Physical Medicine program
frequently asked questions (FAQ)

OVERVIEW

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that manages the utilization of:

- Joint surgery (inpatient and outpatient)
- Spinal surgery (inpatient and outpatient)
- Interventional pain management
- Specialized rehabilitation (physical therapy, occupational therapy and speech therapy)

eviCore manages care for more than 100 million patients. Their pre-authorization reviews promote clinical improvement and better outcomes.

What does eviCore base its decisions on?
eviCore creates its policies (clinical guidelines) internally using information from the best available sources, including contributions from community physician panels, academic institution experts and current clinical literature. eviCore also has dedicated pediatric clinical guidelines. All guidelines align with national professional societies.

eviCore reviews provider-submitted clinical information to evaluate pre-authorization requests. If the clinical information meets the standards of eviCore's evidence-based guidelines, a nurse reviewer approves the request. If the request cannot be approved, it is forwarded to a medical director.

Why is medical management necessary?
It is impossible for a clinician to keep up with all new medical advances. Medical knowledge grows faster than the profession can assimilate it and effectively apply it. Additionally, new information is sometimes proven incorrect through subsequent research, and it can take clinicians years to change contraindicated practices.

eviCore uses its combination of specialized medical professionals, advanced technologies and quality-improvement processes to help providers ensure that each patient receives the right care at the right time and at the right location.

Limiting the utilization of unnecessary or inappropriate services improves quality and reduces costs so we can continue to offer a valuable product at a reasonable price. By using eviCore's solutions, we help members receive the most from their coverage to ensure that requested treatments and procedures are appropriate and medically necessary based on clinical presentation. Our goal is to enable patient-centric care while improving health outcomes.

How can I check whether a service requires pre-authorization? How do I submit a request?
Not all members are subject to eviCore's review. The most efficient way to check a member's pre-authorization requirements and submit a request are via Availity Essentials, **availity.com**.

Does using eviCore's website require me to set up an account?
Yes. A one-time registration is required for each practice or individual. You must sign in prior to requesting authorizations.

I've submitted my pre-authorization request. When will I receive a determination?
eviCore makes determinations within state- and federal-mandated turnaround times for both urgent and standard reviews. Most reviews occur within two business days.

Is there a way to verify whether an approval number has been assigned to a pre-authorization request?
Yes. After signing in at **evicore.com**, users can click on "Authorization Lookup" to determine the status of a case.

How long does my patient's approval last?
Rehabilitation authorizations are valid for 60 days. The authorization's expiration date is included in the approval notification.

You can request a one-time 30-day authorization extension if all visits within the authorization have not been used.

Why do some procedures require specific treatments prior to surgery being approved (e.g., psychological evaluation, a course of physical therapy)?
Evidence shows that spinal surgeries can fail up to 74% of the time. 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). Because of this, eviCore requires that all appropriate conservative treatments be exhausted prior to invasive surgery.

What tools does eviCore offer to support providers?
eviCore offers the following tools and resources:

- A newsletter for providers and their staff
    - To subscribe, visit **evicore.com**, scroll to the bottom of the page, and enter your email address in the Stay Updated with Our Provider Newsletter field.
- Clinical guidelines, available on their website
- Provider training and education via town hall-style meetings, webinars or web-based e-learning modules
- Manuals tailored to provider specialties, available upon request

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY

Why was my patient denied additional visits?
Visits and units should be spread across the already-approved authorization period. If visits and units are used early in the authorization period, your request for additional visits in that period must show medical necessity. If the additional visits and units are not medically necessary, the request will be denied. The denial reason will be included in provider and member letters.

My patient was approved for 24 units and six visits, but we used 24 units in five visits. Can I see the patient for a sixth visit without pre-authorization?
No. Pre-authorization requests are approved in visits and/or in units (e.g., six visits or 24 units). The approved authorization concludes when either of those limits is reached. Additional visits or units require a new pre-authorization request.

I received an authorization for my patient. Why is the authorization broken down by visits rather than units of service?
This means the patient's benefit is based on visits, not units.

If there is a benefit limit, why can't the member receive all the service visits the benefit allows?
eviCore's role is to monitor the use of the patient's benefit. Benefits cover medically necessary services only. Clinical documentation must demonstrate medical necessity.

How often do I need to submit information about my patient's progress?
If visits/units are spread out through the approved period, submit information at the end of that 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 multiple problem areas in the same visit. If multiple conditions are treated at each session, the therapist should submit information to this effect; eviCore will approve additional units per visit to allow management of multiple conditions.

CLAIM DENIALS, PEER-TO-PEER DISCUSSIONS AND APPEALS

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 our system from eviCore. There is also a small delay if an employer group renews or is newly added to eviCore's system. To avoid having a claim mistakenly denied, allow several business days after the authorization is approved for us to receive that information before submitting a claim.

What is a peer-to-peer consultation?
A peer-to-peer consultation is a discussion with an eviCore clinical peer reviewer about a pre-authorization decision. It occurs before services are performed. Peer-to-peer consultations can be requested within 14 calendar days of the determination date and before an appeal has been initiated.

You can request a peer-to-peer consultation by phone, fax or mail.

When you request a peer-to-peer consultation by phone, eviCore transfers the call immediately to an eviCore medical director. If a medical director is not available, eviCore offers a scheduled call-back time that is convenient for you.

For commercial requests: If you disagree with eviCore's determination, you can request a peer-to-peer consultation with eviCore. These reconsiderations are completed by phone and through peer-to-peer discussions with eviCore's medical directors, as applicable. A peer-to-peer consultation cannot occur if an appeal is already in process or has been completed. If the initial decision is upheld, the next step is an appeal. The determination letter provides instructions for appealing a medical necessity decision, including the provider's right to submit additional information.

For Medicare Advantage requests: eviCore is not delegated to process appeals for Medicare Advantage requests. If there is a disagreement with a denial on a Medicare Advantage pre-authorization request, the provider or member should file an appeal with us. The review determination letter provides instructions for appealing a medical necessity decision, including the provider's right to submit additional information. A peer-to-peer discussion is available following a denial for consultation only.

Who conducts peer-to-peer discussions?
eviCore's clinical reviewers have experience in their respective musculoskeletal specialties and can assist you with understanding clinical rationale and the evidence-based guidelines.

CONTACT EVICORE

Register for eviCore's secure web portal, **evicore.com**. From the homepage, click Resources in the top right corner to find:

- Clinical guidelines
- Clinical worksheets
- Training resources and more

Additional training and resources are available on eviCore's website.

Pre-authorization requests can be faxed to (855) 774-1319.
For email support, contact **clientservices@evicore.com**.

Request a peer-to-peer discussion

Phone	Fax	Mail written request
(855) 252-1115	(800) 540-2406	Clinical Appeals, eviCore healthcare 400 Buckwalter Place Blvd. Mail Stop 600 Bluffton, SC 29910