

Chiropractic Services

Health Partners Plans

EviCore
By EVERNORTH



Agenda



Solutions Overview

Chiropractic Management

Submitting Requests

Prior Authorization Outcomes, Special Considerations & Post-Decision Options

EviCore Provider Portal

Overview, Features & Benefits

Provider Resources

Questions & Next Steps

Appendix

- Self-Service Peer-to-Peer Scheduling Tool

Solution Overview

Health Partners Plans Prior Authorization Services

Applicable Membership:

- Medicaid

Prior authorization applies to the following services:

- Physical Therapy
- Occupational Therapy
- Speech Therapy

Prior authorization from EviCore does NOT apply to services performed in:

- Emergency Rooms
- Observation Services
- Inpatient Stays



It is the responsibility of the ordering provider to request prior authorization approval for services.

Evidence-Based Guidelines

The Foundation of Our Solutions



Contributions from a panel of community physicians



Experts associated with academic institutions



Current clinical literature

Aligned with National Societies

- American Academy of **Neurology**
- American Academy of **Orthopedic Surgeons**
- American Academy of **Pediatrics**
- American Academy of **Sleep Medicine**
- American Association of **Child and Adolescent Psychiatrists**
- American Association of **Clinical Endocrinology**
- American Association of **Neurological Surgeons**
- American College of **Cardiology**
- American College of **Chest Physicians**
- American College of **Gastroenterology**
- American College of **Medical Genetics and Genomics**
- American College of **Obstetricians and Gynecologists**
- American **Massage Therapy** Association
- American **Occupational Therapy** Association
- American **Physical Therapy** Association
- American Society of **Acupuncturists**
- American Society of **Nuclear Cardiology**
- American **Speech–Language–Hearing** Association
- American **Thyroid** Association
- American **Urological** Association
- **Centers for Disease Control**
- College of American **Pathologists**
- **Endocrine** Society
- **Heart Rhythm** Society
- National Comprehensive **Cancer** Network
- North American **Spine** Society
- The Society of **Maternal-Fetal Medicine**
- United States **Food and Drug Administration**
- United States **Preventive Services** Task Force

Submitting Requests

How to Request Prior Authorization

The EviCore Provider Portal is the easiest, most efficient way to request clinical reviews and check status.

- **Save time:** Quicker process than requests by phone or fax.
- **Available 24/7.**
- **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 supporting clinical documentation, it can be uploaded on the portal.
- **View and print determination information:** Check case status in real time.
- **Dashboard:** View all recently submitted cases.
- **E-notification:** Opt to receive email notifications when there is a change to case status.
- **Duplication feature:** If you are submitting more than one request, you can duplicate information to expedite submissions.

To access the EviCore Provider Portal, visit [EviCore.com/provider](https://www.evicore.com/provider)



Phone: 888-444-6178
Monday – Friday
7AM – 7PM (local time)

Fax: 855-774-1319

Prior Authorization Process

Clinical Pathway

- 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 number of visits for a condition.
- Acknowledges complexities that may require a greater frequency or intensity of care.
- Allows providers to provide additional information for cases that are not “average.”

Prior Authorization Process

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

Medical Necessity

- There must be high-quality research supporting chiropractic treatment as a specific and effective treatment for the patient's condition.
- The condition is expected to improve significantly in a reasonable and generally predictable period of time. Treatment duration should **not** be ongoing without end.
- The amount, frequency, and length of the services must be reasonable under accepted standards of practice.
 - For these purposes, “generally accepted standards of practice” means standards that are based on credible evidence published in peer-reviewed literature or specialty society recommendations.
- The medical benefit is designed to allow treatment to return the patient to essential activities of daily living.
 - It was **not** designed to allow continued treatment to return to recreational or athletic activities.
 - It was **not** designed to cover acupuncture for the purpose of improving or maintaining general fitness.

You can view the chiropractic guidelines at <https://www.EviCore.com/provider/clinical-guidelines>

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 calendar days** of the requested start date.
- If additional care is needed:
 - You may submit your request as early as **7 calendar 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.

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

Prior Authorization Process

Timely Filing

- Health Partners Plans 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 calendar 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 **180 calendar days**. Please note that any cases after this timeframe will be expired.

Insufficient Clinical | Additional Documentation Needed

Additional Documentation to Support Medical Necessity

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 hold notification will inform the provider about what clinical information is needed as well as the **date by which it is needed**.

The Provider must submit the additional information to EviCore

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.

EviCore will review the additional documentation and reach a determination

Determination notifications will be sent.



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 provider's prescription for treatment 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 treatment.
- Clinical documentation should include the member's response to care, functional improvement, and remaining functional deficits.
- Consider whether the skills of a provider are still necessary and, if it is, identify the specific interventions that require that skill.

Tips to Improve Efficiency

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 treatment 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 treatment 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.

Prior Authorization Process | Important Concepts

Authorization decisions include:

- **Visits** - These represent the total number of visits that can be billed over the approved period.
 - **Units*** - These represent the total number of CPT codes that can be billed over the approved period.
 - **Approved Time Period**
 - **Example** - 4 visits, 16 units
 - **Units example** - $(98940 + 98943) \times 4 = 4 \text{ visits, } 8 \text{ units}$
- Tip!!!** Spread the units over the approved period to prevent a gap in care.

**Dependent upon health plan.*

Prior Authorization Process | Important Concepts

Treating Multiple Conditions

- 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 care is approved.
 - When submitting by the web, you will be asked if you are treating a second condition.
 - Answer “Yes,” then 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.

Prior Authorization Process | Important Concepts

Duplicate Care

- EviCore will approve care by two different providers within the same period only when it is medically necessary.
- If the condition being treated is the same and the member has not discontinued care with their original provider, the request for duplicate care may be denied.

Prior Authorization Process | Important Concepts

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

- Extend for the period that is needed up to a maximum of **30 days**.
- The extension must be requested prior to the expiration of the authorization.

Extensions can be requested by the following methods:

- By phone at **888-444-6178**
- Online at www.EviCore.com

Attention!

Physical Therapy, Occupational Therapy, Speech Therapy, Massage Therapy, Chiropractic Care, and Acupuncture services are eligible for case duplication and date extensions. Are you requesting one of these services?

Date Extension

Continuing Care

Continue to Build a New Case

Requests for Spine Surgery, Joint Replacement, Arthroscopy, and Pain Management, please select "Continue to Build a New Case"

Prior Authorization Process

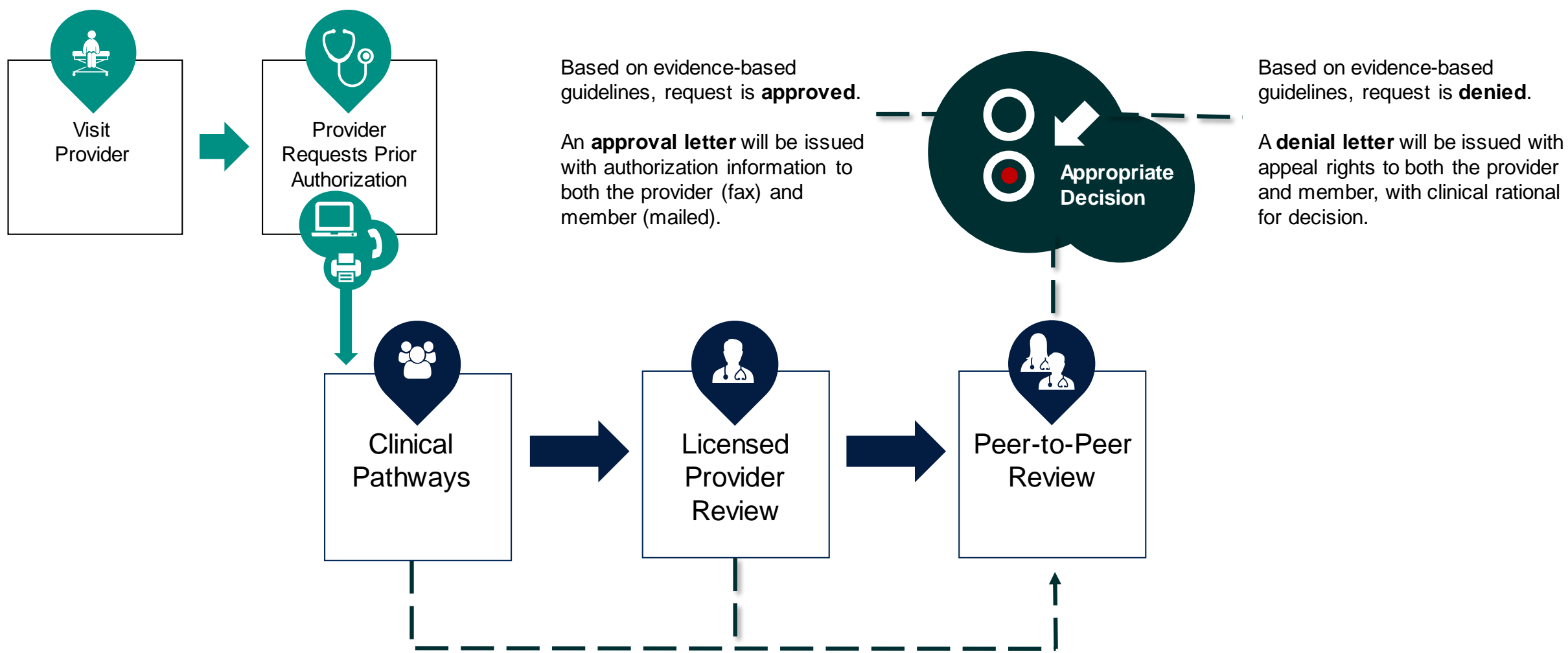
Submitting an initial request via EviCore's Provider Portal

- Submit your request within **7 days** of the requested start date.
- Start date for the request should be the date you want the authorization to begin.

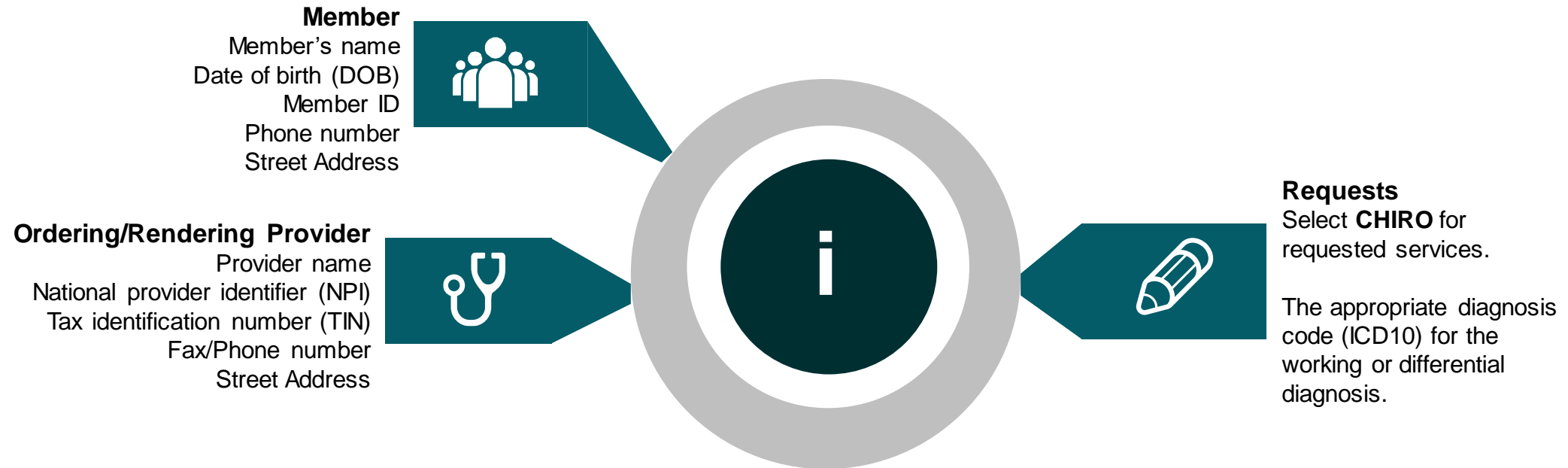
Submitting for continued care via EviCore's Provider Portal

- You may submit your request as early as **7 days** prior to the requested start date.
- The start date should be after the existing authorization expires.
- Remember to provide complete, current clinical information.
- Note: Requests with a start date of > than 7 days in the future will not be accepted. If the member is away from treatment, reassess the condition once treatment has resumed. This allows you to provide current information to allow EviCore to determine medical necessity of ongoing care.

Prior Authorization Process



Information Required for Request



Clinical information needed for requests:

- Patient's subjective complaints, objective examination findings, and quantified measures of function.
- Baseline clinical information from the initial evaluation.
- Current clinical information from follow-up visit.
- Provider's impression of the member's response to treatment (follow-up visits).
- Information from patient-reported functional outcome measures, progress notes, and/or clinical worksheets.
- Complexities that will impact the therapy plan of care.

Prior Authorization Process | Clinical Information

Clinical Information – What EviCore needs and why we need it:

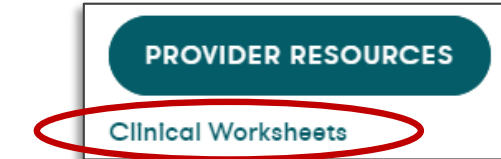
- Clinical information is required to determine whether the services requested are medically necessary.
- Use clinical worksheets located at EviCore.com as a guide to determine what clinical information is required.
 - The **clinical worksheets** are specific to conditions and designed to assist with the submission of the patient and provider information for medical necessity review.
 - Worksheets should be used as a guide for questions the provider will be prompted to answer when completing the online requests.
 - These worksheets should be completed by the provider during the initial consultation/evaluation and treatment planning, collecting the clinical information to allow for ease of submission.
 - Chiropractic, physical therapy, and occupational therapy requests have the ability for a real time decision for the first **two (2)** requests for an episode of care.
- 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.
- **Missing or incomplete clinical information will delay case processing.**

Link to Clinical Worksheets | Chiropractic Services

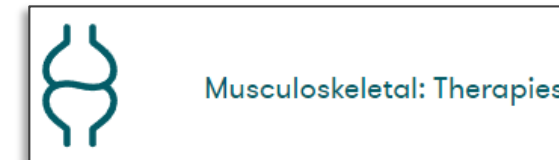
Start at EviCore.com, click on **Resources**.



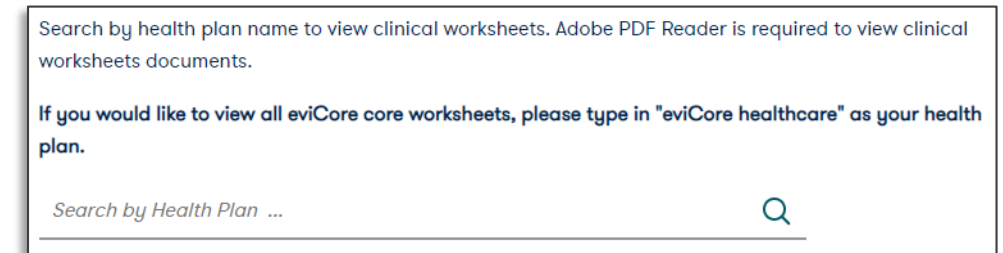
From the Resources dropdown, select **Clinical Worksheets**.



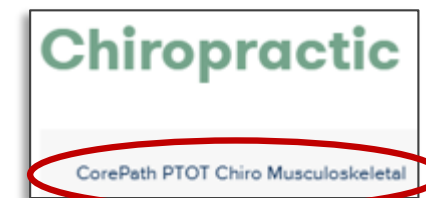
Select Musculoskeletal: **Therapies**.



Enter **Health Plan** name in the search field.



The Chiropractic **worksheets** will be listed under the **Chiropractic** header.



Chiropractic Worksheets (found [HERE](#))

 By EVERNORTH		Musculoskeletal Program: Chiropractic, Physical Therapy, and Occupational Therapy Intake Form <i>Required for all MSK Conditions (Including Hand & Pelvic Pain)</i> Please use this fax form for NON-URGENT requests only. Failure to provide all relevant information may delay the determination. Phone and fax numbers may be found on evicore.com under the Guidelines and Forms section. You may also log into the provider portal located on the site to submit an authorization request. URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE																	
Previous Reference/Auth Number (If Continued Care):		Date of Submission:																	
Service Type Requested: <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Chiropractic																			
Place of Service:																			
PATIENT	First Name:	MI:	Last Name:																
	Member ID:	DOB (mm/dd/yyyy):																	
	Street Address:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Apt #:																
	City:	State:	Zip:																
	Home Phone:	Cell Phone:	Primary: <input type="checkbox"/> Home <input type="checkbox"/> Cell																
	Member Health Plan/Insurer:																		
	I agree that the Ordering Physician on this case is a registered MD, DO, PA, or NP <input type="checkbox"/> Yes <input type="checkbox"/> No																		
	First Name:	Last Name:																	
Primary Specialty:	TIN:	NPI:																	
Physician Phone:	Physician Fax:																		
Address:	Suite #:																		
City:	State:	Zip:																	
Office Contact:	Ext:	Email:																	
PROVIDER	First Name:	Last Name:																	
	Primary Specialty:	TIN:	NPI:																
	Physician Phone:	Physician Fax:																	
	Address:	Suite #:																	
	City:	State:	Zip:																
	Office Contact:	Ext:	Email:																
	Diagnoses: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Code</th> <th style="width: 45%;">Description</th> <th style="width: 15%;">Code</th> <th style="width: 25%;">Description</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>			Code	Description	Code	Description												
	Code	Description	Code	Description															
Start Date for this Request: Is this request for fabricating a splint/orthotic or developing a home exercise program only? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, stop here. If no, please continue.</i>																			
Primary Treatment Area: Choose only one. Primary Treatment Area: Choose only one. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"> Spine: <input type="checkbox"/> Cervical / Upper Thoracic <input type="checkbox"/> Lower Thoracic / Lumbosacral Upper Extremity: <input type="checkbox"/> Shoulder / Arm <input type="checkbox"/> Elbow / Wrist / Forearm <input type="checkbox"/> Hand Lower Extremity: <input type="checkbox"/> Hip / Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot / Leg Other: <input type="checkbox"/> Pelvic Pain / Incontinence </td> <td style="width: 50%; vertical-align: top;"> Secondary Treatment Area: Choose only one. <input type="checkbox"/> No second area being treated Spine: <input type="checkbox"/> Cervical / Upper Thoracic <input type="checkbox"/> Lower Thoracic / Lumbosacral Upper Extremity: <input type="checkbox"/> Shoulder / Arm <input type="checkbox"/> Elbow / Wrist / Forearm <input type="checkbox"/> Hand Lower Extremity: <input type="checkbox"/> Hip / Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot / Leg Other: <input type="checkbox"/> Pelvic Pain / Incontinence </td> </tr> </table>				Spine: <input type="checkbox"/> Cervical / Upper Thoracic <input type="checkbox"/> Lower Thoracic / Lumbosacral Upper Extremity: <input type="checkbox"/> Shoulder / Arm <input type="checkbox"/> Elbow / Wrist / Forearm <input type="checkbox"/> Hand Lower Extremity: <input type="checkbox"/> Hip / Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot / Leg Other: <input type="checkbox"/> Pelvic Pain / Incontinence	Secondary Treatment Area: Choose only one. <input type="checkbox"/> No second area being treated Spine: <input type="checkbox"/> Cervical / Upper Thoracic <input type="checkbox"/> Lower Thoracic / Lumbosacral Upper Extremity: <input type="checkbox"/> Shoulder / Arm <input type="checkbox"/> Elbow / Wrist / Forearm <input type="checkbox"/> Hand Lower Extremity: <input type="checkbox"/> Hip / Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot / Leg Other: <input type="checkbox"/> Pelvic Pain / Incontinence														
Spine: <input type="checkbox"/> Cervical / Upper Thoracic <input type="checkbox"/> Lower Thoracic / Lumbosacral Upper Extremity: <input type="checkbox"/> Shoulder / Arm <input type="checkbox"/> Elbow / Wrist / Forearm <input type="checkbox"/> Hand Lower Extremity: <input type="checkbox"/> Hip / Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot / Leg Other: <input type="checkbox"/> Pelvic Pain / Incontinence	Secondary Treatment Area: Choose only one. <input type="checkbox"/> No second area being treated Spine: <input type="checkbox"/> Cervical / Upper Thoracic <input type="checkbox"/> Lower Thoracic / Lumbosacral Upper Extremity: <input type="checkbox"/> Shoulder / Arm <input type="checkbox"/> Elbow / Wrist / Forearm <input type="checkbox"/> Hand Lower Extremity: <input type="checkbox"/> Hip / Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot / Leg Other: <input type="checkbox"/> Pelvic Pain / Incontinence																		

Member Name: _____	Member ID: _____	Provider Name: _____
Date of initial evaluation: _____	Date of current findings: _____	
Previous Treatment		
Has the member been treated for any other condition in the past 6 months? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Spine: <input type="checkbox"/> Cervical / Upper Thoracic <input type="checkbox"/> Lower Thoracic / Lumbosacral Upper Extremity: <input type="checkbox"/> Shoulder / Arm <input type="checkbox"/> Elbow / Wrist / Forearm <input type="checkbox"/> Hand Lower Extremity: <input type="checkbox"/> Hip / Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Ankle / Foot / Leg Other: <input type="checkbox"/> Pelvic Pain / Incontinence <input type="checkbox"/> Neurologic/Developmental Condition <input type="checkbox"/> Lymphedema <input type="checkbox"/> Vestibular		
Please ONLY complete the following section(s) based upon the Treatment Area(s) selected above. Information specific to the Primary Treatment Area MUST be completed.		
CERVICAL / UPPER THORACIC	TREATMENT AREA: Cervical / Upper Thoracic	
	Post-Surgical Care: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, Date of Surgery:</i> _____	
	Surgery Type: <input type="checkbox"/> Decompression <input type="checkbox"/> Discectomy <input type="checkbox"/> Fusion <input type="checkbox"/> Total Disc Replacement <input type="checkbox"/> Fracture/ORIF <input type="checkbox"/> Post-mastectomy <input type="checkbox"/> Other	
	Complete the following section for initial OR follow-up care as appropriate	
	Initial	Follow-Up
	Functional Assessment Used: <input type="checkbox"/> Neck Disability Index score (NDI) (0-100%) <input type="checkbox"/> FOTO Neck (Focus on Therapeutic Outcomes) <input type="checkbox"/> Other/No Functional Assessment: _____	
	Neck Disability Index score (NDI): _____ Current: _____ Initial score: _____	
	Weakness, sensory changes or radiating pain below elbow: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Number of episodes in past 3 yrs: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >4 <input type="checkbox"/> N/A N/A - Leave Blank for Follow-Up Request	
	Has pt. responded as expected? N/A - Leave Blank for Initial Request <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Indicate the reason below)</i> <input type="checkbox"/> "Overdid" activities/exercise causing increase in symptoms <input type="checkbox"/> Progression of symptoms despite treatment <input type="checkbox"/> Suffered a new injury resulting in significant change <input type="checkbox"/> Unable to complete clinical visits/home program <input type="checkbox"/> Patient is post-surgery with signs of infection N/A - Leave Blank for Initial Request	
UPPER EXTREMITY (ALL CONDITIONS)	TREATMENT AREA: Upper Extremity (All Conditions)	
	Post-Surgical Care: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, Date of Surgery:</i> _____	
	Side(s): <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral	
	<i>If yes, Indicate Type of Surgery from Selection Below:</i>	
	Shoulder/Arm: <input type="checkbox"/> Rotator Cuff <input type="checkbox"/> Total Shoulder <input type="checkbox"/> Biceps/SLAP Repair <input type="checkbox"/> Instability <input type="checkbox"/> Fracture/ORIF <input type="checkbox"/> Sub-Acromial Decompression <input type="checkbox"/> MUA <input type="checkbox"/> Post-mastectomy <input type="checkbox"/> Other Elbow / Wrist / Forearm / Hand: <input type="checkbox"/> Tendon Repair/Debridement <input type="checkbox"/> Ligament Repair <input type="checkbox"/> Fracture/ORIF <input type="checkbox"/> Carpal Tunnel Release <input type="checkbox"/> Other Nerve Procedure <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Debridement/Infection <input type="checkbox"/> Osteochondral/Microfracture <input type="checkbox"/> MUA <input type="checkbox"/> Post-mastectomy <input type="checkbox"/> Other	
	Complete the following section below for initial OR follow-up care as appropriate	
	Functional Assessment Used: <input type="checkbox"/> DASH (0-100) <input type="checkbox"/> QuickDASH (0-100) <input type="checkbox"/> FOTO Shoulder <input type="checkbox"/> FOTO Elbow/Wrist/Hand <input type="checkbox"/> Other/No Functional Assessment: _____	
	Initial	Follow-Up
	Enter Score: _____ Current score: _____ Initial score: _____	
	More than 3 blank answers? <input type="checkbox"/> Yes <input type="checkbox"/> No N/A - Leave Blank for Follow-Up Request Shoulder / Elbow: Does your patient demonstrate (choose all that apply) <input type="checkbox"/> Loss of 15 degrees or more of elbow extension <input type="checkbox"/> Recurrent subluxation/dislocation of shoulder <input type="checkbox"/> Measurable (less than 4/5) weakness of shoulder joint in at least 2 of the following motions (Abduction, Flexion, Extension, Rotation, Extension) <input type="checkbox"/> Shoulder flexion OR abduction less than 120 degrees <input type="checkbox"/> Fracture of humeral head, greater tuberosity, OR olecranon process <input type="checkbox"/> Patient has post-surgery swelling of Grade 2 or more (moderate) <input type="checkbox"/> None of the above	

Chiropractic Worksheets (found [HERE](#))

Member Name:		Member ID:		Provider Name:	
HAND/WRIST ONLY: Does your patient demonstrate (choose all that apply)		<input type="checkbox"/> Crush injury OR fracture of distal radius or olecranon <input type="checkbox"/> Total active range of motion of the thumb less than 100 degrees <input type="checkbox"/> Total active range of motion of any other finger less than 130 degrees <input type="checkbox"/> Post-surgical or post-traumatic swelling of grade 2 or more (moderate) <input type="checkbox"/> None of the above			
Patient responded as expected?		N/A – Leave Blank for Initial Request		<input type="checkbox"/> Yes <input type="checkbox"/> No (Indicate the reason below)	
		N/A – Leave Blank for Initial Request		<input type="checkbox"/> "Overdid" activities causing increase in symptoms <input type="checkbox"/> Progression of symptoms despite treatment <input type="checkbox"/> Suffered a new injury resulting in significant change <input type="checkbox"/> Unable to participate in clinical visits/home program <input type="checkbox"/> Patient is post-surgery with signs of infection	
Please ONLY complete the following section(s) based upon the Treatment Area(s) selected. Information specific to the Primary Treatment Area MUST be completed.					
LOWER THORACIC / LUMBOSACRAL	TREATMENT AREA: Lower Thoracic / Lumbosacral				
	Post-Surgical Care: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date of Surgery:				
	Surgery Type: <input type="checkbox"/> Decompression <input type="checkbox"/> Discectomy <input type="checkbox"/> Fusion <input type="checkbox"/> Total Disc Replacement <input type="checkbox"/> Fracture/ORIF <input type="checkbox"/> Scoliosis/Deformity <input type="checkbox"/> Other				
	Complete the following section for initial OR follow-up care as appropriate				
	Functional Assessment Used: <input type="checkbox"/> Oswestry Disability Index (ODI) (0-100%) <input type="checkbox"/> Roland Morris Questionnaire (RMQ) (0-24) <input type="checkbox"/> FOTO Low Back (Focus on Therapeutic Outcomes) <input type="checkbox"/> Other/No Functional Assessment				
	Enter Score:		Initial Follow-Up		
	Number of episodes in past 3 yrs: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >4 <input type="checkbox"/> N/A		Current score Initial score		
	Does your patient demonstrate either of the following:		N/A – Leave Blank for Follow-Up Request		
	Has pt. responded as expected?		N/A – Leave Blank for Initial Request		
			<input type="checkbox"/> Yes <input type="checkbox"/> No (Indicate the reason below) <input type="checkbox"/> "Overdid" activities causing increase in symptoms <input type="checkbox"/> Progression of symptoms despite treatment <input type="checkbox"/> Suffered a new injury resulting in significant change <input type="checkbox"/> Unable to participate in clinical visits/home program <input type="checkbox"/> Patient is post-surgery with signs of infection		
LOWER EXTREMITY (ALL CONDITIONS)	TREATMENT AREA: Lower Extremity (All Conditions)				
	Side(s): <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral				
	Post-Surgical Care: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date of Surgery:				
	Indicate Type of Surgery from Selection Below:				
	Knee: <input type="checkbox"/> Total/Partial Replacement <input type="checkbox"/> Ligament Reconstruction <input type="checkbox"/> Arthroscopy (not ligament) <input type="checkbox"/> Fracture/ORIF <input type="checkbox"/> Osteochondral/Microfracture <input type="checkbox"/> Quadriceps/Patella Tendon Repair <input type="checkbox"/> MUA <input type="checkbox"/> Other				
	Hip: <input type="checkbox"/> Total/Partial Replacement/Resurfacing <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Fracture/ORIF <input type="checkbox"/> Open Bursectomy/Capsulectomy <input type="checkbox"/> Other				
	Ankle/Foot/ Leg: <input type="checkbox"/> Total Ankle Replacement <input type="checkbox"/> Achilles/Other Tendon Repair <input type="checkbox"/> Bunion Surgery <input type="checkbox"/> Ligament Reconstruction <input type="checkbox"/> Osteochondral/ Microfracture <input type="checkbox"/> Fracture/ORIF <input type="checkbox"/> Other				
	Complete the following section for initial or follow-up care as appropriate.				
	Functional Assessment Used: <input type="checkbox"/> LEFS (0-80 score) <input type="checkbox"/> HOOS Jr (0-100 interval score) <input type="checkbox"/> KOOS Jr (0-100 interval score) Choose only one. <input type="checkbox"/> FOTO Hip/Knee/Ankle/Foot (Focus on Therapeutic Outcomes) <input type="checkbox"/> Other / No Functional Assessment				
	Functional Score:		Initial Follow-Up		
Does your patient demonstrate:		Current score Initial score			
		N/A – Leave Blank for Initial Request			
		<input type="checkbox"/> Loss of 10 degrees or more of knee extension OR less than 5 degrees of ankle dorsiflexion			

Member Name:		Member ID:		Provider Name:	
		<input type="checkbox"/> Grade 3 or 4 laxity of the ankle or distal tibial-fibular joint <input type="checkbox"/> Tinetti Gait/Balance score < 24 OR Berg Balance test < 40 OR TUG test > 13.5 sec Measurable (less than 4/5) weakness of hip joint in at least 2 of the following motions (Abduction, Flexion, External Rotation, Extension) <input type="checkbox"/> None of the above			
Has pt. responded as expected?		N/A – Leave Blank for Initial Request		<input type="checkbox"/> Yes <input type="checkbox"/> No (Indicate the reason below)	
		N/A – Leave Blank for Initial Request		<input type="checkbox"/> "Overdid" activities causing increase in symptoms <input type="checkbox"/> Progression of symptoms despite treatment <input type="checkbox"/> Suffered a new injury resulting in significant change <input type="checkbox"/> Unable to complete clinical visits/home program <input type="checkbox"/> Patient is post-surgery with signs of infection and/or persistent swelling of grade 2 or more (moderate)	
Please ONLY complete the following section(s) based upon the Treatment Area(s) selected above. Information specific to the Primary Treatment Area MUST be completed.					
Pelvic Pain / Incontinence	TREATMENT AREA: Pelvic Pain / Incontinence				
	Complete the following section for initial or follow-up care as appropriate.				
	Indicate which patient reported outcome score was used from the selection below. If no score, select "None Used": <input type="checkbox"/> None used				
		Initial	Follow-Up		
	<input type="checkbox"/> PFDI-20 (Pelvic Floor Distress Inventory)	Summary score (0-300)	Current score Initial score		
	<input type="checkbox"/> PFIQ-7 (Pelvic Floor Impact Questionnaire)	Summary score (0-300)	Current score Initial score		
	<input type="checkbox"/> NIH-CPSO (NIH – Chronic Prostatitis Symptom Index)	Summary score (0-43)	Current score Initial score		
	<input type="checkbox"/> ODI (Oswestry Disability Index)	% (0-100)	Current score % Initial score %		
	<input type="checkbox"/> FOTO Urinary Problems (Focus on Therapeutic Outcomes)		Current score Initial score		
	<input type="checkbox"/> FOTO Pelvic Floor Dysfunction (Focus on Therapeutic Outcomes)		Current score Initial score		
<input type="checkbox"/> FOTO Bowel Constipation (Focus on Therapeutic Outcomes)		Current score Initial score			
<input type="checkbox"/> FOTO Bowel Leakage (Focus on Therapeutic Outcomes)		Current score Initial score			
<input type="checkbox"/> Other/No Functional Assessment		Current score Initial score			
Does your patient demonstrate:		<input type="checkbox"/> Iliac crest height OR Pubic symphysis asymmetry <input type="checkbox"/> Positive provocative S.I. test OR Sacral torsion <input type="checkbox"/> INABILITY to perform repetitive contractions of the pelvic floor muscles <input type="checkbox"/> INABILITY to relax the pelvic floor muscles <input type="checkbox"/> None of the above			
Has pt. responded as expected?		N/A – Leave Blank for Initial Request		<input type="checkbox"/> Yes <input type="checkbox"/> No (Indicate the reason below)	
		N/A – Leave Blank for Initial Request		<input type="checkbox"/> "Overdid" activities/exercise causing increase in symptoms <input type="checkbox"/> Progression of symptoms despite treatment <input type="checkbox"/> Suffered a new injury resulting in significant change <input type="checkbox"/> Unable to complete clinical visits/home program	

Chiropractic Management | Summary of Portal Benefits

- ✓ Elimination of pre-set waivers
- ✓ Increased provider satisfaction
- ✓ Reduced administrative burden for providers
- ✓ Increased opportunity for real-time decisions
- ✓ Expanded, member-focused decisions
- ✓ Decreased case review turn-around-times.
- ✓ Patients able to receive the right amount of care in a timely manner.



Prior Authorization Outcomes, Special Considerations & Post-Decision Options

Prior Authorization Outcomes

Determination Outcomes:

- **Approved Requests:** Authorizations are valid for up to **60 calendar days** from the date of approval.
- **Partially Approved Requests:** In instances where multiple CPT codes are requested, some may be approved and some denied. In these instances, the determination letter will specify what has been approved as well as post decision options for denied codes, including denied Site of Care (if applicable).
- **Denied Requests:** Based on evidence-based guidelines, if a request is determined as inappropriate, then a notification with the rationale for the decision and post decision/ appeal rights will be issued.

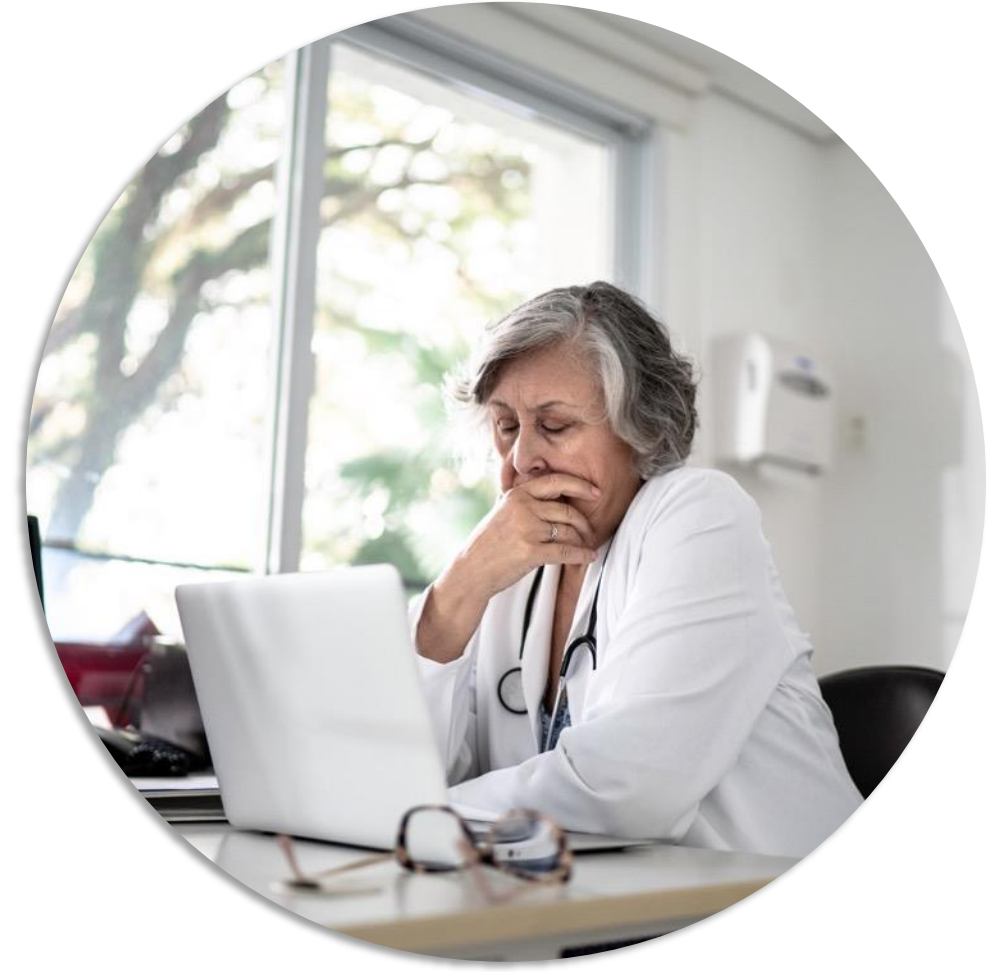
Notifications:

- Authorization letters will be faxed to the ordering provider.
- Web initiated cases will receive e-notifications when a user opts to receive.
- Members will receive a letter by mail.
- Approval information can be printed on demand from the EviCore portal: www.EviCore.com

Special Circumstances

Authorization Update

- If updates are needed on an existing authorization, you can contact EviCore by phone at **888-444-6178**.
- While EviCore needs to know if changes are made to the approved request, any change could result in the need for a separate clinical review and require a new request (and the original approved request would need to be withdrawn).
- If the authorization is not updated, it may result in a claim denial.



Post-Decision Options | 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 **888-444-6178** 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](https://www.evicore.com) to see available options.

Reconsiderations

- Reconsiderations can be requested in writing or verbally via a Clinical Consultation with an EviCore physician.
- Please refer to the determination letter for instructions.

Appeals

- EviCore **will not** process first-level appeals.
- Please refer to the determination letter for appeal options.



Special Circumstances

Retrospective (Retro) Authorization Requests

- Must be submitted within **180 calendar days** from the date of services.
- Reviewed for clinical urgency and medical necessity.
- When authorized, the start date will be the submitted date of service.
- Clinical submitted for retrospective review should include:
 - The requested number of visits and date range.
 - Information from patient-reported functional outcome measures, progress notes, and/or clinical worksheets.

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 cases are typically reviewed within 24 to 72 hours.



Provider Portal Overview

EviCore Provider Portal | Access and Compatibility

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

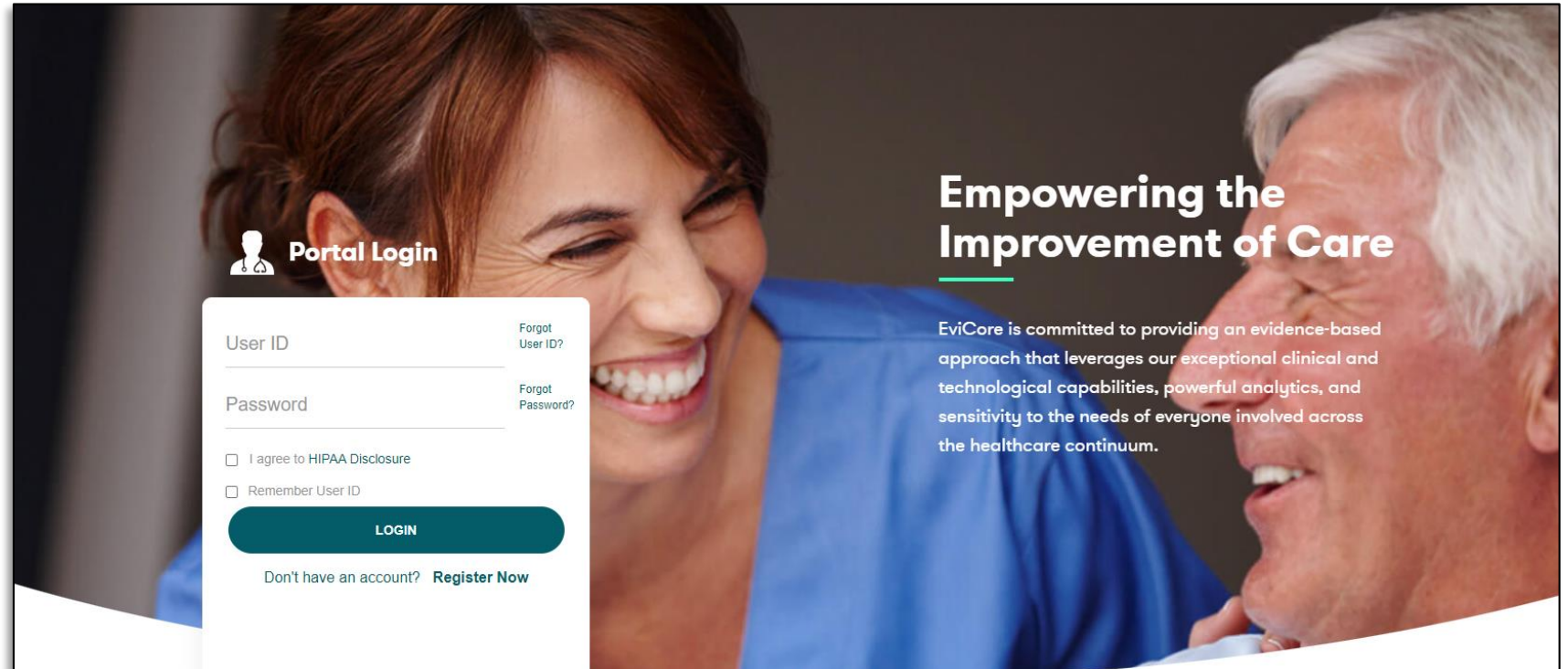
To access resources on the EviCore Provider Portal, visit EviCore.com/provider.

Already a user?

Log in with User ID & Password.

Don't have an account?

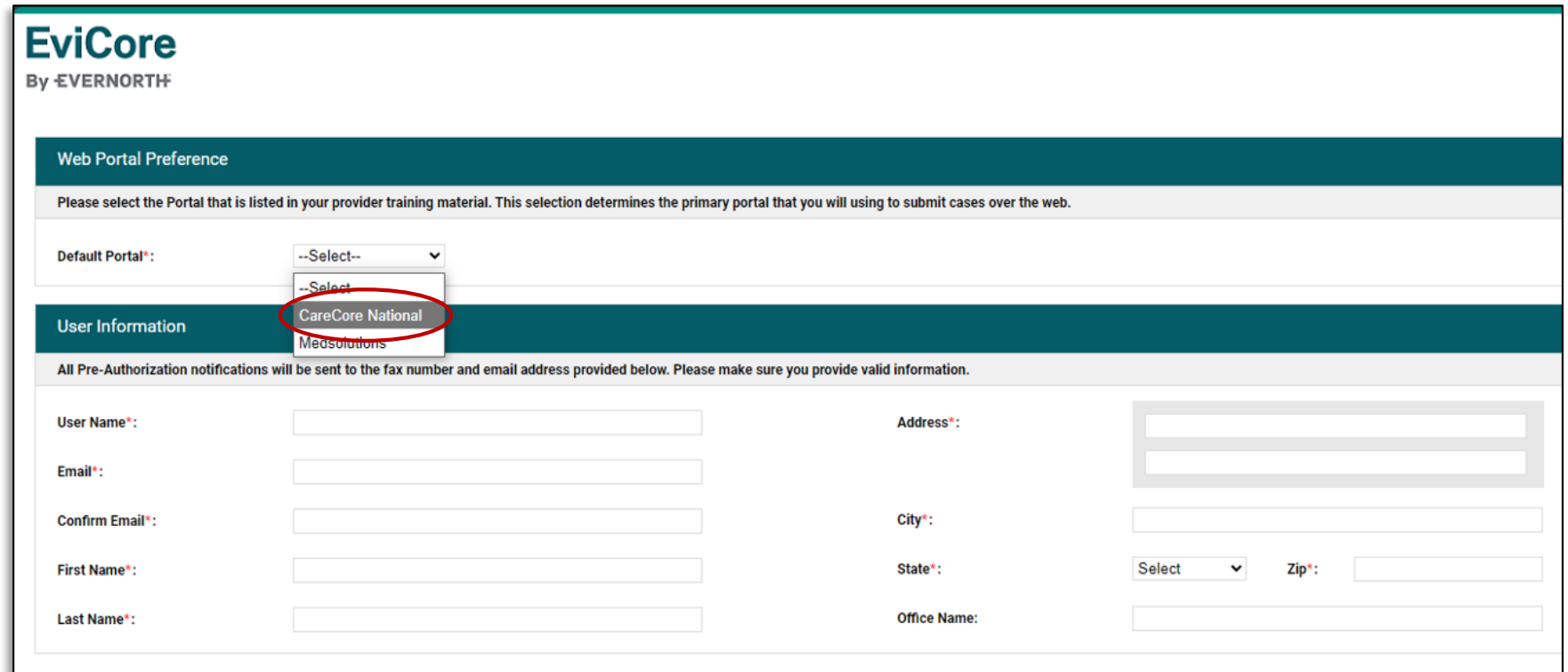
Click **Register Now**.



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.



The screenshot shows the EviCore registration form. At the top, the EviCore logo is displayed with 'By EVERNORTH' underneath. The form is divided into two main sections: 'Web Portal Preference' and 'User Information'.

Web Portal Preference: This section contains a message: 'Please select the Portal that is listed in your provider training material. This selection determines the primary portal that you will using to submit cases over the web.' Below this is a dropdown menu for 'Default Portal*'. The dropdown is open, showing two options: '--Select--' and 'CareCore National'. The 'CareCore National' option is highlighted with a red circle.

User Information: This section contains a message: 'All Pre-Authorization notifications will be sent to the fax number and email address provided below. Please make sure you provide valid information.' Below this are several input fields for user information:

- User Name* (text input)
- Email* (text input)
- Confirm Email* (text input)
- First Name* (text input)
- Last Name* (text input)
- Address* (text input)
- City* (text input)
- State* (dropdown menu with 'Select' as the current selection)
- Zip* (text input)
- Office Name (text input)

Setting Up Multi-Factor Authentication (MFA)

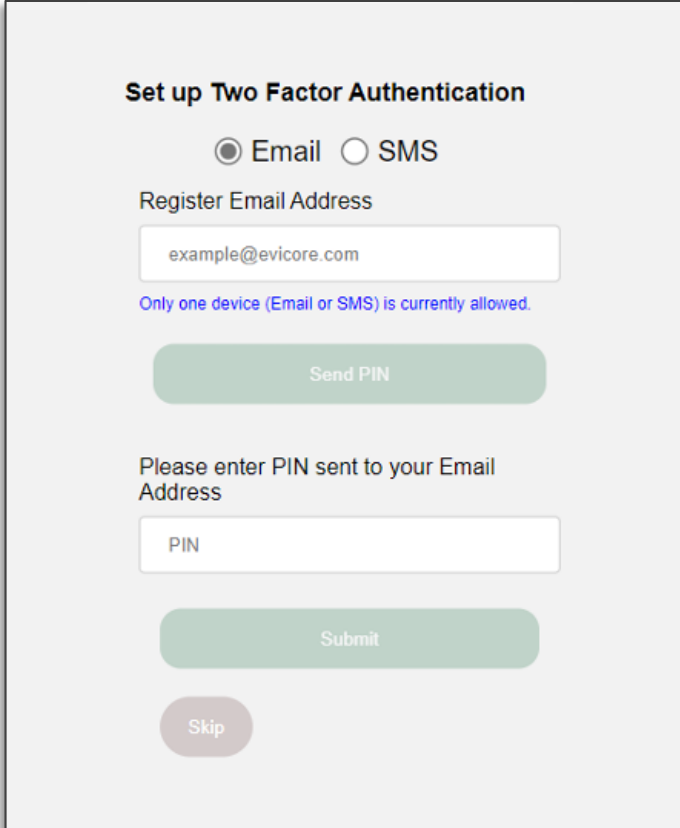
To safeguard your patients' private health information (PHI), we have implemented a multi-factor authentication (MFA) process.

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.

A screenshot of a web form titled "Set up Two Factor Authentication". At the top, there are two radio buttons: "Email" (selected) and "SMS". Below this is a label "Register Email Address" followed by a text input field containing "example@evicore.com". A small blue note below the field states "Only one device (Email or SMS) is currently allowed." Below the field is a green "Send PIN" button. Further down is a label "Please enter PIN sent to your Email Address" followed by a text input field labeled "PIN". Below this field is a green "Submit" button. At the bottom left is a grey "Skip" button.

Set up Two Factor Authentication

☒ Email ☐ SMS

Register Email Address

example@evicore.com

Only one device (Email or SMS) is currently allowed.

Send PIN

Please enter PIN sent to your Email Address

PIN

Submit

Skip

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.

Manage Your Account

Office Name:

Address:

Primary Contact:

Email Address:

ADD PROVIDER

Click Column Headings to Sort

No providers on file

CANCEL

Add Practitioner

Enter Practitioner information and find matches.
*If registering as rendering genetic testing Lab site, enter Lab Billing NPI, State and Zip

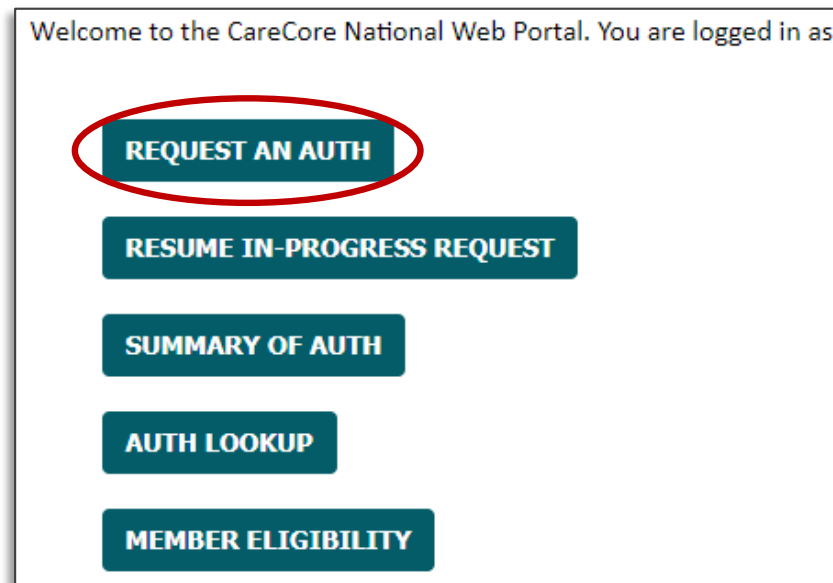
Practitioner NPI

Practitioner State

Practitioner Zip

FIND MATCHES **CANCEL**

Initiating a Case



- Click the **Clinical Certification** tab to get started.
- Choose **Request an Auth** to begin a new case request.

Select Program

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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Request an Authorization

To begin, please select a program below:

- ☐ Durable Medical Equipment(DME)
- ☐ Evicore Medical Oncology Pathways
- ☐ Gastroenterology
- ☐ Lab Management Program
- ☐ Medical Specialty Drugs
- ☒ Musculoskeletal Management
- ☐ Pharmacy Drugs (Express Scripts Coverage)
- ☐ Radiation Therapy Management Program (RTMP)
- ☐ Radiology and Cardiology/Vascular Intervention
- ☐ Sleep Management

CONTINUE

[Click here for help](#)

Attention!

Physical Therapy, Occupational Therapy, Speech Therapy, Massage Therapy, Chiropractic Care, and Acupuncture services are eligible for case duplication and date extensions. Are you requesting one of these services?

Date Extension

Continuing Care

Continue to Build a New Case

Requests for Spine Surgery, Joint Replacement, Arthroscopy, and Pain Management, please select "Continue to Build a New Case"

Always select "Build a New Case" for the 1st authorization request from EviCore.

- Select the **Program** for your certification.

Clinical Certification Request | Search and Select Provider

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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Requesting Provider Information

Select the ordering provider for this authorization request.

Filter Last Name or NPI:

SEARCH

CLEAR SEARCH

	Provider
SELECT	

If the provider's NPI is not listed above, please use the search feature below to add a new provider and continue with case build.

Search By NPI:

SEARCH

BACK

CONTINUE

[Click here for help](#)

- Search for and select the **Provider/Group** for whom you want to build a case. This is the list of providers you added to your account.
- If the **Provider/Group** is not on your list of providers added to your account, you can now **Search by NPI**.

Clinical Certification Request | Search and Select Provider

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
------	-----------------------	----------------------	--------------------	------------------------	------------------------------------	---------------------------------------	-----------	---------------------	---------------------	-------------------

Requesting Provider Information

Select the ordering provider for this authorization request.

Filter Last Name or NPI:

SEARCH

CLEAR SEARCH

Provider	
SELECT	

If the provider's NPI is not listed above, please use the search feature below to add a new provider and continue with case build.

Search By NPI:

SEARCH

	Practitioner Name	NPI	Address	City	State	ZipCode	Phone	Fax
SELECT								

BACK

CONTINUE

[Click here for help](#)

- Once the provider is found by searching **NPI**, the line will turn gray to indicate they are selected.

Attention!

Do you want to add this NPI () to your account for future requests?

YES

NO

By choosing **YES**, the practitioner will be added to the provider list in your account.

Clinical Certification Request | Select Health Plan

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
------	-----------------------	----------------------	--------------------	------------------------	------------------------------------	---------------------------------------	-----------	---------------------	---------------------	-------------------

Choose Your Insurer

Requesting Provider:

Please select the insurer for this authorization request.

Please Select a Health Plan ▼

BACK

CONTINUE

[Click here for help](#)

- Choose the appropriate **health plan** for the request.
- Another drop down will appear to select the appropriate address for the **provider**.
- Click **CONTINUE**.

Clinical Certification Request | Enter Contact Information

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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Add Your Contact Info

Provider's Name:* [?]

Who to Contact:* [?]

Fax:* [?]

Phone:* [?]

Ext.: [?]

Cell Phone:

Email:

☒ Receive notification of case status changes. Please enter email address in box above.

Please review the fax and phone numbers presented for accuracy. Change as necessary and click "Confirm Fax and Continue" to confirm they are correct. Changes apply only to this specific request. If you wish the change to be permanent, please contact the Health Plan.

[Click here for help](#)

[BACK](#) [CONFIRM FAX AND CONTINUE](#)

- Enter/edit the **provider's name** and appropriate information for the point of contact.
- Practitioner name, fax, and phone will pre-populate; edit as necessary.

The e-notification box is checked by default to enable email notices for any updates on case status changes. Make sure to uncheck this box if you prefer to receive faxed notices.

Expected Treatment Date

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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Attention!

What is the expected procedure date or treatment start date for this request? (MM/DD/20YY)

If the Date of Service is unknown, please enter today's date.

SUBMIT

Clinical Certification Request | Enter Member Information

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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Patient Eligibility Lookup

Patient ID:*

Date Of Birth:* MM/DD/YYYY

Patient Last Name Only:*

When entering patient details, please review and confirm the spelling of the patient's name. Verify accuracy of the patient's ID and date of birth.

ELIGIBILITY LOOKUP

BACK

[Click here for help](#)

- Enter **member information**, including patient ID number, date of birth, and last name.
- Click **ELIGIBILITY LOOKUP**.

Search Results

	Patient ID	Member Code	Name	DOB	Gender	Address
<div>SELECT</div>						

BACK

[Click here for help](#)

- Confirm the patient's information and click **SELECT** to continue.

Clinical Certification Request | Procedure and Diagnosis Codes

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
------	-----------------------	----------------------	--------------------	------------------------	------------------------------------	---------------------------------------	-----------	---------------------	---------------------	-------------------

Requested Service + Diagnosis

This procedure will be performed on CHANGE

Musculoskeletal Management Procedures

Select a Procedure by CPT Code[?] or Description[?]

CHIRO

CHIROPRACTIC

Don't see your procedure code or type of service? [Click here](#)

Additional Procedure codes will be collected/presented during the clinical questionnaire

Diagnosis

Primary Diagnosis Code: **M25.50**
Description: **Pain in unspecified joint**
[Change Primary Diagnosis](#)

Select a Secondary Diagnosis Code (Lookup by Code or Description)
Secondary diagnosis is optional for Musculoskeletal Management

LOOKUP

BACK

CONTINUE

- Enter **CHIRO** for Chiropractic.
- Add diagnosis code(s).

Clinical Certification Request | Verify Service Selection

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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Attention!

Patient ID:

Patient Name:

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

OK

[Print this page](#)

- Review the patient's history before proceeding to site selection.
- **Note:** Place of service can vary depending on health plan rules.

Attention!

Will the procedure be performed in your office?

Yes

No

Clinical Certification Request | Site Selection

Home

Certification Summary

Authorization Lookup

Eligibility Lookup

Clinical Certification

Certification Requests In Progress

MSM Practitioner Perf. Summary Portal

Resources

Manage Your Account

MedSolutions Portal

Help / Contact Us

Add Site of Service

Specific Site Search

Use the fields below to search for specific sites. For best results, search by NPI or TIN. Other search options are by name plus zip or name plus city. You may search a partial site name by entering some portion of the name and we will provide you the site names that most closely match your entry.

NPI:

Zip Code:

Site Name:

TIN:

City:

Exact match

Starts with

LOOKUP SITE

- Search for the **site of service** where the procedure will be performed (for best results, search with NPI, TIN, **or** zip code).
- **Select** the specific site where the procedure will be performed.

EviCore

By EVERNORTH

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48

Clinical Certification Request | Clinical Certification

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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Proceed to Clinical Information

You are about to enter the clinical information collection phase of the authorization process.

Once you have clicked "**CONFIRM AND CONTINUE**," you will not be able to edit the Provider, Patient, or Service information entered in the previous steps. Please be sure that all this data has been entered correctly before continuing.

In order to ensure prompt attention to your online request, be sure to complete the clinical review before exiting the system. Even if you will be submitting additional information at a later time, please continue through the final summary page. Failure to formally submit your full request will cause the record to expire with no additional correspondence from eviCore.

☐ I acknowledge that the clinical information I am about to submit for this authorization request is accurate and specific to this member, and that all information will be provided for this request.

BACK

CONFIRM AND CONTINUE

- Verify that all information is entered and correct.
- Check the acknowledgement statement.
- Once you enter the clinical collection phase of the process, the answers to the clinical questions will not save unless the case is completed.
- **You will not have the opportunity to make changes after this point.**

Clinical Certification Request | Standard or Urgent Request

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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Proceed to Clinical Information

Urgency Indicator

If the case you are submitting is found NOT to meet one of the two conditions below, your case will be processed as a standard/routine, non Urgent request. If you have clinical information and this request meets the criteria for urgent, please indicate below.

In order for eviCore to process this case as clinically urgent you must upload clinical documentation relevant to this case. If you are unable to upload clinical documentation at this time contact eviCore to process this case as urgent.

Please indicate if any of the following criteria are true regarding urgency of this request :

- ☒ A delay in care could seriously jeopardize the life or health of the patient or patient's ability to regain maximum function.
- ☐ A delay in care would subject the member to severe pain that cannot be adequately managed without the care or treatment requested in the prior authorization.
- ☐ None of the above

Clinical Upload

In order for eviCore to process this case as clinically urgent you must upload clinical documentation relevant to this case.

If you are unable to upload clinical documentation at this time contact eviCore to process this case as urgent.

Required Medical information checklist

Browse for file to upload (max size 25MB, allowable extensions .DOC,.DOCX,.PDF,.PNG):

Choose File No file chosen

Choose File No file chosen

Choose File No file chosen

Choose File No file chosen

Choose File No file chosen

UPLOAD

Proceed to Clinical Information

Is this case Routine/Standard?

YES

NO


- 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 5MB size)
- Your case will only be considered urgent if there is a successful upload.

Clinical Certification Request | Required Medical Information Checklist

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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Clinical Upload

In order for eviCore to process this case as clinically urgent you must upload clinical documentation relevant to this case.
If you are unable to upload clinical documentation at this time contact eviCore to process this case as urgent.

Required Medical information checklist 

Browse for file to upload (max size 25MB, allowable extensions .DOC,.DOCX,.PDF,.PNG):

No file chosen

No file chosen

No file chosen

No file chosen

No file chosen

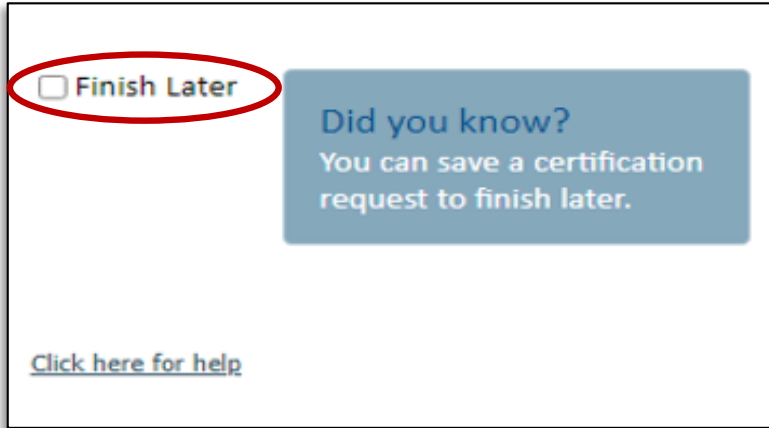
Chiropractic

- ☐ Primary and Secondary Diagnosis/ICD10
- ☐ Primary and Secondary area of treatment (i.e., neck, back, upper/lower extremity)
- ☐ Co-morbidities/Complexities that will impact the therapy plan of care
- ☐ Functional Outcome Measures/Patient Reported Outcome Scores (i.e., Oswestry, Neck Disability)
- ☐ Results of physical performance tests relevant to the condition

- Below the Clinical Upload description, select **Required Medical Information Checklist**.
- Once you open the document, you will search for the **Specialty Therapies** section to review the list of required medical information EviCore requires in order for the prior authorization request to meet medical necessity.
- Direct link to document: [Required Medical Information Check List.pdf \(EviCore.com\)](#)

Clinical Collection

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
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☐ Finish Later

Did you know?
You can save a certification request to finish later.


[Click here for help](#)

- If you need to confirm information you've entered, or need to add additional information, check **Finish Later**, then submit.
- You will then have **until the end of the day** to complete the request.
- If needed, any changes or updates can be made by phone.

Clinical Collection | From the Clinical Worksheets


Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
------	-----------------------	----------------------	--------------------	------------------------	------------------------------------	---------------------------------------	-----------	---------------------	---------------------	-------------------

You requested a treatment start date of 05/08/2025

 Date of initial evaluation


05/08/2025



 Date of onset of CONDITION:

05/01/2025



 Enter date of current findings:

05/01/2025



- The clinical information will be considered out-of-date if the “date of current findings” is greater than **10 days** prior to the “treatment start date” for this request.
- Cases with out-of-date clinical information may be placed on hold, awaiting current clinical information. This may delay an authorization decision.

Criteria Met

You have been approved for 4 visits. Please use these visits before requesting more visits. Your therapist may submit another notification if authorization for additional care is necessary. To check for full benefits and eligibility information for the specific medical service, log in to www.premera.com as a provider and utilize the Prior Authorization tool and/or Benefit and Eligibility tool. Your case has been approved for 4 visits

Provider Name:		Contact:	Amy
Provider Address:		Phone Number:	(999) 999-9999
		Fax Number:	(999) 999-9999
Patient Name:		Patient Id:	
Insurance Carrier:			
Site Name:		Site ID:	
Site Address:			
Primary Diagnosis Code:	M54.51	Description:	Vertebrogenic low back pain
Secondary Diagnosis Code:		Description:	
CPT Code:		Description:	
Authorization Number:			
Review Date:			
Approved Treatment Start Date:			
Expiration Date:			
Status:	You have been approved for 4 visits. Please use these visits before requesting more visits. Your therapist may submit another notification if authorization for additional care is necessary. To check for full benefits and eligibility information for the specific medical service, log in to www.premera.com as a provider and utilize the Prior Authorization tool and/or Benefit and Eligibility tool. Your case has been approved for 4 visits		

- Once the clinical pathway questions are completed and the answers have met the clinical criteria, an **approval** will be issued.
- You can print the certification and store in the patient's record if needed.

Criteria Not Met

- Once you complete the clinical questions, you will have an opportunity to upload additional clinical information.
- You will also receive a summary of your request to print for your records.

Is there any additional information specific to the member's condition you would like to provide?

☐ I would like to upload a document

☐ I would like to enter additional clinical notes in the space provided

☐ I would like to upload a document and enter additional notes

☐ I have no additional information to provide at this time

PRINT

CONTINUE

Your case has been sent to Medical Review.

The prior authorization you submitted, Case A191042756, has been received. Additional case status notifications will be sent if you opted in for email notifications. Thank you.

Provider Name:		Contact:
Provider Address:		Phone Number:
		Fax Number:
Patient Name:		Patient Id:
Insurance Carrier:		
Site Name:		Site ID:
Site Address:		
Primary Diagnosis Code:	G46.3	Description: Brain stem stroke syndrome
Secondary Diagnosis Code:		Description:
Date of Service:	Not provided	
CPT Code:	70551	Description: MRI Brain W/O CONTRAST
Case Number:		
Review Date:		
Expiration Date:	N/A	
Status:	Your case has been sent to Medical Review.	
	The prior authorization you submitted, Case A191042756, has been received. Additional case status notifications will be sent if you opted in for email notifications. Thank you.	

CANCEL

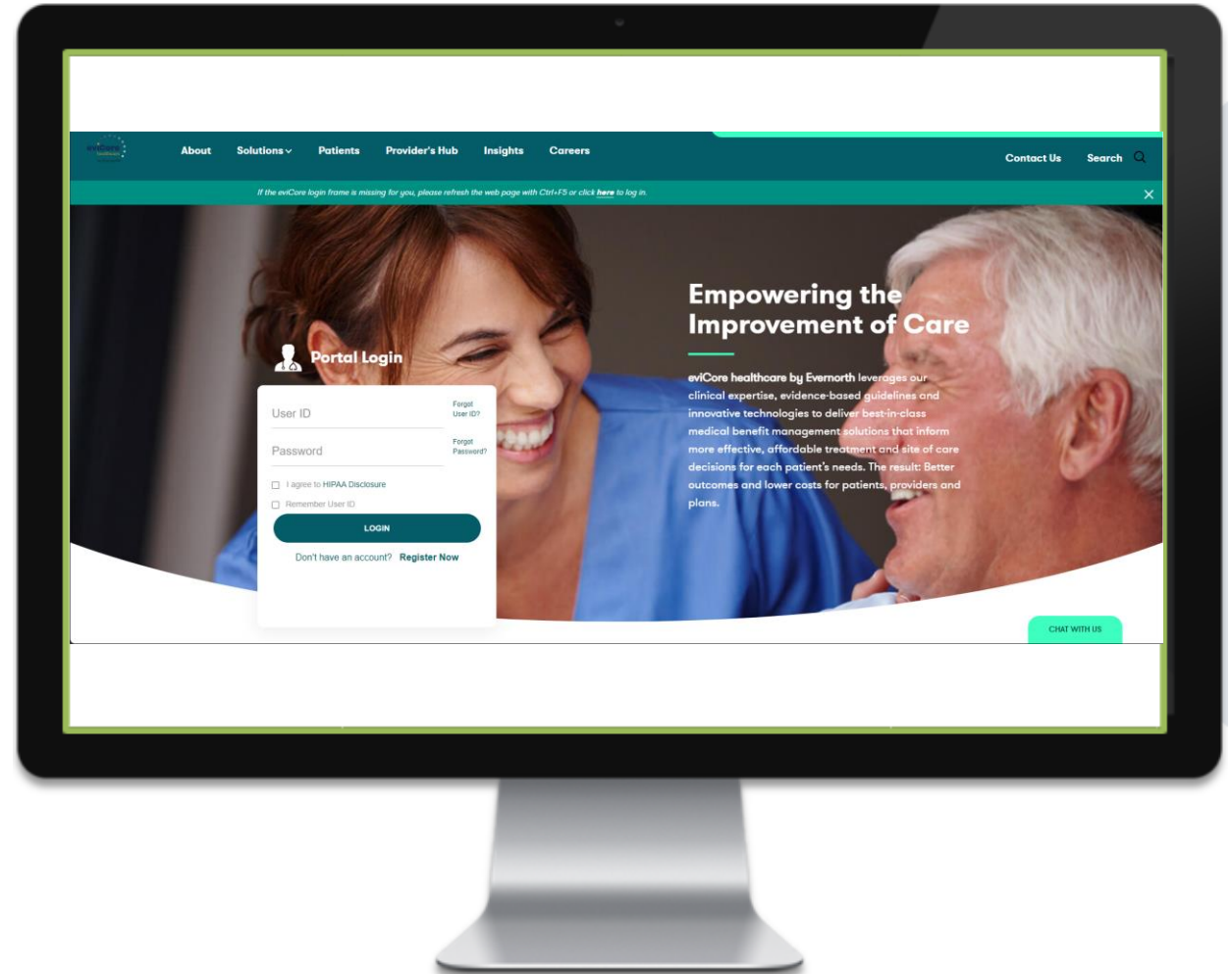
PRINT

CONTINUE

Provider Portal Demo

The EviCore online portal is the quickest, most efficient way to request prior authorization and check authorization status.

Click [HERE](#) to
view
a video demo
(2 min)



EviCore Portal Features

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

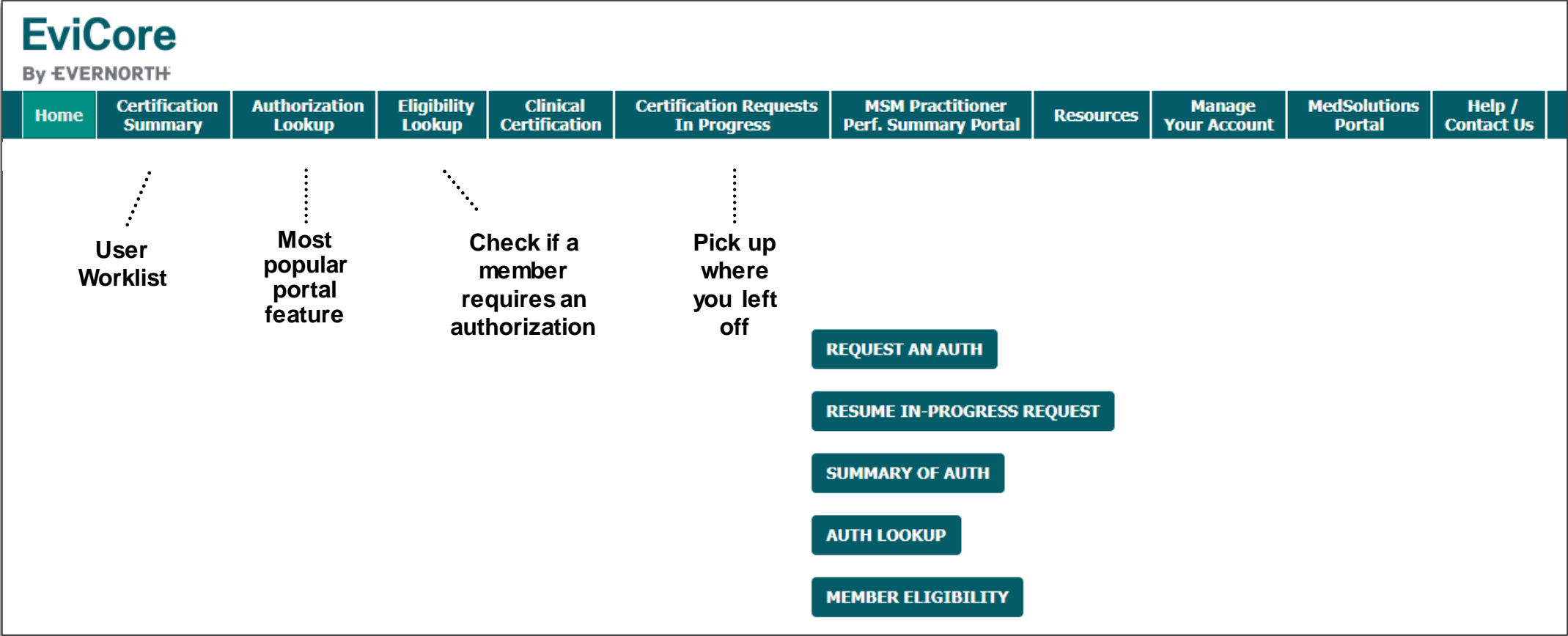
- View and print any correspondence associated with the case.
- Search by member information OR by case number with ordering national provider identifier (NPI).
- Review post-decision options, submit appeal, and schedule a peer-to-peer.

Certification Summary

- Track recently submitted cases.



Provider Portal | Feature Access



Certification Summary | User Worklist

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
------	-----------------------	----------------------	--------------------	------------------------	------------------------------------	---------------------------------------	-----------	---------------------	---------------------	-------------------

Certification Summary

Search For: All Other Programs

Search..

Page 1 of 1

10

	Authorization Number	Case Number	Member Last Name	Ordering Provider Last Name	Ordering Provider NPI	Status	Case Initiation Date	Procedure Code	Service Description
1	NA					Expired / Cancelled	05/01/2024		

Page 1 of 1

10

- The **Certification Summary** tab allows you to track recently submitted cases.
- The worklist can also be filtered.

Authorization Lookup

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	MedSolutions Portal	Help / Contact Us
------	-----------------------	----------------------	--------------------	------------------------	------------------------------------	---------------------------------------	-----------	---------------------	---------------------	-------------------

Authorization Lookup

Search by Member Information

Search by Authorization Number/NPI

OnePA: Prior Authorization Portal for Providers

Search by Claim Number/Health plan

Required Fields

Healthplan:

PRINT

[Click here for help](#)

- You can lookup an authorization case status on the portal.
- Search by member information **OR**
- Search by authorization number with ordering NPI.
- Initiate appeals and/or schedule Peer-to-Peer calls.
- View and print any correspondence.

EviCore

By EVERNORTH

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)

Provider Engagement

Regional team that works directly with the provider community.

[Provider Engagement Manager Territory List](#)



Call Center/Intake Center

Call **888-444-6178**. Representatives are available from 7 a.m. to 7 p.m. local time.

Provider Resource Website

Provider Resource Pages

EviCore's Provider Engagement team maintains provider resource pages that contain educational material to assist providers and their staff on a daily basis. The provider resource pages include, but are not limited to, the following educational material:

- Provider training material
- CPT code list
- Quick Reference Guide (QRG)
- Frequently Asked Questions (FAQ)

To access these helpful resources, please visit:

<https://www.evicore.com/resources/healthplan/health-partners-plans>

EviCore also maintains online resources not specific to health plans, such as guidelines and our required clinical information checklist.

To access these helpful resources, visit EviCore's [Provider's Hub](#).



Ongoing Provider Portal Training

The EviCore Portal Team offers general portal training, twice a week, every week.

All online orientation sessions are free of charge and last approximately one hour. Advance registration is required, so follow the instructions below to sign up:

How to register:

1. Go to <http://EviCore.webex.com/>
2. Click on the “hamburger” menu on the far left hand side (below the EviCore logo), then choose **Webex Training**.
3. On the **Live Sessions** screen, click the **Upcoming** tab. In the search box above the tabs, type: **EviCore Portal Training**.
4. Choose the date and time for the session you would like to attend, and click the **Register** link beside it. (You will need to register separately for each session.)
5. Complete the required information and click the **Register** button.

Immediately after registering, you will receive an e-mail containing the toll-free phone number, meeting number, conference password, and a link to the web portion of the conference. **Please keep the registration e-mail so you will have the Web conference information for the session in which you will be participating.**

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 **Intro to EviCore Online Resources** session to learn how to navigate [EviCore.com](https://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
- Existing prior authorization request status information
- Search for contact information
- Podcasts & insights
- Training resources

To register, go to EviCore.com, then:

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](https://www.EviCore.com).
- Scroll down to the section titled **Stay Updated With Our Provider Newsletter**.
- Enter a valid email address.



Thank You

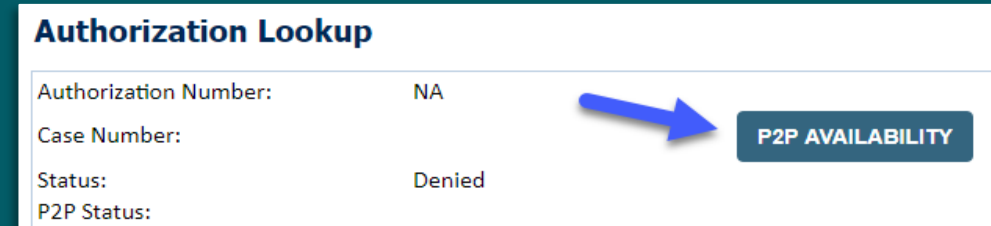
Appendix

Peer-to-Peer (P2P) Scheduling Tool

Schedule a P2P

If your case is eligible for a Peer-to-Peer (P2P) consultation, a link will display, allowing you to proceed to scheduling without any additional messaging.

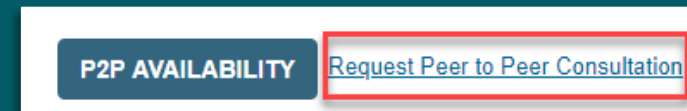
1. Log-in to your account at **EviCore.com**.
2. Perform **Clinical Review Lookup** to determine the status of your request.
3. Click on the **P2P AVAILABILITY** button to determine if your case is eligible for a Peer-to-Peer consultation
4. Note carefully any messaging that displays.*



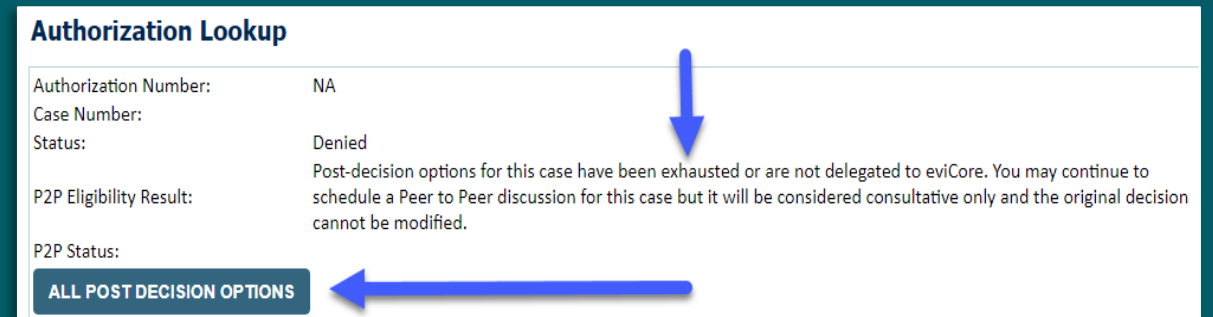
Authorization Lookup

Authorization Number:	NA
Case Number:	
Status:	Denied
P2P Status:	

A blue arrow points from the 'Status: Denied' field to a dark blue button labeled **P2P AVAILABILITY**.



A dark blue button labeled **P2P AVAILABILITY** is next to a link labeled [Request Peer to Peer Consultation](#). The link is highlighted with a red rectangular border.



Authorization Lookup

Authorization Number:	NA
Case Number:	
Status:	Denied
P2P Eligibility Result:	Post-decision options for this case have been exhausted or are not delegated to eviCore. You may continue to schedule a Peer to Peer discussion for this case but it will be considered consultative only and the original decision cannot be modified.
P2P Status:	

A blue arrow points from the 'Status: Denied' field down to a dark blue button labeled **ALL POST DECISION OPTIONS**.

*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.

Schedule a P2P

1. Upon first login, you will be asked to confirm your default time zone.
2. You will be presented with the case number and member date of birth.
3. Add another case for the same Peer-to-Peer appointment request by selecting **Add Another Case**.
4. To proceed, select **Lookup Cases**.
5. You will receive a confirmation screen with member and case information, including the level of review for the case in question.
6. Click **Continue** to proceed.

The image displays two screenshots of the EviCore 'New P2P Request' interface, illustrating the steps for scheduling a Peer-to-Peer appointment.

Top Screenshot: New P2P Request Form

- Navigation bar: Case Info, Questions, Schedule, Confirmation.
- Form fields: Case Reference Number (with placeholder text: Case information will auto-populate from prior lookup), Member Date of Birth.
- Buttons: + Add Another Case, Lookup Cases >

Bottom Screenshot: New P2P Request Confirmation

- Case Ref #: [Case Reference Number] (indicated by a blue arrow).
- Buttons: Remove, P2P Eligible (indicated by a blue arrow).
- Message: Reconsideration allowed through eviCore until 11/11/2020 12:00:00 AM. (indicated by a blue arrow).
- Member Information:
 - Name
 - DOB
 - State
 - Health Plan
 - Member ID
- Case P2P Information:
 - Episode ID
 - P2P Valid Until: 2020-11-11
 - Modality: MSK Spine Surgery
 - Level of Review: Reconsideration P2P (indicated by a blue arrow)
 - System Name: ImageOne
- Button: Continue (indicated by a blue arrow).

Schedule a P2P

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

Case Info

1st Case

Case #

Episode ID

Member Name

Member DOB

Member State

Health Plan

Member ID

Case Type

Level of Review

MSK Spine Surgery

Reconsideration P2P

Questions

Please indicate your availability

Preferred Days

Mon	Tues	Wed	Thurs	Fri
✓	✓	✓	✓	✗

Preferred Times

Morning					Afternoon						
7:00 to 8:00	8:00 to 9:00	9:00 to 10:00	10:00 to 11:00	11:00 to 12:00	12:00 to 1:00	1:00 to 2:00	2:00 to 3:00	3:00 to 4:00	4:00 to 5:00	5:00 to 6:00	6:00 to 7:00
✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Time Zone

US/Eastern

Continue >

The list of physicians returned are all trained and prepared to have a Peer to Peer discussion for this case.

← Prev Week

5/18/2020 - 5/24/2020 (Upcoming week)

Next Week →

1st Priority by Skill

Mon 5/18/20	Tue 5/19/20	Wed 5/20/20	Thu 5/21/20	Fri 5/22/20	Sat 5/23/20	Sun 5/24/20
6:15 pm EDT	-	-	-	-	-	-
6:30 pm EDT						
6:45 pm EDT						

1st Priority by Skill

Mon 5/18/20	Tue 5/19/20	Wed 5/20/20	Thu 5/21/20	Fri 5/22/20	Sat 5/23/20	Sun 5/24/20
3:30 pm EDT	2:00 pm EDT	4:15 pm EDT	3:15 pm EDT	-	-	-
3:45 pm EDT	2:15 pm EDT	4:30 pm EDT	3:30 pm EDT			
4:00 pm EDT	2:30 pm EDT	4:45 pm EDT	3:45 pm EDT			
4:15 pm EDT	2:45 pm EDT	5:00 pm EDT	4:00 pm EDT			
Show more...	Show more...	Show more...	Show more...			

Schedule a P2P


1. 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
2. Click **Submit** to schedule the appointment.
3. You will be presented with a summary page containing the details of your scheduled appointment.
4. Confirm contact details.




The screenshot shows a web form for scheduling a Peer-to-Peer (P2P) appointment. At the top, there is a progress bar with four steps: Case Info (checked), Questions (checked), Schedule (checked), and Confirmation (active, indicated by a yellow circle). The form is divided into two main sections. The left section, titled 'P2P Info', contains fields for Date (Mon 5/18/20), Time (6:30 pm EDT), and a 'Reviewing Provider' dropdown. Below this is a 'Case Info' section with a table listing case details: Case #, Episode ID, Member Name, Member DOB, Member State, Health Plan, Member ID, Case Type (MSK Spine Surgery), and Level of Review (Reconsideration P2P). The right section, titled 'P2P Contact Details', contains several input fields: 'Name of Provider Requesting P2P' (with a blue arrow pointing to it), 'Contact Person Name', 'Contact Person Location' (a dropdown menu), 'Phone Number for P2P' (with a blue arrow pointing to it), 'Phone Ext.' (with a blue arrow pointing to it), 'Alternate Phone', 'Phone Ext.' (with a blue arrow pointing to it), 'Requesting Provider Email', and 'Contact Instructions' (with a blue arrow pointing to it). A 'Submit' button is located at the bottom right of the form.

The screenshot shows a 'Scheduling' summary page. At the top, there is a 'Scheduling' header with a calendar icon. Below this, the word 'Scheduled' is displayed. A summary bar shows the appointment date and time: 'Mon 5/18/20 - 6:30 pm EDT'. To the right of this bar, the word 'SCHEDULED' is enclosed in a red circle, indicating the appointment status.


P2P Contact Details

1. Use the radio button option to select who will perform the P2P with the EviCore Medical Director.
2. Open fields will manually open to input the provider's first, last name, and their credential.

 **P2P Contact Details**


Appointment Details
 Fri 5/24/2024
 7:00 am PDT
 Tamara Fackler

Who will be performing the P2P consultation? *Required*
☐ Requesting Provider
☐ Contact Person
☐ Someone else

 PROVIDER

Name of Referring Physician on Case *Required*

Credential *Required*
Select... ▼

 CONTACT PERSON

Contact First Name *Required* **Contact Last Name** *Required*
Contact Person Location *Required*

▼

Call Notes

1. Use the radio button to select options if applicable.
2. If “Procedure was performed on” is selected, then the date is required.

Contact Instructions

Call Notes

☐ ALT REC declined

☐ Procedure was performed on:

☐ Caller requested MD Specialty match

☐ Appeal LOR attestation requirement

☐ OH State Regulation: Member Consent obtained

☐ TX licensed physician - Caller is aware P2P does not meet SSL match and wants to proceed with P2P per same-specialty match requirement.

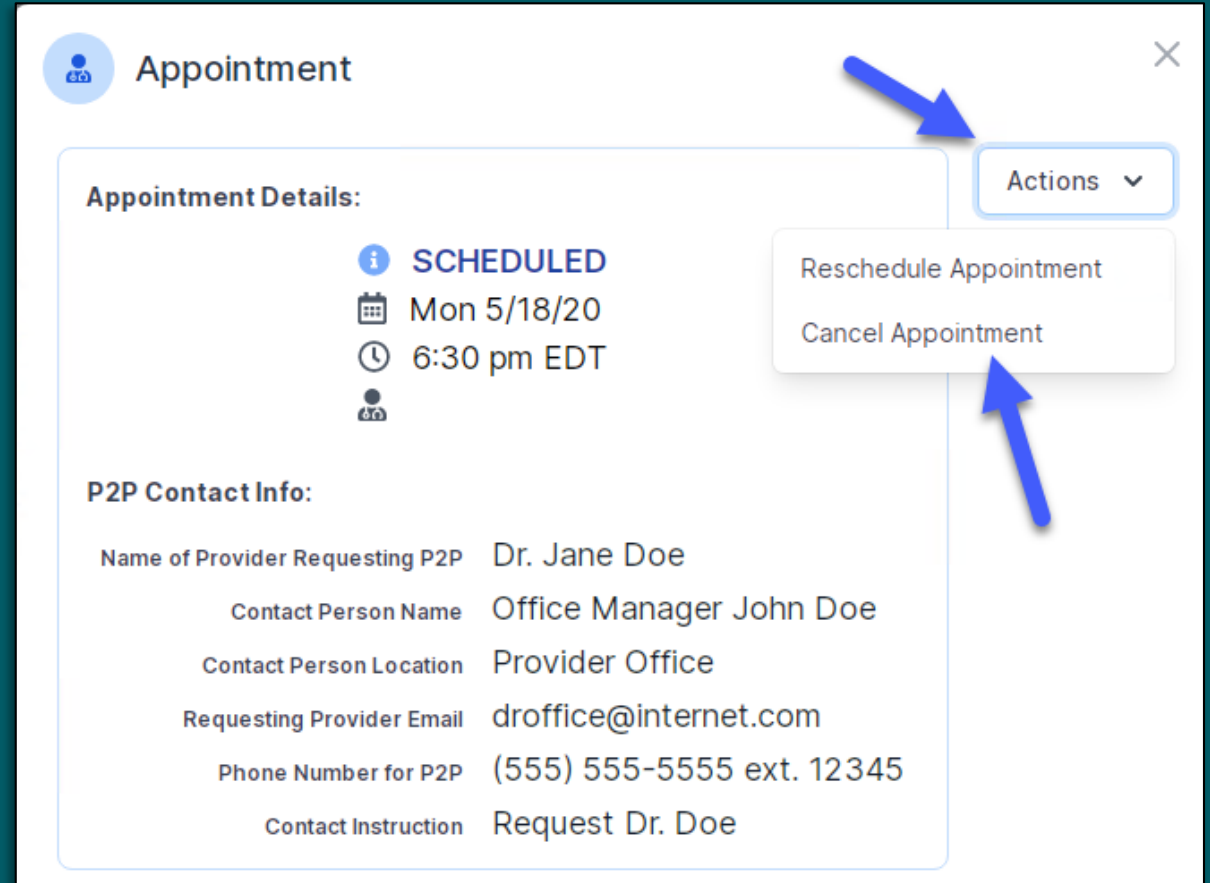
☐ TX licensed same specialty - Caller is aware P2P does not meet TX SSL/specialty match and wants to proceed with P2P

Schedule Appointment

Cancel or Reschedule a P2P Appointment

To cancel or reschedule an appointment:

1. Access the scheduling software and select **My P2P Requests** on the left-pane navigation.
2. Select the request you would like to modify from the list of available appointments.
3. When the request appears, click on the schedule link. An appointment window will open.
4. 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.
5. Close the browser once finished.



The screenshot shows a window titled "Appointment" with a close button (X) in the top right corner. The window is divided into two main sections: "Appointment Details:" and "P2P Contact Info:". The "Appointment Details:" section includes a status icon (info) and the text "SCHEDULED", followed by a calendar icon and "Mon 5/18/20", a clock icon and "6:30 pm EDT", and a person icon. The "P2P Contact Info:" section contains a table with the following information:

Name of Provider Requesting P2P	Dr. Jane Doe
Contact Person Name	Office Manager John Doe
Contact Person Location	Provider Office
Requesting Provider Email	droffice@internet.com
Phone Number for P2P	(555) 555-5555 ext. 12345
Contact Instruction	Request Dr. Doe

On the right side of the window, there is an "Actions" drop-down menu. A blue arrow points to this menu, and another blue arrow points to the "Cancel Appointment" option in the expanded menu. The "Reschedule Appointment" option is also visible in the menu.