eviCore healthcare Q&A: Physical Medicine program
(part of the musculoskeletal solution)

OVERVIEW

eviCore healthcare (eviCore) provides its musculoskeletal solution to Regence, which manages the utilization of:

- Joint surgery
- Spine surgery
- Interventional pain management
- Specialized therapy (physical therapy, occupational therapy, speech therapy, massage therapy, chiropractic and acupuncture)

This document is designed to educate providers about eviCore's purpose and process.

Who is eviCore?

eviCore manages supports the health care of 100 million Americans, utilizing the industry's best evidence-based clinical protocols based on a comprehensive assessment of research studies. eviCore's care management reviews are designed to promote clinical improvement and better outcomes.

Through its solutions, eviCore works with more than 570,000 providers across the United States and employs more than 250 medical directors across 28 specialties.

What does eviCore use as the source of its policies and how does eviCore create medical necessary criteria?

eviCore's policies (clinical guidelines) are internally created with the most current input from the best available sources, including contributions from community physician panels, academic institution experts and current clinical literature. eviCore also has dedicated pediatric guidelines. Guidelines align with those of national professional societies.

Additionally, requests are evaluated based on the clinical information provided using eviCore's evidence-based guidelines. If the available clinical information indicates that the request is appropriate based on eviCore's guidelines, the nurse reviewer approves the request. If the request cannot be approved, it is forwarded to a medical director.

Why is medical management necessary?

Health care costs are rising. Limiting the utilization of unnecessary or inappropriate services improves quality and reduces costs so Regence can continue to offer a valuable product at a reasonable price. By utilizing eviCore's solutions, Regence helps members receive the most from their coverage by ensuring that requested treatments and procedures are appropriate and medically necessary based on clinical presentation. The shared goal is to provide patient-centric care while improving health outcomes.

Additionally, it is impossible for a clinician to keep up with the deluge of new medical advances. Medical practice is expanding at an exponential rate. In 2010, the volume of medical knowledge was projected to double in 3½ years. It is now estimated that by the year 2020, medical knowledge will double in only 73 days. Medical knowledge is expanding faster than our ability to assimilate it and apply it effectively, and this is as true in education and patient care as it is in research[1].

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3116346/

And many of these "advances" are later proven incorrect through subsequent research[2]. However, it can take clinicians years to change contraindicated practices[3]. eviCore uses its combination of specialized medical professionals, advanced technologies and quality-improvement processes to help providers and to ensure that each patient receives the right care at the right time and at the right location.

Why is medical management necessary for physical therapy, occupational therapy, speech therapy, chiropractic, acupuncture and massage (POSTCAM) services?
The utilization of POSTCAM services is growing exponentially and so are the costs. Americans spend $30 billion annually on chiropractic services, increasing at 2.2% per year[4]. Annual expenditures on physical therapy services are $35 billion with a growth rate of 4%[5]. Medical management of these services is necessary to ensure that patient outcomes are maximized and that unnecessary visits are reduced. eviCore's integrated patient- and condition-specific approach is comprised of three main components:

1. Streamlining the approval process for providers who order appropriately using evidence-based guidelines
2. Identifying provider outliers for more focused clinical review
3. Authorizing personalized visit allocation/episode length based on the patient's specific needs.

What is the most efficient way to set up cases? How can I reduce red tape?
The most efficient way to submit a pre-authorization request is via eviCore's secure web portal. Demographic and, when indicated, clinical information is entered into the web portal, and when the request meets the requirements for an approval, or when clinical criteria are met, an authorization for a quantity of visits and services valid for a specific duration is issued in real time. If the request does not meet the evidence-based clinical criteria, real-time authorization is not provided. When this occurs, the provider is advised to furnish either additional information using a free text option within the web portal.

Why was my patient only approved for a certain number of visits? Why isn't this number higher?
For the physical therapy, occupational therapy and speech therapy programs, the initial request results in a waiver, which is a bundle of visits with minimal to no clinical information required.

- Non-surgical request: 6 visits to initiate care
- Post-surgical request: Between 6 and 12 visits based on the type of surgery and the date of surgery

After the approved visits are used, the therapist can request additional visits if ongoing therapy is medically necessary. The second request requires submission of clinical information. Clinical information is reviewed to ensure the request is medically necessary and to determine the intensity, frequency and duration of care.

For the chiropractic, massage therapy and acupuncture programs, an authorization is provided for an initial trial of care. The number of visits authorized is in accordance with the severity of the patient's condition. Additional visits are authorized for patients receiving therapy for post-surgical conditions.

[2] https://www.theatlantic.com/health/archive/2017/02/when-evidence-says-no-but-doctors-say-yes/517368/
[3] https://jamanetwork.com/journals/jama/fullarticle/209653
[4] http://brandongaille.com/27-provocative-chiropractic-industry-trends
[5] Outpatient Physical Therapy Q1 2016 - Capstone Partners

My patient was approved for a number of visits but then was denied for more visits. Why did that happen?
When visits and units are approved, they should be spread appropriately over the approved period. If used up too quickly, eviCore will review to determine if it's medically necessary to add visits and units to the existing approval period. If the additional care is not medically necessary, the request may be denied. The reason for denial is always included in the letters that the provider and member receive.

My patient was authorized for a number of visits, but it looks as though another provider is using visits on my authorization. Is this possible?
Each authorization is linked to the requesting provider. It is the therapist's responsibility to discuss the management of the condition with the patient to ensure care coordination with other therapy providers.

If there is a benefit limit, why can't the member receive all the service visits the benefit allows?
The benefit allows for medically necessary services only, which may not include all visits based on each member's clinical presentation. Clinical documentation provided by the therapist should justify that their request is medically necessary to ensure that the patient does not receive unnecessary care.

Why do some procedures require specific treatments prior to surgery being approved (e.g., psychological evaluation, a course of physical therapy)?
Evidence shows that spine surgeries can have a failure rate of up to 74 percent[6]. And one- and two-year surgery follow-up studies show the same or worse results for pain and function when compared to more conservative management (e.g., physical therapy)[7]. As such, eviCore requires that all appropriate conservative treatments (e.g., physical therapy, chiropractic services) be exhausted prior to invasive surgery.

I have a valid authorization on file, but my claim was denied. Why?
It can take up to four business days for authorizations to be loaded into the Regence system from eviCore. The same is true if an employer group renews or is newly added to our system. If a claim is received before our system receives the updated authorization information, it can cause a claim to be mistakenly denied.

After visits are authorized, please allow several business days for Regence to receive the authorization before submitting a claim.

What does it mean when eviCore shows that a member is "not eligible"?
This means that a pre-authorization is not required; this doesn't mean the member is not active. Providers are encouraged to check the Program participation list on **regence.com** to determine whether a member participates in the specialized therapy program.

My patient was approved for 24 units and six (6) visits, but we used 24 units in five (5) visits. Can I see the patient for a sixth visit without pre-authorization?
Pre-authorizations are approved in visits or in units (e.g., 6 visits or 24 units). Whichever is used first in the authorization request, units or visits, will be used for the approved authorization. Additional visits or units will require the submission of an additional pre-authorization request.

[6] https://www.beckersspine.com/spine/item/3189-dr-trang-h-nguyen-leads-study-spinal-fusions-have-poor-outcomes-for-workers-compensation-patients.html
[7] Nguyen, T. H., Randolph, D. C., Talmage, J., & Travis, R. (2011). Long-term outcomes of lumbar fusion among workers' compensation subjects: An historical cohort study Spine, 36 (4): 320–331.

Who is available for a peer-to-peer discussion? Is the person licensed and experienced in the specific area of service for this?
When a pre-authorization is denied, the provider can request a reconsideration and a peer-to-peer discussion with an eviCore clinical peer reviewer. eviCore's clinical reviewers have experience in their respective musculoskeletal specialties and can assist the provider with understanding clinical rationale and the evidence-based guidelines.

Peer-to-peer discussions about member appeals are conducted with Regence staff.

My patient will need services for weeks or months. Why is my patient authorized for such a brief episode of care?
Visits in Idaho, Oregon and Utah are typically approved for 30-day periods to allow eviCore to review and monitor the patient's response to therapy. In Washington, POSTCAM services are authorized for 45 days. Based on the clinical presentation, the frequency and/or intensity of the therapy may be modified throughout the course of treatment.

Why does my patient's progress have to be submitted every week?
If the visits/units are spread out through the approved period, information should be submitted at the end of the approved period if additional care is medically necessary.

I am treating the patient for more than one area of the body. Why was I given only one authorization?
eviCore provides a single authorization for multiple therapy sites because therapists can address all problem areas in the same visit. eviCore allows therapists to submit information when multiple conditions are treated and will approve additional units per visit to allow management of multiple conditions.

I received an authorization for my patient. Why is the authorization broken down by visits rather than units of service?
The patient benefit is denominated in visits, not units.

I disagree with eviCore's determination on a case. What should I do?
For non-Medicare requests: If you disagree with eviCore's determination, you can request a reconsideration from eviCore. Reconsiderations are completed via the telephone and through peer-to-peer discussions with eviCore's medical directors, as applicable. If the initial decision is upheld, then the next step is a first-level appeal. The review determination letter will provide instructions for appealing a medical necessity decision, including your right to submit additional information.

To request a reconsideration or a peer-to-peer discussion, you can also call (855) 252-1115 or you can submit a written request via fax or via mail:

Fax: (866) 699-8128
Mail: Clinical Appeals
eviCore healthcare
400 Buckwalter Place Blvd.
Mail Stop 600
Bluffton, SC 29910

For Medicare requests: eviCore is not delegated to process appeals for Medicare requests. If there is a disagreement with a denial on a Medicare request, the provider or member should file an appeal with Regence. The review determination letter will provide instructions for appealing a medical necessity decision, including your right to submit additional information.

What tools does eviCore offer to support providers?
eviCore FAQs about the Physical Medicine program are posted on our provider website: Programs>Medical Management>Physical Medicine.

eviCore also publishes a quarterly newsletter for providers and their staff. To sign up to receive the provider newsletters, please visit www.evicore.com, scroll to the bottom of the page, and enter your email/required contact information in the Stay Updated field provided.

eviCore is also able to conduct provider training and education via town hall-style meetings, webinars or web-based e-learning modules, per provider preferences. They also publish their clinical guidelines online. Providers can also request personalized manuals tailored to their practices.