

## Frequency Asked Questions

### Physical Therapy / Occupational Therapy / Speech Therapy / Chiropractic

#### **What services require prior authorization through the Therapy Program?**

The Physical Medicine and Therapy UM Program manages outpatient services for:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Chiropractic

A complete list of CPT codes that require authorization can be found on the eviCore/Passport implementation website at

<https://www.evicore.com/implementation/pages/ImplementationResourceDetails.aspx?ImpID=54>

#### **What Passport Health Plan members are included in the Program?**

Medicaid

#### **If Commercial/Medicare are primary and Passport is secondary, is an authorization required?**

Yes, if Passport is secondary, authorization is still required with one exception:

- Authorization is not required if the member has Medicare A&B or TriCare.

Please note that authorization is required if Medicare A or Commercial Insurance I primary.

#### **What is a Notification?**

A notification is the initial authorization request submitted to eviCore healthcare informing Passport 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 for your patient's episode.

The notification consists mostly of patient demographic information. Minimal clinical information is requested to 1) determine whether the request is for a new condition and/or 2) establish whether a physical or occupational therapy patient presented with a post-operative condition (post-operative may not be applicable for chiropractic). Note: The initial evaluation should be conducted prior to notifying eviCore healthcare. This will insure you have information to complete the notification process. The Notification must be submitted within 7 days of the initial visit.

### **Although Passport Health Plan will not allow retrospective requests, what if the member receives Retro Eligibility?**

For members who are truly Retro Eligible, authorization of OP services (PT, OT, SLP, Chiro, PM) do not require retro authorization. If a member has Passport Health Plan and an authorization is not obtained, eviCore will allow the retro for an initial evaluation only otherwise a retro for any other reason is not allowed.

### **What is a Treatment Request?**

The Treatment Request is required for submission of patient and practitioner information for medical necessity review. Treatment Requests are condition-specific based on the type of service requested and done when an episode requires additional visits after the initial authorization is exhausted

The preferred method to submit Treatment Requests is online at [www.eviCore.com](http://www.eviCore.com). With online submission, you may receive an instantaneous review determination for your Treatment Request.

If you have an urgent request, you may call eviCore at 877-791-4099, 7 a.m. through 7 p.m. local time Monday through Friday or fax 858-774-1319. As a last resort you may fax requests and include eviCore's clinical worksheets. Please understand fax requests may create a delay if the clinical information is not provided. Submission of additional information beyond the clinical worksheet is not necessary. If the worksheet is completed thoroughly there is enough information to perform a medical necessity review.

Worksheets are available at [www.evicore.com](http://www.evicore.com). Completion of the worksheet prior to submitting a Treatment Request will simplify/speed the process.

### **What clinical information will be asked for during the Treatment Request submission?**

The information is tailored to the patient condition and therefore varies. In general, we ask for the following clinical information:

- Diagnosis/ICD-10 code
- Pain level and the percent of time they have 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 and/or hospitalizations, if applicable
- Restrictions
- Co-morbidities

- Conditions that would prohibit the safe delivery of care
- Range of motion and strength findings
- Gait assessment/special tests
- Functional assessment
- For pediatric therapy,
  - recent standardized test scores and behaviors
  - plan of care with short term goals and baseline measures for each
- Additional information that will help us make a decision

Refer to the condition specific Treatment Request Clinical Worksheets on the eviCore website for the clinical information required using the link below:

<https://www.evicore.com/resources/pages/providers.aspx>

**Do the services provided in an inpatient setting at a hospital or emergency room setting require an authorization?**

Therapy services provided during an emergency room treatment visit or inpatient stay do not require an authorization.

**If the CPT code is previously authorized by Passport Health Plan and is not on the eviCore CPT code list, does it still need authorization through Passport Health Plan?**

Not for physical therapy, occupational therapy or speech therapy. Passport will be using the list proposed by eviCore effective 10/01/2016. The authorization is required for Chiropractic.

**Will Passport Health Plan honor existing authorizations received through the health plan during the transition phase effective 10/1/2016? If patients are receiving ongoing care for a period of time will a new authorization be needed with eviCore after 10/01/2016 if authorizations have already been obtained from Passport?**

Passport will honor existing authorizations for Physical Therapy, Occupation Therapy and Speech Therapy. If Passport has already approved visits for dates of service after 10/01/2016, these authorizations will be honored, and the provider will need to request additional visits from eviCore on the next review date, if needed.

Chiropractic will require an authorization for any applicable visit benefits currently in place. The authorization should be obtained through eviCore starting 10/1/2016. Although Passport Health Plan will continue to allow 26 visits per calendar year, visits must be authorized through eviCore. Under the new program, the benefit limit will remain at 26 visits per year however managed through eviCore beginning 10/1/2016.

**What are the medical necessity review requirements for the Program?**

If you are a Passport Health Plan participating practitioner, you may be required to submit a Treatment Request for all treatment after the initial visit.

### **Will a medical necessity review specify the number of services approved?**

The authorization will include visits and an approved time period. The number of approved visits is based on the clinical information provided at the time of the request. More complicated cases typically receive authorization for a greater number of visits than less complicated cases. Payment for approved visits always depends upon the patient's eligibility and available insurance benefit.

### **How many visits will eviCore healthcare approve when I submit a prior authorization?**

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

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

Requests for continuing care will be reviewed for medical necessity. Visits will be authorized based on the clinical information provided.

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

Follow your routine Passport Health Plan process for eligibility verification. For more information please check Passport Health Plan website at [www.passporthealthplan.com/providers/](http://www.passporthealthplan.com/providers/)

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

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

### **If a Primary Care Physician refers a patient to a therapist for services that require authorization, who needs to request the authorization?**

The therapist/facility would request the authorization.

### **What is an Approved Time Period?**

The Approved Time Period is the time period (duration) available to use approved visits. Visits must be spread throughout the authorized period to avoid a gap in care at the end of the Approved Time Period.

### **How long are Approved Time Periods?**

For adult and pediatric orthopedic conditions, medical necessity authorizations are typically approved for a 30-day period, allowing the servicing practitioner to assess the patient's response to treatment. Medical necessity authorizations for pediatric

developmental/neurologic conditions may be approved for longer periods. Periods may be shorter or longer depending on the member's condition and timing of the request.

**Are the clinical criteria available for review?**

Yes. Evidence-based criteria will be available online through the eviCore practitioner web portal at <http://www.evicore.com/solution/Pages/Musculoskeletal.aspx>.

**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, the Treatment Request is required for medical necessity reviews.

**Will separate authorizations be required for a patient with two concurrent diagnoses?**

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

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

For initial prior authorization requests (Notification), the Start Date is the patient's initial evaluation date. Again, the Notification must be submitted within 7 days of the initial visit. For continuing care requests, the Start Date is the first visit that requires authorization after the previous Approved Time Period expiration. Do not enter the first date of the patient's treatment episode for continuing care requests. Continuing care requests must be submitted within 7 days of the Start Date.

**How far in advance can I submit a Treatment Request?**

Submit Treatment Requests no more than seven 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 current findings date reported on your Treatment Request should be within ten 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.

**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 normal Passport Health Plan process for all DME. For more information please check the Passport website.

### **What is the timeframe for a case to go through the Treatment Request review process?**

If medical necessity can be established based on evidence-based criteria, visits will be authorized at the time of your Treatment Request submission. When you submit online, this authorization will be instantaneous. 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 there is insufficient information to make a determination, eviCore will fax you a letter indicating the information that is still required. To avoid a delay in approval, have updated clinical information available before contacting eviCore.

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

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

### **How can I track the status of my Treatment Requests?**

To check the status of a case, log on to [www.eviCore.com](http://www.eviCore.com). Click on Provider login, and select the CareCore portal. From there you can select "Authorization Lookup."

### **Can I request more treatments after my Approved Time Period expires?**

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

### **Can I extend the End Date of an authorization if I didn't use all the approved visits?**

Yes. eviCore will approve one extension per Approved Time Period up to 30 days. A date extension will not be granted if requested after the authorization period has expired. A date extension may be requested online at [www.eviCore.com](http://www.eviCore.com), click on Provider login, and select the CareCore portal or by calling eviCore at 877-791-4099. Date extension requests via fax will not be accepted.

### **If a member goes to a new practitioner for services, will a new authorization be required?**

Yes. When a member changes to a treating practitioner who is not within the same practice, a new prior authorization request is required. If the member has an active authorization with a different provider, you will be asked to provide a discharge date or summary from the initial provider to confirm that the initial care has been discontinued.

### **Will treatment be authorized for chronic conditions if the condition gets worse without occasional treatment and other options have been exhausted?**

Each case is specifically considered. If the care delivered requires the skills of a therapist and meets the guidelines for medical necessity, we will authorize visits 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 in 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.

**Can the member receive treatment for the same condition from two providers (same specialty) at the same time?**

In most cases, this would be considered duplicate care and would not be approved.

**Is peer-to-peer consultation available?**

Yes. When there is a request for a peer-to-peer conversation, eviCore makes an effort to immediately transfer the call to an available eviCore clinical reviewer. When one 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.

**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.

**Where do I submit claims?**

Follow your routine Passport Health Plan Insurance process for claims submission. For more information please check the Passport Health Plan website.

**Does the first visit for evaluation need to have an exam code?**

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

**When requesting more treatment, do I charge the patient for re-evaluation exam CPT code every 30 days?**

The information submitted for a medical necessity review is available via ongoing, routine assessment of the patient's response to care so a formal re-evaluation will not be necessary.

**My practice employs providers of different specialties that bill under my tax identification number. Who should be obtaining the 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 authorization using their credentials.

### **What information about the authorization will be visible on the eviCore Web site?**

The authorization status function on the Web site will provide the following information:

- Authorization Number/Case Number
- Status of Request
- CPT Code(s) and quantities of the code(s)
- Procedure(s) Name
- Site Name and Location
- Authorization Date
- Expiration Date

Using the web portal increases the possibility of an immediate decision. It is available 24/7.

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

The eviCore web portal does not function as the source of plan benefit eligibility. eviCore only provides program authorization requirements.

### **Why is my location not showing correctly on the eviCore site?**

If you have any issues finding your location on the website, please call eviCore Provider Relations at (800) 646-0418 option 3. Please keep in mind that you should be credentialed at the location that you wish to locate within the eviCore Provider Portal.

*Note:* verification of participation of a specific location/demographic updates should be done via the health plan.

### **Are there tools I can use to get familiar with the site?**

eviCore Provider Relations team is happy to provide one-on-one portal training to providers. Additionally, the eviCore website contains videos on registration and web submission, CPT code list, FAQ, Quick Reference Guide, and more at

<https://www.evicore.com/implementation/pages/ImplementationResourceDetails.aspx?ImplD=54>

### **How will all parties (performing provider and member) be notified if the request has been approved?**

Performing providers will be notified of the authorization via fax. Members will be notified in writing of any adverse determinations. Authorization is also available on the web portal at any time.

### **If a request is not approved, what follow up information will the performing provider receive?**

The performing provider will be informed of the reason for denial, as well as how to initiate a reconsideration or appeal. If a provider resubmits an authorization request for a service within the timeframe allowed for an appeal that was previously denied, eviCore will consider this request an appeal. If the timeframe to file an appeal has expired, the request



will be treated as a new request for authorization. Within fourteen (14) business days after the denial has been issued, the provider may request reconsideration with an eviCore Medical Director to review the decision.

**Is there is an appeals process if the authorization is not approved?**

Yes. Appeal rights are detailed in communications sent to the providers with each adverse determination. Providers may also request reconsideration from eviCore within fourteen days of the denial decision.

**What is the format of the eviCore authorization number?**

An authorization number is (1) one Alpha character followed by (9) nine numeric numbers. For example: A123456789.