Network Health / eviCore
Therapy Provider Orientation Sessions
Questions and Answers

The new eviCore prior authorization program being implemented includes physical and occupational therapy services (PT/OT).

- Beginning May 24, 2021, eviCore will begin accepting prior authorization requests for outpatient specialty therapy (PT/OT) for **Medicare and Commercial members** for dates of service beginning on or after June 1, 2021.
- If you have questions on whether a service requires prior authorization, please contact the Network Health member experience team at 800-826-0940.
- If you have questions or issues with the eviCore portal or need to speak with an eviCore web specialist, call 800-646-0418 (Option #2) or email portal.support@evicore.com

Q: If treatment is provided on the date of evaluation, is authorization required?
A: Yes, while evaluations do not require prior authorization, prior authorization is required for all treatment, including when provided during an evaluation and treatment session. Network Health allows a seven (7) business day grace period to allow for treatment following evaluation without delaying care and maintain the requirement of timely submission of prior authorization requests.

Q: What happens if I forget to submit my treatment request within 7 business days?
A: You will receive an administrative denial, indicating you did not submit your request within the required timeframe. Your request will not be reviewed for medical necessity and you may not balance bill the member for failure to obtain prior authorization within the required timeframes.

Q: For patients with Network Health that already have had an authorization requirement historically AND they need a signed order within the last 30 days, with the transition of care to eviCore, is this still needed?
A: Complete and current clinical information, including patient reported functional outcome measures, are required for the medical necessity review process. eviCore clinical guidelines can be found at https://www.evicore.com/provider/clinical-guidelines

Q: If patient is now currently being seen in therapy, will an authorization be required for the continuation of treatment after 6/1/21?
A: Yes, all therapy services taking place on or after June 1, 2021 will require prior authorization.

Q: In Medicare cases, you said to only request the expected number of units. We generally do a 12-week treatment plan. Do you cover the whole 12 weeks with one authorization or is it a 90-day span or so many units?

A: eviCore does not asks therapists/providers to enter their requested visits/units/duration when requesting therapy; rather focus on answering all questions as this information will be used to determine whether services are medically necessary. If services are deemed to be medically necessary, the frequency/intensity/duration of care is required at that point in the episode.

- The authorization period will vary based on the type and severity of the condition and the patient's response to care.
- eviCore encourages providers to develop individualized plans of care rather than relying on historical practice patterns that are not evidence based.

Q: What evaluation and treatment start dates do I enter when submitting the authorization request if the patient was under a plan of care prior to 6/1/21?

A: If after June 1, 2021, enter the evaluation date as June 1, 2021 and the start date of when the treatment began (June 1, 2021 or after). eviCore will review the clinical information and see the eval was completed prior to June 1, 2021.

Q: If a member already has an approved authorization on file for dates of service on or after June 1, 2021, will it be honored at go-live, or will providers need to resubmit a new authorization request?

A: All authorizations that have been issued prior to this eviCore implementation for outpatient specialty services with dates of service extending beyond June 1, 2021, will be honored.

Q: Does the eviCore portal allow more than 2 diagnosis codes (primary and secondary) to be entered?

A: No, the eviCore portal will allow only a primary and secondary diagnosis to be entered.

- For web portal submissions, the provider should upload or add any additional information they would like to share, including additional diagnoses codes that, when present, will impact the therapy plan of care and/or patient's response to care. **Note: Uploading is not available at the initial request.**
- For phone submissions, please call 855-727-7444 and simply tell the agent that there is additional information relevant to the case. Practitioners can provide whatever additional information they feel is necessary to share.
- For fax submission, please include the information as an attachment to the clinical worksheets.
    - Provider partners should utilize fax #855-774-1319 to fax eviCore PT/OT authorization requests.
    - Providers should download and use the worksheets available on the eviCore provider resource site at https://www.evicore.com/provider/online-forms-details?solution=msk%20therapies&hPlan=Network%20Health%20WI.
    - There are 4 worksheets available for PT/OT

Q: I keep seeing references for PT/OT. Do you not require authorization for Speech Therapy (ST)?

A: eviCore does not manage speech therapy reviews. Speech therapy requests sent to eviCore will be returned to the provider. Providers can submit requests for speech therapy for our Employee Trust Fund (ETF)/State of Wisconsin membership directly to Network Health's utilization management team via our electronic authorization portal, iExchange. ETF is the only group with a speech therapy prior authorization requirement. If you have questions on benefits, please contact Network Health member experience at 800-826-0940.

Q: If a member sees a new provider for services, will a new prior authorization request be required? Do we need to let you know? Like for vacation coverage they may see another therapist within the same company?

A: A new authorization is not required if member is seeing a different provider within the same practice. When a member changes to a treating provider who is not within the same practice, a new authorization request is required.

Q: If a provider is requesting additional visits, does the previous functional score automatically populate?

A: No, providers will need to enter the previous functional score as well as the current functional score when requesting additional visits.

Q: Therapists/Providers at our location will not be doing the authorization requests, but they would be the ones to do Peer to Peer/clinical consultations; how would they schedule that?

A: Therapists/Providers can:

1. Register for portal access so that they can utilize the authorization lookup function and other portal functions.
2. Contact eviCore at 855-727-7444 and speak to an agent for assistance with scheduling the clinical consultation.
3. Request a consultation online at www.eviCore/provider.com. Scroll down to Request a consultation with a Clinical Peer Reviewer and select 'Book Now.'

Q: Can a patient be seen at 2 different locations for 2 different conditions?

A: eviCore will allow 2 different locations for 2 different conditions if specialized care is required and the original therapist does not have training to provide that care. For example, knee pain and vestibular condition. Please note: if specialized care is not required, we would expect that all care would be provided by one therapist. Example, back pain and ankle pain.

Q: Will authorizations be issued per "visit" or "units"?

A: Authorizations will be issued for visits. Medical necessity is determined for number of visits, which will be established based upon the plan of care and clinical documentation submitted.

Q: Individuals receiving therapy (PT/OT) in their natural home environment as part of the Birth-to-3 program, do these therapy visits require prior authorization?
A: Yes, Birth-to-3 therapy visits in the home require prior authorization from eviCore and are included in this program expansion.

Q: Can we create our login for the evicore authorization portal today? If we all have separate logins can we see all the authorizations for our clinic or only those we have individually created?
A: Yes, provider groups can create individual logins for the eviCore portal today. Each user will only be able to see the cases they create under the 'Certification Summary' tab or what some people call the "work list". Users are able to find other authorizations via the 'Authorization Lookup' function (this is a view only function to see the case record information and status.)

Q: Will a plan of care be needed for additional visit requests?
A: Yes, complete and current clinical information, including patient reported functional outcome measures, is required to complete the medical necessity review process.

Q: For additional visit requests, do we need a *signed* progress note returned from the physician to continue? We do progress notes once every 30 days or every 10 visits, whichever comes first. If 8 visits are authorized, do we need to get a *signed* progress note from the ordering provider for the 8th visit and then submit that progress note for more visits? Or, can the progress note be submitted with the therapist signature only (not including the physician)?
A: eviCore does not need a signed progress report. The therapist/provider will need to answer the questions posed within the portal or on the worksheets. If the patient has complexities that the worksheet or portal does not capture, progress reports can be uploaded. eviCore would not reject a progress note that is not signed by an MD (or therapist); we would review to extract the information that should be considered when the medical necessity determination is being made.

Q: It was mentioned during the orientation sessions, that 1st & 2nd requests do not need clinicals? Can you elaborate on that?
A: You will always need to provide complete and current clinical information when requesting prior authorization. If the condition is a musculoskeletal (MSK) condition and you submit your request via eviCore's web portal or by phone, you will only need to provide answers to a few questions (see clinical worksheets posted at www.eviCore.com for details). For MSK conditions, start uploading clinical documents at the third request. These cases are sent to a therapy reviewer. Attaching clinical notes allows them to see what additional factors may be influencing the need for a longer episode of therapy.

Q: If a patient is currently being seen for authorized visits and a new diagnosis is added (i.e. currently low back pain and now we are adding shoulder pain) do we have to submit an authorization for the shoulder pain or can we add that diagnosis when we ask for more visits?

A: Providers should use the visits remaining from the low back authorization to treat both conditions. When additional visits are needed, please submit a new request and report that two conditions are being treated.

- When submitting via web portal, you will be asked questions that will allow you to identify that there are now two conditions.
- When submitting by phone, advise the eviCore agent that two conditions are now being treated and you would like to provide information for each.
- When submitting by fax, please comment about the change on the fax cover sheet and complete the sections of eviCore's worksheet specific to each condition.

Q: I am familiar with eviCore due to use with another local health plan. Will prior auth for Network Health be similar?

A: The process is similar but there are differences in requirements. For example, the clinical collection process is slightly different so the clinical worksheets you should use are different. To ensure you meet the Network Health requirements, we encourage providers to review the information available on the eviCore webpages specifically dedicated to Network Health at https://www.evicore.com/resources/healthplan/network-health-wisconsin.

Q: Are the clinical worksheets the same as what we use for another Wisconsin-based Health Plan?

A: The worksheets for musculoskeletal (MSK) conditions and Pediatric Neurodevelopmental conditions have slight differences because different versions of the clinical pathways (corePath) are used. The other worksheets are the same. To ensure you meet the Network Health requirements, we encourage providers to review the information available on the eviCore webpages specifically dedicated to Network Health at https://www.evicore.com/resources/healthplan/network-health-wisconsin.

Q: In the past, we were told appeals would only be granted if the denial was due to not being medically necessary and the documentation shows the therapy was medically necessary. If we get a denial because we went past the approved visits or past approved date, the denial would stand and appeal would not be allowed. Is that still the case?

A: As the provider you can submit an appeal on behalf of a member when services are denied as not medically necessary. If you receive an "administrative" denial, but you did not request authorization timely, you have contractual dispute rights through Network Health. You can submit a provider dispute through the Network Health provider portal.

Q: What if we bill as a group and not by individual therapist? Can you start authorization requests under the group or does it have to be a specific therapist?
A: Please start authorizations under the individual NPI. You do not need to contact Network Health or eviCore to update your group NPI, Network Health will pay claims at the group level. As a reminder, a new authorization is not required if the member receives services from a different provider within the same practice.

Q: Is authorization required for therapy services when billed by a Skilled Nursing or Home Health Provider?
A: If charges are submitted on a UB04/Facility claim with Type of Bill (TOB) 032X (Home Health Facility/Hospital Based or Inpatient), prior authorization is not required. If charges are submitted with any other bill type, **or** on a HCFA 1500/Professional claim, prior authorization is required.

Q: If care is provided at a SNF will the NPI of the facility be sufficient for payment or do you need NPI of the therapist providing care?
A: Providers should submit prior authorization requests the same as they are going to bill/submit claims. If your group NPI option is available, enter authorizations under the group NPI. However, if your group NPI is not listed, please start authorizations under the individual NPI. You do not need to contact Network Health or eviCore to update your group NPI, Network Health will pay claims at the group level. As a reminder, a new authorization is not required if the member receives services from a different provider within the same practice.

Q: Why does the portal show a unit and a visit count when my letter only has a visit count?
A: There is currently a glitch that is scheduled to be fixed on June 24, 2021. Please disregard the unit count. The visit count is what is applicable to your authorized episode of care.

Q: Are the Medicare guidelines for the diagnosis (DX) still followed?
A: While eviCore follows Medicare guidelines and LCD information, the specific diagnosis formatting is not necessary for our reviews. We request that the provider accurately identify their diagnosis.

Q: When I start a case on the portal, do I have to finish it right away or can I save and complete it later?
A: You can save and complete the request; the “finish later” button allows providers to stop and go back in to finish a prior authorization request for up to 48 hours. You must click the “finish later” check box in order to not have the case expire that evening. The eviCore system expires anything unfinished every night. In order to not lose what you’ve already entered, complete your submission by the end of business each day.