Frequently Asked Questions

Specialized Musculoskeletal Therapies

Who is eviCore healthcare?
eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for Network Health Wisconsin.

What is eviCore healthcare's Specialized Therapies Prior Authorization Program?
eviCore's Prior Authorization Program consist of requests for Prior Authorization Medical Necessity Determinations for the following services.

- Physical Therapy (commercial and Medicare lines of business)
- Occupational Therapy (commercial and Medicare lines of business)

Important Note: eviCore is not delegated to prior authorize for Speech Therapist services. Please contact Network Health as speech therapy requires prior authorization review under certain plans. If it is determined the member in question has a prior authorization requirement for speech therapy, those requests should be submitted directly to Network Health via the Network Health authorization portal, iExchange.

How do I check the eligibility and benefits of a member?
Member eligibility and benefits should be verified on https://networkhealth.com/ before requesting prior authorization through eviCore.

Who needs to request prior authorization through eviCore?
All clinicians who perform services are required to obtain a prior authorization for services prior to the service being rendered.

How do I request a prior authorization through eviCore healthcare?
Providers and/or staff can request prior authorization in one of the following ways:

Web Portal
The eviCore portal is the quickest, most efficient way to request prior authorization and is available 24/7. Providers can request authorization by visiting www.evicore.com

Call Center
eviCore's call center is open from 7 a.m. to 7 p.m. local time. Providers and/or staff can request prior authorization and make revisions to existing cases by calling 855-727-7444

Fax option
While not preferred, providers and/or staff may submit a request for prior authorization to 855-774-1319

Do services performed in an inpatient setting at a hospital require prior authorization?
No. Studies performed during an inpatient stay do not require prior authorization.

What information is required when requesting prior authorization?
When requesting prior authorization, please ensure the proprietary information is readily available:

Member

- First and Last Name
- Date of Birth
- Member ID

Ordering Provider

- First and Last Name
- National Provider Identification (NPI) Number
- Tax Identification Number (TIN)
- Phone and Fax Number

Clinical(s)

- Diagnosis/ICD-10
- Date of current objective findings
- Date of the initial evaluation
- Date and Mechanism of onset
- Date and type of surgery (If Applicable)
- Restrictions
- Co-morbidities/Complexities
- Conditions that would prohibit safe delivery of care
- Pain Level and duration of time member has pain
- Range of Motion and Strength Findings
- Gait Assessment/Special tests
- Functional Assessment (using the Patient Specific Functional Scale)
- Additional information that supports the need for therapy

How to avoid inappropriate denials when services are appropriate?

Services that are deemed appropriate are those that follow clinical and/or medical necessity guidelines. You can find those guidelines at www.eviCore.com. Click the resources drop down button at the top right side of the web page to find the link to those guidelines.

If a provider follows guidelines that govern clinical and/or medical necessity criteria, but still experiences high denial rates, the reason may be due to clinical information missing from the case request. This is a list of information usually required:

- Primary and Secondary Diagnosis/ICD10
- Co-morbidities/Complexities that will affect the therapy plan of care
- Date of current findings
- Standardized test scores (a minimum of annually for pediatric neurodevelopmental conditions
- Functional Outcome Measures/Patient Reported Outcome Scores
- Surgery – Date and type
- Provide current pain medication
- Patient's status to Provider prescribed pain medication
- New condition not previously treated or previous condition
- Average level of pain (Rate 1 - 10)
- List of activities the patient is not able to perform within the last week (Rate level of difficulty 1 - 10)
- Patient's response to care
- Reasons for patient not responding to care
- How many new re-occurrences has the patient experienced in last 12 months?
- Additional information for non-MSK conditions: date of most recent medical evaluation, current medical co-management, and condition-specific outcome measures

For therapy, additional documentation is accepted only on the 2nd request for continuing case. If a 2nd continuing care is needed, please share the initial and updated test scores. We look for an established baseline and then clarification on the patient's response to care. Daily notes do not normally provide this information. We see this type of information often reported in a progress note/progress summary with an updated plan of care.

Note: eviCore suggests utilizing the clinical worksheets when requesting authorization for services if available

Where can I access eviCore healthcare's clinical worksheets and guidelines?

eviCore's clinical worksheets and guidelines are available online 24/7 and can be found by visiting one of the following links:

Clinical Worksheets
www.evicore.com/provider/online-forms

Clinical Guidelines
www.evicore.com/provider/clinical-guidelines

What is the most effective way to get authorization for urgent requests?

Urgent requests are defined as a condition that is a risk to the patient's health, ability to regain maximum function and/or the patient is experiencing severe pain that require a medically urgent procedure. Urgent requests may be initiated on our web portal at www.evicore.com, or by contacting our contact center at 855- 727-7444.

Once prior authorization has been requested, how long will it take for eviCore to make the determination?

- Decisions for non-urgent prior authorization requests are typically made within two 2-3 business days of receipt of all necessary clinical information, but would not take longer than 14 calendar days.
- When services are required due to a medically urgent condition, eviCore healthcare will usually give a decision within 24 hours of receiving all necessary demographic and clinical information, but would not take longer than 72 hours. Please indicate that the authorization is for medically urgent care.

If a member goes to a new provider for services, will a new pre-service authorization request be required?

Yes. When a member changes to a treating provider who is not within the same practice, a new authorization request is required. If the member has discontinued care with the original provider, please include the discharge date with the original provider when submitting your request. eviCore will not provide authorization for overlapping services or duplicate care as it is not medically necessary.

What do I enter as the "Start Date" on my authorization request?

The start date of each authorization request should reflect the date in which you need an authorization to begin. For continuing care requests, the start date should reflect the first visit that requires authorization after expiration of any previously approved visits or authorization timeframe. Do not enter the first date of the member's treatment episode/evaluation for continued care requests.

When will I receive the authorization number once the prior authorization request has been approved?

Once the prior authorization request has been approved, the authorization information will be provided to clinician's office via fax. It's possible to receive a 'real time' authorization immediately after web submission, and clinician offices may also visit www.evicore.com to view the authorization determination. The member will receive an approval letter by mail.

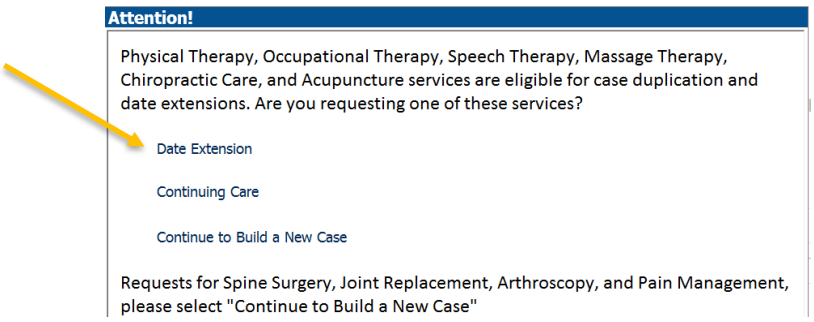
Note: The authorization number will begin with the letter 'A' followed by an eight-digit number.

How long is the authorization valid?

Authorizations are normally valid for 60 -90 calendar days. If the approved services are not performed within the authorized timeframe, or if additional care is needed, please contact eviCore prior to expiration date.

My authorization will expire soon, but I still have visits remaining. Can I request an extension?

Yes. A date extension can be granted for a therapy case in which a provider has visits authorized, but was unable to perform those visits in the amount of time given. You may request a date extension via our web portal or telephonically by calling eviCore at 855-727-7444.



Please note the following conditions for a date extension:

- There must be one or more visits from an existing authorization that have not been used.
- An extension can only be requested during an open coverage period. If the coverage period has already expired, a new pre-service authorization request is required.
- Only one (1) extension is allowed per authorization.
- Authorizations can only be extended for up to an additional 30 days.
- An extension cannot overlap with another request for the same specialty.

Does eviCore review cases retrospectively if no authorization was obtained?

Retrospective requests must be initiated within 7 business days following the date of service. Please submit all relevant clinical information at the time of your request.

What if an authorization is issued and revisions need to be made?

The requesting provider or member should contact eviCore at 855-727-7444 with any change to the authorization. It is very important to update eviCore of any changes to the authorization in order for claims to be correctly processed for the facility that receives the member.

How can the provider confirm that the existing prior authorization number is valid?

Providers can confirm that the prior authorization is valid by logging into our web portal, which provides 24/7 access to view prior authorization numbers. To access the portal, please visit www.evicore.com. To request a fax letter with the prior authorization number, please call eviCore at 855-727-7444 to speak with a customer service specialist.

If eviCore healthcare denies a prior authorization of a study, do we have the option to appeal the decision?

Yes. Post decision options are available, and will be detailed in the denial letter sent to the requesting clinician and the member/participant. In the event of an adverse determination, eviCore welcomes post decision consultations between the provider and the eviCore healthcare Medical Director.

Who will handle a request for an appeal?

Please refer to the denial letter for details regarding post decision options.

Where do I submit my claims?

All claims will continue to be filed directly to Network Health Wisconsin.

How do I submit a program related question, or report an issue?

For program related questions or concerns, please email: clientservices@evicore.com

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

If a member currently has an approved authorization on file for dates of service after June 1, 2021, will it be honored in the new system on go-live, or will the provider need to resubmit the request?

All authorizations that were issued prior to the eviCore implementation for therapy service with dates of service on or after June 1, 2021, will be honored.

Is prior authorization for individuals currently in physical/occupational therapy that will continue June 1, 2021, and after required (no current authorization on file)?

Yes, Therapy (all lines of business) services will need a prior authorization for any services taking place on or after June 1, 2021. Providers can start submitting these requests with the program go live as early as May 24, 2021.

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

Yes. When a member changes to a treating provider who is not within the same practice, a new authorization request is required. If the member has discontinued care with the original provider, please include the discharge date with the original provider when submitting your request. eviCore will not provide authorization for overlapping services or duplicate care as it is not medically necessary.

Note: A new authorization is not required if member is seeing a different provider within the same practice.

Where can I find additional educational materials?

For more information and reference documents, please visit our resource page at www.evicore.com/provider.