

1. Q. What is eviCore healthcare's role in managing authorizations for physical, occupational and speech therapy services by therapists and physical medicine services by chiropractors?

A. eviCore makes determinations on authorization requests for:

- Physical, occupational and speech therapy services by therapists for BCN HMOSM (commercial) and BCN AdvantageSM members
- Physical medicine services by chiropractors for BCN HMOSM (commercial) members

2. Q. How should I submit an authorization request for initial therapy services?

A. Through May 26, 2019, submit requests for initial services to BCN using the e-referral system. Starting May 27, 2019, submit requests for initial services to eviCore in one of these ways:

- Through the eviCore provider portal. This is the most efficient way to submit an authorization request and check its status.
- By calling eviCore at 1-855-774-1317 (Normal business hours are 8 am to 7 pm Eastern time, Monday through Friday.) Listen for the appropriate prompt.
- By faxing the request to eviCore at 1-855-774-1319. Fax the completed clinical worksheet pertinent to the authorization request you're submitting.

Requests for follow-up services should be submitted as follows:

- Through May 26, 2019, submit requests for follow-up visits through the Landmark Healthcare provider portal.
- Starting May 27, 2019, submit requests for follow-up visits to eviCore. This includes continued services for authorization requests originally submitted through the Landmark Health provider portal.

Note: Starting May 27, you'll be able to view all authorization requests — whether completed or in process — in the eviCore portal. In the Landmark portal, you won't be able to make any additional changes to requests.

3. Q. How do I access the eviCore provider portal?

A. You can access the eviCore provider portal in one of these ways:

- Through the eviCore healthcare website. To do that, visit www.evicore.com.* Under the Portal Login heading, enter your user ID and password. Check the boxes, as appropriate, and click *Login*.
- Through web-DENIS. On the Eligibility / Coverage screen, click the Authorizations and Referrals button for that member, in the Prior Authorization column of the table. (This option will be available starting May 31, 2019.)

4. Q. What clinical information do I need to submit through the eviCore provider portal?

A. Submit the following information for each request

- Member's name, date of birth, plan name and plan ID number.
- Ordering doctor's name, national provider identifier, tax identification number and fax number
- Place of service
- Rendering facility's name, NPI, TIN, street address and fax number
- Service being requested
- Diagnosis codes
- All relevant clinical notes, including imaging and X-ray reports, patient history and physical findings

When you're submitting an authorization request through the eviCore provider portal, be sure to answer the questions that are presented to you within the portal.

5. Q. Where can I find eviCore's clinical worksheets — the ones I need to submit if I'm faxing my authorization request?

A. To access the worksheets, complete these steps:

1. Visit www.evicore.com.
2. Click *Providers*, at the upper right.
3. Scroll down and click *Clinical Worksheets*.
4. Click *Musculoskeletal: Therapies*.
5. Enter Blue Care Network in the "Search by Health Plan..." field.
6. Click *Blue Care Network*.
7. Click to open the document you want to see, underneath the heading for the pertinent therapy type.

6. Q. How can I submit an authorization request for medically urgent services?

A. You should submit urgent requests (requests for which you need an expedited determination) in one of these ways:

- In the eviCore provider portal. Access the portal through the Eligibility/Coverage screen in the Blue Cross web-DENIS system. Click the Authorizations and Referrals button associated with the member on that screen. (This option will be available starting May 31, 2019.)
- By calling eviCore at 1-855-774-1317. Listen for the appropriate prompt.

Important! Do not submit urgent requests by fax.

Urgent requests must include a physician's attestation that the services are necessary for a condition that is jeopardizing the member's life or health and that is deemed life-threatening. eviCore will process urgent requests within four hours and no later than the end of the business day on which the request is received.

7. Q. How can I check the status of an authorization request?

A. You can check the status of an authorization request in one of these ways:

- In the eviCore provider portal. Access the portal through the Eligibility/Coverage screen in the Blue Cross web-DENIS system. Click the Authorizations and Referrals button associated with the member. (This option will be available starting May 31, 2019.)
- By calling eviCore at 1-855-774-1317. Listen for the appropriate prompt.

8. Q. Will an approved authorization have an identifying number on it?

A. Yes. An authorization that's been approved by eviCore is assigned an eight-digit number preceded by the letter A.

9. Q. How will eviCore notify providers and members of the determination made on an authorization request?

A. eviCore will send written notification of the determination made on an authorization request — whether it's an approval or a denial — to the requesting professional provider and to the member. Facilities will not receive a written notification. Once a service is denied, an appeal must be filed to have the request reviewed again.

10. Q. How long is an authorization valid?

A. Authorization time frames vary depending on the member's benefit. Check your authorizations in the eviCore provider portal to see the time frame that applies to each. Then:

- If none of the authorized services is performed within the time indicated — for example, within 45 days from the time the authorization request is approved — you should withdraw the authorization.
- If some but not all of the services are performed within the time indicated, you can request a one-time date extension for that authorization through the eviCore provider portal or by calling eviCore at 1-855-774-1317, if the member's benefit limit allows (or has not been met).

11. Q. How can I request a peer-to-peer review (consultation) of an authorization request that was denied?

A. We encourage you to submit requests for peer to peer reviews (consultations) using the eviCore website. This is the most efficient way to submit a request, to avoid being on hold on the phone. Here's how to submit the request:

1. Visit the eviCore website at www.evicore.com. Access the portal through the Eligibility/Coverage screen in the Blue Cross web-DENIS system. Click the Authorizations and Referrals button associated with the member on that screen. (This option will be available starting May 31, 2019.)
2. Click *Providers*, in the upper right corner of the home page.
3. Click *Request a Consultation with a Clinical Peer Reviewer*, under the "I Would Like to" heading.
4. Select *Blue Care Network* in the first drop-down menu on the Request a Consultation page.
5. Select *Musculoskeletal* in the second drop-down menu on that page.
6. Complete the fields.
7. Click *Submit*.

You'll receive an email with the peer-to-peer review appointment information.

You can also submit the request by calling eviCore at 1-855-774-1317 or through the eviCore provider portal. The instructions for using the provider portal to submit a request for a peer-to-peer review will be explained in the provider training.

Note: For BCN HMO members, a peer-to-peer review may result in a reconsideration and a change in the decision on an authorization request. For BCN Advantage members, it's not possible to change an authorization decision through a peer-to-peer review. For those members, eviCore can conduct a peer-to-peer discussion but you'll need to submit an appeal to request a change in the decision on an authorization.

12. Q. Will eviCore review authorization requests retrospectively if I didn't submit an authorization prior to the services being provided?

A. Yes. eviCore will review authorization requests if they are submitted within two calendar years after the service was provided. To be eligible for approval, the services must meet the clinical criteria for appropriateness.

Claims submitted for services that are not authorized are subject to denial and you cannot seek reimbursement from the member.

13. Q. How can I verify that I'm a contracted provider for BCN HMO and BCN Advantage?

A. You can verify your credentialing and contracting status by calling the Blue Cross Provider Enrollment and Data Management department at 1-800-822-2761.

14. Q. How can I join the BCN HMO or BCN Advantage provider network if I'm not already participating?

A. You can enroll with BCN by visiting bcbsm.com/providers. Click [Enroll to become a provider](#) and follow the instructions on the page that opens.

15. Q. How does eviCore determine whether a provider is in network?

A. eviCore receives a provider file from BCN that shows all participating and nonparticipating providers.

You can verify which provider networks you belong to by following the instructions on the *Finding your Blues plans* document. To access that document, visit bcbsm.com/providers, log in to Provider Secured Services and click *BCN Provider Publications and Resources*. Click *BCN Products*. Look under the “General product information” heading.

16. Q. How can I check a member’s eligibility and benefits?

A. You can check a member’s eligibility and benefits through web-DENIS. To access web-DENIS, visit bcbsm.com/providers and log in to Provider Secured Services.

17. Q. Where do I submit claims for services authorized by eviCore?

A. Submit therapy claims for BCN HMO and BCN Advantage members in the same ways you submit other claims. Refer to the Claims chapter of the *BCN Provider Manual* for information on submitting claims for BCN HMO members. Refer to the BCN Advantage chapter of the *BCN Provider Manual* for information on submitting claims for BCN Advantage members.

18. Q. How do I file a complaint?

A. Submit the complaint to eviCore at clientservices@evicore.com.

19. Q. What materials does BCN use to educate members about outpatient rehabilitation benefits? How do these materials show that treatments must be based on medical necessity and that there may be a difference between the limits of the member’s benefits and the visits that are approved?

A. All new members get a member handbook with a customized benefit summary. In addition, when BCN Customer Service representatives give information to members on their benefits and how authorization works, they tell members:

- If the member has a benefit based on the number of visits, the visits approved during clinical review may differ from the member’s benefit limits. For example, a member may have a 60-visit benefit but that this doesn’t guarantee approval of a request for all 60 visits by eviCore healthcare. The authorization decision is based on whether the visits are medically necessary.
- If the member has a benefit based on a specific number of days, all medically necessary visits need to be completed by the end of the benefit period. The benefit period count starts with the date of the first treatment. For example, a member with a 60-calendar-day benefit may receive medically necessary care from June 18, 2019, to August 17, 2019. The benefit is exhausted after August 17, 2019.

Note: Some members have a benefit that gets renewed — for example, after surgery.

20. Q. eviCore may authorize the evaluation and treatment dates at the same time — on the same date and in the same authorization request. If the claim shows an evaluation date that occurs before the date of the first treatment visit, how are these dates handled when the claim is received? (Providers are told that the benefit start date is the date of the first treatment visit.)

A. All therapy services, including both the evaluation and treatment visits, must be covered by a date span specified in the authorization request. Providers should enter both the evaluation and the treatment visits on the same authorization request. For each service, providers can enter a date span that starts on a different date. In addition:

- The initial evaluation does not require authorization. If you're requesting authorization before the treatment begins, complete the evaluation and then submit the authorization request within seven days of the evaluation date. The start date on the authorization request should be the first day of treatment. If treatment was provided on the same day as the evaluation, use the evaluation date as the requested start date. If treatment was not provided during the evaluation, use the date of the first treatment following the evaluation.

Note: Contact eviCore at 1-855-774-1317 if the treatment start date needs to be changed.

- If the evaluation and treatment start on the same date, the start date of the authorization (as requested by the provider) is the start date of the member's benefit for that service.

If the claim for the evaluation shows a date of service that is before the authorization's start date, the claim is pended; it isn't automatically denied. Instead, BCN Claims staff will contact eviCore and arrange for the start date on the evaluation line to be moved back. The date span on the modalities line, however, remains unchanged. This way, the evaluation claim can be paid and the member is afforded the full date span for his or her treatments.

21. Q. What therapy requests need to be submitted directly to BCN through the e-referral system?

A. Submit the following therapy requests to BCN through the e-referral system and not to eviCore:

- Therapies done by skilled nursing facilities
- Stand-alone orthotic splints
- Stand-alone massage therapy

Note: Physical, occupational and speech therapy services for members under the age of 19 with a diagnosis of autism do not require authorization.

22. Q. Can members opt out of reporting some of their rehab visits to eviCore? Example: A BCN member may need treatments beyond a 60-calendar-day time frame; intervals of treatment may be needed throughout the year. Some families with children would prefer using benefits for treatment during the summer and want to opt out of reporting visits during the other times of the year.

A. Members must report *all* outpatient rehab visits. Reporting some visits and not others isn't an option.

23. Q. What can providers do to limit their financial liability when they know one of the following? That -

- **Authorization won't be given.**
- **The member's benefits don't include the services they provide.**
- **The member is about to or has exhausted his or her benefits.**
- **The member chooses to opt out of reporting visits to BCN.**

A. Guidelines for providers are outlined in the "Exclusions and limitations" section of the [BCN Advantage chapter](#) of the *BCN Provider Manual*. These guidelines apply to members with BCN HMO (commercial) or BCN Advantage coverage.

24. Q. Do providers need to submit functional limitation G codes for BCN Advantage members like they do for Original Medicare members?

A. For dates of service on or after Jan. 1, 2019, you don't need to report the nonpayable functional limitation G codes and their applicable modifiers.

For dates of service prior to Jan. 1, 2019, you must report the nonpayable functional limitation G codes and their applicable modifiers when billing outpatient physical, occupational and speech therapy services for BCN Advantage members. Functional assessment reporting codes submitted in conjunction with therapy services are used to gather data on Original Medicare claim submissions. There is no payment for these services.

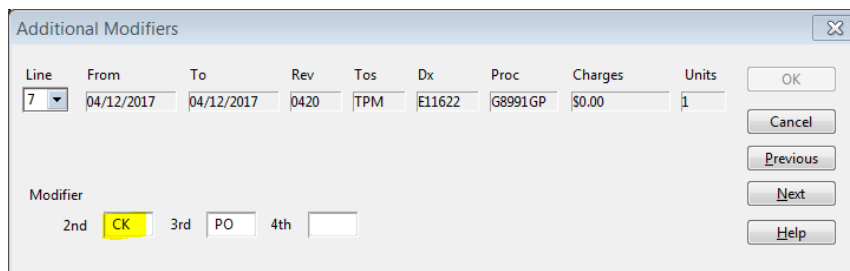
Report the modifiers for the nonpayable G codes as secondary modifiers and not as primary. Modifiers reported as primary will cause an error in our payment system and the claim will be denied.

Here's an example showing how to report these codes and modifiers correctly:

- **Report as primary:** In the line item, report the BCN Advantage modifier for the type of therapy (physical, occupational or speech) along with the G code.

04/12/2017	04/12/2017	0420	TPM	G8991GP	1	\$0.00	E11622
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- **Report as secondary:** In the "Additional Modifiers" box, report the required Centers for Medicare & Medicaid Services modifier.



Line	From	To	Rev	Tos	Dx	Proc	Charges	Units
7	04/12/2017	04/12/2017	0420	TPM	E11622	G8991GP	\$0.00	1

Modifier

2nd ☒ 3rd ☐ 4th ☐

OK Cancel Previous Next Help