EviCore
By EVERNORTH

Providence MSK Specialized Therapy Program

Frequently Asked Questions

Who is EviCore?

EviCore (EviCore) is an independent specialty medical benefits management company that provides utilization management services for Providence Health Plan**.**

What is EviCore's Specialized Therapy Program?

EviCore's Specialized Therapy program, which is a part of our Musculoskeletal (MSK) solution, is a patient-centric approach to utilization management. Our program has been designed to approve the appropriate amount and duration of treatment needed to enhance patient outcomes, based on the individual patient's specific condition, via a streamlined prior authorization process.

What services are managed through EviCore's MSK Specialized Therapy Program?

EviCore manages the following specialized therapy services for Providence Health Plan. Starting January 1, 2021, Chiropractors, Acupuncturists and Massage Therapists will require prior authorization for specific therapy codes. A full list of CPT codes that require prior authorization can be found on the Providence Health Plan Resources | EviCore by Evernorth.

✓ Physical Therapy	✓ Occupational Therapy	✓ Specialty Therapy Care Providers *billing CPT codes included on the PHP CPT code list

* Specialty Therapy Care providers include Chiropractors, Acupuncturists, and Massage Therapists. Please create your request by selecting MSMPT.

Note to Chiropractors: Prior Authorization via EviCore applies to adjunct therapy ONLY

Which patients require medical necessity review?

The following patients require a medical necessity review:

- Commercial*
- Individual*
- ASO Groups *not inclusive of INTEL

*In accordance with WA RCW 48.43.016 Washington Commercial and Individual patients do not require a medical necessity review for the initial evaluation and management visit and up to 6 subsequent visits of an episode of care.

How do I verify patient eligibility?

Follow your routine Providence Health Plan process for eligibility verification. For more information, please visit https://www.providencehealthplan.com/providers/about-provlink

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Who needs to request medical necessity reviews?

Medical Necessity review requests should be submitted by the provider who will be rendering/performing the specialized therapy services.

Note: The referring provider should NOT initiate the prior authorization request.

How do I request a medical necessity review?

You may request medical necessity review online at **www.EviCore.com**. Online submissions are the quickest and most efficient way to submit requests and have the highest potential of returning an automatic approval!

You may also request a review telephonically by calling EviCore at 866-803-8052**.** EviCore is available for telephonic case initiation Monday through Friday between 7 AM and 7 PM local time (Pacific Standard Time).
Fax submissions may be submitted to 855-774-1319**,** using the applicable clinical worksheet available at: **www.EviCore.com.**

Note: Requests submitted by fax have a higher likelihood of requiring full clinical review. To avoid delays, we encourage web submission.

Does the patient's initial evaluation require a medical necessity review?

Providers must obtain authorization through EviCore for all therapy services including the initial evaluation/examination*.
To ensure claims payment, the following is recommended:

1) Evaluate your patient and submit a request to EviCore. You will be required to report minimal clinical information with the initial request.
2) In most cases, twelve (12) visits** will be granted for an initial request. The initial visit will be counted as part of the first 12 visits.
3) If additional visits are necessary, you must submit a request to EviCore to obtain a medical necessity review.

*In accordance with WA RCW 48.43.016 Washington Commercial and Individual patients do not require a medical necessity review for the initial evaluation and management visit and up to 6 subsequent visits of an episode of care.
**Based on benefit availability

Note: Requests may be submitted up to seven (7) business days prior to the treatment start date and up to forty-five (45) business days past the start date.

Important Note: Washington State RCW 48.43.016 changes what providers need to do for outpatient rehabilitation service. The health plan won't require providers to request a medical necessity review through EviCore for the first 6 treatment visits of an episode of care (active treatment within a 90day period) for outpatient rehabilitation services.

- We'll allow an initial evaluation and management visit, and up to 6 subsequent visits without a treatment plan on file.
- After the initial evaluation and management visit and 6 consecutive visits, providers **must** submit a request for medical necessity review to EviCore for any on-going treatment.

How will I know how many visits the member has used?

- Visit accumulation can be accessed via https://www.onehealthport.com/sso-payer/providence-health-plans
- Note: The Physical Medicine benefit is shared by numerous specialties. If the member is receiving care from multiple specialties, either simultaneously or within the same benefit year, coordinating use of the available visits will reduce the risk of claim denial.

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What clinical information is requested during the medical necessity review process?

The clinical information requested by EviCore during review may differ by each specialized service, patient age and condition, and request type (i.e., initial request, second or more).

Baseline clinical information typically includes:

- Diagnostic information
- History of surgery, as applicable
- Complexities and additional information about recent surgery (i.e. type and date)
- Primary area of complaint; pain distribution
- Select examination findings, i.e. range of motion and strength
- Outcome Measurement Test scores
- Standardized test scores, as applicable

Note: Refer to "*What Outcomes Measurement Tests are commonly used by EviCore?*"

The following may be collected during a review request for continuing care:

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

Can I attach additional clinical information when requesting medical necessity review?

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

- ✓ For web-initiated cases, the initial and second requests may restrict your ability to include attachments or notes for review. This is intentional. Our clinical pathways have been specifically designed to collect all clinical information we need to make a decision for a patient's condition during these intervals of treatment. Completed pathways will likely yield an immediate approval of services.
- ✓ If we are unable to render an immediate approval, and require additional clinical information for review, the option to upload attachments or notes will become available after all pathway questions are answered. Cases with uploaded clinical information or additional comments are not eligible for immediate approval and will be sent to clinical review.
- ✓ You may also include additional clinical information that you would like to consider during the review process for a fax-initiated case; however, submissions that include notes or attachments **will** require additional clinical review and are not eligible for immediate approval.

What Outcome Measurement Tests are commonly used by EviCore?

Listed below are some examples of outcome assessment tests EviCore uses during its medical necessity review process. Condition specific tools vary based on the patient's region of complaint.

✓ Neck Disability Index (NDI)	✓ Oswestry Disability Index (ODI)
✓ Lower Extremity Functional Scale (LEFS)	✓ Roland Morris Disability Index (RMDI)
✓ HOOS, JR. (For Joint Replacement)	✓ KOOS, JR. (For Joint Replacement)
✓ Disabilities of Arm, Shoulder and Hand DASH/QuickDASH)	

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

What Standardized Test Scores does EviCore consider?

EviCore considers Standardized Test Scores for Pediatric cases. Please see Appendix at bottom of page for full list.

Can an Athletic Trainer initiate a medical necessity review request to provide physical therapy?

No. The therapist is responsible for requesting medical necessity review for services.

Will separate review requests be required for a patient with two concurrent diagnoses?

No. EviCore considers all diagnoses reported during the review process and allows for collection of additional information specific to secondary treatment areas, as applicable.

Note: Separate requests for review are required if the patient is receiving care from multiple healthcare providers or specialties.

How long do I have to submit a request for medical necessity review?

In order to process claims timely, providers are encouraged to obtain authorization within seven (7) days of the requested start date. However, if a provider is unable to request authorization at the time of service, Providence will consider a retrospective request for authorization up to forty-five (45) business days after the requested start date. Retrospective requests that meet the forty-five 45 business day requirement will be processed by EviCore.

The following documentation should accompany your request to EviCore:

- List each date of service and the total # of visits you are requesting authorization for
- Initial evaluation, progress reports, and discharge summary, if applicable
- Clinical notes for each date of service you are requesting authorization for
- Functional outcome measures collected

Note: For extenuating circumstances, Providence will consider processing a retro request that is beyond forty-five (45) business day limit. Requests beyond 45 business days should be faxed to Providence at: 503-574-8179.

What do I enter as the start date on my medical necessity review request?

The Start Date should reflect the date you want the authorization to begin.

How far in advance can I submit a request for medical necessity review?

Requests for review may be submitted up to **seven (7)** business days prior to the requested start date.

Is there a timeline associated with consideration of current clinical findings?

Clinical information for adult and pediatric cases that are not neurodevelopmental must be recent. Standardized test scores for pediatrics should be dated within **one year** of the request. Requests with insufficient clinical information may be placed on hold awaiting current clinical information.

How can I request a medical necessity review for a medically urgent request?

Medically urgent requests – defined as conditions that are a risk to the patient's life, health, ability to regain maximum function or cause severe pain that may require a medically urgent procedure – may be initiated either online or via phone. All fax cases will be considered standard.

Note: Cases should not be classified as medically urgent solely for the convenience of the patient or healthcare provider

Do services provided in an inpatient setting at a hospital or in an emergency room require medical necessity review?

No. EviCore's Specialized Therapy Program manages outpatient services only. Services performed during an inpatient stay or in an emergency room setting do not require a review request per this program.

How long is an approved authorization period?

Approved coverage periods may vary based on patient age, condition, surgical history and request type (initial or subsequent). Most cases will have a 90-day coverage period, but some requests may have a coverage period of up to 180 days.

How many visits are generally approved?

For a new episode of care, typically 12 visits will be approved at the initial request. The number of visits for additional requests will vary based on each individual patient's condition, severity and complexity, and response to treatment received once provided.

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

Yes, EviCore will allow up to one (1) extension per approved coverage period for up to thirty (30) days. The extension must be requested online or telephonically before the approved coverage period expires. Date extensions cannot be requested via fax.

Can additional visits be requested?

Yes. If additional visits are medically necessary, the treating provider may submit a request to EviCore. Visits can be requested via the EviCore Portal and will require medical necessity review. Requests for additional visits will be accepted as early as seven (7) days prior to the requested start date.

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

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

- OR members two (2) business days from receipt of request
- WA members five (5) calendar days from receipt of request

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

Yes. Our decision will include the total number of visits and units approved over a specific coverage period duration.

Note: EviCore's decision is based solely on the medical necessity of the requested services and does not guarantee payment. Payment may be subject to further eligibility and benefit checks.

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What is the format of the EviCore case Number?

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

Is clinical criteria available for review?

Yes. Our clinical criteria are available online at https://www.EviCore.com/provider/clinical-guidelines

How can I track the status of my medical necessity review request?

You may track the status of your authorization request online at www.EviCore.com. After logging in, select **"Authorization Lookup"** to view the status of your request.

What information will be visible on the EviCore website?

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

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

Can I speak to a reviewer regarding a denied request?

Yes, a peer-to-peer discussion can be requested online at www.EviCore.com. After logging in and selecting "Authorization Lookup", the reconsideration options can be reviewed. When a reconsideration is appropriate there will be a button to select to schedule the peer-to-peer. This is a self-service scheduling tool and allows you to schedule the discussion at a time that you are available. You may request a peer-to-peer discussion telephonically by calling EviCore at 866-803-8052.

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

It is recommended that you utilize reconsideration processes before requesting a formal appeal. Reconsiderations may be initiated online or telephonically by calling 866-803-8052.

Note: Determination letters associated with any denied service(s) will contain additional information specific to applicable appeal processes. Claims considerations can be submitted at Fax 503-574-8179.

Where do I submit claims?

Follow your routine Providence Health Plan process for claims submission. For more information, you may also visit https://www.onehealthport.com/sso-payer/providence-health-plans.