



Specialized Therapy Program

Frequently Asked Questions

Which members do EviCore manage for the Specialized Therapies programs?

EviCore manages prior authorization for commercial and Individual members who are enrolled in the following plans:

- Premera Blue Cross - Washington plans
- LifeWise – Washington Plans
- Premera Blue Cross Blue Shield - Alaska plans

Which Specialized Therapies require prior authorization for Premera?

This program manages outpatient member services for the following Specialized Musculoskeletal services:

- Physical Therapy
- Occupational Therapy
- Massage Therapy (Discontinued after 1/1/2027)

The list of codes that require pre-service authorization can be viewed on the provider resource website at: [Premera Blue Cross Provider Resources | EviCore by Evernorth](#)

Who needs to request prior authorization through EviCore?

All requesting (treating) therapists are required to obtain prior authorization for services prior to rendering the service in an office or outpatient setting.

Am I required to wait for prior authorization before treating my patient?

You can perform the initial evaluation (authorization is not needed for the evaluation) and provide treatment (authorization needed) on the initial date of service because we understand that this often occurs. After the initial evaluation, you should **submit a request for authorization within 7 days and enter the start date of treatment as the evaluation date** (because that was also the first date of treatment). If treatment is initiated on a different date than the initial evaluation date, you would need to obtain prior authorization before the initial treatment visit occurs.

Note: For Washington members, authorization is not needed until after the first 6 visits. This applies to each service (6 Massage Therapy, 6 Physical Therapy, 6 Occupational Therapy).

When should a pre-service authorization request be submitted for therapy services?

If additional therapy is required after the initial request, requests for ongoing care may be submitted as early as seven (7) days prior to the requested start date. The current findings date on your pre-service authorization request should be within fourteen days of your requested start date. Delays may occur if the request is made too far in advance and/or if the clinical information is incomplete or too old.



How many visits will EviCore approve when I submit a pre-service authorization request?

The number of visits approved will vary based on the condition/complexity/response to care. When the requested care is medically necessary, EviCore will approve a number of visits to be utilized over a specific period of time to treat the patient's condition, demonstrate progress and allow for a meaningful evaluation of the need to continue care beyond what has already been approved.

Visits should be spread over the approved period to prevent a gap in care. EviCore reduces or denies a request (also known as an adverse determination), the letter will include clinical rationale to explain why. The rationale is written in language a member can understand in order to comply with regulatory standards. If there has been an adverse determination, the letter will include directions for reconsiderations, clinical consultation (Peer to Peer), or the appeal process. Please review your letter for information on next steps.

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.



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

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

How do I request prior authorization through EviCore?

Practitioners and/or staff can request prior authorization in one of the following ways:

Web Portal

The EviCore portal is the quickest, most efficient way to request prior authorization and is available 24/7. Practitioners can request authorization by visiting [Provider's Hub | EviCore by Evernorth](#)

Call Center

EviCore's call center is open from 7 a.m. to 7 p.m. local time. Practitioners and/or staff can request prior authorization and make revisions to existing cases by calling 855-252-1115.

What are the benefits of using EviCore's Web Portal?

Our web portal provides 24/7 access to submit or check 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
- **Opportunity for a real time decision** – You may receive a real time decision if the clinical information provided meets criteria for approval.

Is registration required on EviCore's web portal?

Yes. A one-time registration is required for each practice or individual. You will be required to log-in prior to submitting pre-service authorization requests on the web. If you have an existing account, a new account is not necessary.

How do I check an existing prior authorization request for a member?

Our web portal provides 24/7 access to check the status of existing authorizations. To check the status of your authorization request, please visit www.EviCore.com, see Check Prior Authorization Status.

What is the difference between the "ordering" and the "rendering" provider?

When requesting a pre-service authorization for Physical Therapy or Occupational Therapy, the "ordering" and "rendering" provider is the therapist who is submitting the request.



Note: There is no need to enter information about the provider that referred the member for therapy.

I practice within a group practice. Should the pre-service authorization request be created under my individual NPI or under the group's NPI?

The way claims are submitted to Premera should inform the way you create your pre-service authorization request. If claims are billed under a group NPI, the pre-service authorization request should search and select the group's NPI, address, etc. on the **Site of Service screen**. Using the group NPI allows providers practicing within a group to share the same authorization if coverage is necessary. If claims are billed to Premera using individual provider NPI's, the pre-service authorization request should search and select the individual provider's NPI, address, etc. on the **Site of Service screen**.

What information is required when requesting prior authorization?

When requesting prior authorization, please ensure the proprietary information is readily available:

Member

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

Ordering Provider

Note: For therapy requests, the ordering/rendering provider are the same.

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

Rendering (Performing) Provider

- Facility Name
- National Provider Identification (NPI) Number
- Tax Identification Number (TIN)
- Street Address

Clinical Pediatric Neurodevelopmental

- Diagnosis/ICD10
- Date of current objective findings
- Date of initial evaluation
- Date of onset
- Standardized test scores collected within one year of the requested start date
- Plan of care – planned frequency/intensity/duration of care
- Clinical observations

Clinical Adult

- Diagnosis/ICD-10
- Date of current objective findings
- Date of the initial evaluation
- Date of onset
- Co-morbidities/Complexities
- Functional Assessment (using Patient Reported outcomes including the NDI, ODI, Roland Morris Disability Score, DASH/Quick DASH, LEFS, HOOS JR, KOOS JR, etc. See clinical worksheets for details.)



Will separate pre-service authorizations be required for a member with two concurrent diagnoses?

No. Each medical necessity review considers all reported diagnoses for the member.

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

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

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.

Important: Please refer to the specific guidelines referenced in the decision letter.

What services are not considered medically necessary?

The following services are generally not considered medically necessary. (Refer to specific health plan policy for specific-coverage policies.)

- + 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.)



Are Retrospective Authorization Requests allowed and what should be included?

Retrospective Authorizations are allowed for Therapy services. For Therapy services:

- + Requests submitted between 7 days post treatment start date and 14 days post treatment start date would be considered retrospective for Oregon members.
- + Requests submitted between 14 days post treatment start date and 730 days post treatment start date would be considered retrospective for Alaska and Washington members.

Please include the following with any retrospective request:

- + List all dates of service for which you are requesting authorization
- + The initial evaluation and progress reports/re-evaluation. Submitted Documentation should include objective test and measures and clinical assessment reporting member's response to care.

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 [Provider's Hub | EviCore by Evernorth](#) or by contacting EviCore at 855-252-1115.

What is the turnaround time for a determination on a standard pre-service authorization request?

All requests are processed within 2 days from receipt of request, not to exceed 14 calendar days. Please make certain all necessary clinical information has been submitted initially.

What is the authorization period for approved services?

Generally, EviCore will approve services for a period of 60 days from the start date identified on your authorization request. The authorization period may differ based on the member's condition.

Where can I access EviCore's clinical worksheets and guidelines?

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

- [Clinical Worksheets & Online Forms | EviCore by Evernorth](#)
- [Clinical Guidelines | EviCore by Evernorth](#)



Can I request additional visits beyond what was already approved?

Yes. EviCore will review and approve services in accordance with what is required for the member to demonstrate progress over a specific period. Upon expiration of an approved authorization, you may request additional visits as early as seven (7) days prior to the requested start date by submitting another authorization request via web or phone. The request should include current clinical information (collected within the prior 14 days for adult and pediatric non-neurodevelopmental conditions; 20 days for pediatric neuro developmental conditions), including the patient's response to any treatment already approved and rendered.

If denied, what follow-up information will the requesting therapist receive?

The requesting therapist will receive a denial letter that contains the reason for denial as well as appeal rights and processes.

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

Yes. A date extension can be granted for a therapy case in which a provider has visits authorized but was unable to perform those visits in the amount of time given. You may request an extension via our web portal or telephonically by calling EviCore at: 855-252-1115.

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"

Please note the following conditions for a date extension:

- There must be one or more visits from an existing authorization that have not been used AND units must still be available. **Note:** If visits are available but the approved units have been used, submit a request for continuing care instead of requesting a date extension.
- An extension can only be requested during an open coverage period. If the coverage period has already expired, a new pre-service authorization request is required.
- Only one (1) extension is allowed per authorization.
- Authorizations can only be extended for up to an additional 30 days; the extension is required for a shorter period, specify the duration as long as it is less than 30 days.
- An extension should not overlap with another request for the same specialty.

Will clinical reviews be done by a practitioner of the same discipline?

Requests requiring clinical evaluation will be reviewed by appropriate specialty clinicians.



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

Providers can confirm that the prior authorization is valid by logging into our web portal, which provides 24/7 access to view prior authorization numbers. To access the portal, please visit [Provider's Hub | EviCore by Evernorth](#). To request a fax letter with the prior authorization number, please call EviCore at 888-333-8641 to speak with a customer service specialist.

How do I determine if a practitioner is in network?

EviCore receives a provider file from Premera with all independently contracted participating and non-participating practitioners. Participation status can be verified by accessing [Availity Essentials - Sign In](#). Practitioners may also contact EviCore at 855-252-1115.

Where do I submit my claims?

All claims will continue to be filed directly with Premera.

How do I submit a program related question or concern?

For program related questions or concerns, please submit an inquiry via [ECRM Consumer Services](#)

Who do I contact for online support/questions?

Please submit an inquiry via [ECRM Consumer Services](#) 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: [Premera Blue Cross Provider Resources | EviCore by Evernorth](#)