Authorization Request Overview for Physical, Occupational, and Speech Therapy Services

Provider Orientation for Security Health Plan

July 2023

eviCore healthcare by Evernorth

Security Health Plan Prior Authorization Services

eviCore manages prior authorization requests for therapy services for Security Health Plan

Applicable Membership	Prior authorization applies to the following services	Prior authorization does NOT apply to services performed in
• Commercial • Medicare • Medicaid	• Outpatient • Elective/Non-emergent	• Emergency Rooms • Observation Services • Inpatient Stays

Providers should verify member eligibility and benefits via the eligibility Lookup tool on the eviCore portal, or through Security Health Plan's eligibility confirmation process.

Program Goals

- Authorize **medically necessary** services which require the knowledge and 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**

Medical Necessity

To be considered medically necessary:

- The services must be specific and effective treatment for the condition.
- The condition is expected to improve significantly in a reasonable (and generally predictable) period of time. Therapy duration should be reasonable and not ongoing without end.
  - **Exception** – Medicare members
- The amount, frequency, and length of the services must be reasonable under accepted standards of practice.
- Services shall be of such a level of complexity and sophistication that they can only be performed by a therapist or therapy assistant.

Medical Necessity for Medicare

- Medical necessity based on the need for skilled services not on progress or lack of
- Documentation should explain why the skills of a therapist are necessary
- Skilled maintenance therapy services are covered for members if the specialized skill, knowledge and judgment of a qualified therapist are required to:
  - To establish or design a maintenance program appropriate to the capacity and tolerance of the member
  - To educate/instruct the member or appropriate caregiver regarding the maintenance program
  - Perform periodic re-evaluations of the maintenance program
  - Provide reasonable and necessary care to prevent or slow further deterioration. Coverage will not be denied based on the absence of potential for improvement or restoration as long as skilled care is required.

Submitting Requests

Prior Authorization Process

What are the ways to request authorization through eviCore?

- Web - Preferred Method
  - Opportunity for real time decision for the initial and second request
  - Use worksheets as a guide to prepare to answer questions on the web
  - After the initial request, you have the ability to upload clinical documentation if patient is complex or not progressing as expected
- Phone
  - Opportunity for real time decision for the initial and second request
  - Use worksheets as a guide to prepare to answer questions on the web
  - Providing answers to the questions posed on the web to a non-clinical agent
- Fax
  - Least desired form of submission
  - Eliminates opportunity for a real time decision
  - Old technology so it is prone to transmission errors
  - Complete worksheet
  - Only send clinical notes if patient is complex or not progressing as expected.

Necessary Information for Prior Authorization

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

Member
- Health Plan ID
- Member name
- Date of birth (DOB)

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

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

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

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 of 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.**
- **<u>Medicare</u> 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

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”

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.

Prior Authorization Process

What is used to determine if services are medically necessary?

- Clinical Criteria
  - Available 24/7 @ www.evicore.com
  - Synthesis of research, guidelines, expert consensus
  - Updated annually and approved by the Health Plan
- Clinical Information
  - Should be current
    - Adult within the prior 10 days
    - Peds within the prior 20 days; standardized tests 1x/year
  - Complete the questions
    - ***If there is no information or information has gaps, it will delay the decision***
    - Worksheets are available at www.evicore.com to guide your clinical collection

Prior Authorization Process

Requesting Authorization

- For the first request
  - Evaluate the member before you request prior authorization
    - Evaluation codes do not require prior authorization
  - Submit your request within 7 days of the requested start date
- 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
- 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.

Prior Authorization Process

Timely Filing

- Security Health Plan 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.
- Authorization for treatment beyond the initial visit must be requested prior to providing care.
- Retrospective requests will be accepted up to 7 calendar days. Please note that any cases after 7 calendar days will be expired.

Insufficient Clinical | Additional Documentation Needed

If during case build 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 requesting additional documentation.	The provider must submit the additional information to eviCore.	eviCore will review the additional documentation and reach a determination.
The hold letter will inform the provider about what clinical information is needed as well as the **date by which it is needed.**	Requested information must be received within the timeframe as specified in the hold letter, or eviCore will render a determination based on the original submission.	Determination notifications will be sent.

Treating Multiple conditions within the same auth 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 visits and 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

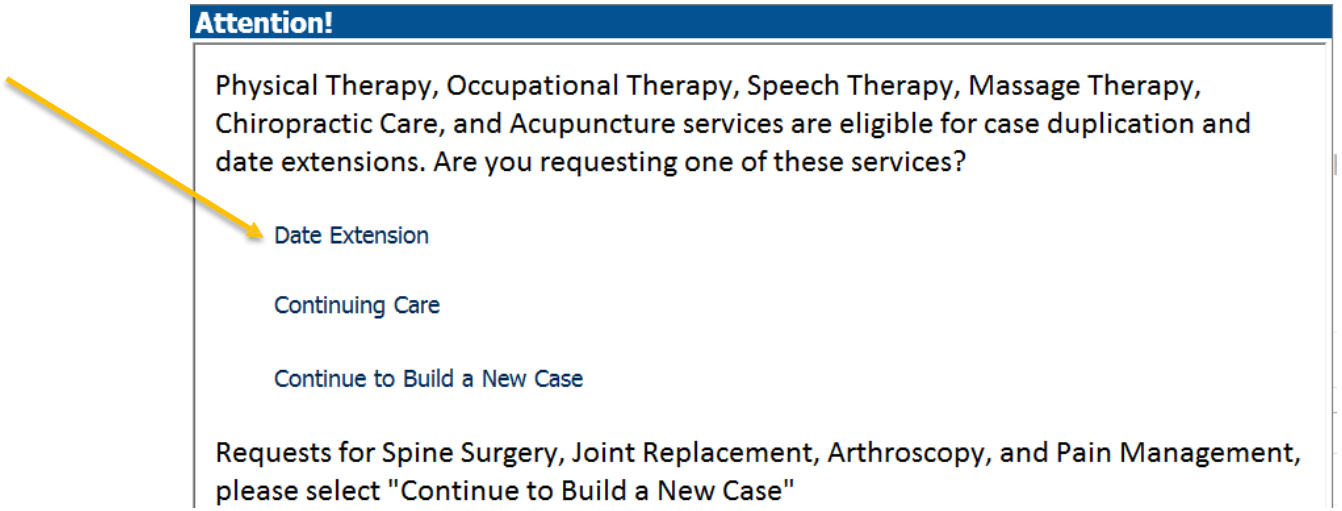
Duplicate Care

- 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 visits within the approved period

- Must be requested prior to the expiration of the authorization
- All therapy cases with a date of service after 5/1/2019 need a new authorization from eviCore. eviCore cannot extend authorizations originally provided by SHP.
- Available by phone 888-444-6185 or online at: https://carriers.carecorenational.com/PreAuthorization/screens/CreateCase.aspx
- One date extension is available per case
- You may extend a case for up to an additional 30 days



Prior Authorization Outcomes, Special Considerations & Post-Decision Options

Prior Authorization Determination Outcomes

Determination Outcomes

- **Approved Requests:** Depending on the condition, authorizations are valid for between 60 - 180 days from the treatment start date.
- **Partially Approved Requests:** The determination letter will specify what has been approved, as well as post-decision options for what has been denied.
- **Denied Requests:** If a request is determined as inappropriate based on evidence-based guidelines, a notification with the rationale for the decision and post-decision/ appeal rights will be issued.

Notifications

- Authorization letters will be faxed to the ordering physician.
- Web-initiated cases will receive e-notifications if a user opted in to this method.
- Members will receive a letter by mail.
- Approval information can be printed on demand from the **eviCore portal**.

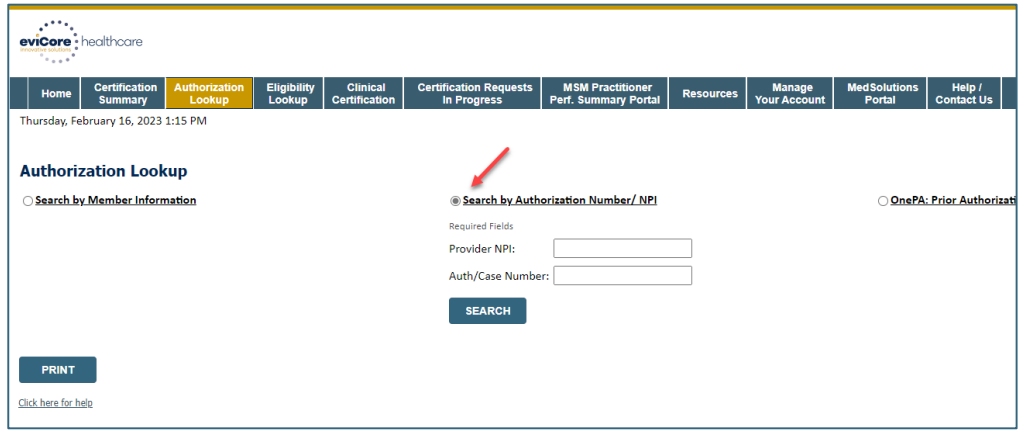
Notifications

- **Read the letters!** They include information to explain any adverse determination (reduction or denial)
  - Clinical Rationale related to the clinical decision
  - Written in terms the member understands
    - Does not include medical jargon
  - Reconsideration and Appeal Information
  - Provides information on requesting a Peer to Peer (P2P) discussion
    - P2P discussions are allowed for Medicare cases and will impact the determination only if it occurs prior to the official determination being rendered. Once the official determination has been rendered on a Medicare case, eviCore cannot change the determination. In that case, an appeal must be made to the health plan.

Clinical Consultation/Peer to Peer

Clinical Consultation/Peer to Peer

- Provides the ability to review clinical aspects of the case with a peer
- Be prepared to provide information that was not submitted previously
- Recall that P2P discussions are allowed for Medicare cases and will impact the determination only if it occurs prior to the official determination being rendered. Once the official determination has been rendered on a Medicare case, eviCore cannot change the determination. In that case, an appeal must be made to the health plan.
- Schedule the P2P directly on the eviCore portal via the Authorization Lookup feature:



- Or click this link to request that eviCore contacts you to schedule the P2P: https://www.evicore.com/Pages/requestaconsultation.aspx

Special Circumstances

Retrospective Authorization Requests

- Must be submitted within 7 business days from the date of services
- Any submitted beyond this timeframe will be administratively denied
- Reviewed for **clinical urgency** and medical necessity
- Processed within 2 business days
- When authorized, the start date will be the submitted date of service

Urgent Prior Authorization Requests

- Generally with therapies an urgent request will be very rare; however if you have an urgent request for commercial members eviCore has up to 72 hours for review-Medicare/Medicaid up to 24 hours for the review after receipt of all relevant clinical information.
- Reviewed for **clinical urgency** and medical necessity
- A provider can either call in an urgent request or submit via web. Please note the eviCore standard is for a turn around time of 4 hours.

Post-Decision Options
Commercial & Medicaid Members

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 may also call eviCore at 888-444-6185 to speak with an agent who can provide available option(s) and instruction on how to proceed.

Alternatively, select 'All Post Decisions' under the authorization lookup function on **eviCore.com** to see available options.

Reconsiderations

- Reconsiderations must be requested within 10 business days after the determination date.
- Reconsiderations can be requested in writing or verbally via a Clinical Consultation with an eviCore physician.

Appeals

- eviCore will not process appeals. Please refer to your denial letter for instructions on how to file an appeal.

Post-Decision Options
Medicare Members

My case has been denied. What's next?

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 appeals. Please refer to your denial letter for instructions on how to file an appeal.

eviCore Provider Portal

eviCore Provider Portal | Features

Eligibility Lookup

- Confirm if patient requires clinical review

Clinical Certification

- Request a clinical review for prior authorization on the portal

Prior Authorization Status Lookup

- View and print any correspondence associated with the case
- Search by member information OR by case number with ordering national provider identifier (NPI)
- Review post-decision options, submit appeal, and schedule a peer-to-peer

Certification Summary

- Track recently submitted cases

eviCore Provider Portal | Access and Compatibility

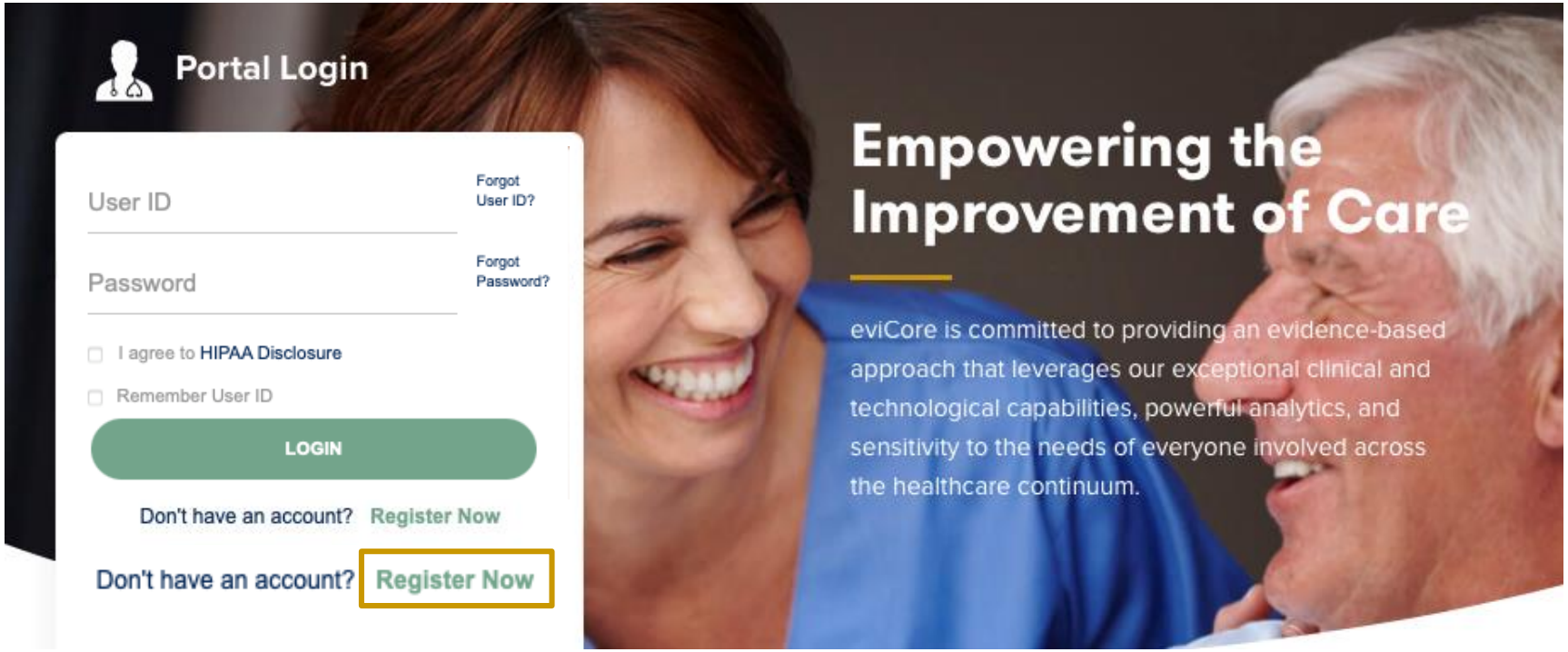
Most providers are already saving time submitting clinical review requests online vs. telephone

To access resources on the eviCore Provider Portal, visit **evicore.com/provider**

Already a user?

Log in with User ID & Password

Don't have an account?
Click **Register Now**



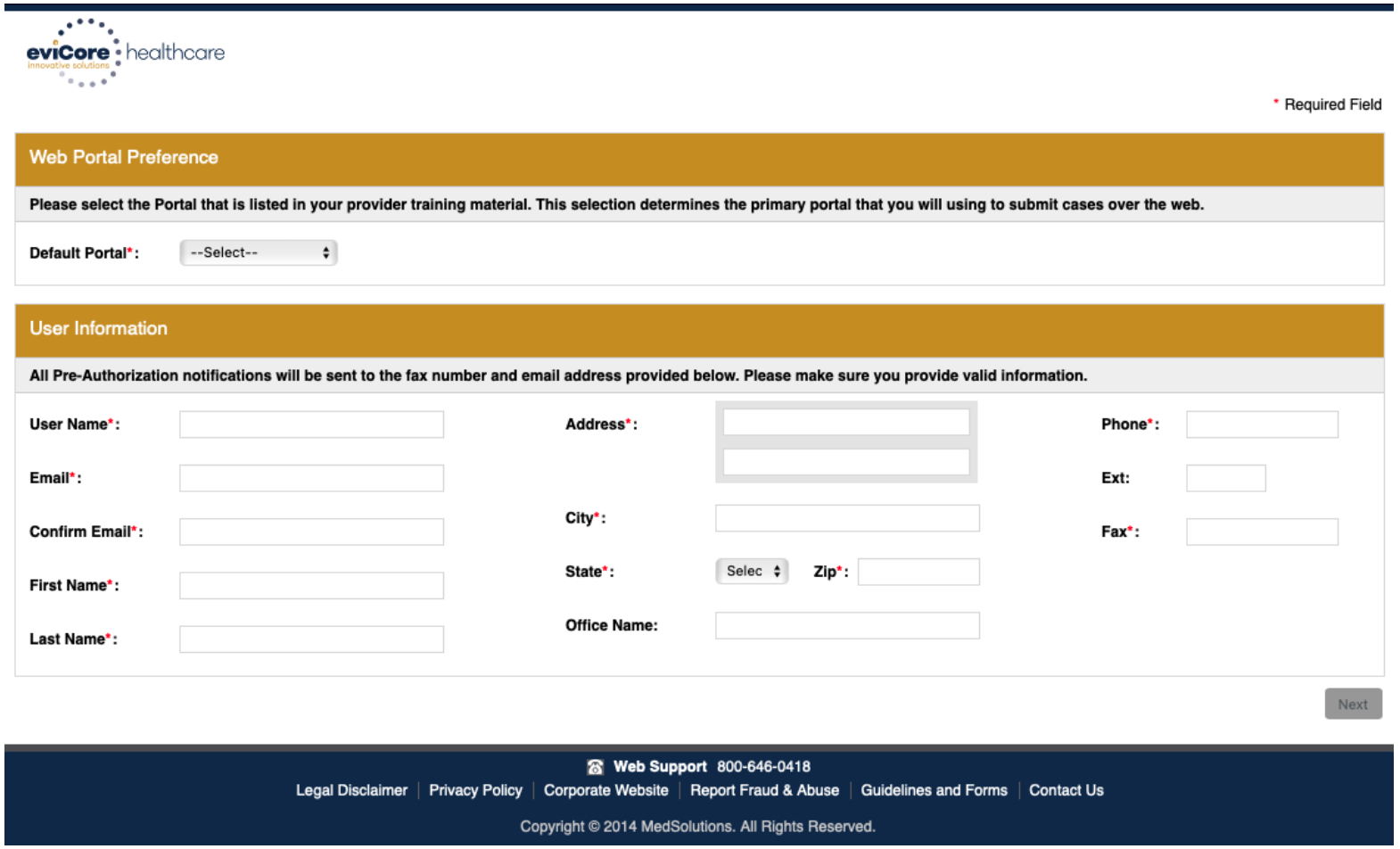
eviCore's website is compatible with all web browsers. If you experience issues, you may need to disable pop-up blockers to access the site.

Creating an eviCore Provider Portal 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 login page.



Setting Up Multi-Factor Authentication (MFA)

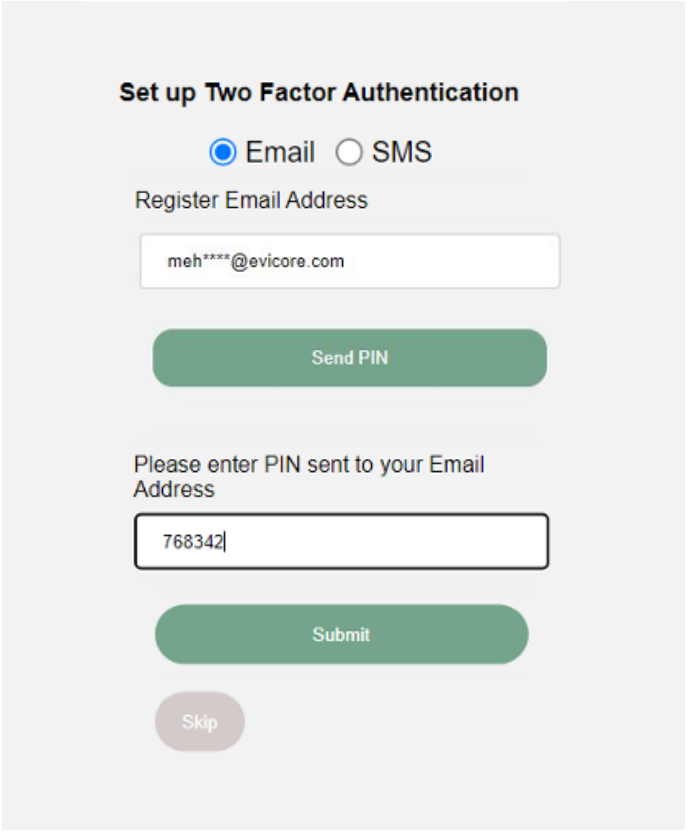
To safeguard your patients' private health information (PHI), we have implemented a multi-factor authentication (MFA) process.

After you log in, you will be prompted to register your device for MFA.

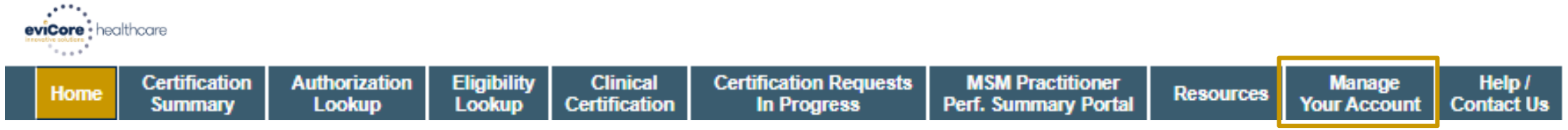
Choose which authentication method you prefer: Email or SMS. Then, **enter your email address or mobile phone number.**

Select **Send PIN**, and a 6-digit pin will be generated and sent to your chosen device.

After entering the provided PIN in the portal display, you will successfully be authenticated and logged in. **Your MFA authentication will expire after five hours of inactivity.** After this time, you will be automatically logged out and need to log in again.

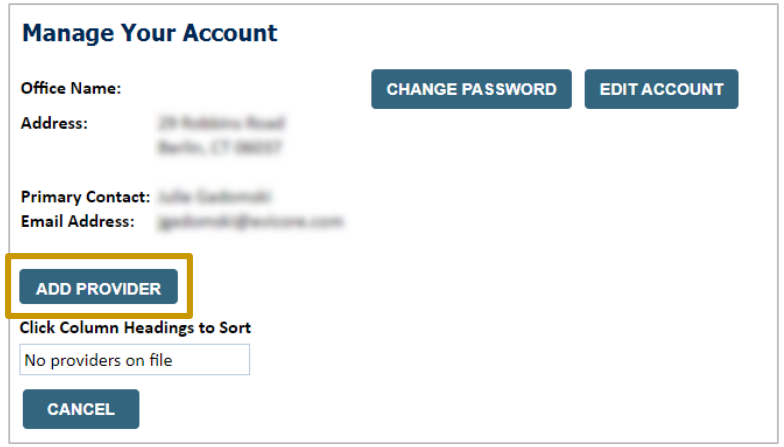


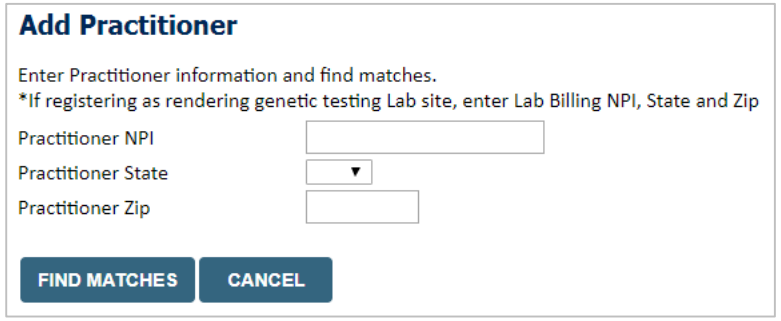
eviCore Provider Portal | Add Providers



Providers will need to be added to your account prior to case submission

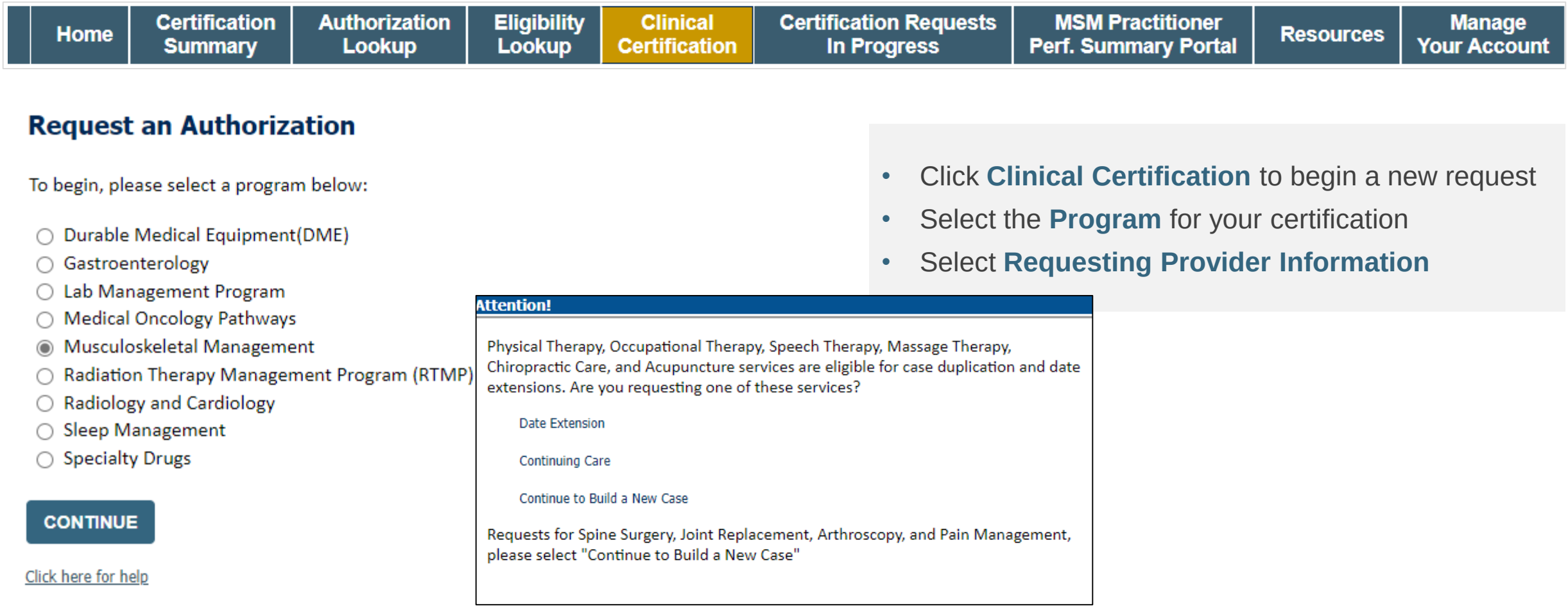
- Click the **Manage Your Account** tab to add provider information
- Select **Add Provider**
- Enter the NPI, state, and zip code to search for the provider
- Select the matching record based upon your search criteria
- Once you have selected a practitioner, your registration will be complete
- You 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





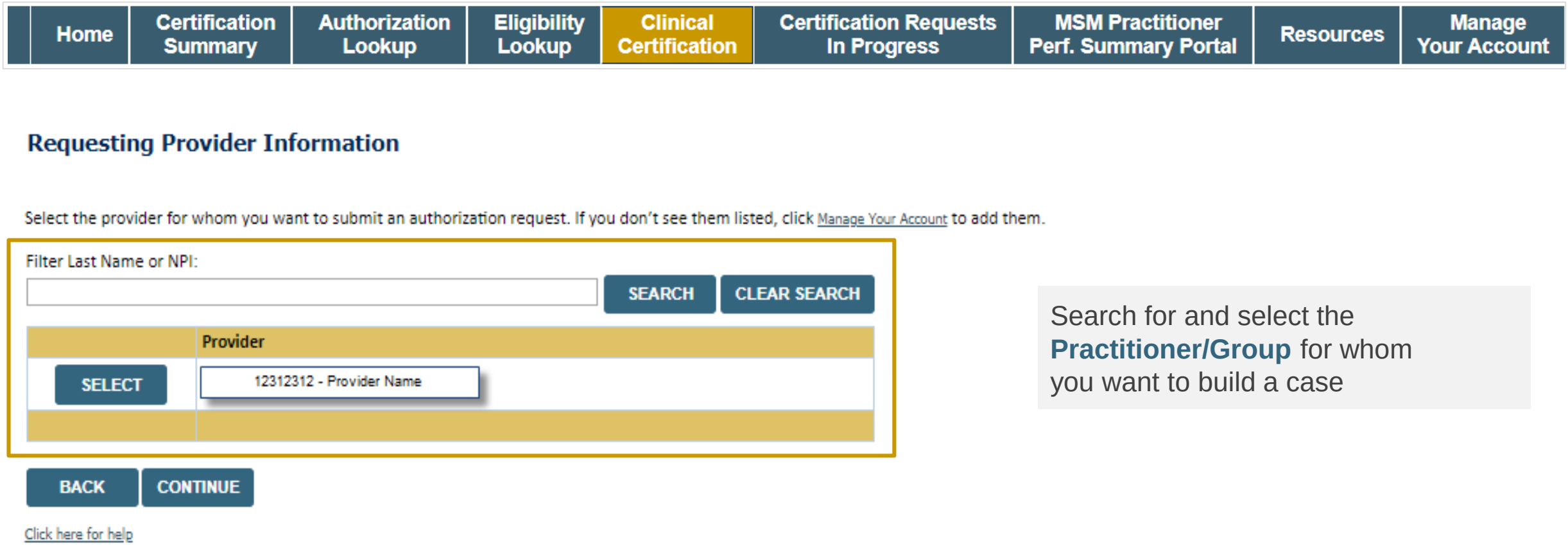
Portal Case Submission

Clinical Certification Request | Initiating a Case



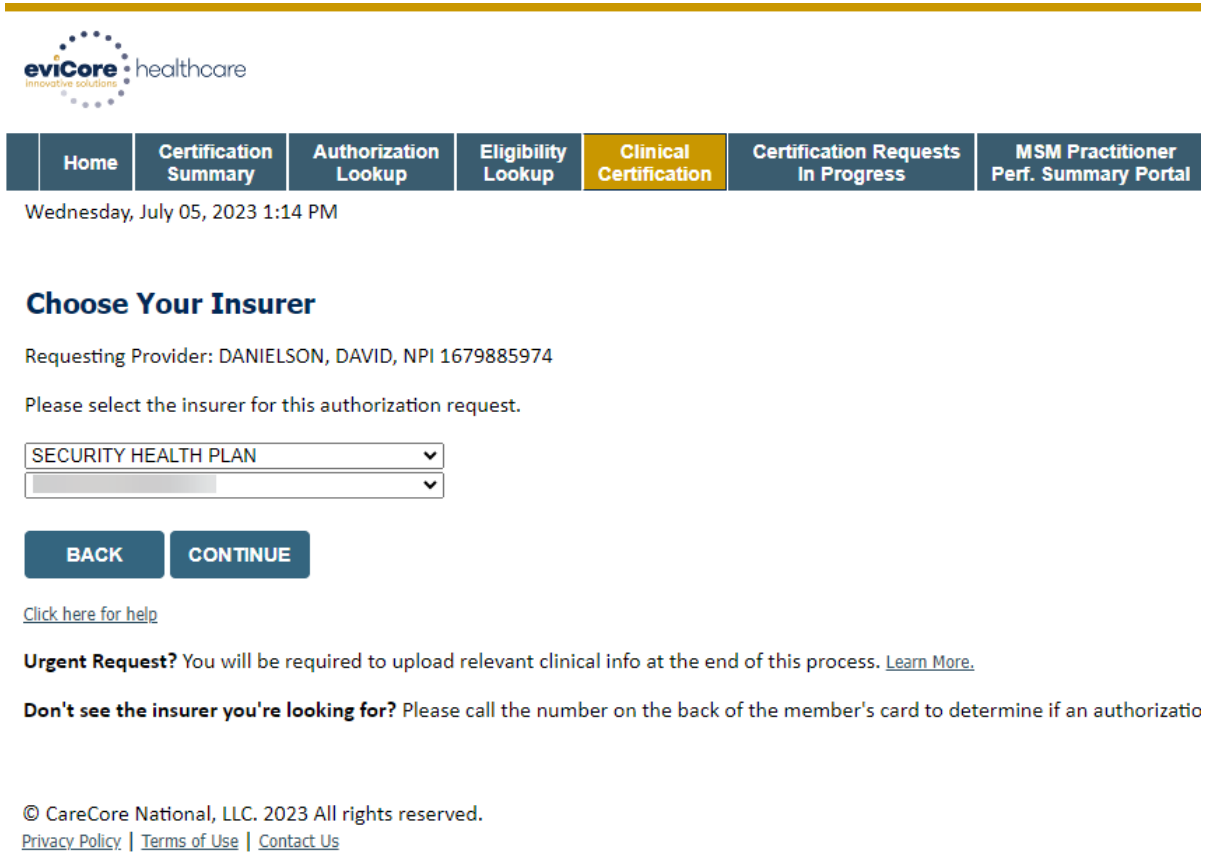
- Click **Clinical Certification** to begin a new request
- Select the **Program** for your certification
- Select **Requesting Provider Information**

Clinical Certification Request | Search for and Select Provider



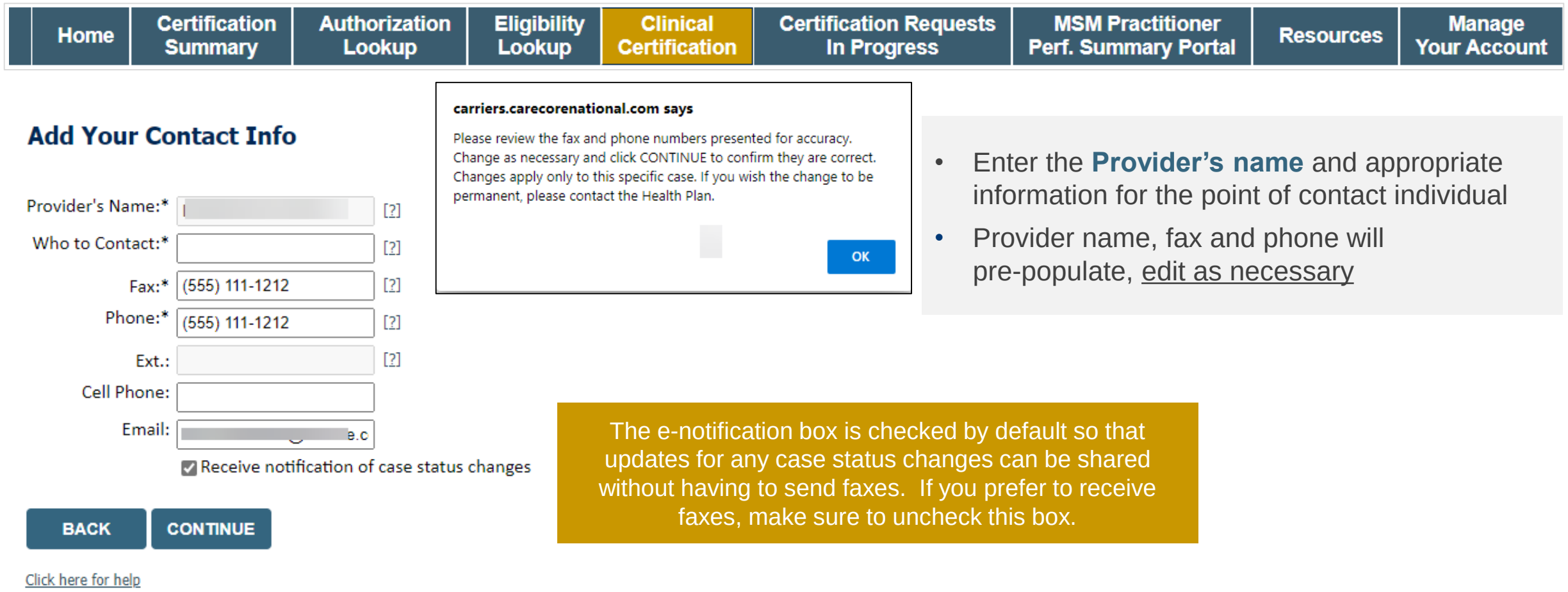
Search for and select the **Practitioner/Group** for whom you want to build a case

Clinical Certification Request | Select Health Plan



- Choose the appropriate **Health Plan** for the request
- Select the appropriate provider address from the drop down menu.
- Select **CONTINUE**

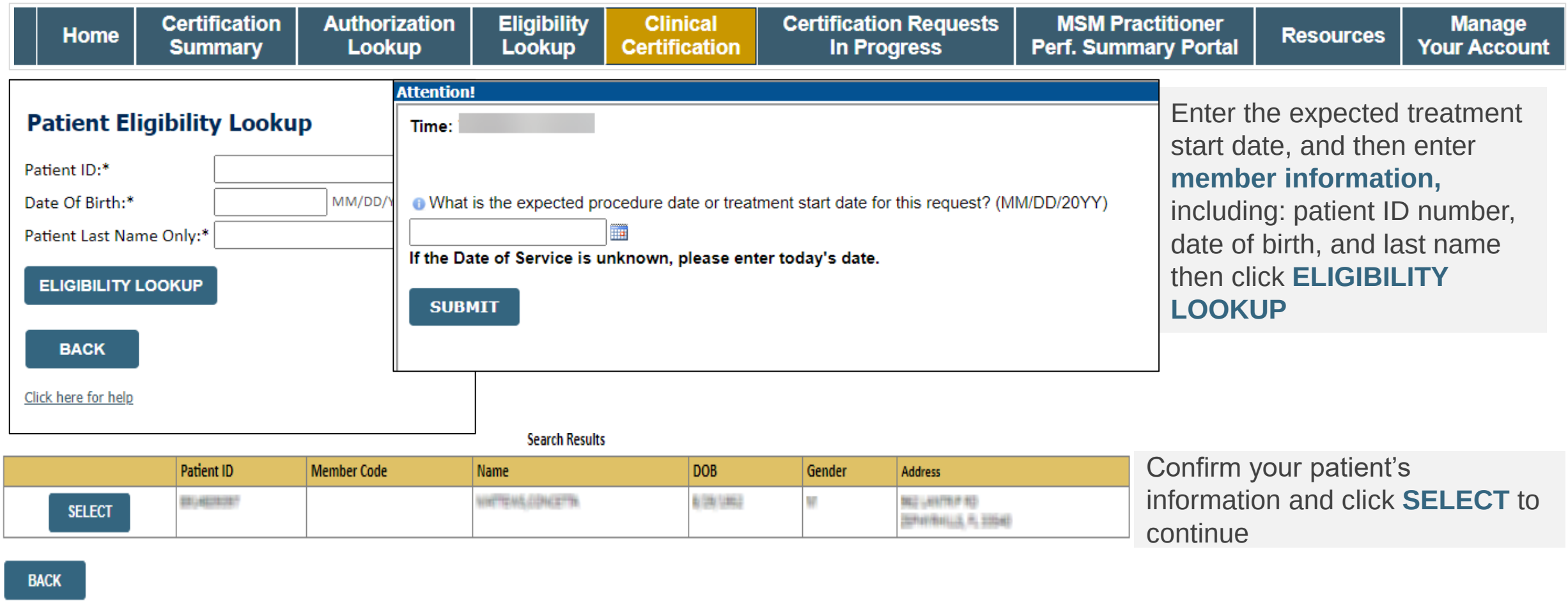
Clinical Certification Request | Enter Contact Information



- Enter the **Provider's name** and appropriate information for the point of contact individual
- Provider name, fax and phone will pre-populate, edit as necessary

The e-notification box is checked by default so that updates for any case status changes can be shared without having to send faxes. If you prefer to receive faxes, make sure to uncheck this box.

Clinical Certification Request | Enter Member Information

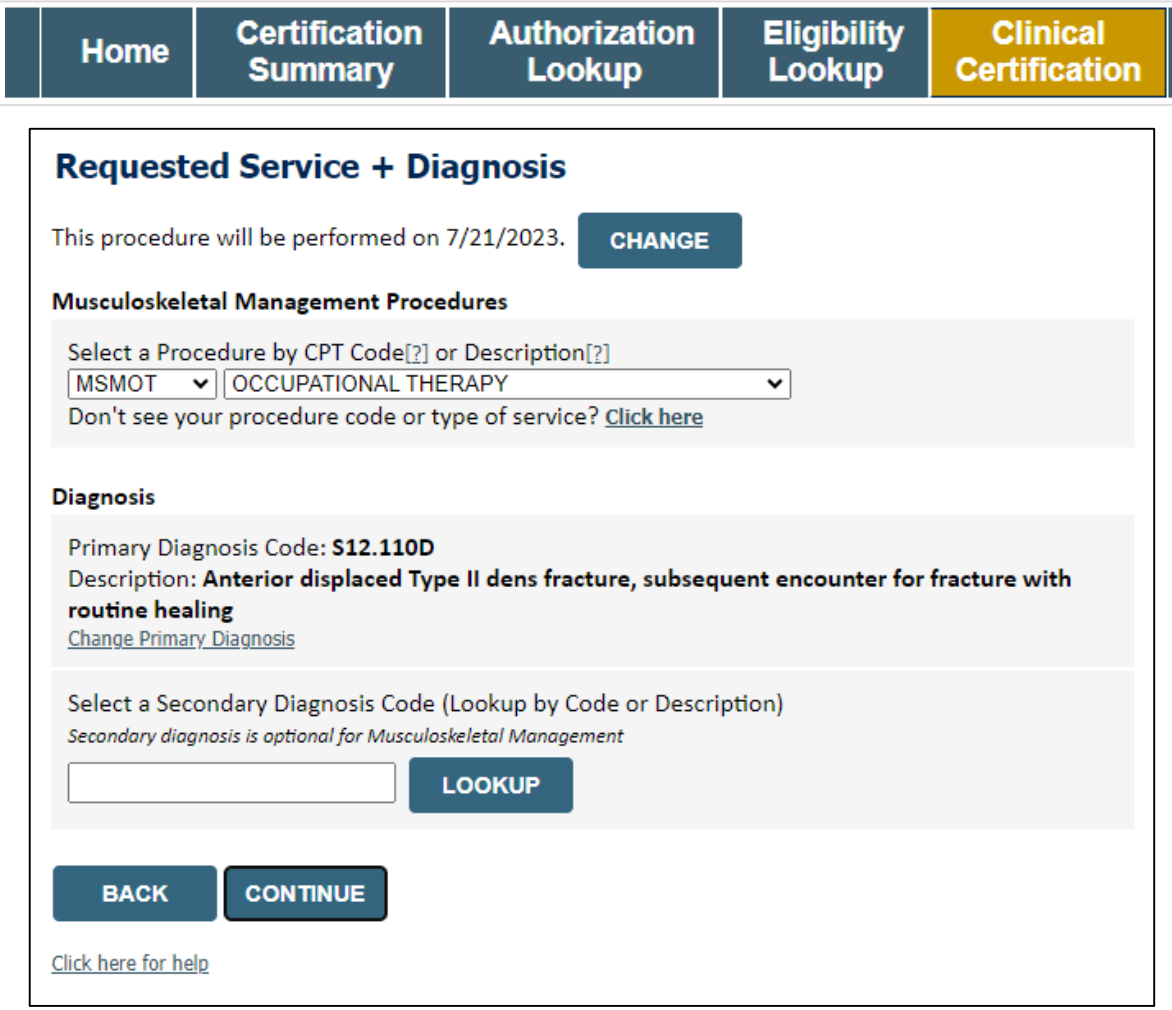


Enter the expected treatment start date, and then enter **member information,** including: patient ID number, date of birth, and last name then click **ELIGIBILITY LOOKUP**

Confirm your patient's information and click **SELECT** to continue

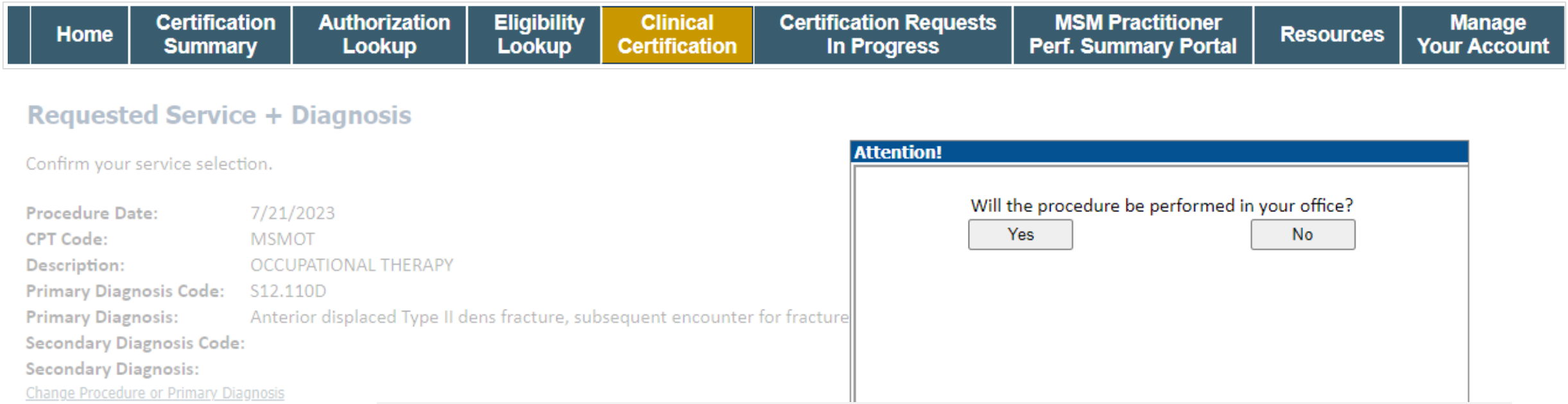
Clinical Certification Request

Enter Requested Procedure and Diagnosis



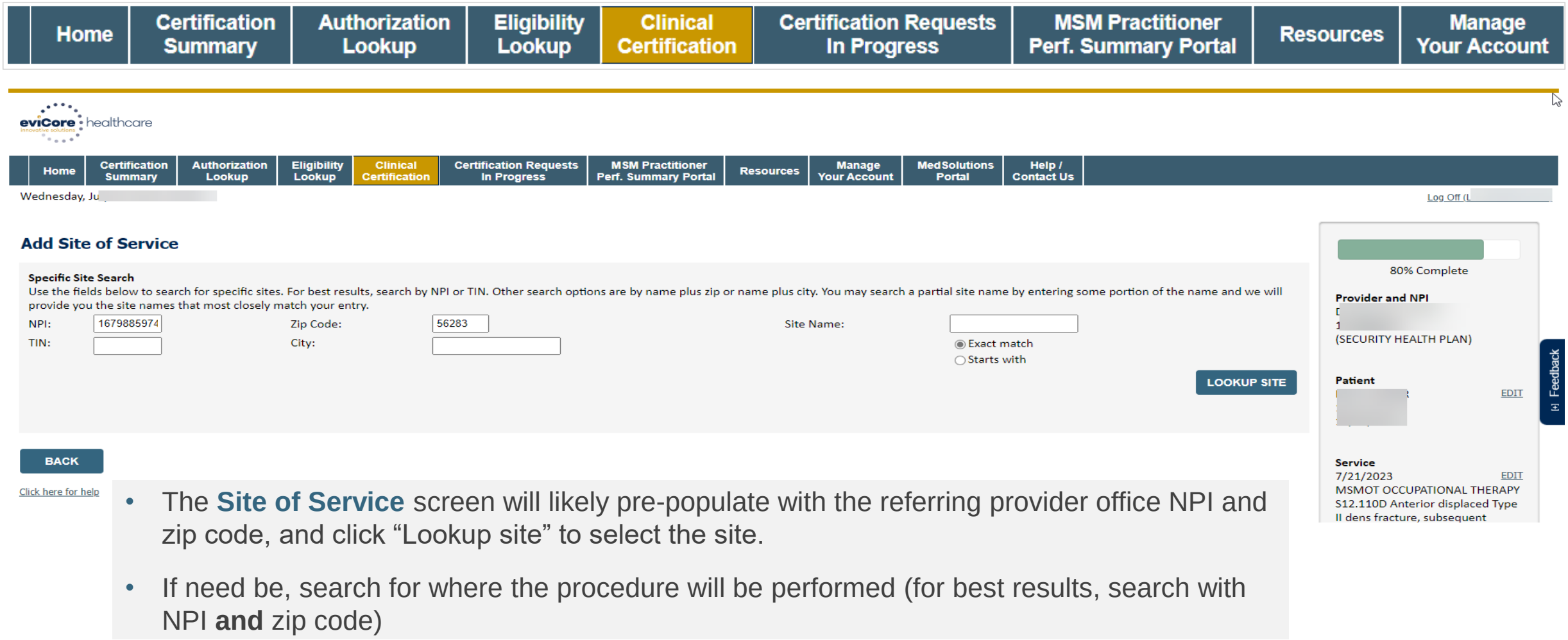
Select the procedure by selecting MSMPT (for physical therapy), MSMOT (for occupational therapy), and MSMST (for speech therapy). Then select the primary and secondary (if applicable) **Diagnosis codes**

Clinical Certification Request | Verify Service Selection



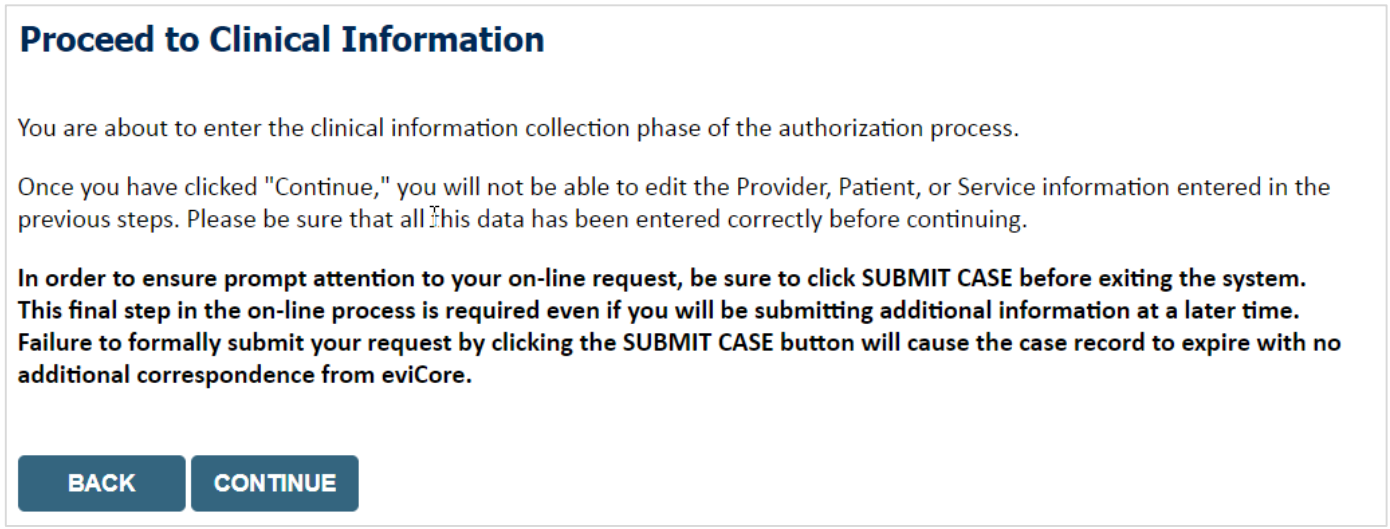
- Tell us whether services will be performed in office or some other place of service.
- Then verify requested service & diagnosis
- Edit any information if needed by selecting **Change Procedure** or **Primary Diagnosis**
- Click **CONTINUE** to confirm your selection

Clinical Certification Request | Site Selection



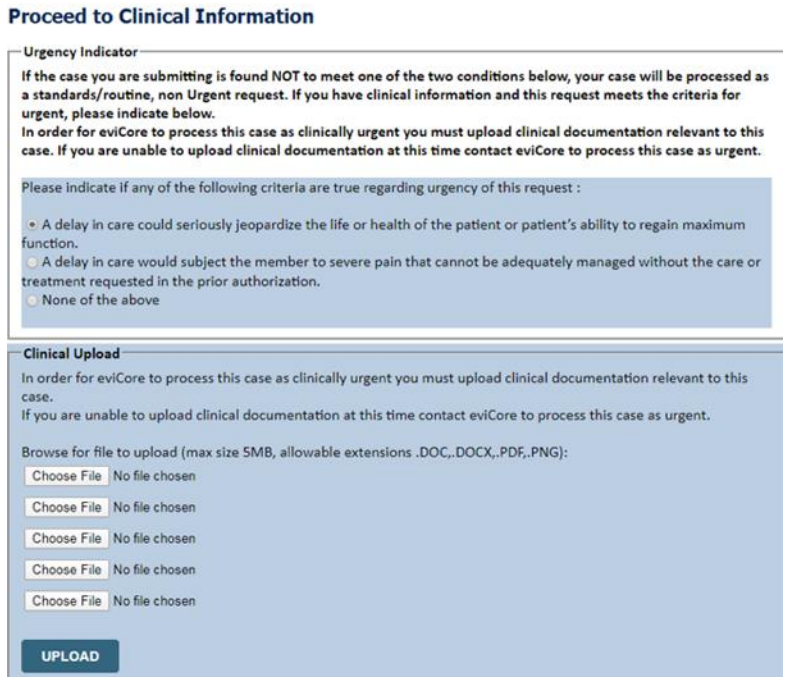
- The **Site of Service** screen will likely pre-populate with the referring provider office NPI and zip code, and click “Lookup site” to select the site.
- If need be, search for where the procedure will be performed (for best results, search with NPI **and** zip code)

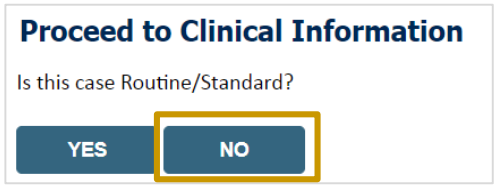
Clinical Certification Request | Clinical Certification



- Verify that all information is entered and correct
- **You will <u>not</u> have the opportunity to make changes after this point**

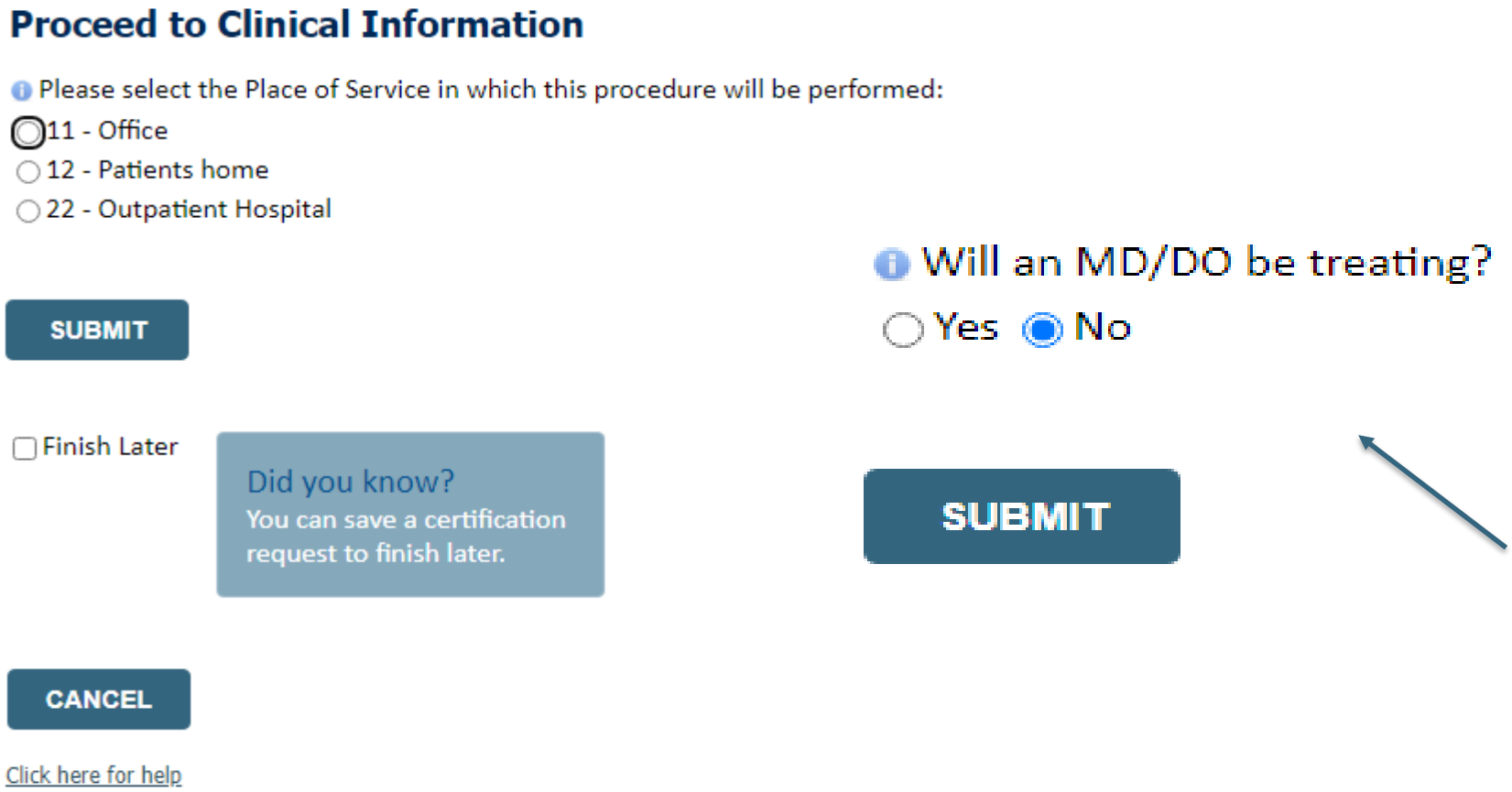
Clinical Certification Request | Standard or Urgent Request?





- If the case is **standard,** select **Yes**
- If your request is **urgent,** select **No**
- When a request is submitted as urgent, you will be **required** to upload relevant clinical information
- Upload up to **FIVE documents**
  (.doc, .docx, or .pdf format; max 25MB size)
- Your case will only be considered urgent if there is a successful upload

Proceed to Clinical Information – Example of Questions

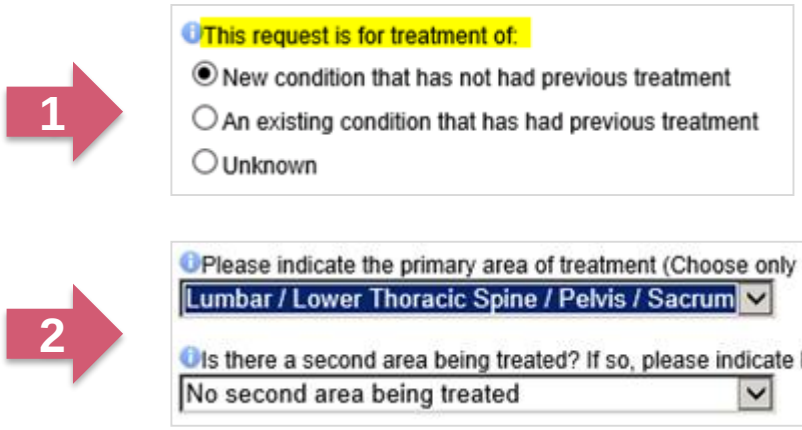


Note: **Prior authorization is only required for physical therapists/occupational therapists/speech pathologists performing physical, occupational, speech therapy. Medical Doctors (MD) and Doctors of Osteopathic Medicine (DO) do not require pre-authorization through eviCore Healthcare**

Clinical Certification questions may populate based upon the information provided
Note: You can save your request and finish later that day if needed.
You may be able to resume a saved request by going to "Certification Requests in Progress," or call intake to complete the case.

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….

If the ODI or RMDQ or FOTO Low Back test was performed, please enter the score; if the test was NOT performed, please leave the Default value in place

Please indicate the functional assessment used:

- ○ FOTO Low Back (Focus On Therapeutic Outcomes)
- ○ ODI (Oswestry Disability Index)
- ○ Other functional assessment / No functional assessment
- ○ RMDQ (Roland Morris Disability Questionnaire)

Please enter the (for ODI in %; for RMDQ 0-24; for FOTO 0-100. Leave the listed score value in place if the score is not available)

101

Enter the number of LBP episode(s) in the past 3 years:

- ◉ 0 or N/A
- ○ 1
- ○ 2
- ○ 3
- ○ 4 or more

Does your patient demonstrate either of the following: (Choose all that apply)

☐ Weakness, sensory changes, or radiating pain below the knee ☐ Tinetti Gait / Balance score less than 24 OR Berg Balance test <40 OR TUG test >13.5 seconds

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

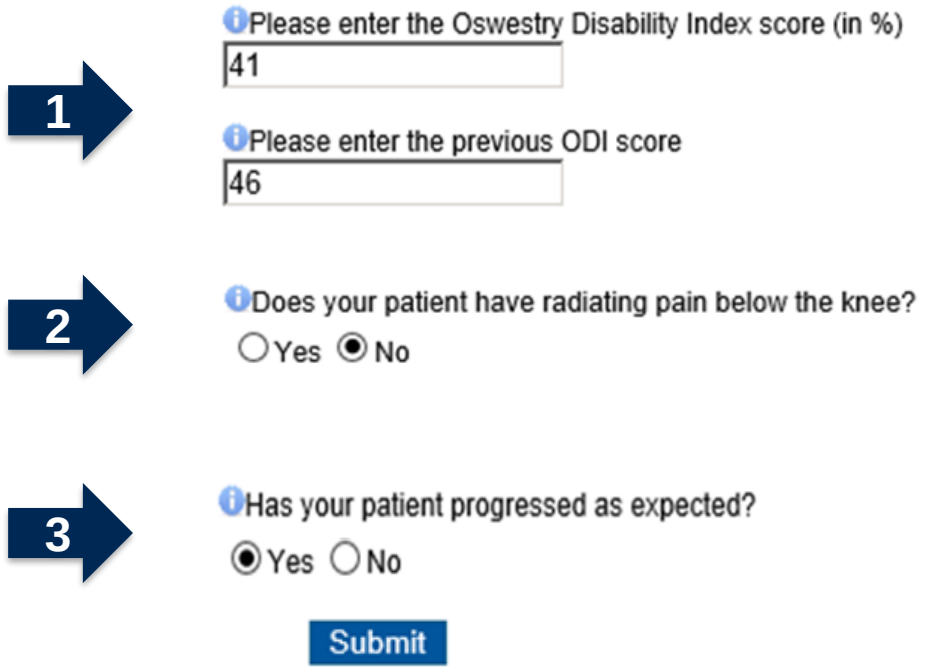
High Potential for Immediate Approval When Pathway is Completed!

Sample Therapy corePath^{SM} Pathway

Follow-up request

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.

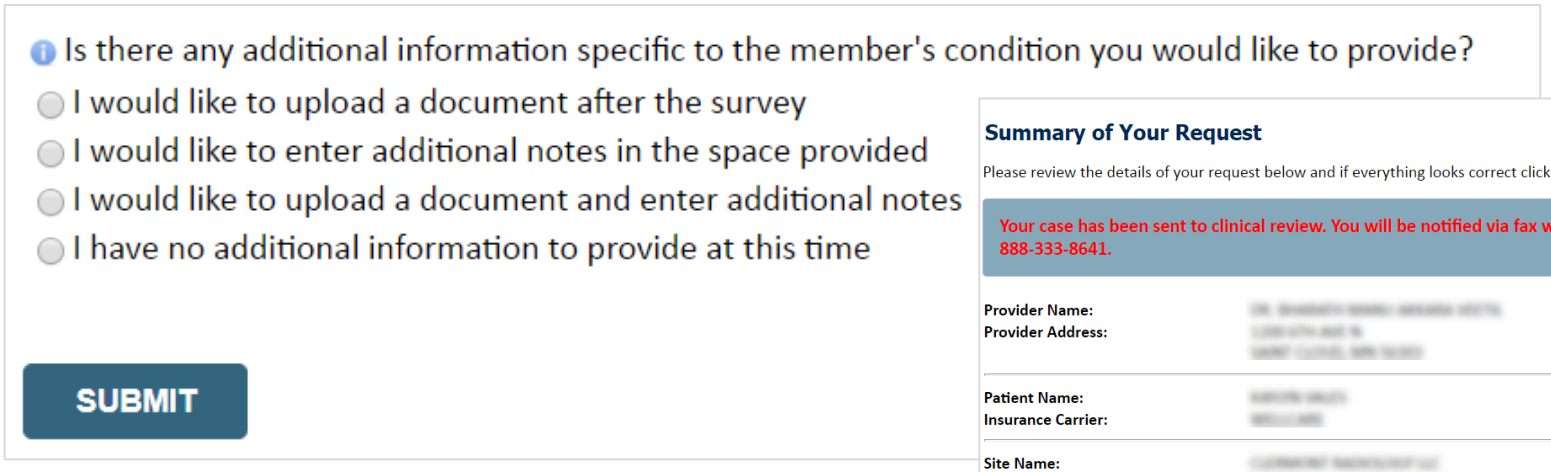
N/A

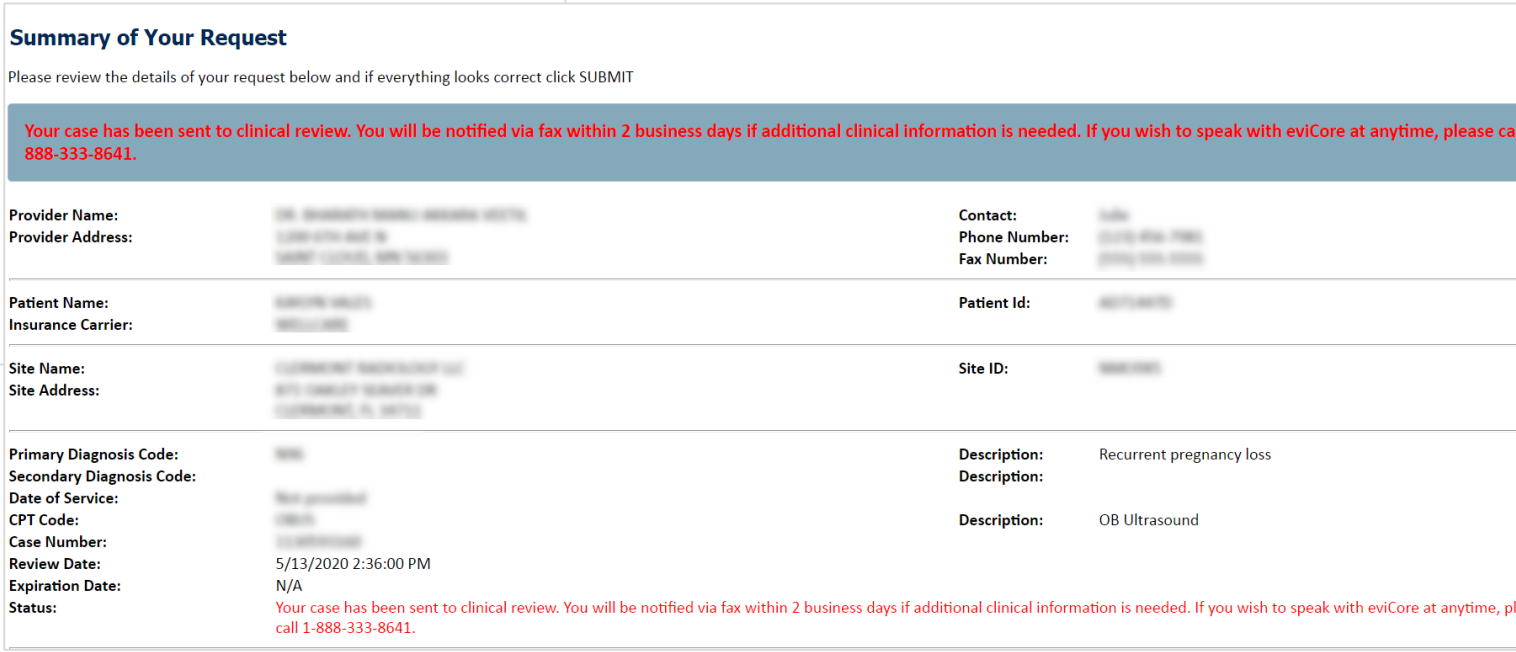
Lack of progress:

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

Criteria not met

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

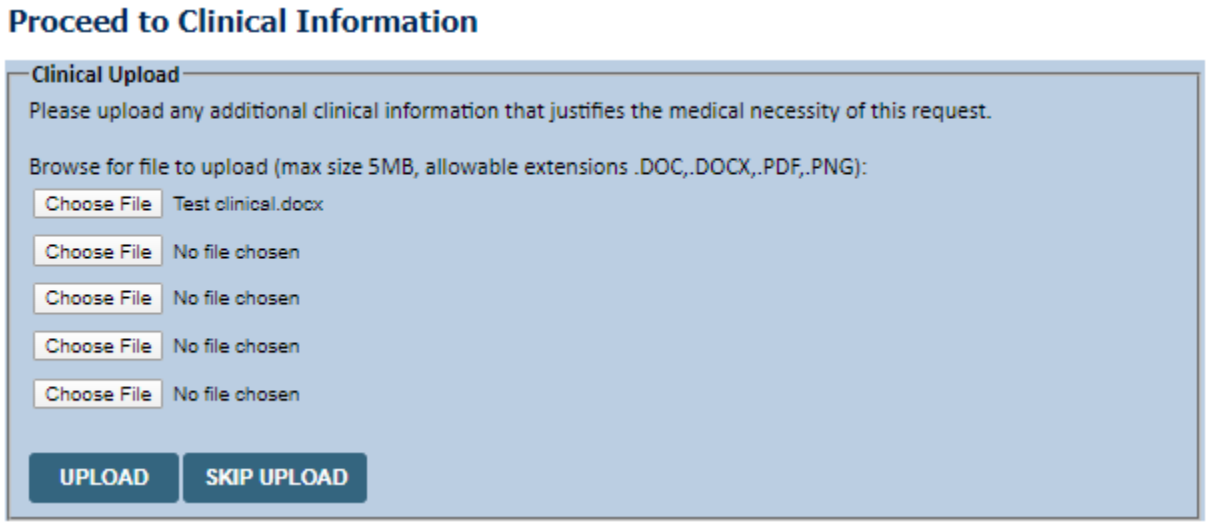




Tips:

- You may upload clinical notes on the portal
- Enter additional notes only when necessary
- Additional information uploaded to the case will be sent for clinical review
- Print out summary of request that includes the case # and indicates ‘Your case has been sent to clinical review’

Clinical Certification Request | Request for Clinical Upload



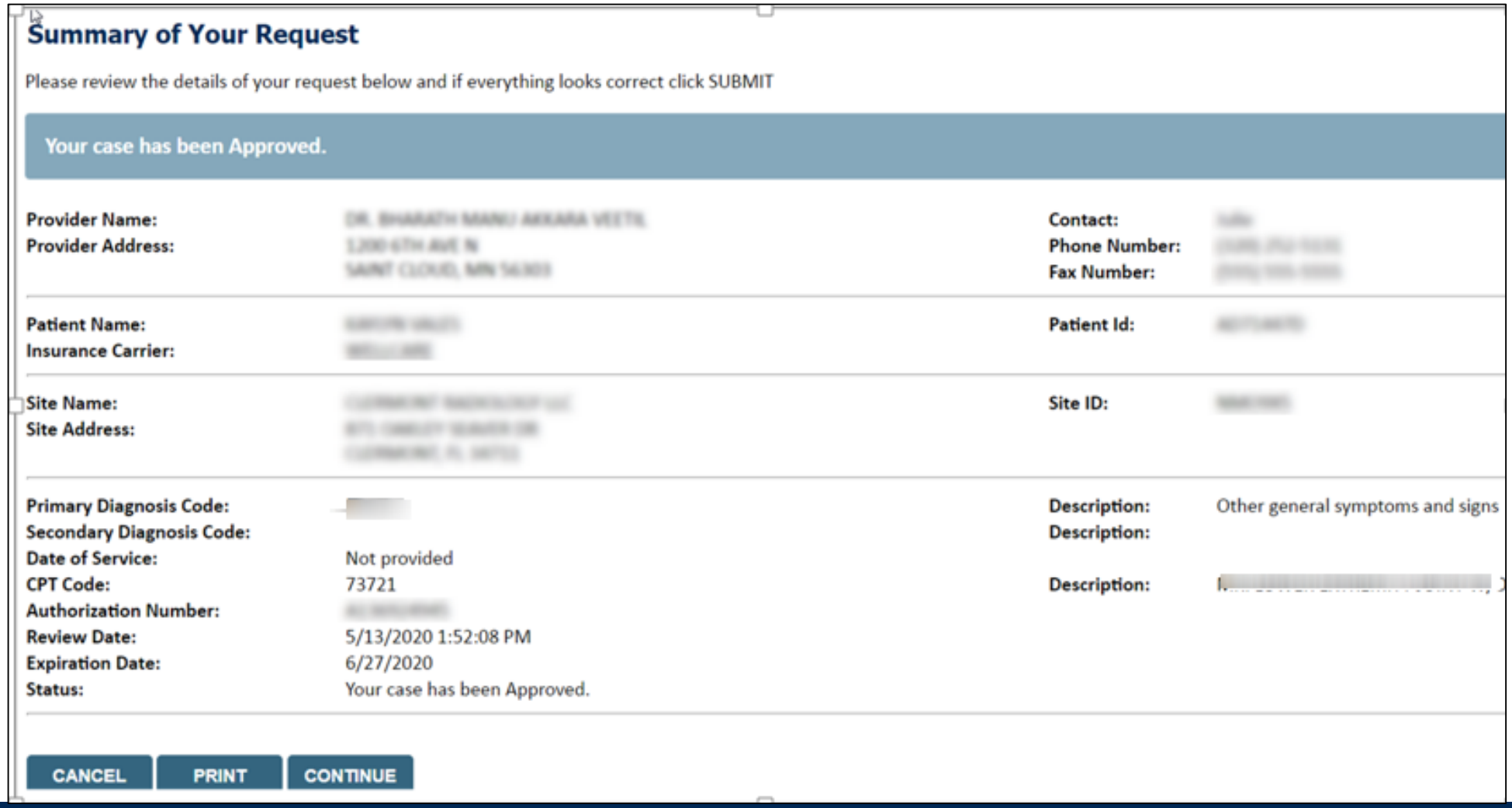
If **additional information** is required, you will have the option to upload more clinical information for review.

Tips:

- Providing clinical information via the web is the fastest and most efficient method
- 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

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

Scheduling Visits

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 and passive modalities

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.

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.

Provider Resources

Contact eviCore's Dedicated Teams

Client and Provider Services

For eligibility issues (member or provider not found in system) or transactional authorization related issues requiring research.

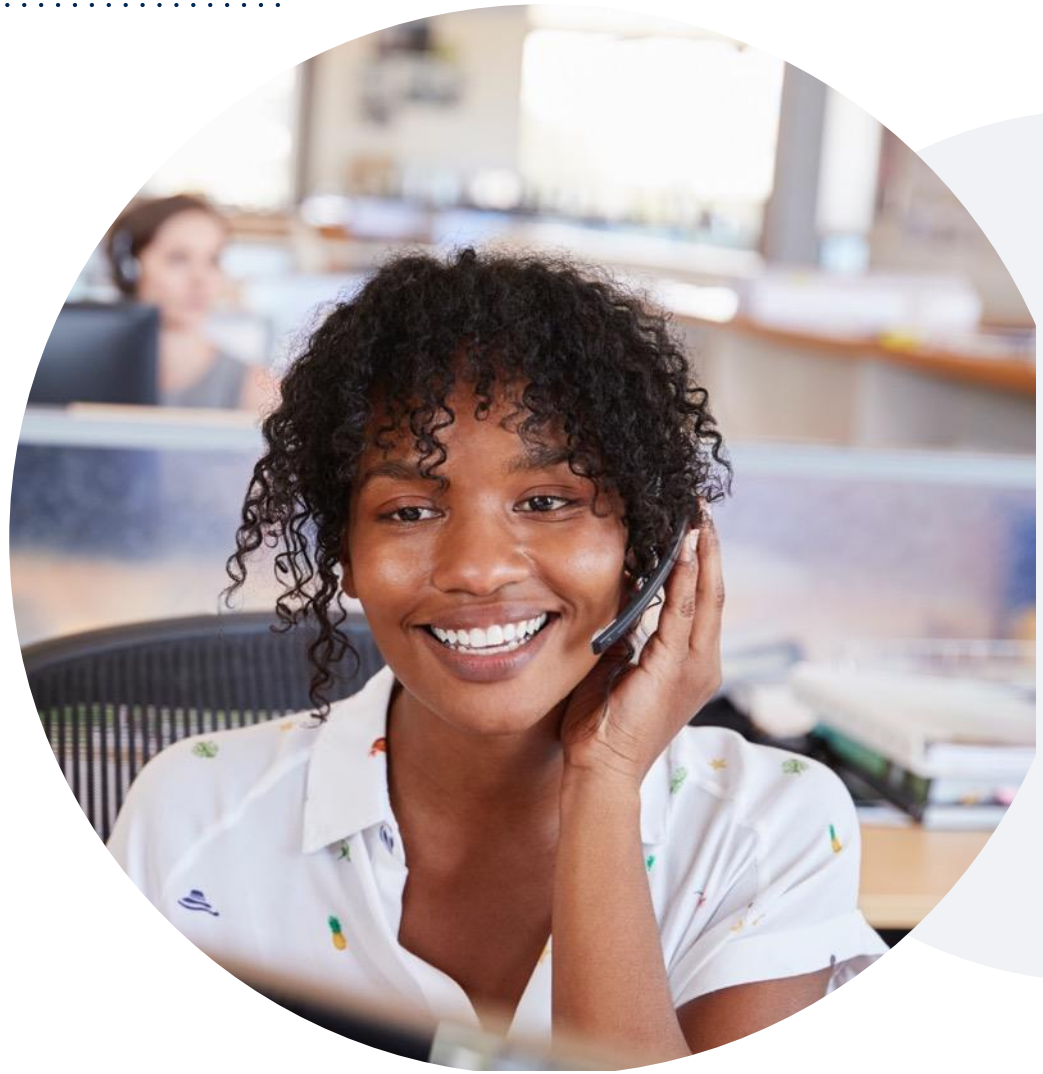
- Email: **clientservices@evicore.com**
- Phone: **(800) 646-0418** (option 4).

Web-Based Services and Portal Support

- Live chat
- Email: **portal.support@evicore.com**
- Phone: **800-646-0418** (option 2)

Call Center

- Call **888-444-6185** representatives are available from 7 a.m. to 7 p.m.



Provider Resource Website

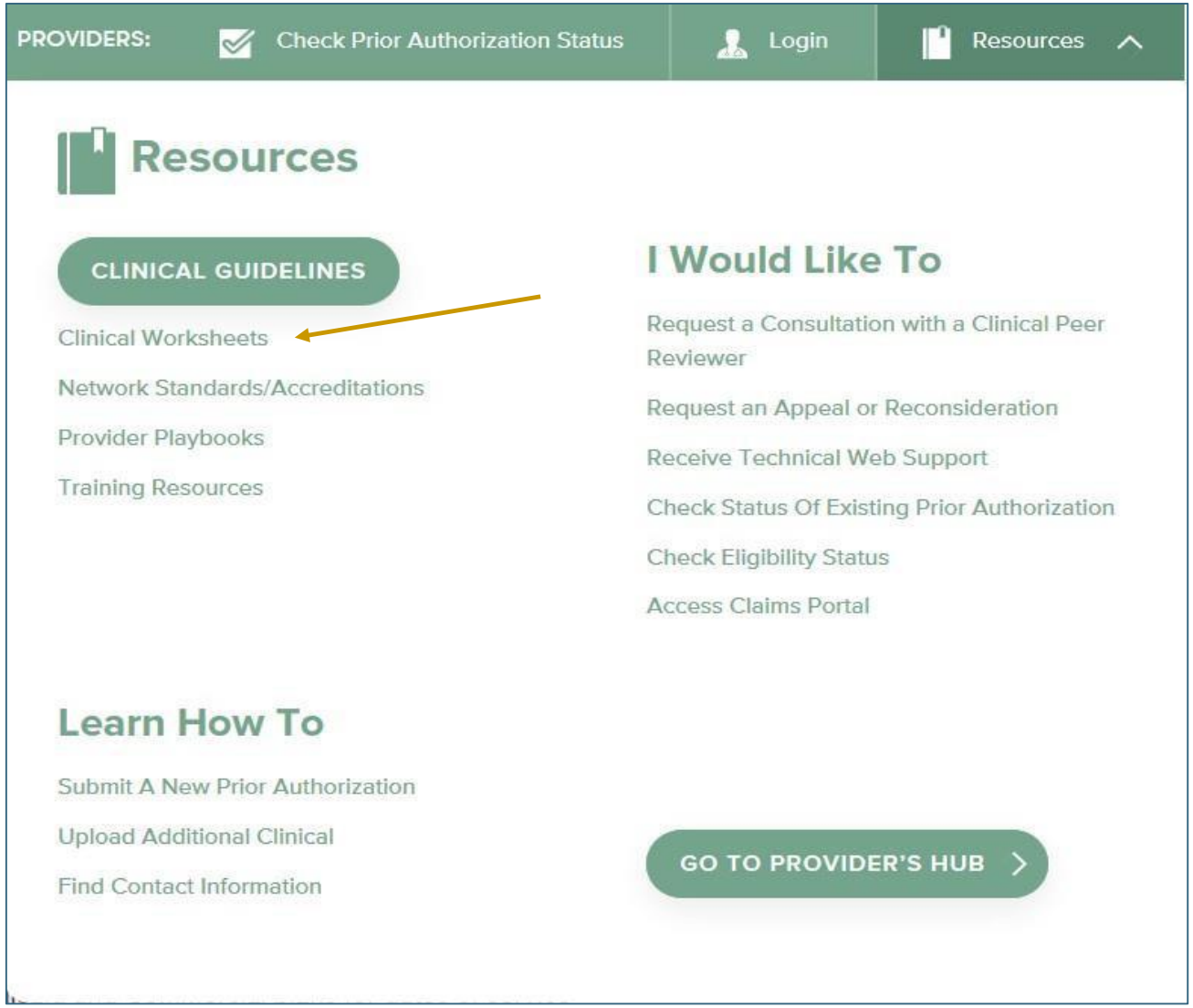
eviCore's Client and Provider Services team maintains provider resource pages that contain client- and solution-specific educational materials to assist providers and their staff on a daily basis.

This page will include:

- Frequently asked questions
- Quick reference guides
- Provider training
- CPT code list

To access these helpful resources, visit:
https://www.evicore.com/healthplan/shp

Musculoskeletal Online Resources



Clinical Guidelines, PT and OT Worksheets, FAQ's, Online Forms, and other important resources can be accessed at www.evicore.com.

- The worksheets are very helpful tools to help familiarize the user of the types of questions that will be asked in the clinical pathway.

Provider Resource Review Forum

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 learn how to navigate **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
- Existing prior authorization request status information
- Search for contact information
- Podcasts & insights
- Training resources

Register for a Provider Resource Review Forum:

Provider's Hub > Scroll down to eviCore Provider Orientation Session Registrations > Upcoming

eviCore's Provider Newsletter

Stay up-to-date with our free provider newsletter

To subscribe:

- Visit **eviCore.com**
- Scroll down to the section titled **Stay Updated With Our Provider Newsletter**
- Enter a valid email address

Peer-to-Peer (P2P) Scheduling Tool

Provider Resources | Schedule a P2P Request

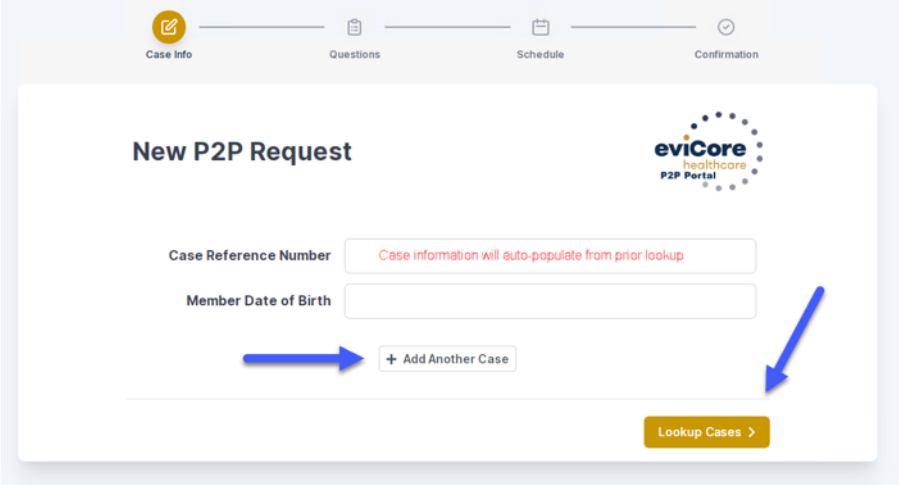
If your case is eligible for a Peer-to-Peer (P2) consultation, a link will display, allowing you to proceed to scheduling without any additional messaging

- Log-in to your account at **eviCore.com**
- Perform **Clinical Review 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 consultation
- Note carefully any messaging that displays*

*In some instances, a Peer-to-Peer consultation is allowed, but the case decision can not be changed. In such cases, you can still request a **Consultative-Only Peer-to-Peer.** You can also click on the **ALL POST-DECISION OPTIONS** button to learn what other action can be taken.

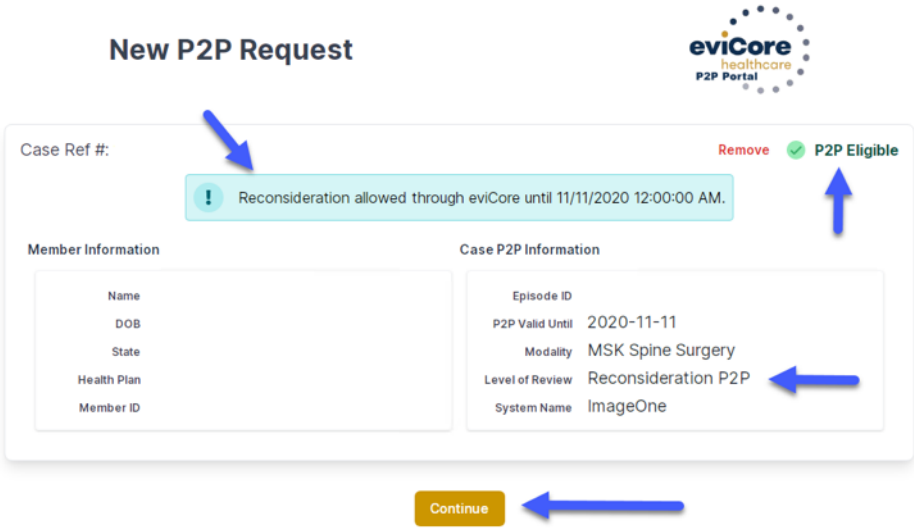
Once the **Request Peer-to-Peer Consultation** link is selected, you will be transferred to our scheduling software via a new browser window.

Provider Resources | Schedule a P2P Request (con't.)

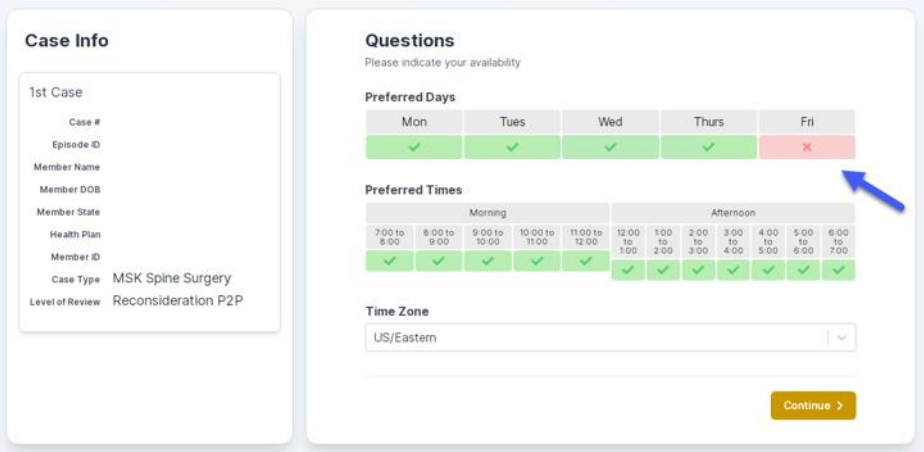


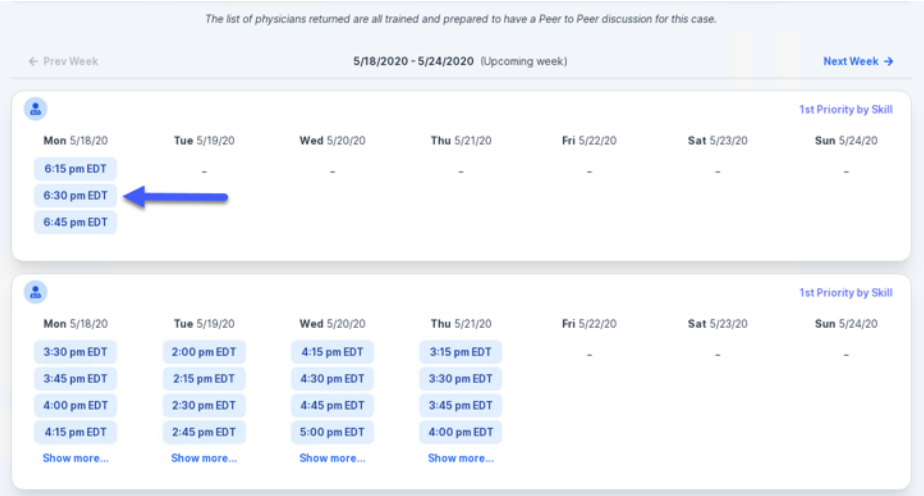
- Upon first login, you will be asked to confirm your default time zone
- You will be presented with the Case Number and Member Date of Birth
- Add another case for the same Peer-to-Peer appointment request by selecting **Add Another Case**
- To proceed, select **Lookup Cases**

- 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



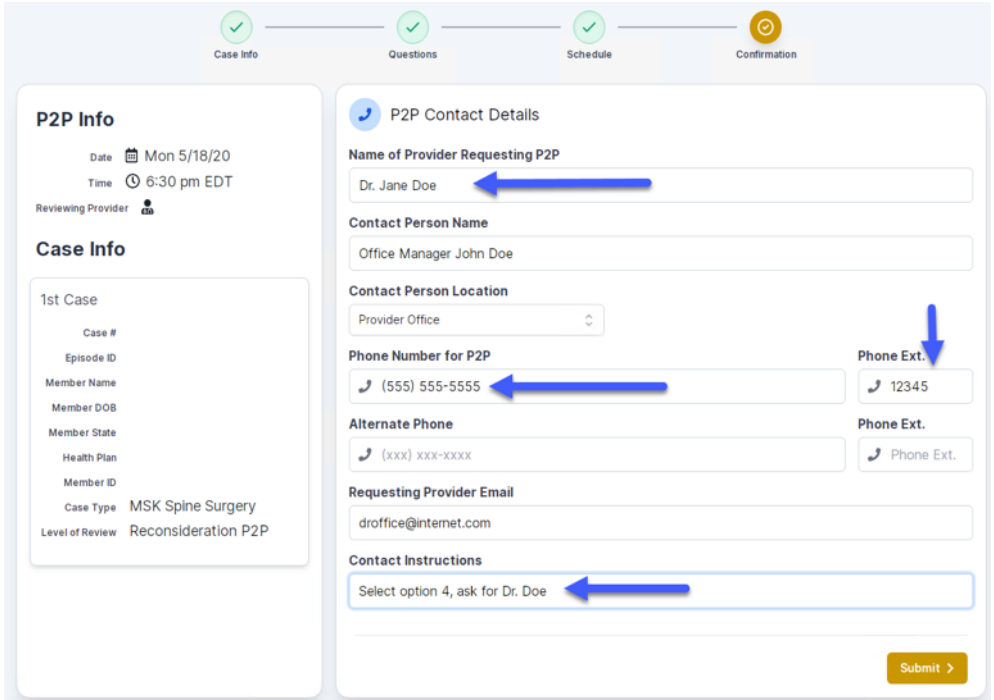
Provider Resources | Schedule a P2P Request (con't.)

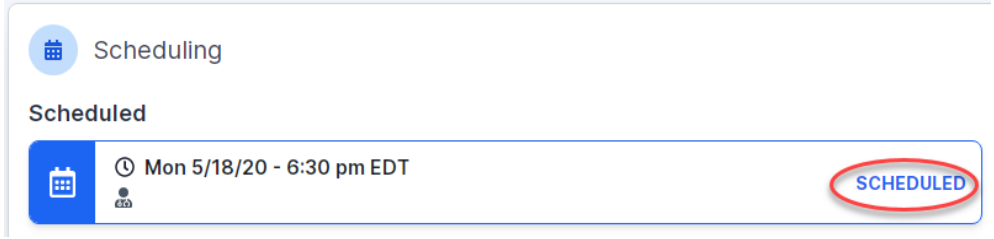




- You will be prompted with a list of eviCore Physicians / Reviewers and appointment options
- Select any of the listed appointment times to continue
- You will be prompted to identify your preferred days and times for a Peer-to-Peer consultation (all opportunities will be automatically presented)
- Click on any **green checkmark** to **deselect** that option and then click **Continue**

Provider Resources | Schedule a P2P Request (con't.)





Update the following fields to ensure the correct person is contacted for the Peer-to-Peer appointment:

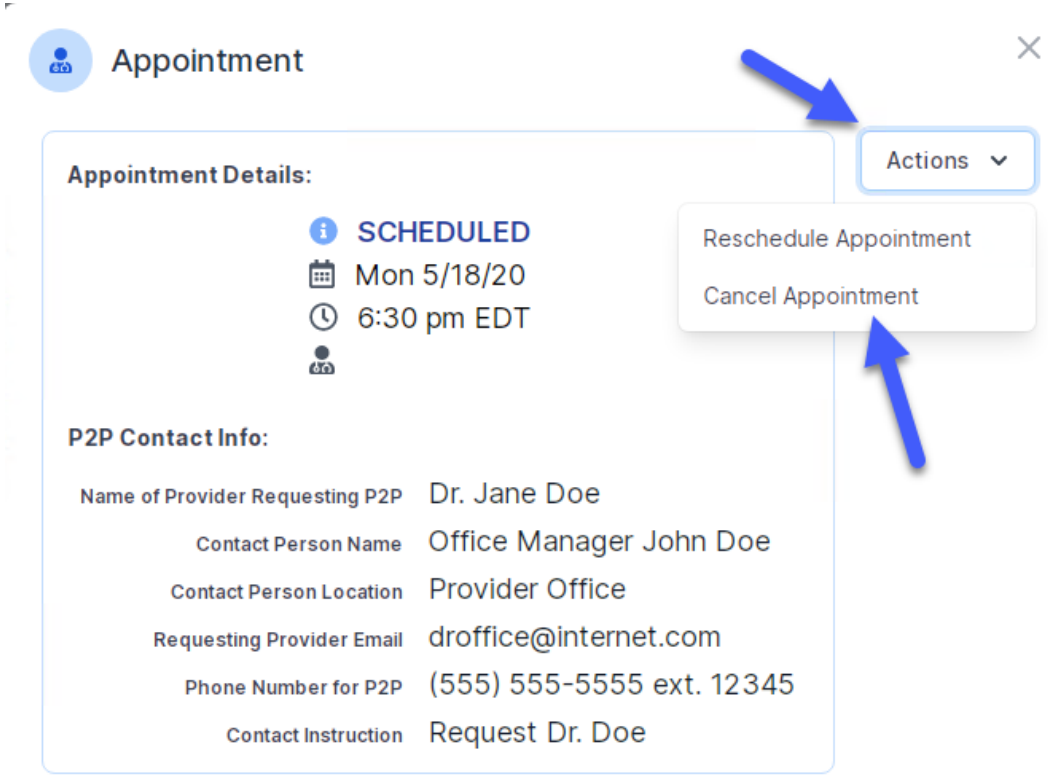
- Name of Provider Requesting P2P
- Phone Number for P2P
- Contact Instructions

Click **Submit** to schedule the appointment

You will be presented with a summary page containing the details of your scheduled appointment

Confirm contact details

Provider Resources | Cancel or Reschedule a P2P Appointment



To cancel or reschedule an appointment:

- Access the scheduling software and select **My P2P Requests** on the left-pane navigation
- Select the request you would like to modify from the list of available appointments
- When the request appears, 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,** select a new date or time as you did initially
    - **If choosing to cancel,** input a cancellation reason
- Close the browser once finished

Thank You