Musculoskeletal Therapies Program

Frequently Asked Questions
Moda Health

What is the relationship between Moda Health and eviCore healthcare?
Moda Health has partnered with eviCore to provide authorization for musculoskeletal therapy services.

How does the eviCore healthcare program work?
The ordering physician should contact eviCore healthcare prior to the study being scheduled and performed. The request may be immediately processed or additional information may be requested. Response time for medical necessity review does not begin until all pertinent information has been received.

What services are managed through the Musculoskeletal Therapies Program?
This program manages outpatient member services for the following Musculoskeletal Therapy Services:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Chiropractic
- Massage Therapy
- Acupuncture

The list of codes that require prior authorization can be viewed on the provider resource website at: https://www.evicore.com/healthplan/moda.

Will eviCore be processing claims for Moda Health?
No, eviCore will only manage prior authorization requests.

How do I submit a prior authorization request?
There are three ways to submit requests to eviCore for outpatient member therapy services:

- Web Portal: www.eviCore.com (preferred method)
- Phone: 844-303-8451, Monday through Friday from 7AM – 7PM, local time
- Fax: 855-774-1319

What are the benefits of using eviCore healthcare's Web Portal?
Our web portal provides 24/7 access to submit 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.

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 prior authorization requests on the web. If you have an existing account, a new account is not necessary.

Can one user submit prior authorization requests for multiple providers with different Tax ID numbers on the portal?

Yes, you can add the providers to your account once you have registered. In the Options Tool section at the top right of the portal, choose "Preferences" from the drop-down menu to set preferred Tax IDs for a physician or facility. By adding the preferred Tax IDs for a physician or facility to your account, you will be able to view the summary of cases submitted for those providers and facilities.

Who do I contact for online support/questions?

Web portal inquiries can be emailed to portal.support@evicore.com.

Why is prior authorization required if the member has not reached their benefit limit?

Medical necessity is included in all provider and member contracts. eviCore's role is to monitor the use of the member's benefit and review requests in accordance with what is needed for the member to return to basic function.

> ***Important!*** Authorization from eviCore healthcare does not guarantee claim payment. Services must be covered by the health plan and the member must be eligible at the time in which services are rendered. Claims submitted for unauthorized services are subject to denial and the member must be held harmless. You may verify member eligibility via eviCore's web portal or by calling the health plan directly.

What clinical information will a provider need to initiate a prior authorization request?

The clinical information required to initiate a prior authorization request may vary based upon the type of service requested and the member's specific condition. When using eviCore's web portal, users will be prompted to answer specific questions based upon these factors. Prior authorization requests submitted via fax or the appropriate eviCore Clinical Worksheet may require more clinical information. Generally, any of the following clinical information may be required:

- Diagnosis/ICD-10
- Date of the current objective findings
- Date of the initial evaluation
- Date of onset
- Mechanism of onset
- Date and type of surgery, if applicable
- Restrictions 3
- Co-morbidities
- Conditions that would prohibit the safe delivery of care
- Pain level and duration/percent of time a member has pain
- Range of motion and strength findings
- Gait assessment/special tests
- Functional assessment (using the Patient Specific Functional Scale)
- For Pediatric PT/OT Developmental or Pediatric ST requests:
  - Standardized test scores and behaviors
  - Plan of care with short term goals and baseline measures for each
- Additional information that supports the need for therapy

Where can I find the Clinical Worksheets needed to initiate prior authorization via fax?

Clinical worksheets may be found online at www.eviCore.com under the "Resources" section. When submitting by fax, please ensure all fields are completed in entirety to avoid delays in processing. 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.

Can I use my own forms when requesting authorizations?
No. To ensure that clinical peer reviewers receive necessary and complete information, and to make consistent clinical determinations, eviCore's Clinical Worksheets are required for fax submission.

When should a prior authorization request be submitted for therapy services?
Initial prior authorization requests should be requested through eviCore (by web, phone or fax) within seven days of the member's initial evaluation. Requests for ongoing care may be submitted as early as 7 days prior to the 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.

Will separate prior authorizations be required for a member with two concurrent diagnoses?
No. Each medical necessity review considers all reported diagnoses for the member.

Do services provided in an emergency room setting require an authorization?
Therapy services provided during an emergency room treatment visit do not require an authorization.

Who should submit a prior authorization request?
The rendering (treating) provider should submit the prior authorization request. Services should always be requested and performed by appropriately licensed providers, practicing within the scope of their licensure and using their credentials.

Can an Athletic Trainer initiate an authorization for physical therapy?
No, an Athletic Trainer may not initiate a case for Physical Therapy.

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

What do I enter as the "Start Date" on my prior authorization request?
The start date of each prior authorization request should reflect the date in 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.

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 prior authorization request. The authorization period, however, may differ based on the member's condition. For instance, pediatric therapy requests are often approved for a longer duration to allow sufficient time for the member to demonstrate progress. What is the turn-around time for a determination on a prior authorization request? Standard requests will be processed in accordance with all applicable state and federal regulatory guidelines and health plan requirements.

Urgent requests will be reviewed within 24-72 hours. Depending on the patient's condition, and if clinical criteria is met, providers may be able to obtain a real-time authorization when submitting a prior authorization request via web or phone. It is important to answer all clinical questions and provide any supporting clinical information on the initial request to avoid processing delays.

How do I request an urgent procedure?

All urgent requests must meet the NCQA medically urgent criteria, which are defined as conditions that are a risk to the patient's life, health, ability to regain maximum function, or the patient is having severe pain that required a medically urgent procedure. All urgent requests must be initiated telephonically. Most requests will receive a real-time approval, however if clinical documentation is requested, then a determination will be processed within 24 - 48 hours of receiving all clinical information.

> ***Important!*** Requests submitted by web portal and fax are treated as standard requests. ***Urgent requests should be initiated telephonically only.***

Will a medical necessity review specify the number of visits approved?

Yes, the authorization will included visits and an approved time period. The number of approved visits is based on the clinical information provided at the time of the request.

How will I be notified of a determination?

Determination letters will be faxed to the rendering provider/facility. Members are notified of the determination via mail. Authorization details are also available on eviCore's web portal at any time.

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 of time. Upon expiration of an approved authorization, you may request additional visits by submitting another prior authorization request via web, phone or fax. The request should include current clinical information (collected within the prior 10 days), including the patient's response to any treatment already approved and rendered. Authorizations cannot overlap. As such, be sure that the start date for a continuing care request is after the expiration of your previous authorization.

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 a date extension via our web portal or telephonically by calling eviCore at 844-303-8451.

Please note the following conditions for a date extension:

- Initial determination must have been a full or partial approval.
- 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.

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

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

What clinical guidelines will be used to make a determination of medical necessity?

eviCore clinical guidelines will be followed. These are available at www.evicore.com.

What are my options when there is an adverse determination on my request?

For Commercial and Medicaid members, there are two options: A reconsideration review or a peer-to-peer discussion.

A reconsideration review can be requested if there is additional clinical information available without the need for the provider to participate in a discussion. This must occur within 45 calendar days in writing from the date which the original request was denied.

A peer-to-peer discussion can be requested within 10 calendar days of denial and will be scheduled with an eviCore clinician of the same specialty expertise. During the conversation, the reason for the denial will be discussed and additional information can be provided to support the medical necessity of the request. The rendering provider will be notified at the end of the peer-to-peer discussion if the denial is overturned or upheld. A reconsideration review and a peer-to-peer discussion can be requested up to and including the date of service. A peer-to peer can be scheduled by logging into your eviCore portal account (preferred), or by calling 844-303-8451.

Where do I submit claims?

Follow your routine Moda Health process for claims submission. For more information please check Moda Health's website.

Who should I contact with questions?

If you have additional questions about the medical necessity review program, please contact the Client Services department at eviCore healthcare via the following email address: clientservices@evicore.com.