Specialty Therapy
Frequently Asked Questions (FAQs)

Who is EviCore?
EviCore is an independent specialty medical benefits management company that provides utilization management services.

Which services under the Specialty Therapy Musculoskeletal Management program require prior authorization for EOCCO?
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Chiropractic

Please refer to the list of CPT codes that require prior authorization at EOCCO Provider Resources | EviCore by Evernorth.

Which members will EviCore manage for the Specialty Therapy Musculoskeletal program?
EviCore will manage prior authorization for Specialty Therapy services for EOCCO members.

How do I check the eligibility and benefits of a member?
Member eligibility and benefits should be verified by the health plan on their Benefit Tracker before requesting prior authorization through EviCore.

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

- **Web Portal**
  The EviCore portal is the preferred method to initiate a request. It is the quickest, most efficient way to request prior authorization and is available 24/7. Providers can request authorization by visiting www.EviCore.com

- **Call Center**
  EviCore's call center is open from 7 a.m. to 7 p.m. local time. Providers and/or staff can request prior authorization and make revisions to existing cases by calling **844.303.8451.**

What are the benefits of using EviCore Web Portal?
Our web portal provides 24/7 access to submit a request or check on the status of your request. The portal also offers additional benefits for your convenience:

- **Speed** – Requests submitted online require half the time (or less) than those taken telephonically. They can often be processed immediately.
- **Efficiency** – Medical documentation can be attached to the case upon initial submission, reducing follow-up calls and consultation.
- **Real-Time Access** – Web users are able to see real-time status of a request.
- **Member History** – Web users are able to see both existing and previous requests for a member.

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What information is needed to request authorization of Physical and Occupational Therapy services?
EviCore requires clinical information to determine if services are medically necessary. Submitted cases lacking complete clinical information often take longer to process and may result in a reduction of services or denial. To reduce the time needed to create a case on the web or phone, have the following information available:

- Member information, including Name, Date of Birth, Address, Phone #, Health Plan ID
- Provider information, including Name, NPI #, TIN, Phone #, Fax #, Address, Specialty Type
- Current Clinical information
  - Adult – use EviCore's clinical worksheets to identify the clinical information needed
  - Pediatrics - use EviCore's clinical worksheets to identify the clinical information needed, including:
    - Standardized test scores within 1 year
    - Current clinical (typically collected within the prior 20 days)
- Progress toward goals
- Patient reported functional outcome measures (ODI, NDI, LEFS, HOOS JR, KOOS JR, or DASH/QuickDASH)
- Requested start date – this is the date you would like the authorization to begin.

Where can I access EviCore clinical worksheets?
EviCore's clinical worksheets are available online 24/7 and can be found by visiting the following link: Musculoskeletal: Therapies Clinical Worksheets | EviCore by Evernorth. EviCore's Clinical Worksheets were designed to collect all clinical information needed to perform a thorough medical necessity review. As such, additional information beyond the Clinical Worksheet is not necessary, but may be submitted if desired.

Where can I access EviCore's clinical guidelines?
EviCore's clinical guidelines are available online 24/7 and can be found by visiting the following link: Musculoskeletal: Advanced Procedures | EviCore by Evernorth. However, for EOCCO members, Medical Necessity decisions are made based on the Oregon Health Authority policies and guidelines: OHP Policies, Rules and Guidelines.

What do I enter as the "Start Date" on my prior authorization request?
The start date of your request should reflect the date on which therapy treatment began. For continuing care requests, the start date should reflect the first visit that requires authorization after expiration of any previously approved visits or authorization timeframe. Do not enter the first date of the member's treatment episode/evaluation for continued care requests.

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Will EviCore approve visits or units?
EviCore will approve visits for use within an approved period. Please refer to the authorization letters to clarify visits or units approved. Visits should be spread over the approved period to prevent a gap in care.

How soon can I request additional visits?
To prevent interruption in care, submit requests for additional visits **as early as 7 days prior to the requested start date.**

Will EviCore approve services performed by two providers (same specialty) within the same period of time?
EviCore authorizations for a specific specialty, such as Physical Therapy (PT), cover all conditions treated within the approved authorization period. We do allow members to switch providers without requiring a formal discharge date from the previous provider. Ultimately, it is the member's responsibility to track their benefit usage.

In cases involving duplicate providers for specialty conditions, whether in the same clinic or different clinics, approval may be granted if the clinical rationale supports the need for specialized or concurrent care. For example, the first therapist is providing care for lower back conditions, and the second therapist is providing care for vestibular problems.

Will EviCore approve services performed by two providers (different specialties) within the same period of time?
Approval of care by multiple specialties during the same authorization period depends on the conditions being treated and the providers' plans of care. EviCore may approve care from two different specialties when:

1. Providers are treating distinct conditions (e.g., Chiropractic care for a lumbar condition and Occupational Therapy for a hand injury), or
2. Providers are treating the same condition but with different goals and plans of care (e.g., PT and OT services following a brain injury). However, each discipline must have separate treatment plans.

How can I determine if services are medically necessary?
To be considered medically necessary, the following conditions must be met:

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.
- The services shall be of such a level of complexity and sophistication, or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy, by or under the supervision of a therapist.
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

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What services are not considered medically necessary?
The following services are generally not considered medically necessary.

- Service(s) that can be self-administered or safely and effectively furnished by an unskilled person without the direct or general supervision of a therapist.
- Training in nonessential self-help, recreational tasks, or sport-specific performance.
- Services related to activities for the general good and welfare of the members, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation.
- Passive modalities that extend beyond the acute phase of recovery.
- Non-skilled routine, repetitive and reinforced procedures that do not require one-to-one intervention, such as stationary bike riding, progressive resistive exercise after instruction, and passive range of motion.
- Services not provided under a therapy plan of care.
- Services provided by staff who are not qualified or appropriately supervised. (The unavailability of a competent person to provide a non-skilled service does not mean it becomes a skilled service when the therapist furnishes it.)

Can I request an extension?
Yes. A date extension can be granted for a therapy case in which a provider has visits authorized but was unable to perform those visits in the amount of time given. You may request a date extension via our web portal or telephonically by calling EviCore at 844-303-8451.

- Providers have up to 30 days from the original authorization expiration date to request an extension
- Only one (1) extension is allowed per authorization.
- Authorizations can only be extended for up to an additional 30 days.
- An extension cannot overlap with another request for the same specialty.

Does EviCore review cases retrospectively if no authorization was obtained prior to the service being performed?
Retrospective requests must be initiated within 14 calendar days following the date of service and prior to claim submission.

Important: Please have all clinical information relevant to your request available when you contact EviCore.

What is the most effective way to get authorization for urgent requests?
Urgent requests are defined as a condition that is a risk to the patient's health, ability to regain maximum function and/or the patient is experiencing severe pain that requires a medically urgent procedure. Urgent requests may be initiated on our web portal at www.EviCore.com or by contacting our contact center at **844.303.8451.** Urgent requests will be processed within 24 hours from the receipt of complete clinical information.

Note: Please select urgent for those cases that truly are urgent and not simply for a "quicker" review. Also note that if a request is selected as urgent but does not meet guidelines to be considered urgent, the case may be reassigned as a routine case.

After I submit my request, when and how will I receive the determination?

After all clinical info is received, for normal (non- urgent) requests a decision is made within 2-3 business days. The provider will be notified electronically or by fax. Determination notices are also available on the Web portal 24/7.

How long is the authorization valid?

Authorizations are typically valid for 180 days. If the service is not performed within this time frame, please contact EviCore to request an extension.

What are my options if I receive an adverse determination?

The referring and rendering provider will receive a denial letter that contains the reason for denial as well as post decision options. Please refer to the denial notices for specific case instructions.

Note: Providers can request a Clinical Consultation / peer-to-peer (P2P) discussion with an EviCore Medical Director to better understand the decision rationale. However, the P2P discussion will not change the determination.

How do I make a revision to an authorization that has been performed? How do I make a revision to authorization that has not been performed?

The requesting provider or member should contact EviCore with any change to the authorization, whether or not the procedure has already been performed. It is very important to update EviCore with any changes to the authorization for claims to be correctly processed for the facility that receives the member.

What information about the prior authorization will be visible on the EviCore website?

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

- Prior Authorization Number/Case Number
- Status of Request
- Site Name and Location
- Prior Authorization Date and Expiration Date

Where do I submit questions or concerns regarding this program?

For assistance with membership, claims, provider network issues, etc., submit the issue to our dedicated teams via EviCore Communication Relationship Management (ECRM):

- Access: ECRM Services
- ECRM educational resources: ECRM Resources | EviCore by Evernorth
- Trouble using ECRM? Send an email to: ECRMSupport@EviCore.com

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Who do I contact for online support/questions?
Web portal inquiries can be emailed to portal.support@EviCore.com or call 800-646-0418 (Option 2).

Where can I find additional educational materials?
For more information and reference documents, please visit our resource page at EOCCO Provider Resources | EviCore by Evernorth.

How do I determine if a provider is in network?
Participation status can be verified through the health plan. EviCore receives a provider file from the health plan with contracted participating and non-participating providers.

Where do I submit my claims?
Claims should be filed with the health plan.