

EviCore Conservative Therapies Frequently Asked Questions & Tips for Therapy Providers

Who is EviCore?

EviCore, an Evernorth Health Services business, is a specialty medical benefits management company that partners with health plans to provide certain utilization management services.

Which members will EviCore manage for The Health Plan?

EviCore will manage prior authorization of certain services for members who are enrolled in the following The Health Plan plans:

- CHIP (West Virginia only)
- Commercial
- Medicaid (West Virginia only)
- Medicare

What services will require prior authorization from EviCore?

- Chiropractic
- Massage therapy
- Physical therapy
- Occupational therapy
- Speech therapy

Creating a Prior Authorization Request

Why does EviCore recommend that providers initiate prior authorization via EviCore's web portal?

Advantages of the Web:

- **Saves time:** The process is faster than submitting authorization requests over the phone.
- Potential for a real-time decision.
- **Available 24/7:** You can access the portal any time, on any day.
- **Save your progress:** If you need to step away, you can save your progress and resume later. You have until the end of the day to complete your request.
- **Upload additional clinical information:** No need to fax supporting clinical documentation. Clinical can be uploaded in the portal to support a new request or when additional information is requested. Upload clinical information that supports/demonstrates the need for medically necessary, skilled therapy, such as the initial evaluation, a recent progress report/re-evaluation, or patient-reported outcome tools.
- **View and print determination information:** Check case status in real-time.
- **Dashboard:** View all recently submitted cases. This enhancement allows providers to easily review and track the status of a submission.
- **Duplication feature:** If you are submitting more than one prior authorization request, you can duplicate information to expedite submissions.
 - The case duplication feature provides several options. When creating a case via EviCore's web portal, the following options are presented:

You can also start a new request using some of the same information.

Start a new request using the same:

- Program (Musculoskeletal Management)
- Provider
- Program and Provider (Musculoskeletal Management and
- Program and Health Plan (Musculoskeletal Management and)

TIP: Group EviCore authorization requests together to reduce the need to log in for each individual request.

TIP: Eligibility for a real-time decision depends on the method of submission, condition type, request number, and completeness of information provided with the request. Real-time decisions are limited to requests initiated by web or phone. MSK conditions are eligible to receive real-time decisions at the initial request and first follow-up, as long as sufficient clinical information is provided. **Note:** If the prior authorization request is from the state of Washington, and the episode is eligible for use of six visits before prior authorization is required, eligibility for a real-time decision is limited to the initial prior authorization request. Non-MSK conditions are only eligible for a real-time decision at the initial request.

Why do I need to enter the discipline when requesting authorization via www.EviCore.com?

In situations where health plans allow multiple provider types to utilize a physical medicine benefit, EviCore currently allows a variety of provider types to create a case using the MSMP code. Entering the specialty type (discipline) ensures that the request will route to the correct specialty reviewer (e.g., PT, chiropractor, acupuncturist, massage therapist) for review.

TIP: Chiropractors: When a prior authorization request is created under the CHIRO code, the authorization will cover both spinal manipulation AND any relevant physical medicine CPT codes.

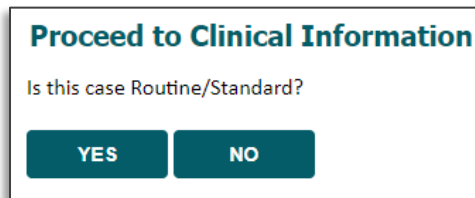
I want to change my answer. Why am I unable to move backward in a case created via the web portal?

Depending where you are in the case, your ability to move backward to correct answers may be limited. If you are answering the initial administrative questions, you will be able to move backward to correct errors. However, once you enter the clinical portion of the process and begin answering clinical questions, you will be unable to go back to change your answers. **This limitation is intentional.** It prevents providers from modifying answers if they are not satisfied with the determination they obtain. While this may not be a concern for therapy cases, it is for cases submitted for some of the other specialties EviCore manages.

TIP: Once you enter the clinical portion of the pathway, review your answer before submitting and moving to the next page.

When I create a case on the web, why am I asked if the request is for routine care?

This question helps identify requests that are “urgent,” to ensure that each request is processed correctly. Most therapy cases do not meet the definition of urgent. To be considered urgent, there must be risk to life, limb, or the ability to regain maximal function. The following will be presented when creating a case on the web:



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.

TIP: Unless the request meets the definition of Urgent, answer “Yes” to the question “Is this case Routine/Standard?” to continue to create your request.

What clinical information do I need to submit?

In general, for the initial request, EviCore asks for information about the condition, complexity, and functional status. If the request is for *continuing* care, the focus is on the resolution of complexities, change in functional status, and response to care. EviCore has created clinical worksheets to help you prepare a case via web or phone. In many offices, the therapist will answer the clinical questions on the worksheet. This reduces the potential for errors and eliminates the need for a non-clinical employee to retrieve information from the clinical record. Most of the information you will be required to enter (i.e., except for an updated patient-reported outcome score) is collected via routine assessment. There is no need to perform a formal re-evaluation or progress report. Worksheets are available here:

[Musculoskeletal: Therapies Clinical Worksheets | EviCore by Evernorth](#)

TIP: Have the clinician provide answers to the clinical questions included in the worksheet. This allows non-clinical staff to quickly provide the answers when creating a case by web or phone.

What verification elements are required when clinical documentation is provided to EviCore?

EviCore requires name (first and last) and one additional identifier from the list below:

- Date of birth
- Correct case number/Episode ID
- Member identification number
- Full address (street, city, state and zip code)
- Full phone number including area code
- Driver’s license number or other government-issued ID

Although it is desirable, patient identity verifiers are not required on every page. If there are no conflicting identifiers present, it is acceptable to assume each page is a continuation of the prior page. A cover page with two patient identifiers present will satisfy HIPAA verification if no patient discrepancy is present within subsequent pages.

What guidelines are used by EviCore to render Medical Necessity Determinations?

The program's purpose is to ensure that specialized therapy services provided to members are consistent with national guidelines. EviCore healthcare's Clinical Guidelines can be found here: [Clinical Guidelines | EviCore by Evernorth](#)

Why must I enter a patient-reported outcome with each request?

EviCore's decision considers the condition, complexities, functional status, and response to care, as well as historical information available at the time of the review. Each component is important in determining the medical necessity of the request. If any questions are unanswered, the visit allocation may be less than if the outcome score was included. (See the following TIP.)

TIP: The answer entered for each question is considered when the visit/unit allocation is determined. If relevant information is lacking, fewer visits may be allocated. For example, a patient with shoulder pain and no patient-reported outcome score may only receive an approval for six visits. However, if a DASH or QuickDASH score is reported and demonstrates functional impairment, then eight or more visits may be approved.

TIP: When submitting your request via the web, the fields associated with outcome scores are pre-populated with numbers that do not make sense. **This is intentional.** These fields must be populated to enable the user to move to the next question. If you have a score to report, replace the pre-populated score. If you do not have a score to report, leave the pre-populated scores and move to the next question.

TIP: When submitting a follow-up outcome score, please re-administer and submit scores from the same functional outcome tool used initially. This will allow EviCore to assess the patient's functional change since the last request.

How can I request visits for a limited service, for example instruction in a home exercise program, or fabrication of a splint (only)?

If ongoing care is not necessary but 1-2 visits are required for a limited service, answer "Yes" to the question asking if care is for a home program or splint/orthotic only. This pathway shortcut allows a provider to obtain 1-2 visits without requiring a therapist to submit clinical information for review.

Why can't I attach clinical documents when requesting an authorization via EviCore's web portal?

To allow the opportunity for a real-time decision, EviCore limits the ability to upload additional clinical documentation. For MSK conditions, you can begin uploading clinical documentation at the third request. For non-MSK conditions, you can begin uploading clinical documentation at the second request.

When can I expect a review to be completed?

EviCore strives to complete reviews within two (2) business days of receipt. However, turnaround times may vary based on the jurisdiction, federal/state regulations, line of business (Medicare/Medicaid/Commercial), or health plan requirements. For example, CMS allows up to 14 days to communicate a decision to a member.

TIP: Submitting requests by web or phone increases the likelihood you will receive a real time decision with reduced care delays.

How long will an authorization remain valid?

Authorization durations can vary based on state requirements, health plan rules, or type of condition. Typically, the authorization duration will range from 30 to 180 days.

TIP: Check with the specific health plan to determine what specific rules apply in determining the authorization duration.

Timely Filing

Note: Timely filing rules vary by health plan. Please consult the specific health plan's guidance to determine what the plan allows.

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How will all parties be notified if the prior authorization has been approved?

Ordering and rendering providers/facility will receive written notification via fax and urgent requests via phone. You can also validate the status using the EviCore provider portal at www.EviCore.com or by calling EviCore at 877.791.4104. Members will be notified in writing by mail and urgent requests via phone. If you have opted to receive email notifications, then you will receive an email prompting you to log in to your EviCore account and view the case's status. In order to protect PHI, the email will not contain the determination or any related documents.

If a prior authorization is not approved, what follow-up information will the ordering provider receive?

The ordering provider will receive a denial letter that contains the reason for denial as well as appeal rights and processes. If you have opted to receive email notifications, then you will receive an email prompting you to log in to your EviCore account and view the case's status. In order to protect PHI, the email will not contain the determination or any related documents.

Note: After a denial has been issued for a Medicare member, no changes to the case decision, such as a reconsideration, can be made. Speaking with an EviCore Medical Director is for educational purposes only.

How do I receive email notifications of a case’s change in status?

When verifying your contact information during the case build process, you can opt to receive email notifications by checking the box seen below and entering your email address.

This feature significantly reduces the number of faxes received by providers. When there has been an update to your authorization request, you will receive an email prompting you to log in to your EviCore account and view its status. **Note:** In order to protect PHI, the email will not contain the determination or any related documents.

If my patient requires more therapy, how early can I submit my request?

Requests for additional visits may be submitted as early as seven (7) days before the requested start date of the additional therapy.

TIP: If additional care is required, do not wait until all approved visits have been exhausted before submitting a request for additional care. Submitting a request in advance of the requested start date will reduce the likelihood of interrupting the patient’s care.

Post-Decision Activities

Post-Decision Options

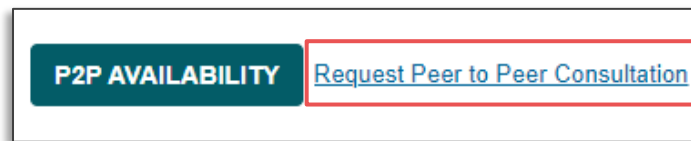
Information related to reconsideration/appeal is included in the letter you receive with the prior authorization determination.

Peer-to-Peer/Clinical Consultation

To schedule a peer-to-peer conversation via the web, log in to your account at www.EviCore.com. Perform “Authorization Lookup” to determine the status of your request. Click on the “P2P Availability” button to determine if your case is eligible for a peer-to-peer conversation:

| Authorization Lookup | |
|-----------------------|----|
| Authorization Number: | NA |
| Case Number: | 12 |
| Patient Name: | WI |
| DOB: | 9/ |
| Status: | De |
| P2P Status: | |

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



Pay attention to any messaging that displays. In some instances, a Peer-to-Peer conversation is allowed, but the case decision cannot be changed. When this happens, you can still request a consultative-only Peer-to-Peer. You may also click on the “All Post-Decision Options” button to learn what other action may be taken. Once the “Request Peer-to-Peer Consultation” link is selected, you will be transferred to EviCore’s scheduling software via a new browser window.

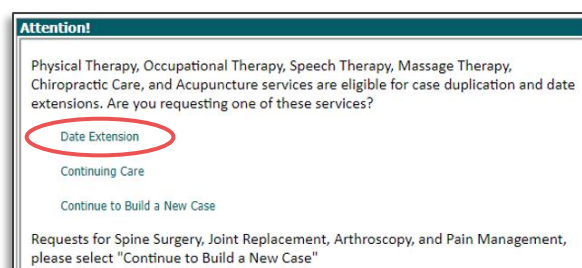
TIP: A Peer-to-Peer must be conducted by a clinician, for example, therapist to therapist.

TIP: Be prepared to share new supporting information that explains why additional care is medically necessary. If the original decision can be modified based on a Peer-to-Peer conversation, new information (not previously presented) must be provided.

Date Extensions

Date extensions are available if you are unable to use all visits within the approved period. You may extend the period needed, up to a maximum of 30 days. One date extension is available per case.

TIP: The extension must be requested prior to the expiration of the authorization. You can request a date extension at www.EviCore.com



TIP: If your patient experiences a gap in care due to vacation, illness, etc., requesting a date extension will allow you to use approved visits without the need to provide additional clinical information. Once the approved visits have been used, you can submit a request for additional care if necessary. Updated clinical information must be submitted with that new request.

Checking Authorization Status

You can look up authorization status on the portal. Search by member information OR by authorization number with ordering NPI. You can view and print any correspondence related to the case.

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|------|-----------------------|----------------------|--------------------|------------------------|------------------------------------|---------------------------------------|-----------|---------------------|---------------------|-------------------|
| 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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Thursday, April 25, 2024 10:11 AM

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:

Provider Resources

Prior Authorization Call Center: 877.791.4104

Call centers are open from 7 a.m. to 7 p.m. (local time). Providers can contact our PA call center to perform the following:

- Check status of existing authorization requests.
- Discuss questions regarding authorizations and case decisions.
- Change facility or CPT code(s) on an existing case.
- Request to speak to a clinical reviewer.
- Schedule a clinical consultation with an EviCore Medical Director.

Client and Provider Services

This dedicated team addresses provider-related requests and concerns, including:

- Questions regarding Accuracy Assessment, accreditation, and/or credentialing
- Requests for an authorization to be re-sent to the health plan
- Eligibility issues (member, rendering facility, and/or ordering physician)
- Issues experienced during case creation.

Providers can initiate a support request with Client and Provider Services via the following methods:

- **ECRM (EviCore Communication Relationship Management)**
 - Register or log in at <https://ecrm.Evernorth.com/ecrm>
 - ECRM resources available at <https://www.EviCore.com/ecrm-resources>
- **Phone:** 800.646.0418, option 4

EviCore Web Support

- Initiate a support request via [ECRM](#).
- Call 800.646.0418, option 2.
- Live chat at www.EviCore.com

Where can I find additional educational materials?

For more information and resource documents, please visit:

<https://www.EviCore.com/resources/healthplan/health-plan>

A review of our TIPS for improving your experience:

- Check with the health plan to determine what specific rules apply in determining the authorization duration.
- Timely filing rules vary by health plan. Please consult the specific health plan's guidance to determine what the plan allows.
- Submitting requests by web or phone increases the likelihood of receiving a real-time decision as the episode of care begins.
- Eligibility for a real-time decision depends on the method of submission, condition type, request number, and completeness of information provided with the request. For example, real-time decisions are limited to requests initiated by web or phone.
- MSK conditions are eligible to receive real-time decisions at time of the initial request and first follow-up as long as sufficient clinical information is provided. However, if the prior authorization request is from Washington state, and the episode is eligible for use of six visits before prior authorization is required, eligibility for a real-time decision is limited to the initial prior authorization request. Non-MSK conditions are eligible for a real-time decision only at the initial request.
- Have the clinician provide answers to the clinical questions included in the worksheet. This allows non-clinical staff to quickly provide the answers when creating a case by web or phone.
- The answer entered for each question may be key when the visit/unit allocation is determined. If there is information lacking, fewer visits may be allocated. For example, a patient with shoulder pain and no patient reported outcome score may receive approval for only six visits. However, if a reported DASH or QuickDASH score demonstrates functional impairment, eight or more visits may be approved.
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- When submitting a follow-up outcome score, please re-administer and submit scores from the same functional outcome tool used initially. This will enable EviCore to assess the patient's functional change.
- Once you enter the clinical portion of the pathway, review your answer before submitting and moving to the next page.
- Unless the request meets the definition of Urgent, answer "Yes" to the question "Is this case Routine/Standard?" to continue to create your request.
- If additional care is required, do not wait until all approved visits have been exhausted to submit a request for additional care. Submitting a request for additional care in advance of the requested start date will reduce the likelihood of interrupting the patient's care. A Peer-to-Peer must be conducted by a clinician, for example, therapist to therapist. Be prepared to share additional (new) information that explains why additional care is medically necessary.
- Group EviCore authorizations together to reduce the need to log in for each individual request.
- Chiropractors: When a prior authorization request is created under the Chiro code, the authorization covers both spinal manipulation AND physical medicine CPT codes. There is no need to create a separate MSMP request to cover physical medicine CPT codes.

- If your patient experiences a gap in care due to vacation, illness, etc., requesting a date extension will allow you to use remaining approved visits without the need to provide additional clinical information. Once the approved visits have been used, you can submit a request for additional care if necessary. Updated clinical information must be submitted with that new request.