eviCore’s
Physical Medicine and Therapy UM Program
FAQs
The Scope of the Program

What is eviCore healthcare?

eviCore healthcare (eviCore) is a medical benefits management company committed to making a positive impact in healthcare. It is our passion, our purpose, and our promise.

We’re built with the size and scale to address the complexity of today’s healthcare system. Through our exceptional capabilities – and an acute sensitivity to the needs of everyone involved – we harness healthcare’s evolving demand and inherent change to better manage and optimize health benefits.

The result is an evidence-based approach that utilizes our proven talent and leading-edge technology to realize better outcomes.

Our experienced professionals – including our clinical staff of doctors and nurses – have the breadth of expertise needed to embrace the perspectives and challenges of our constituents, enabling us to support the design of custom solutions and innovative services.

Our technology is a robust platform that identifies, generates, and distributes the precise data, analytics, and reports needed for quicker, more informed decision-making in each of the millions of cases we handle each year.

From our unique position at the heart of the patient, provider, and plan, we cultivate, connect, and integrate the intelligence and insights that prompt more focused actions and improve results.

It’s a mindset that proves quality, cost and competence are aligned. One that transcends simply saving resources and time; one that works to improve the system – and ultimately achieves better outcomes.

Asking the right questions leads to delivering the right answers at the right time to the right people – patients, providers, and plans.

Why did the Health Plan partner with eviCore?
The Health Plan supports its members to ensure that they receive appropriate care, to assist them with managing a limited benefit, and to serve as a responsible steward of the cost of healthcare by paying for only necessary services. Health plans partner with us to provide quality support that is based on our in-depth experience in overseeing physical medicine.
services. The shared goal is delivering patient-centric service to reach the best possible outcomes.

Why the need for prior authorization now?
Healthcare costs are rising. Limiting the utilization of unnecessary services will help control costs so the Health Plan can continue to offer a quality product at a reasonable price. Through prior authorization, the Health Plan helps members get the most from their coverage by making sure that proposed treatments are right for their condition, effective, and medically necessary. The shared goal is patient-centric case with the best possible outcome.

Why is authorization required if the member has not reached their benefit limits?
Medical necessity is included in all provider and member contracts. eviCore’s role is to monitor the use of the member’s benefit. Medical necessity is not always “what the doctor ordered” but what the patient needs to return to basic everyday functioning.

What services are managed through the Physical Medicine and Therapy Utilization Management (UM) Program?
The Physical Medicine and Therapy UM Program manages outpatient services for the following treatments:

- Acupuncture
- Speech therapy
- Physical therapy
- Massage therapy
- Occupational therapy
- Chiropractic/manipulation

*Please note: as of 5/15/2017, prior authorization is not needed for select chronic pediatric diagnosis codes. The diagnosis codes do not require prior authorization for acupuncture; chiropractic/manipulation treatments; physical, occupational, speech and massage therapies.
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Which CPT codes are included in the program?
The CPT codes included in the program are available at the Health Plan’s provider website, in the Pre-Authorization section. The CPT code lists are also available on eviCore’s website:


Which practice specialties are included in the program?
The program is focused on the CPT codes used for physical medicine and therapy services.

- To determine which procedures to pre-authorize, this program uses the CPT codes listed in the CPT Code List, not the condition or diagnosis.
- Each of these CPT procedure codes requires authorization for proper claims payment.
- An authorization/reference number is required for both provider professional and facility claims for those procedures included in the program.

Does this program apply to naturopathic physicians (NDs) who perform physical medicine procedures?
This program applies to any physician, therapist, or other healthcare professional billing any of the CPT codes under the scope of our Physical Medicine Program. Any provider billing codes on the CPT Code List for an in-scope member require authorization from eviCore.

Which Health Plan members are included in the UM Program?
Please refer to the detailed information on the Physical Medicine section of the Health Plan’s website to determine which members are included in the UM Program.

Does eviCore healthcare require that rehabilitation be performed by a physical therapist?
Qualified practitioners can provide all of the services that fall within their scope of practice. No specific CPT code is designated for “rehabilitation”; however, many CPT codes can be used when helping a member recover function, which is often referred to as rehabilitation.

Is there a feedback mechanism for providers with eviCore?
You can send feedback regarding the program directly to the Health Plan, or you can contact the eviCore Provider Relations department by email: providerrelations@evicare.com or by calling (800) 646-0418 prompt 3. The Provider Relations department will direct your feedback to the proper area for review and response.
## What is a Notification?

A *Notification* is the initial authorization request submitted to eviCore informing the Health Plan that a member is starting an episode of care. At the time of Notification, a reference number will be issued to authorize the initial visits and units for your patient's episode.

The Notification consists mostly of patient demographic information. Minimal clinical information is requested, to assist in the collection of outcomes data and to establish whether a physical or occupational therapy patient presented with a post-operative condition.

### How many visits will eviCore approve when I submit a Notification?

The initial authorization is based on the average number of visits used for the type of service being requested:

- Acupuncture and massage therapy Notifications are eligible for a four-visit initial episode of care.
- Chiropractic Notifications are eligible for a six-visit initial episode of care.
- Physical/occupational therapy Notifications are eligible for a six-visit initial episode of care.
  - Qualifying conditions (e.g., post-operative) can entitle additional visits.
- Speech therapy Notifications are eligible for a six-visit initial episode of care.

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**Table: Notification Process**

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<th>Step</th>
<th>Instructions</th>
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<td><strong>Notification</strong></td>
<td>- Within 7 days of service, submit Notification that the member is starting care. - Notification can be sent up to 7 days before or after the first visit.</td>
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<tr>
<td><strong>Determination</strong></td>
<td>- Pre-authorization may be instant after Notification, or it may require medical review, depending on the member’s treatment history. - Medical review is completed within 2 days, depending on your jurisdiction. - Standard authorization periods are for 30 days. Note the visits, units, and expiration date of the authorization.</td>
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<tr>
<td><strong>Treatment Request</strong></td>
<td>- Within 7 days of the unauthorized visit, submit a treatment request for ongoing care. - Notification can be sent up to 7 days before or after the unauthorized visit. - Clinical information must be less than 14 days old to be considered current.</td>
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<tr>
<td><strong>Determination</strong></td>
<td>- Medical review is completed within 2 days, depending on your jurisdiction. - Standard authorization periods are for 30 days. Note the visits, units, and expiration date of the authorization. - Monthly treatment requests and medical review are required until release from care or referral as needed.</td>
</tr>
</tbody>
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**What are the Notification submission requirements?**

All practice specialties billing CPT codes in the Physical Medicine Program must submit a Notification within 7 calendar days of the start of treatment, to obtain the Notification reference number.

The Notification may be submitted by the servicing practitioner or his/her office staff.

- The **most efficient** method to submit the Notification information is online at [www.eviCore.com](http://www.eviCore.com). Online submissions are available 24/7.

- Providers can also submit a Notification via phone, 7 a.m. to 7 p.m. local time, Monday through Friday at (855) 252-1115.

**What is a Treatment Request?**

The Treatment Request is the process of submitting required information for medical necessity review when an episode requires additional visits after the initial authorization is exhausted.

The Treatment Request Clinical Worksheets facilitate the clinical intake process. The forms are specialty-oriented, and tailored to specific conditions. We recommend collecting the clinical information on the worksheets to facilitate submission on the Web, by phone, or by fax.

Treatment Requests may be submitted by the servicing practitioner or his/her office staff by any of the following methods:

- Submit online at [www.eviCore.com](http://www.eviCore.com).

- Call eviCore at (855) 252-1115 from 7 a.m. to 7 p.m. local time, Monday through Friday.

- Fax a Treatment Request Clinical Worksheet to (855) 774-1319.

Select the worksheet that best fits the patient’s condition. When submitting paper forms, be sure to complete every applicable section. Treatment Requests with incomplete sections may result in a request for complete clinical information.

How do I request authorization for a new episode if I previously obtained authorization for a different condition?

Submit a Notification if your patient presents with a uniquely different condition or if it has been at least 90 days since you last treated the patient. A Notification authorization is available for the new episode of care as previously described, provided that the member has not reached the maximum available benefit.

Can I fax my own forms to eviCore to request a medical necessity review?

No. To ensure that clinical peer reviewers receive the necessary and complete information to make consistent clinical determinations, submit authorization requests on an eviCore Treatment Request Clinical Worksheet. However, if you believe that supporting documentation is required for a particularly complex case, attach the documentation to the Treatment Request Clinical Worksheet.

Can I submit my Notifications via fax using a Treatment Request?

We encourage all providers to submit their Notifications online. The Treatment Requests are condition-specific worksheets intended to gather the clinical information that eviCore needs to make a Medical Necessity Determination. Because Notifications require minimal clinical information, the online process is the most efficient.
Can the Notification or Treatment Request be entered by a representative for the provider group, such as a therapy assistant, authorization representative, etc.?

Either the practitioner or a member of his/her office staff can submit Notifications and Treatment Requests, as long as all required clinical information is provided.

Are there forms for patients to complete so that our office can get the information you want in a simple, easy-to-understand (for the patient) format?

Members are not required to fill out paperwork for the Notification or Treatment Request processes. Providers are encouraged to use standardized outcome assessment forms such as the Oswestry or NDI; however, these forms are not required. If you are required to submit clinical information, the required information will come from the information you already collect in your daily progress notes, examination forms, and patient intake form.

If the initial authorization is good for 30 days, why do we have to submit the Notification within 7 calendar days of the initial visit?

A Notification is required within 7 calendar days of the initial visit because all services require authorization. The Health Plan's claim system cannot pay claims unless an authorization is in place.

Are we allowed to complete an initial evaluation before we submit a Notification for a second condition?

Yes. If the member will be returning for treatment of a new condition, complete the evaluation and treatment during the first visit and submit the Notification within 7 calendar days.

Should I fax patient records with the Treatment Request?

No, in most cases the condition-specific Treatment Request provides eviCore's clinical peer reviewers with the information necessary to make a Medical Necessity Determination. However, if you believe that supporting documentation is required for a particularly complex case, attach the documentation to the Treatment Request when submitting online or when faxing it.

Will pre-authorizations specify the number of service units approved?

Yes. When visits are authorized, the authorization will also provide the number of approved service units for those visits.

How many visits and service units will be authorized as a result of a Medical Necessity Determination?

The number of approved visits and units will be based on the clinical information provided at the time of the request. More complicated cases typically receive authorization for a higher
number of visits and units than less complicated cases. Payment for approved visits and units always depends upon the patient’s eligibility and available insurance benefit.

**Am I required to wait for pre-authorization before I treat my patient?**

You can provide the initial evaluation (and treatment, if both occur on the same day) prior to submitting an initial authorization request. The initial evaluation and treatment occurring on the same day will be covered with a timely submission of a Notification (within 7 calendar days of the initial evaluation), provided that the member is eligible and has not exhausted his or her benefit.

**Does the first visit for evaluation need to have an exam code? When requesting more treatment, do I charge the patient for re-evaluation exam CPT code every 30 days?**

There are no requirements to use Evaluation & Management (E&M) codes on the first visit. Services should be submitted to the Health Plan, and members are only responsible for applicable deductible, coinsurance, copayments and non-covered services.

**What is an Approved Time Period?**

The Approved Time Period is the time period (beginning and end dates) available to use approved visits and units. Visits and units should be used within the range of dates in the Approved Time Period to avoid a gap in care at the end of the Approved Time Period.

**Why are Approved Time Periods typically limited to 30 days?**

Medical necessity authorizations are typically approved for a 30-day period, allowing the practitioner to assess the patient’s response to treatment.

**What do I enter as the "Start Date" on my Notifications or Treatment Requests?**

For initial Notifications, the Start Date is the patient's initial evaluation date. When requesting additional visits for an existing condition, your first Treatment Request Start Date will be the first visit occurring after the initial authorization expiration date, or when the initial visits and/or units are exhausted. For continuing care requests, the Start Date is the first visit that requires pre-authorization following expiration of the previously Approved Time Period. Do not enter the first date of the patient's treatment episode for continuing care requests.
How far in advance can I request authorization?

Submit requests no more than 7 calendar days prior to the proposed Start Date. Requesting care too far in advance does not allow you to report up-to-date examination findings.

The objective findings date reported for continuing care requests should be within 7 calendar days of your requested Start Date. To avoid a delay in receiving a review determination, provide current clinical findings, paying particular attention to how you document the patient’s progress with the services you have already provided.

What clinical information will be required for a Medical Necessity Determination?

The required information may vary as it is tailored to the patient condition. In general, we ask for the following clinical information:

- Diagnosis/valid ICD code
- Pain level and the percent of time experiencing pain
- Start date for the treatment plan
- Date of the current objective findings
- Date of the initial evaluation
- Date of onset
- Mechanism of onset
- Date of surgery if applicable
- Restrictions
- Comorbidities
- Conditions that would prohibit the safe delivery of care
- Range of motion and strength findings
- Gait assessment/special tests
- Functional assessment.

Refer to the condition-specific Treatment Request Clinical Worksheets on the eviCore website for the clinical information required. If you believe that supporting documentation is required
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for a particularly complex case, attach the documentation to the eviCore Treatment Request Clinical Worksheet.


Can I extend the End Date of an authorization if I didn’t use all approved visits?
Yes. The end date of an authorization can be extended up to 30 days from the current expiration date. A date extension will not be granted if requested after the authorization period has expired. A date extension can be requested online at www.eviCore.com or by calling eviCore at (855) 252-1115. Date extension requests via fax will not be accepted.

Can I include Durable Medical Equipment (DME) supplies on an authorization request to eviCore?
You may document that a patient requires specialized DME equipment; however, orthotics, DME, and supplies will not be authorized by eviCore. Follow the standard Health Plan process for all DME.

What is the timeframe for a case to go through the medical necessity review process?
If medical necessity can be established based on evidence-based criteria, visits and units will be pre-authorized at the time of your Treatment Request submission. When you submit online, the pre-authorization will be instantaneous if all information necessary to make an approval decision is present. When a clinician review is required, eviCore’s review determination timeframes will comply with applicable regulations.

The turnaround times are dependent upon all necessary information being provided to eviCore. If the information is insufficient to make a determination, eviCore will fax you a hold letter indicating the information that is still required. To avoid this scenario, please have updated clinical information available before contacting eviCore. Typically, the turnaround time is 2 days, depending on your jurisdiction, and submission of complete and sufficient clinical information.

The Treatment Request Clinical Worksheets facilitate online and phone submission or serve as a paper form that you can fax to eviCore. When submitting a Treatment Request electronically or by phone, the information needed for authorization is readily available from the form.

Will the clinical reviews be done by a practitioner of the same discipline?
Requests requiring clinical evaluation will be reviewed by appropriate specialty clinicians. For example, chiropractors review Treatment Requests for chiropractic services. All adverse determinations for services are reviewed by physicians or appropriate specialty clinicians.
Is peer-to-peer consultation available?
Yes. When there is a request for a peer-to-peer consultation, eviCore makes an effort to immediately transfer the call to an available eviCore clinical reviewer. When a clinical reviewer is not available, a scheduled call-back is offered at a time that is convenient for your practice. These timeframes will comply with applicable regulation and law.

How can I track the status of my Treatment Requests?
To check the status of a case, log on to the Client Portal from eviCore.com and select “Look up an existing authorization.” Enter the health plan name, provider’s NPI, patient’s ID and date of birth, and case number or authorization number.

Can I request more treatment after my Approved Time Period expires?
Yes. If you believe a patient will require more visits/units after the Approved Time Period expires, submit an updated Treatment Request for continuing care. Keep in mind that Treatment Request periods cannot overlap. Therefore, be sure the Start Date of your request for continuing care is after the expiration of your previous authorization.

To facilitate continuing care requests, please have your existing authorization number available when contacting eviCore online or by phone. If you are faxing a Treatment Request, please indicate the existing reference/authorization number in the space provided at the top of the form.

Can I file an appeal for cases that have been denied or partially denied?
We recommend that you utilize the reconsideration process before filing a formal appeal. Reconsiderations are completed via the telephone and through peer-to-peer consultations 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 peer-to-peer/reconsideration, call (855) 252-1115.

The provider can appeal a clinical decision in writing to:
Fax: (866) 699-8128
Mail: Clinical Appeals
eviCore healthcare
400 Buckwalter Place Blvd.
Mail Stop 600
Bluffton, SC 29910

Are the clinical criteria available for review?
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Yes. Evidence-based criteria are available online through the Physical Medicine page of the eviCore healthcare website:

Are separate authorizations required for a patient with two concurrent diagnoses?

No. Each medical necessity review considers all reported conditions for the patient. However, separate Notifications and Treatment Requests are required for patients receiving care from multiple practitioners or specialties (e.g., for a patient receiving both physical therapy and speech therapy).

Do you require a full exam each time the patient needs treatment?

No. A “full exam” is not required each time you seek an authorization. When you request continuing treatment for the member for an existing condition, you will be prompted to complete a Treatment Request during a member’s course of care. At that time you will be required to provide clinical information describing the member’s condition. For example, you will be asked about the member’s chief complaint (e.g., pain rating) and you may be asked about functional deficits, range of motion, or other objective findings.

If a member visits a new practitioner for services, will a new Notification be required?

Yes. When a member changes to a treating practitioner who is not within the same practice, a new Notification is required.

If a primary care provider (PCP) refers a patient, will that make any difference in the approval?

No. There are no differences in requirements for Health Plan members in regards to physician referrals. Authorizations are based on medical necessity and evidence-based criteria.

For massage therapy and acupuncture treatments, will Health Plan members require referrals from their physician, or will they continue to be able to self-refer?

The rules regarding patient referrals are not changing. Please continue to follow the same referral rules you are currently following.

Are SOAP notes for massage therapy required?

SOAP notes are not specifically required, but clinical information on each visit should be recorded in order to monitor the member’s current condition and response to treatment.
If a patient visits one clinician and does not receive authorization for continuing treatment, and then the patient visits another clinician, is the patient then covered because s/he used a different clinician?

Each case will be evaluated based on the specific clinical findings associated with the member at the time the authorization is requested.

If the second clinician seeing the member is in a separate practice from the first, then the second clinician will in all likelihood have the initial assessment covered under the Notification that care has started. If the second clinician is in the same practice as the first, then it will be considered continuing care.

If the Health Plan’s patient has a high-deductible plan, will I need to get pre-authorization for treatment that goes toward the deductible?

Patients will be best served having their benefits coordinated through the authorization program. Visits with CPT codes that are covered under the Physical Medicine Program require authorization. Please see the Physical Medicine Program content in the Care Management section of the website for CPT code list.

What do we need to do if a patient is treated and discharged, but has an aggravation months later and calls to book an appointment?

When a member returns for care after an extended break in treatment (greater than 90 days), you can evaluate and treat the member as you would normally. Submit a Notification within 7 days of this visit to obtain authorization for the new care.

How do you authorize care for patients who are suffering from long-term pain or chronic conditions, such as multiple sclerosis? Some conditions don’t show measurable improvement. How will these conditions be treated?

Each case is evaluated individually according to the clinical information provided. In general, therapy services are authorized when care requires the services of a skilled professional and there is evidence of progress and improvement. It is appropriate for the treating clinician to educate the member and the caregiver in a home management program. If the member’s condition changes significantly and additional skilled services are required, additional services can be requested and authorized.

Will treatment for a chronic condition be authorized if the condition worsens without occasional treatment and other options have been exhausted?

Each case is evaluated individually according to the clinical information provided. If the care delivered is skilled and meets the guidelines for medical necessity, we will authorize visits/units based on the clinical information presented. We will expect the home management program to be updated and if needed, the patient and caregiver should be instructed on additional procedures to maintain maximum function for the member. We would expect the care to be
spread over time and the practitioner should take on a role of a consultant to assist the member in managing the condition.

Is prior authorization needed for chronic pediatric diagnosis codes?
As of 5/15/2017, prior authorization is not needed for select chronic pediatric diagnosis codes. The diagnosis codes do not require prior authorization for acupuncture; chiropractic/manipulation treatments; physical, occupational, speech and massage therapies.

Services are still subject to benefit limitations. If the member's enrolled dependent receives multiple types of treatment that share a benefit limit, we ask that providers coordinate care to ensure his or her benefits are conserves for use throughout the plan year.

When an enrolled dependent diagnosed with one of these conditions turns 18, services will be subject to the Physical Medicine program requirements according to his or her plan benefits.

If you request authorization for an excluded pediatric diagnosis, you will see the following message on the eviCore portal: “As of 5/15/2017, no prior authorization is required for this diagnosis code with patient age is 17 and under. For questions about benefits, please contact the health plan using the phone number on the back of the member ID card.”

My practice employs providers of different specialties that are billed under my tax identification number. Who should be obtaining the prior authorization?
As in all cases, services should be performed by appropriately licensed clinicians practicing within the scope of their license. It is best if each clinician type treating Health Plan members obtains the prior authorization using their credentials.

Can an Athletic Trainer initiate an authorization for physical therapy?
No, an athletic trainer can not initiate a case for physical therapy. While Washington state law allows athletic trainers to perform specific tasks related to physical therapy, these must be performed under the supervision of a physical therapist. The physical therapist is responsible for initiating authorization.

What level of an evaluation are you expecting for the initial chiropractic visit?
The level of E&M code should depend on the level of service that is medically necessary. Based on the CPT definitions of these codes, typically the lower level E&M codes are used at the beginning of a course of chiropractic care. In many instances an E&M code would not be considered medically necessary, as manipulation codes already cover pre-service and post-service work associated with the procedure. As with other provider types, these E&M codes do not require separate authorization.

Can chiropractors create therapy cases?
Therapy cases can only be initiated by a licensed therapist. Chiropractors should build Chiropractic cases. Chiropractors can perform therapy procedures under a Chiropractic authorization. Please see the Health Plan’s list of procedure codes that require authorization under the Physical Medicine Program.

**Does the number of massage therapy sessions that are authorized depend upon the number of visits in the member’s benefit or the doctor’s referral?**

The number of authorized massage therapy sessions is determined by the clinical situation and whether or not the treatment is determined to be medically necessary according to the medical policy. There is no change to the referral requirements that are in place today.

**Why is mid-back pain not an approved code for acupuncture?**

There are no restrictions on coverage for mid-back pain. Musculoskeletal conditions in general are covered by this program. There is also acupuncture coverage for some non-musculoskeletal conditions such as asthma and allergies. Medical necessity criteria apply to all conditions covered by this program.

**Who do I call to verify member eligibility?**

Follow your standard Health Plan process for eligibility verification.

**Why am I being asked to report outcomes?**

The reporting of outcomes is voluntary. In an effort to enhance the program based on medical necessity, this information is being collected to determine the most commonly used measurements of outcomes.

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**eviCore Provider Portal – FAQs**

**Why does the eviCore site say that the member is no longer eligible for its plan?**

eviCore’s Web portal does not function as the source of plan benefit eligibility. eviCore provides only Physical Medicine program authorization requirements.

**Why is my location not shown correctly in the eviCore site?**

If you have any issues finding your location on the website, please call eviCore’s Provider Relations at (800) 646-0418, opt 3. Please keep in mind that you should be appropriately credentialed for the place that you wish to locate within the eviCore Provider Portal. Note that the Health Plan should be contacted to verify or update participation of a specific location/demographic.
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**Are there tools I can use to get familiar with the site?**

eviCore's Provider Relations team is happy to provide one-on-one portal training to providers. Additionally, the eviCore [website](#) provides videos on registration and web submission.

**How do I ensure that I am paid for services after verifying that a patient does not require authorization?**

When checking a patient's eligibility for the program requirements, and the system gives the "No prior authorization is required" message, take a screenshot for your records. eviCore and the Health Plan will honor this and allow for retro-authorizations.

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**Non-Participating Providers – FAQs**

**All Physical Medicine and Therapy Networks**

**Can non-participating providers log into the eviCore site to submit pre-authorizations?**

Yes, non-participating providers do have online access for requesting prior authorization.

**How does the authorization/Notification requirement affect out-of-network providers (non-participating providers)?**

We encourage non-participating providers to follow our pre-authorization process, and the Health Plan will reimburse for services with pre-authorization approval through available non-participating benefits. Also note:

- If the non-participating provider does not request pre-authorization, we will review medical records once the claim is submitted to determine medical necessity.

- If a non-participating provider receives a denial for a service deemed not medically necessary, the member is responsible for payment.

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**Claims – FAQs**

**When should I submit my claim to the Health Plan?**

For your claim to process correctly, it is imperative that you receive the approved Notification from eviCore at least 4 days prior to submitting the actual claim to the Health Plan for processing.
Where do I submit claims?
Follow your standard Health Plan process for claims submission.

Does the authorization number need to be on the claim?
No. There are no changes for submitting a claim. Follow the standard Health Plan claims-filing process.

Where do I enter the authorization number on the claim form?
The claims process is not changing and the authorization number is not needed on the claim submission. Please use the same procedure that you currently use for claims submission.

Does billing go through the same electronic process or does this affect where we bill, and, if so, what about auto-posting?
Billing will remain the same.

Physical Therapy and Chiropractic Practitioner Performance Summary – FAQs

What is the Practitioner Performance Summary (PPS)?
The PPS is a suite of reports available for you to monitor how you perform relative to your Health Plan peers on several efficiency measures, including: your total visit utilization over time, your average per-visit use of key therapeutic interventions, and your utilization by diagnostically related categories. The PPS also allows chiropractors to monitor radiology services per patient.

To access your PPS, log in to the eviCore.com website and select “Practitioner Performance Summary.”

How do I access the claim data used in my PPS profile?
You will be prompted to enter a PPS Security Code to enable the drill-down into patient claim data. If you do not know your code, click “Request PPS Security Code” in the PPS dashboard and select your fax number. Once you’ve entered the Security Code, click any “Your Value” data point in the PPS dashboard to access your associated claim data.

How is PPS data aggregated for my practice?
PPS analysis is based on Health Plan claims data, aggregated by provider tax payer identification (TIN).
How does the profiling take into account that my cases are more complex on average compared to Health Plan peers?

The \textit{visits per episode of care} metric is risk-adjusted to account for differences in age, gender, and diagnostic category between your patient population and those of your peer practitioners in the Health Plan network. eviCore utilizes an externally validated statistical model to account for these three factors.

Measuring risk-adjusted visits per episode (RAVE) allows practitioners with different patient populations to be fairly compared with their peers. Where patient characteristics are shown to increase the number of visits typically used, the risk factors described above adjust the visit averages of practitioners who treat such patients. For example, if a physical therapist with a high number of neuro-rehab patients has a 6.9 visit average before risk adjustment, the average may fall to 6.4 RAVE after applying the risk-adjustment factor. You will see a similar result if you treat a comparatively elderly population.

What is a “patient episode of care”? 

When determining RAVE, a patient episode of care is all treatment provided to a member for a body part or related body part within a given 12-month period. When the focus of treatment changes from one body part to a distinctly different body part, the member is considered to have experienced two episodes of care for that 12-month period. The provider’s RAVE measurement is calculated by dividing the patient’s treatments between the two distinct episodes.

What is the “peer average?”

Peer averages are calculated based on Health Plan claims data gathered from like-practitioners. Physical therapy and chiropractic claims data are calculated independently.

Does eviCore adjust for co-morbidities?

Co-morbidities are not an explicit adjustment factor. Co-morbidities are randomly distributed across a given population, so it is likely that you will have as many or as few Health Plan members with co-morbidities as the next practitioner.

Do you monitor factors other than number of visits and service units billed (e.g., functional outcome improvements with a patient)?

At this time, the PPS is based on visit and service units (CPT codes) available in the Health Plan claim data. We have asked that you voluntarily submit outcomes data on your authorization requests.

Who should I contact if I have questions about the PPS?
How does the reimbursement process work?

- If a participating provider follows our Physical Medicine Program pre-authorization process and receives a denial for some services that are considered not medically necessary, then those services are non-covered services. The provider can bill a member for services that are not medically necessary only if the provider has obtained appropriate member consent in writing, signed by the member. The member's consent form must remain on file in the provider's office and be available if we request a copy. A sample Non-Covered Member Consent Form (PDF) is located on the Health Plan’s provider website in the Library section (select Forms, then select Miscellaneous Forms).

- If a participating provider does not follow our Physical Medicine Program pre-authorization process and then receives a denial for covered services because the provider failed to comply with such process, the provider cannot bill the member for such covered services (except for deductibles, copayments, or coinsurance).

- If a member exhausts his or her benefits as provided for in the Member Agreement, then the services that the provider renders to that member are no longer subject to the terms of the Provider Agreement, except for the claim or claim line that results in the benefit maximum to be exceeded. For that claim or claim line, any balance that the provider bills to the member will be the lesser of billed charges or allowed amounts under the Provider Agreement, less any amounts paid by eviCore healthcare.

- We encourage non-participating providers to follow our pre-authorization process, and will reimburse for services with pre-authorization approval through available non-participating benefits. If the non-participating provider does not request pre-authorization, we will review medical records once the claim is submitted to determine medical necessity. If a non-participating provider receives a denial for a service deemed not medically necessary, the member is responsible for payment.

References/Resources

Quick Links:

- eviCore healthcare Homepage
  - eviCore.com
- Clinical Criteria
- Treatment Request Clinical Worksheets
**Physical Medicine and Therapy**


- **Tutorial Videos**

- **CPT Codes (Check with the health plan)**

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<td>Treatment requests, authorization inquiries, peer-to-peer consultation</td>
<td>eviCore Main Line</td>
<td><strong>(855) 252-1115</strong></td>
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