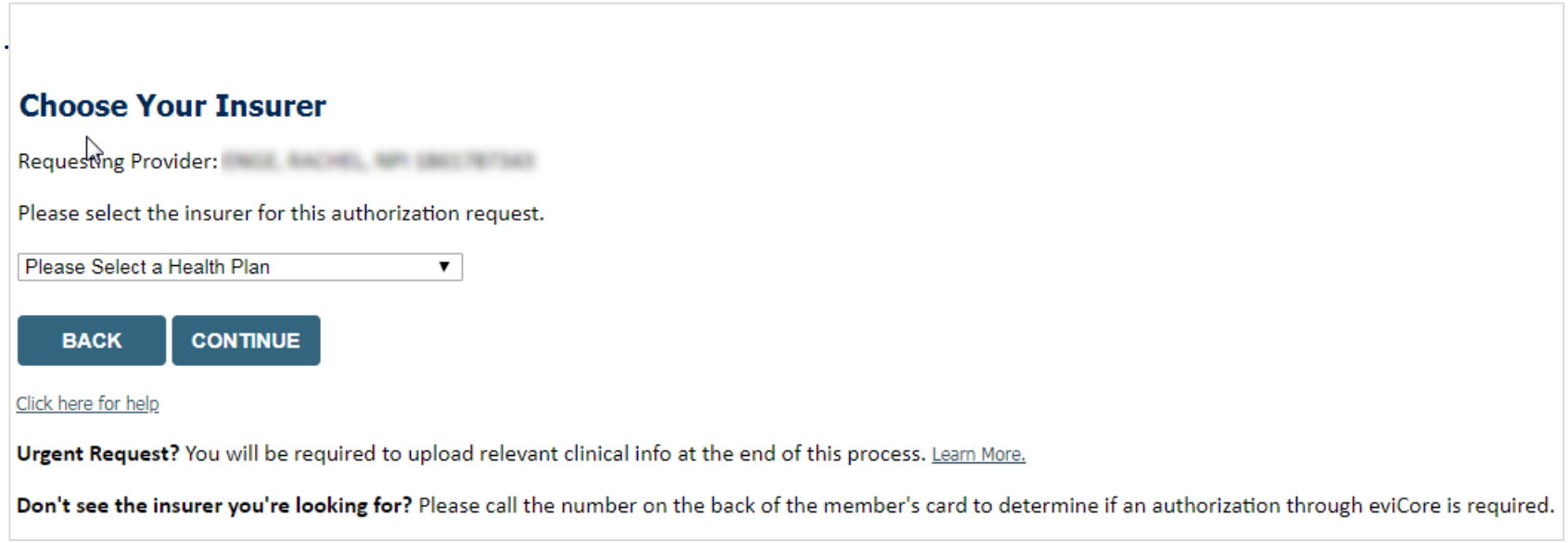
- Choose **Clinical Certification** to begin a new request
- Select the **Musculoskeletal Management**
- You can duplicate via **Date Extension** or **Continuing Care**
- You case also **Build a New Case**

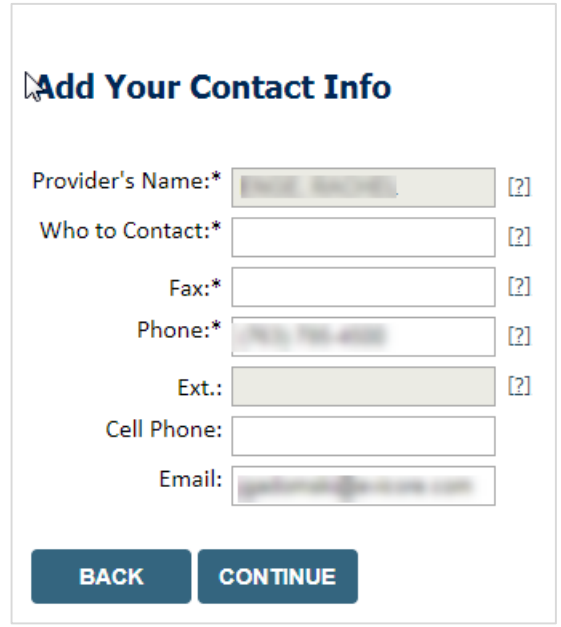
Initiating A Case – Provider Selection



- Select requesting provider information

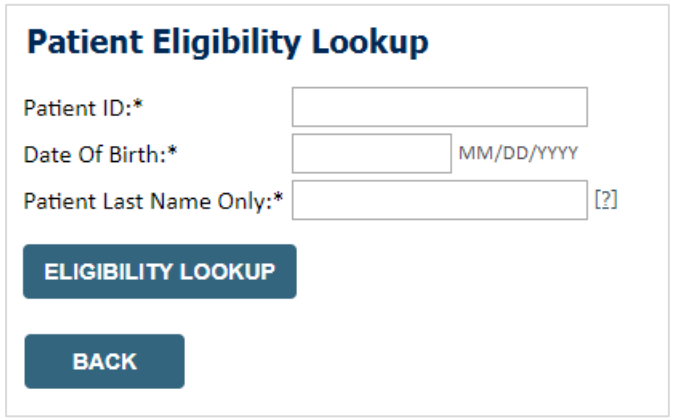
Select Health Plan & Provider Contact Info

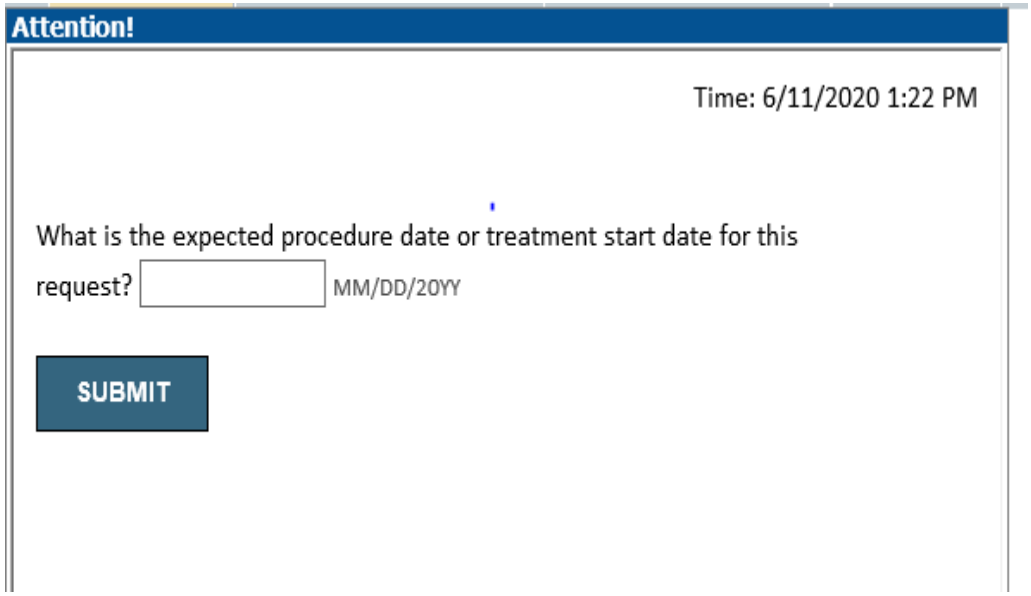




- Choose Network Health Wisconsin as your **Health Plan**
- Once the plan is chosen, select the provider address in the next drop-down box
- Select CONTINUE and on the next screen Add your contact info
- Provider name, fax and phone will pre-populate, you can edit as necessary
- By entering a valid email you may receive future e-notifications

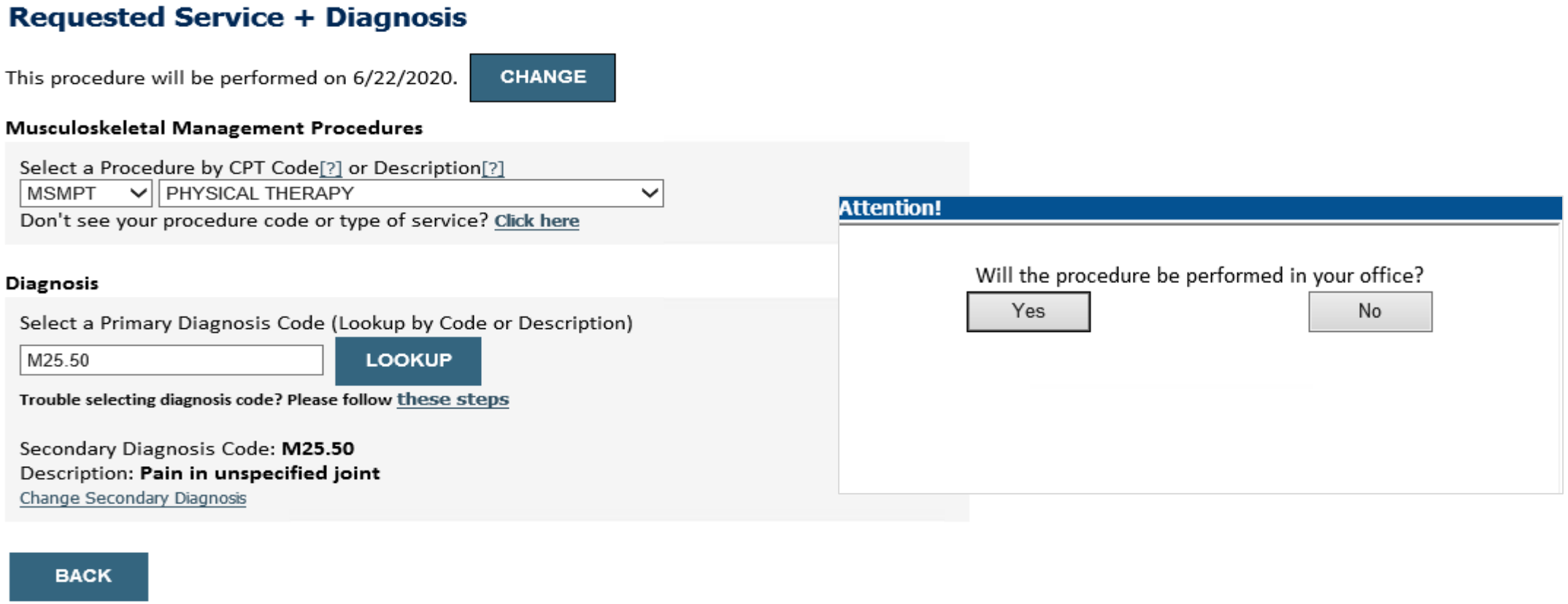
Request & Member Information





- The first box that will pop-up will require the treatment start date
- Enter the **member information** including the patient ID number, date of birth and last name. Click **Eligibility Lookup**

Request Information



- Next you can enter CPT code (MSMPT or MSMOT)
- Also add diagnosis code(s)
- Note: Place of service vary depending on health plan rules.

Verify Service Selection

Requested Service + Diagnosis

Confirm your service selection.

Procedure Date:	6/22/2020
CPT Code:	MSMPT
Description:	PHYSICAL THERAPY
Primary Diagnosis Code:	M25.50
Primary Diagnosis:	Pain in unspecified joint
Secondary Diagnosis Code:	
Secondary Diagnosis:	

Change Procedure or Primary Diagnosis

Change Secondary Diagnosis

BACK CONTINUE

Click here for help

Attention!

Patient ID: [redacted] Time: 6/19/2020 6:38 PM

Patient Name: [redacted]

Please review the patient's MSM history. You may be asked about this history during clinical review.

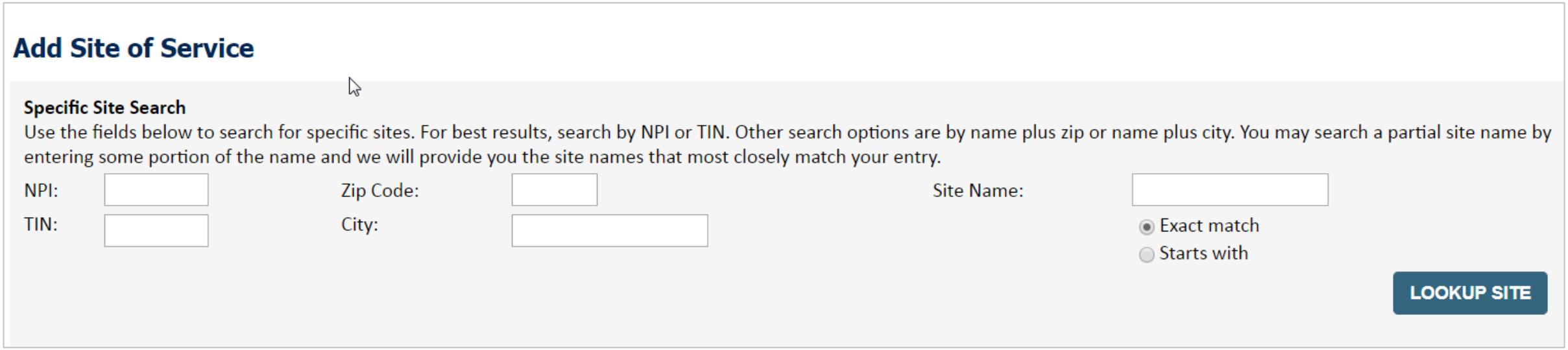
MSM History

Episode Date	Episode ID	Patient Name	CPT Code	CPT Description	Case Status
4/7/2020	[redacted]	[redacted]	MSMPT	PHYSICAL THERAPY	A
3/18/2020	[redacted]	[redacted]	MSMOT	OCCUPATIONAL THERAPY	A
9/17/2019	[redacted]	[redacted]	MSMOT	OCCUPATIONAL THERAPY	A
7/18/2019	[redacted]	[redacted]	MSMOT	OCCUPATIONAL THERAPY	A
4/26/2019	[redacted]	[redacted]	MSMPT	PHYSICAL THERAPY	A

- Review the patient's history
- Verify requested service & diagnosis
- Edit any information if needed by selecting change procedure or primary diagnosis
- Click **continue** to confirm your selection

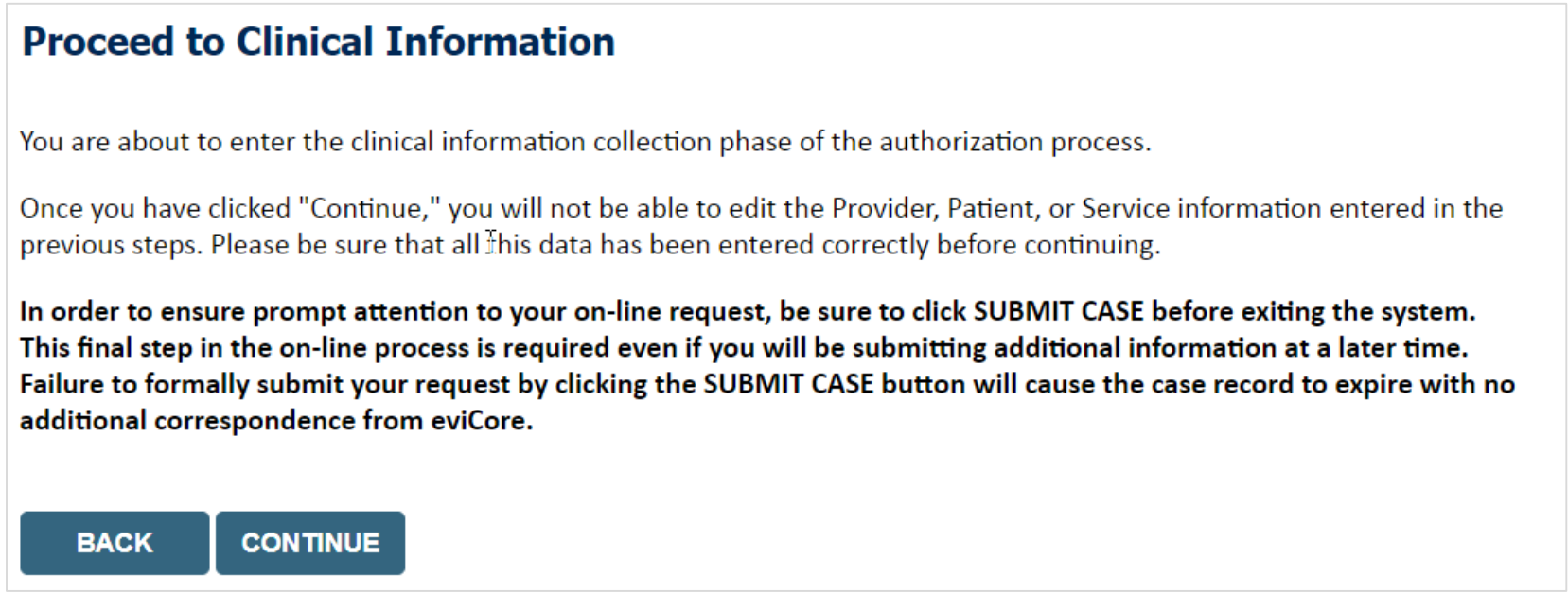
Site Selection

Start by searching NPI or TIN for the site where the procedure will be performed. You can search by any fields listed. Searching with NPI, TIN, and zip code is the most efficient.



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

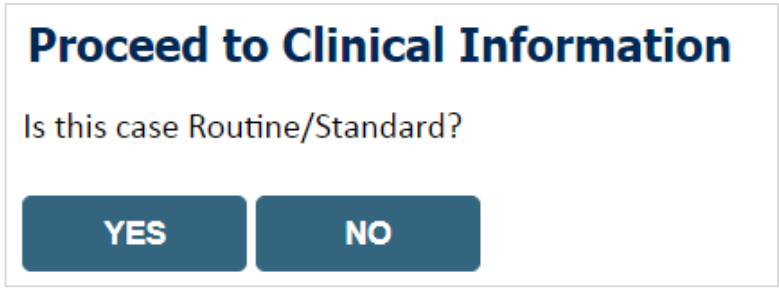
Clinical Certification



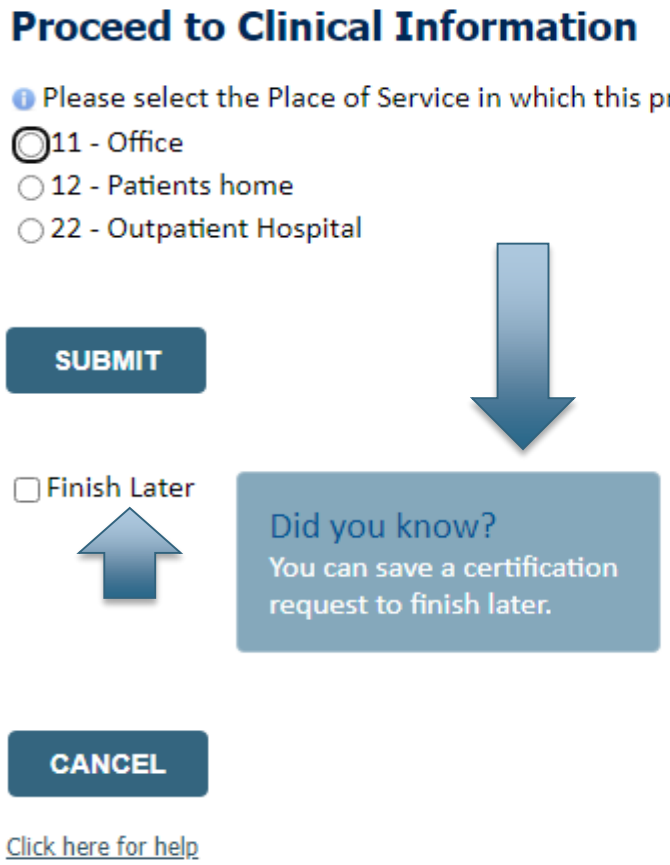
- **Verify that all information is entered and make any changes needed**
- **You will not have the opportunity to make changes after this point**

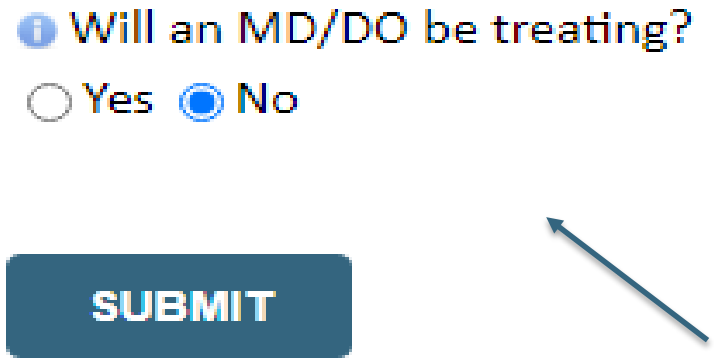
Standard or Urgent Request?

- If your request is urgent select **No**
- When a request is submitted as Urgent, you will be required to upload relevant clinical information
- You can upload up to FIVE documents in .doc, .docx, or .pdf format
- Your case will only be considered Urgent if there is a successful upload
- If the case is standard select **Yes**



Example of Questions



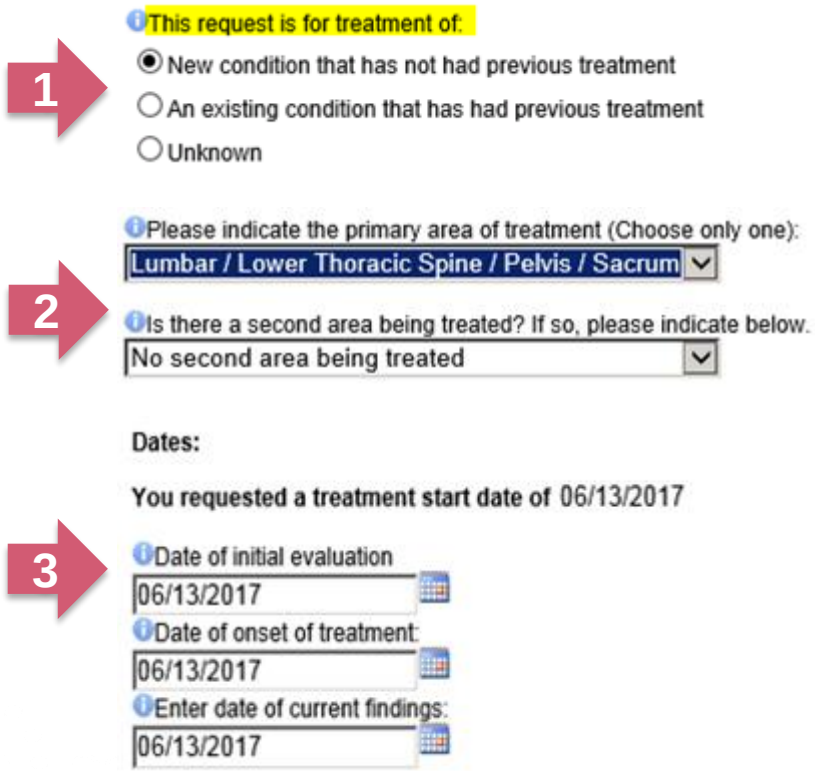


Note: Prior authorization is only required for physical therapists/occupational therapists/speech pathologists performing physical, occupational, speech therapy. Medical Doctors (MD) and Doctors of Osteopathic Medicine (DO) do not require pre-authorization through eviCore Healthcare

Clinical Certification questions may populate based upon the information provided
Note: You can save your request and finish later if needed, and you will have 2 business days to complete the case
When logged in, you can resume a saved request by going to “Certification Requests in Progress”

Sample Therapy corePath^{SM} Pathway

Initial Requests



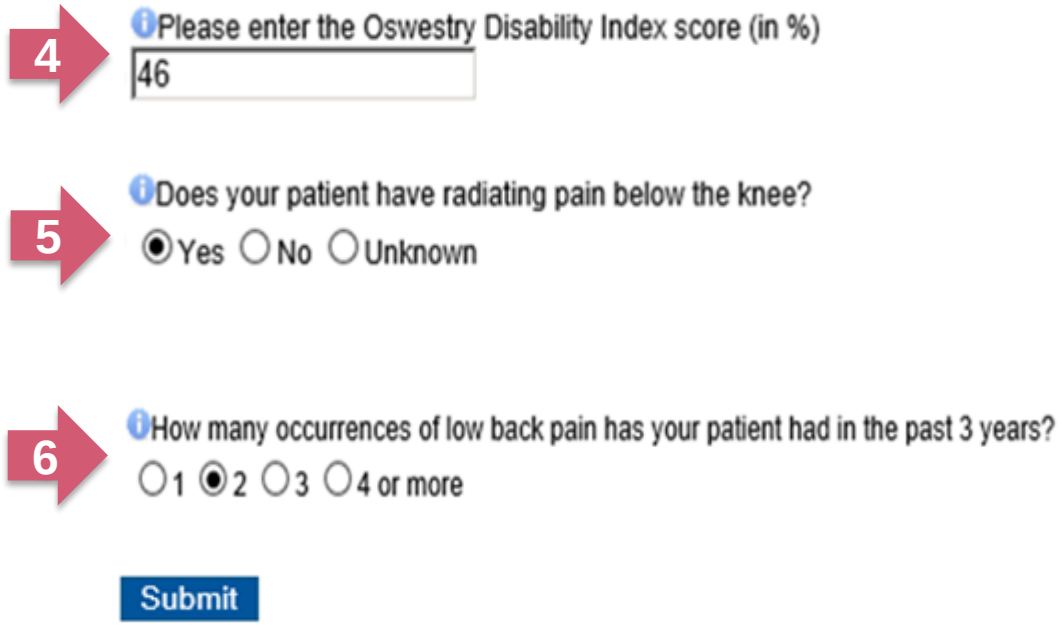
Case related questions:

- 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

Many screens have imbedded messages that help you understand the criteria

Sample Therapy corePath[SM] Pathway

Initial Requests, continued….



High Potential for Immediate Approval When Pathway is Completed!

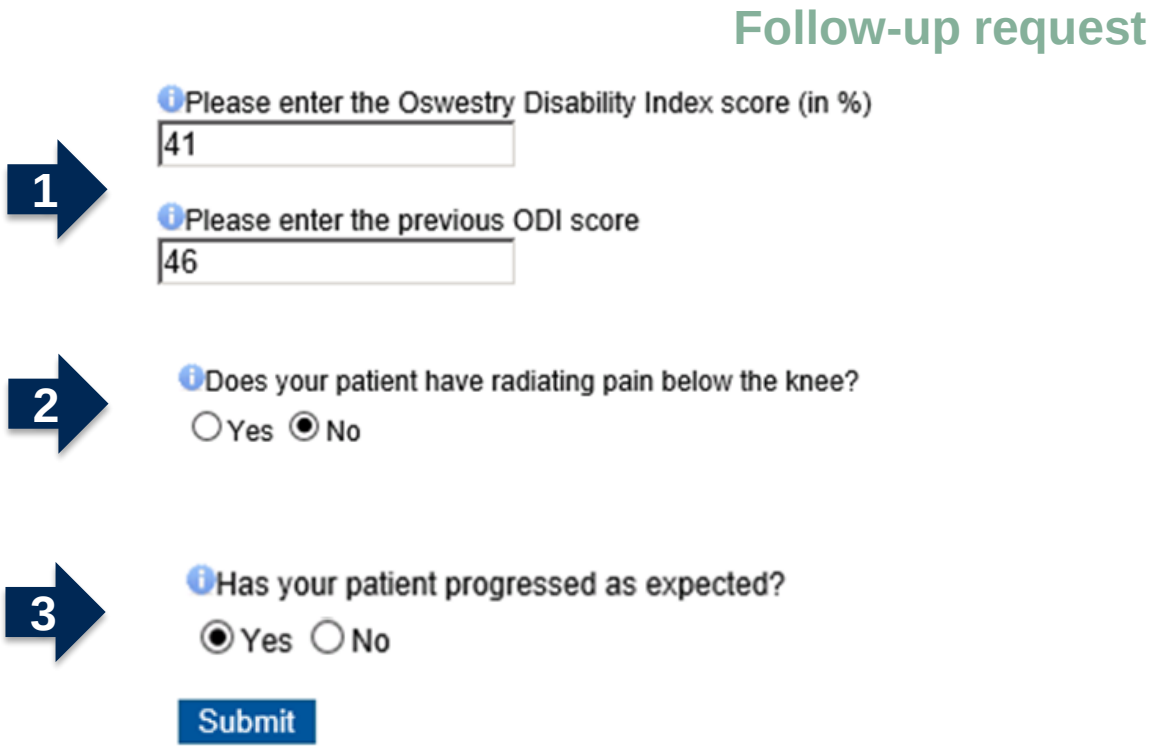
Initial clinical questions:

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

Sample Therapy corePath^{SM} Pathway

Follow-up clinical questions:

- Current and previous functional score
- Complexity question – neural signs
- Progress
  - Validated scores have MCD (minimal clinical difference) as progress indicator
  - Clinical assessment



High potential for immediate approval when pathway is completed.

Sample Therapy corePath^{SM} Pathway

Follow-up request – Lack of progress identified

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

- [x] 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

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

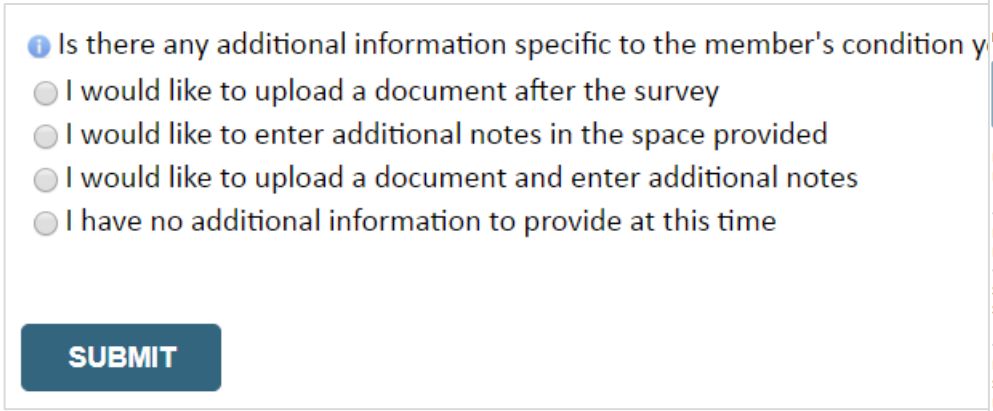
N/A

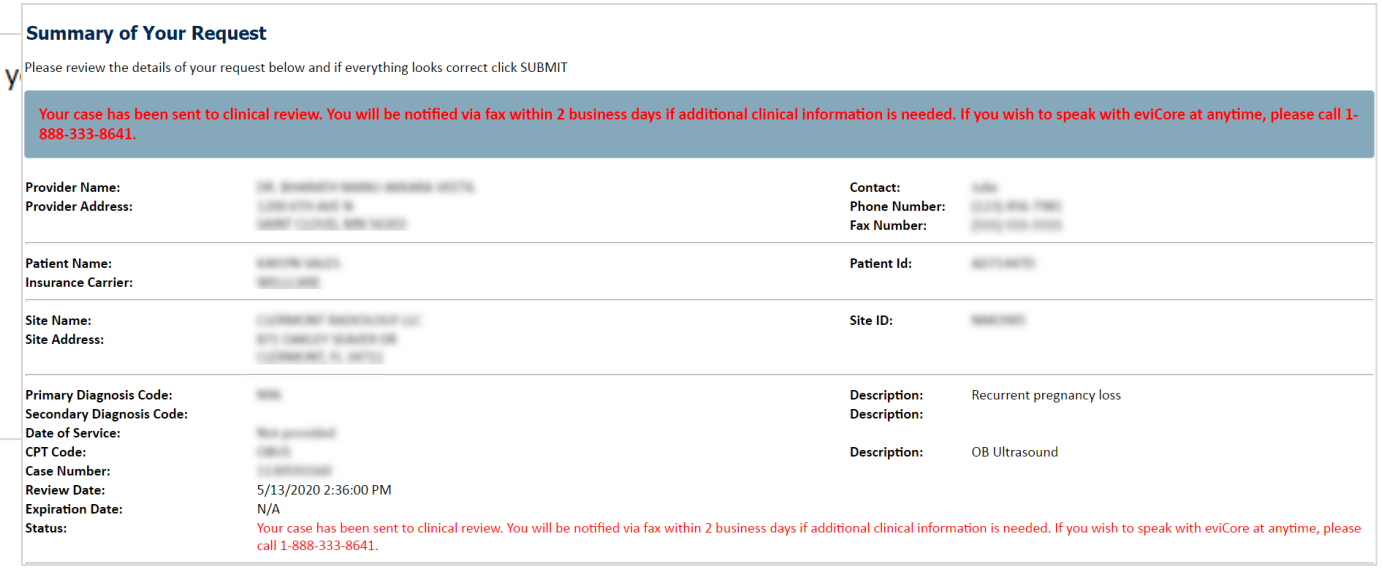
Lack of progress:

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

Next Step: Criteria not met

If criteria are not met based on clinical questions, you will receive a similar request for additional info:



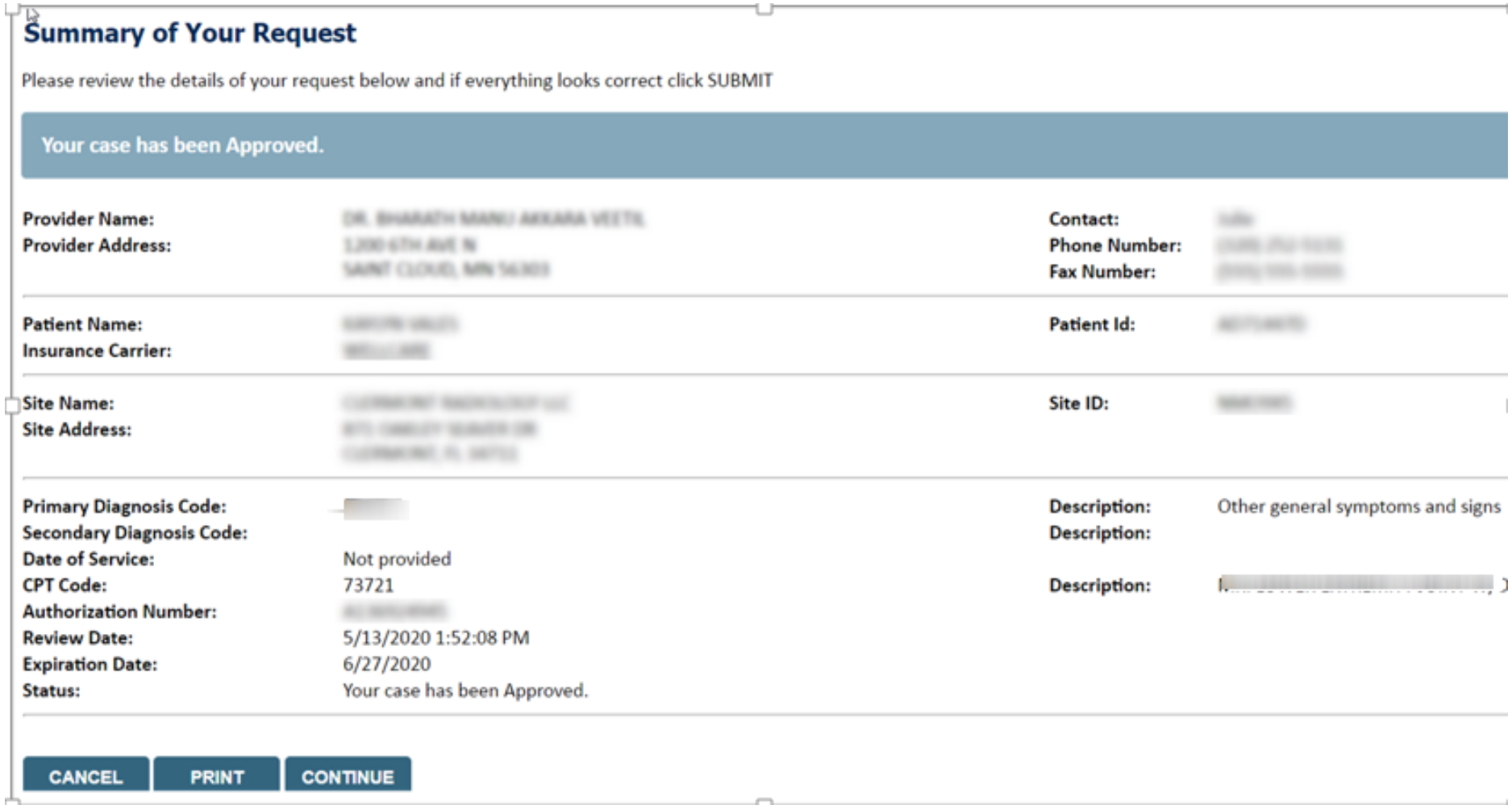


Tips:

- Upload clinical notes on the portal, to avoid any delays (e.g., by faxing)
- Enter additional notes in the space provided only when necessary
- Additional information uploaded to the case will be sent for clinical review
- Print-out a summary of the request that includes the case # and indicates ‘Your case has been sent to clinical review’

Criteria Met

If your request is authorized during the initial submission you can print out the summary of the request for your records.



Summary of Your Request

Please review the details of your request below and if everything looks correct click SUBMIT

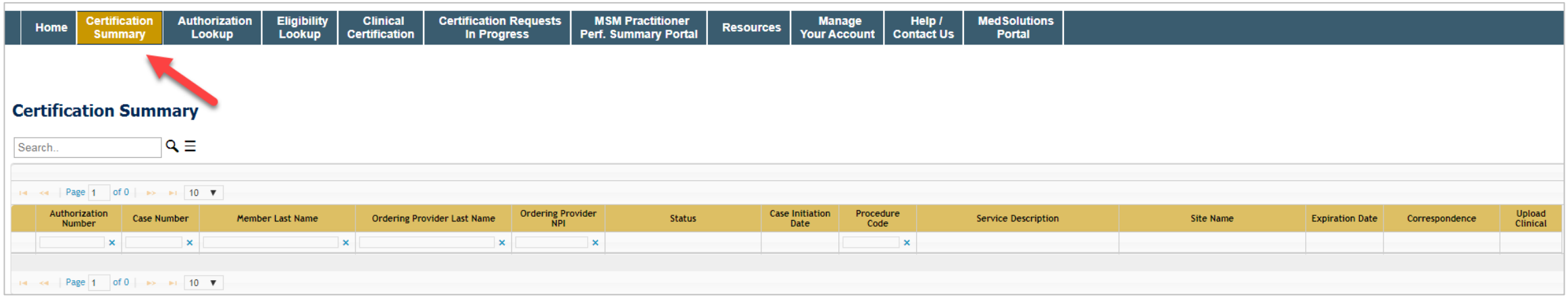
Your case has been Approved.

Provider Name:	[redacted]	**Contact:**	[redacted]
Provider Address:	[redacted]	**Phone Number:**	[redacted]
		Fax Number:	[redacted]
Patient Name:	[redacted]	**Patient Id:**	[redacted]
Insurance Carrier:	[redacted]		
Site Name:	[redacted]	**Site ID:**	[redacted]
Site Address:	[redacted]		
Primary Diagnosis Code:	[redacted]	**Description:**	Other general symptoms and signs
Secondary Diagnosis Code:		**Description:**	
Date of Service:	Not provided		
CPT Code:	73721	**Description:**	[redacted]
Authorization Number:	[redacted]		
Review Date:	5/13/2020 1:52:08 PM		
Expiration Date:	6/27/2020		
Status:	Your case has been Approved.		

CANCEL PRINT CONTINUE

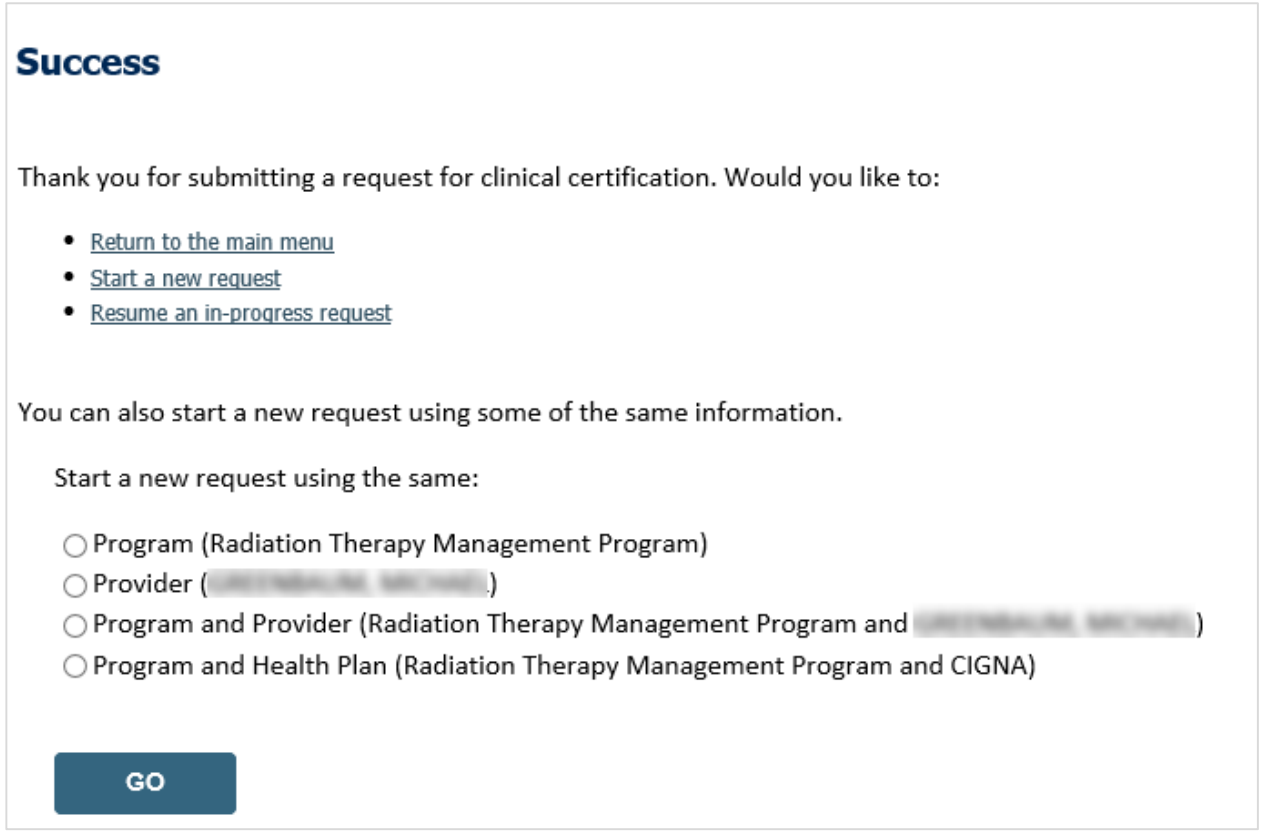
Additional Provider Portal Features

Certification Summary



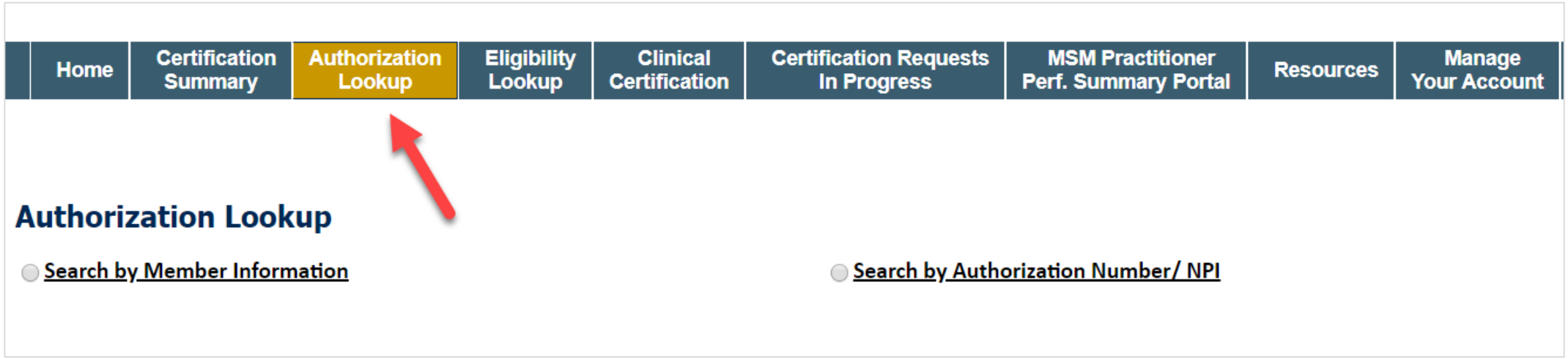
- Certification Summary tab allows you to track recently submitted cases
- The work list can also be filtered

Duplication Feature



- Duplicate feature allows you to start a new request using same information
- Eliminates entering duplicate information
- Time saver!

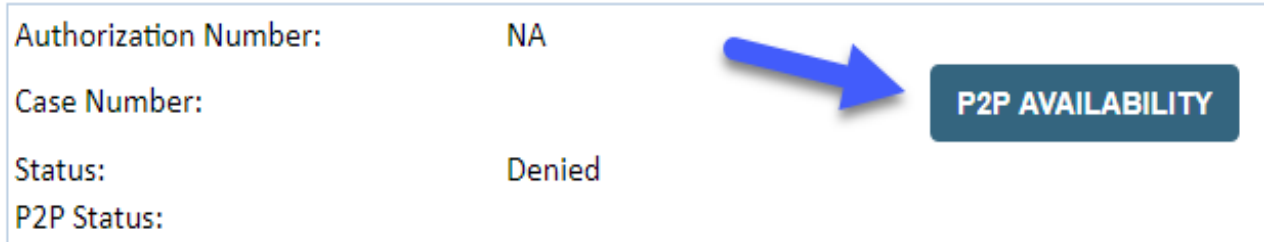
Authorization Lookup



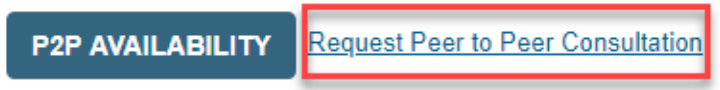
- You can look-up authorization status on the portal
- Search by member information OR
- Search by authorization number with ordering NPI
- View and print any correspondence

How to schedule a Peer to Peer Request

- Log into your account at www.evicore.com
- Perform Authorization Lookup to determine the status of your request.
- Click on the “P2P Availability” button to determine if your case is eligible for a Peer to Peer conversation:

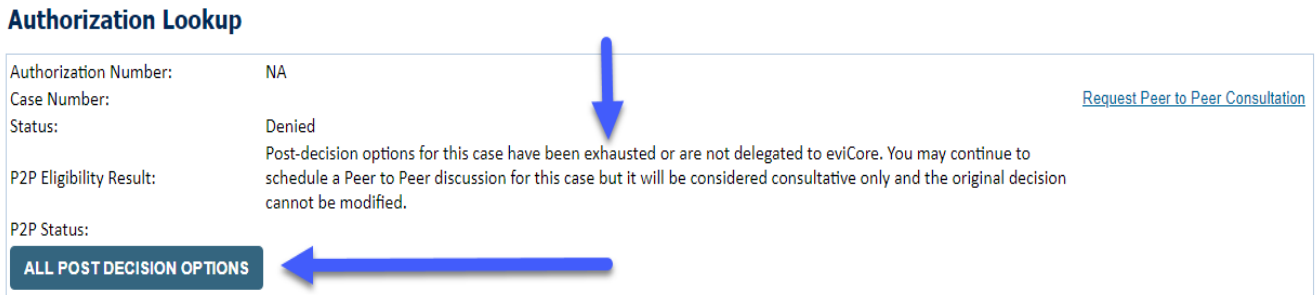


- If your case is eligible for a Peer to Peer conversation, a link will display allowing you to proceed to scheduling without any additional messaging.



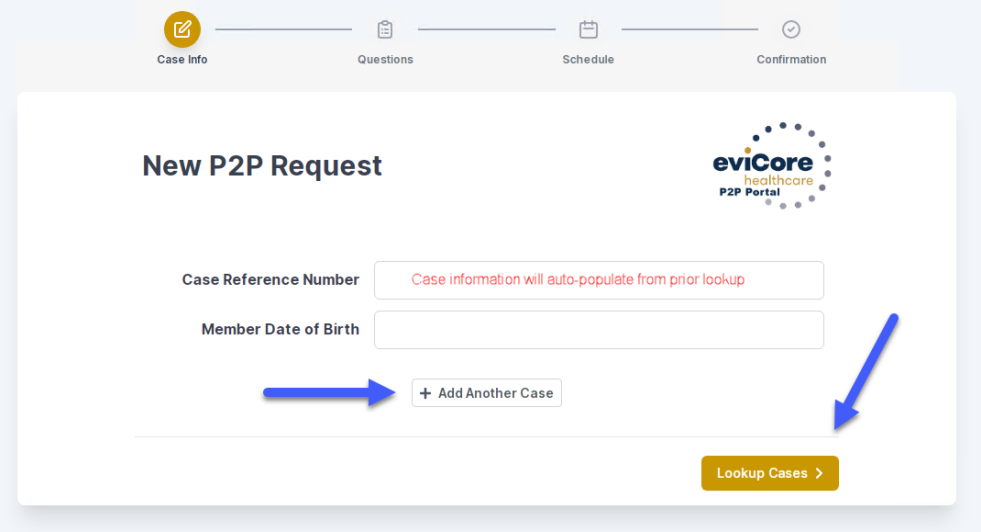
How to schedule a Peer to Peer Request

Pay attention to any messaging that displays. In some instances, a Peer to Peer conversation is allowed, but the case decision cannot be changed. When this happens, you can still request a Consultative Only Peer to Peer. You may also click on the “All Post Decision Options” button to learn what other action may be taken.



Once the “Request Peer to Peer Consultation” link is selected, you will be transferred to our scheduling software via a new browser window.

How to Schedule a Peer to Peer Request



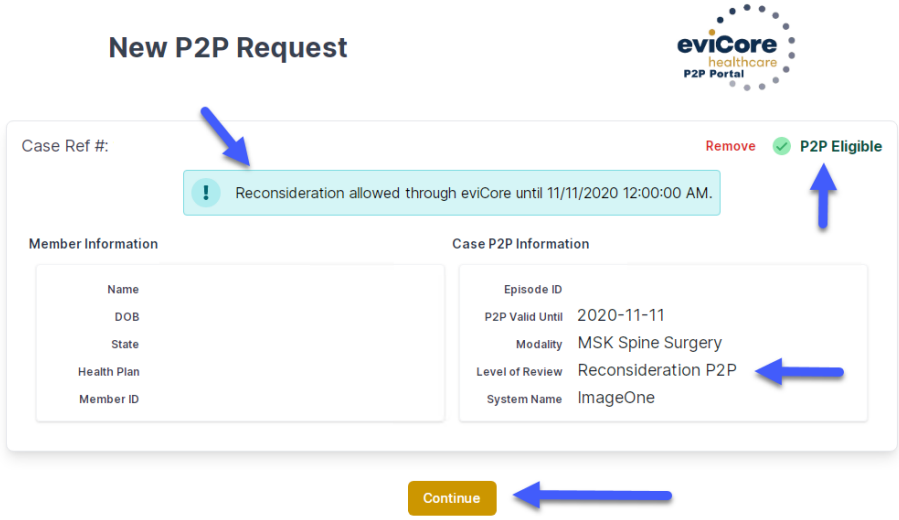
Upon first login, you will be asked to confirm your default time zone.

You will be presented with the Case Number and Member Date of Birth (DOB) for the case you just looked up.

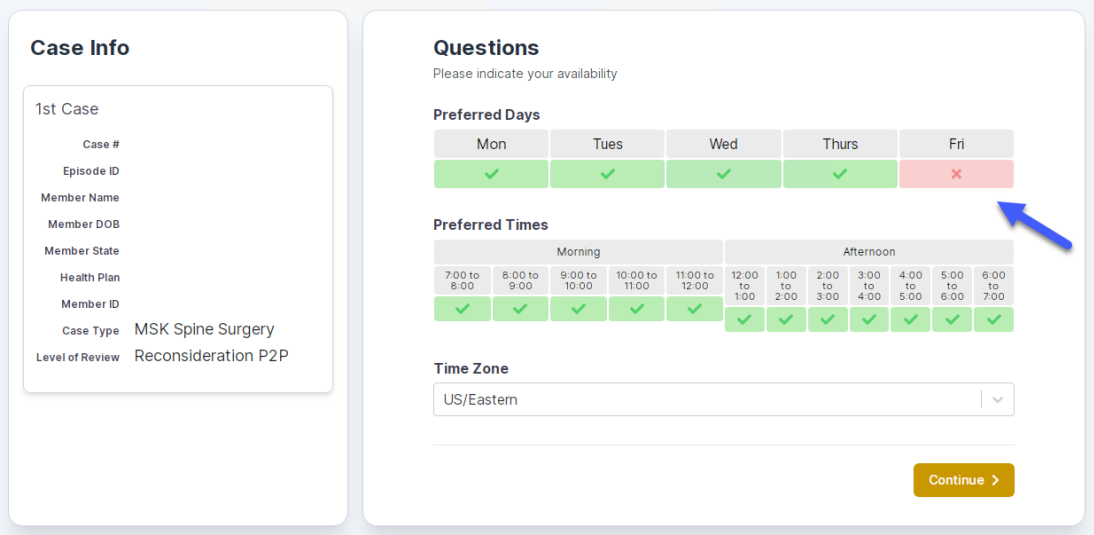
You can add another case for the same Peer to Peer appointment request by selecting “Add Another Case”

To proceed, select “Lookup Cases”

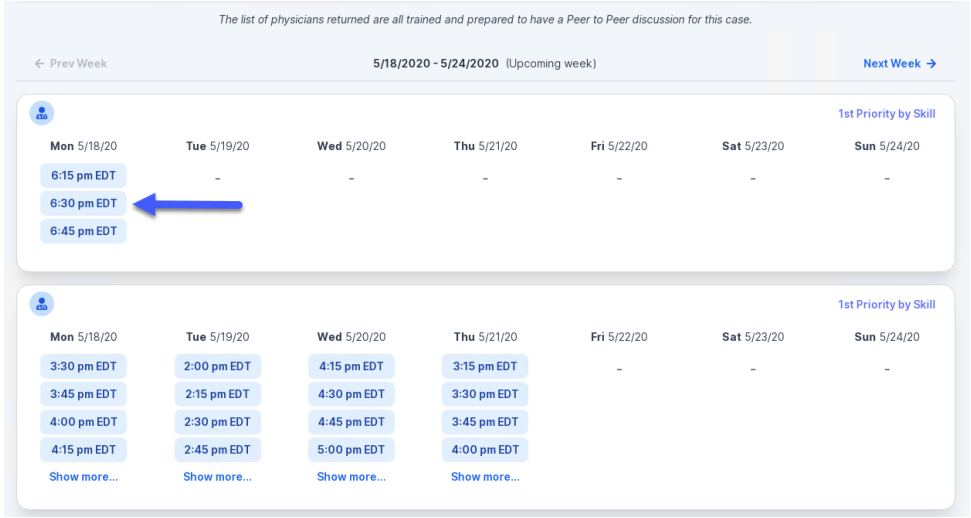
You will receive a confirmation screen with member and case information, including the Level of Review for the case in question. Click Continue to proceed.



How to Schedule a Peer to Peer Request



You will be prompted with a list of eviCore Physicians/Reviewers and appointment options per your availability. Select any of the listed appointment times to continue.

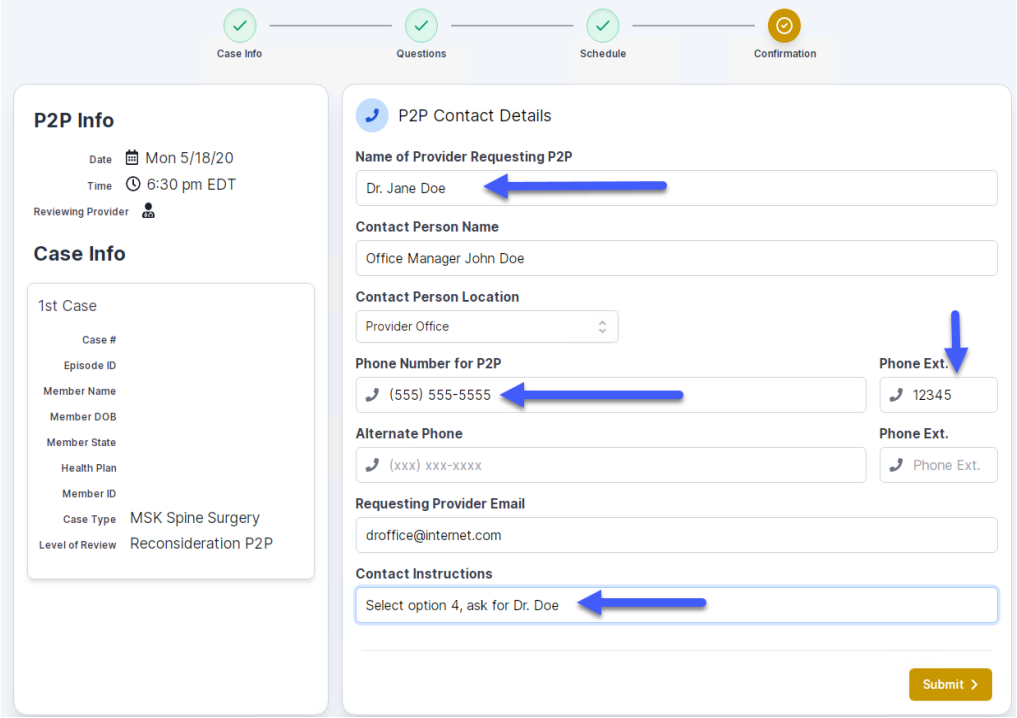


You will be prompted to identify your preferred Days and Times for a Peer to Peer conversation. All opportunities will automatically present. Click on any green check mark to deselect the option and then click Continue.

How to Schedule a Peer to Peer

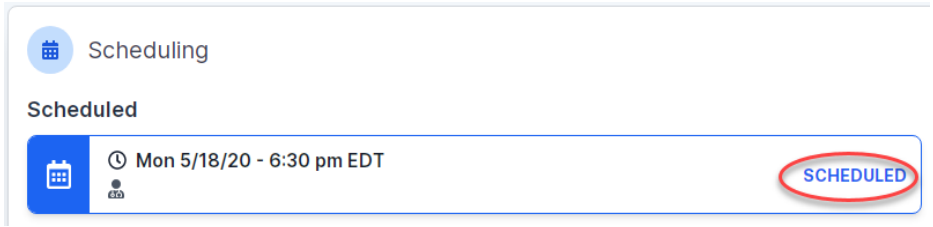
Confirm Contact Details

- Contact Person Name and Email Address will auto-populate per your user credentials



- Be sure to update the following fields so that we can reach the right person for the Peer to Peer appointment:
  - Name of Provider Requesting P2P
  - Phone Number for P2P
  - Contact Instructions

- Click submit to schedule appointment. You will be presented with a summary page containing the details of your scheduled appointment.



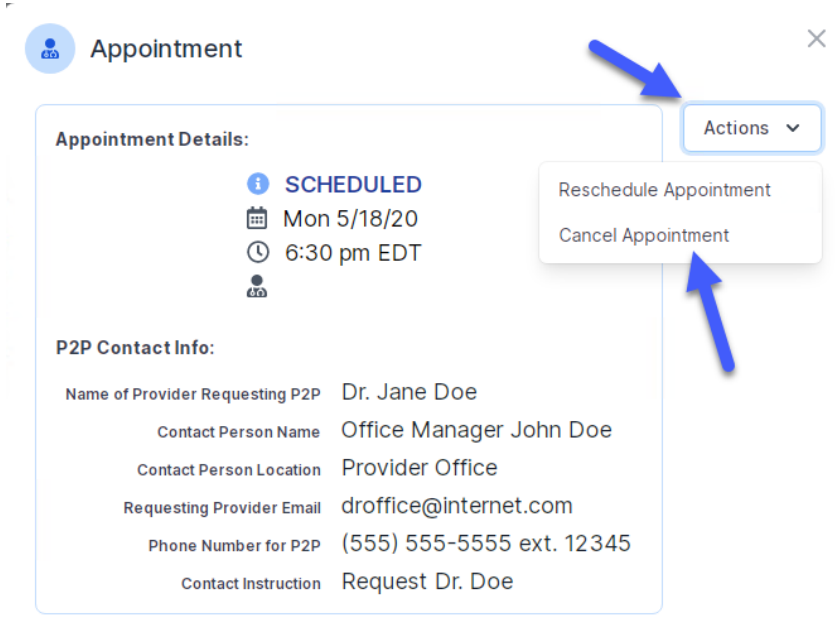
Canceling or Rescheduling a Peer to Peer Appointment

To cancel or reschedule an appointment

- Access the scheduling software per the instructions above
- Go to “My P2P Requests” on the left pane navigation.
- Select the request you would like to modify from the list of available appointments
- Once opened, click on the schedule link. An appointment window will open
- Click on the Actions drop-down and choose the appropriate action

    If choosing to reschedule, you will have the opportunity to select a new date or time as you did initially.

    If choosing to cancel, you will be prompted to input a cancellation reason



- Close browser once done

Provider Resources

Dedicated Call Center

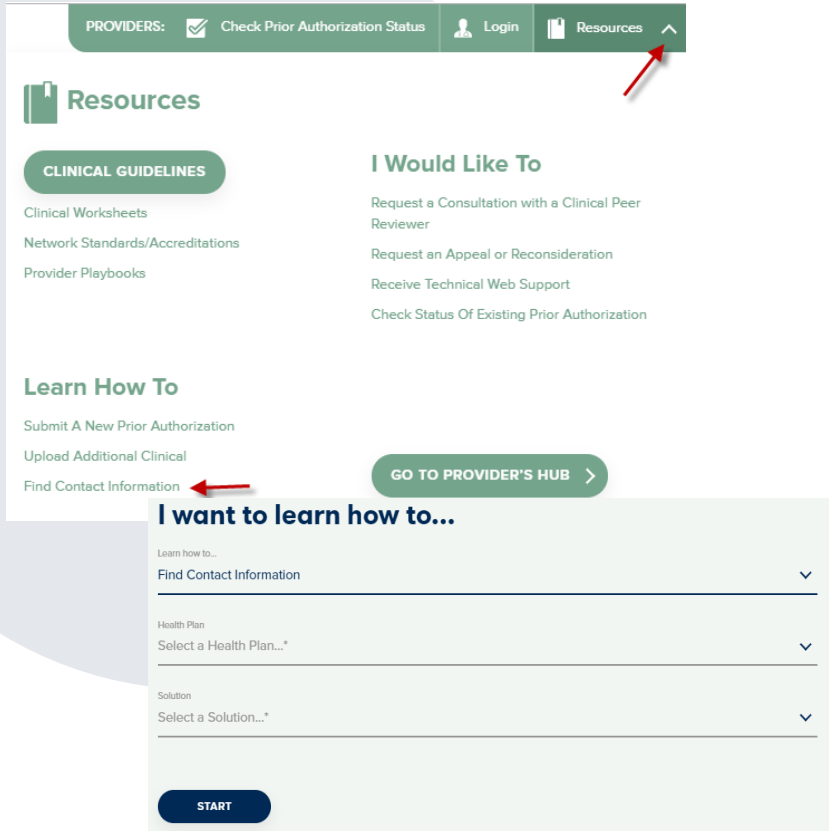
- **Prior Authorization Call Center – 855-727-7444**

Our call centers are open from 7 a.m. to 7 p.m. (local time).

Providers can contact our call center to perform the following:

- Request Prior Authorization
- Check Status of existing authorization requests
- Discuss questions regarding authorizations and case decisions
- Change facility or CPT Code(s) on an existing case
- Request to speak to a clinical reviewer
- Schedule a clinical consultation with an eviCore Medical Director

Online Resources



Web-Based Services and Online Resources

- You can access important tools, health plan-specific contact information, and resources at www.evicore.com
- Select the Resources to view Clinical Guidelines, Online Forms, and more.
- Provider's Hub section includes many resources
- Provider forums and portal training are offered weekly, you can find a session on www.eviCore.WebEx.com, select WebEx Training, and search upcoming for a "eviCore Portal Training" or "Provider Resource Review Forum"

- The quickest, most efficient way to request prior authorization is through our provider portal. Our dedicated **Web Support** team can assist providers in navigating the portal and addressing any web-related issues during the online submission process.

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

Provider Resource Website

Client Specific Provider Resource Pages

eviCore's Provider Experience team maintains provider resource pages that contain client- and solution-specific educational materials to assist providers and their staff on a daily basis. The provider resource page will include, but is not limited to, the following educational materials:

- Frequently Asked Questions
- Quick Reference Guides
- Provider Training
- CPT code list

To access these helpful resources, please visit

https://www.evicore.com/resources/healthplan/network-health-wisconsin

Network Health Wisconsin Provider Services: 800-207-5769
TTY/TDD# 800-947-3529
Fax 920-720-1918

Client & Provider Operations Team

Client and Provider Services

Dedicated team to address provider-related requests and concerns including:

- Questions regarding Accuracy Assessment, Accreditation, and/or Credentialing
- Requests for an authorization to be resent to the health plan
- Eligibility issues (member, rendering facility, and/or ordering physician)
- Issues experienced during case creation

How to Contact our Client and Provider Services team

Email: ClientServices@evicore.com (preferred)

Phone: 1 (800) 646 - 0418 (option 4)

For prompt service, please have all pertinent information available. When emailing, make sure to include the health plan in the subject line with a description of the issue, with member/provider/case details when applicable.

Provider Engagement Team

Provider Engagement team

Regional team that on-boards providers for new solutions and provides continued support to the provider community. How can the provider engagement team help?

- Partner with the health plan to create a market-readiness strategy for a new and/or existing program
- Conduct onsite and WebEx provider-orientation sessions
- Provide education to supporting staff to improve overall experience and efficiency
- Create training materials
- Monitor and review metrics and overall activity
- Conduct provider-outreach activities when opportunities for improvement have been identified
- Generate and review provider profile reports specific to a TIN or NPI
- Facilitate clinical discussions with ordering providers and eviCore medical directors

How to contact the Provider Engagement team?

You can find a list of Regional Provider Engagement Managers at evicore.com → Provider's Hub → Training Resources

Provider Newsletter

Stay Updated With Our Free Provider Newsletter

eviCore's provider newsletter is sent out to the provider community with important updates and tips. If you are interested in staying current, feel free to subscribe:

- Go to eviCore.com
- Scroll down and add a valid email to subscribe
- You will begin receiving email provider newsletters with updates

Provider Resource Review Forums

The eviCore website contains multiple tools and resources to assist providers and their staff during the prior authorization process.

We invite you to attend a Provider Resource Review Forum, to navigate www.eviCore.com and understand all the resources available on the Provider's Hub. Learn how to access:

- eviCore's evidence-based clinical guidelines
- Clinical worksheets
- Check-status function of existing prior authorization
- Search for contact information
- Podcasts & Insights
- Training resources

How to register for a Provider Resource Review Forum?

You can find a list of scheduled **Provider Resource Review Forums** on www.eviCore.com → Provider's Hub → Scroll down to eviCore Provider Orientation Session Registrations → Upcoming

Thank You!

Tips to Improve Efficiency

Medical necessity and patient-focused care

- **The member's needs determine medical necessity.**
  - The member's clinical presentation and specific needs are the primary factors considered when determining medical necessity.
  - The physician's prescription for therapy frequency and duration does not demonstrate medical necessity.

- **Review medical necessity regularly.**
  - The member's response to care should be evaluated each visit to allow modification of the treatment plan based on the member's current status.
  - Complete a review of continuing medical necessity at least every 30 days. This allows you to assess how the member is responding to therapy.
  - Clinical documentation should include the member's response to care, functional improvement, and remaining functional deficits.
  - Consider whether the skills of a therapist are still necessary and if it is, identify the specific interventions that require that skill

More Tips to Improve Efficiency

Members have different needs.

- Evaluate and determine each member's specific needs. Members with the same or similar diagnoses have different needs based on their own circumstances. Avoid following "cookbook" protocols.

Once or twice a week may work.

- Many members do not need therapy three times a week. Members may be seen once or twice a week as they work toward their goals following their comprehensive home program.

Let progress determine frequency.

- Do not schedule an entire series of visits at a set frequency. Instead, determine the date of the member's next visit based on the member's progress after each visit. Set goals for the member's next visit during each therapy appointment.

Decrease frequency during strengthening and stretching phase.

- Strengthening and stretching take time. After instructing the member in a strengthening and/or flexibility home program, allow time for the member to work on the exercises. The intensity of care should be decreased during this phase. Often the member needs to be seen only once or twice a week to update the home program.

Passive motion can be taught.

- Passive-motion exercises can be taught to a family member or other caregiver. After providing a home program in passive motion, check with the member once or twice weekly to monitor progress.

Reduce passive modalities.

- Reduce or eliminate passive modalities after the acute phase of therapy.

Final Tips

Members' independent work

Responsibility for success.

Let members know they will be responsible for the success of their therapy program. Inform members of their responsibilities and reinforce them at each visit or as necessary. Have the member demonstrate the home program at each visit to ensure that it is being done correctly and that the member is compliant.

Warming up is not billable.

Using a bicycle or treadmill to warm up prior to treatment is not skilled care and should not be a billed procedure. The member can usually be taught to do warm-up exercises independently.

Independent exercise can be done without skilled supervision.

Once a member is able to complete an exercise safely, make it part of the member's independent program. Time spent exercising independently is not reimbursable.

Eliminate repetitive exercise.

Eliminate repetitive exercise under skilled supervision. The member should do this independently.

Long-term modality can be done at home.

For members who need a long-term modality such as electrical stimulation, paraffin wax, contrast baths, etc., instruct them in this for home use.

Instruct the member about edema reduction and pain management.

Instruct the member in a home program for edema reduction and pain management.