# Tips about eviCore Authorizations for BCN Members

## Elements of an authorization

For eviCore healthcare (formerly Landmark Healthcare™), the treatment authorization for BCN members includes two elements:

- The number of visits authorized
- The period of time (duration) in which those authorized visits can be used, referred to as the "Approved Time Period" (This is included in the body of the letter.)

  Note: The benefit period is *not* the same as the authorized duration. The benefit period is the period of time included in the member's contractual benefit.

Visits must be spread throughout the authorized duration to avoid a gap in care at the end of the time period (duration). Medical necessity authorizations are usually approved for a 30-day period.

If the member has a setback or complication, additional visits may be requested before the authorized time period is over; however, an updated eviCore treatment plan must be submitted with objective clinical findings and a detailed explanation of the reasons for the early request for additional visits. Without this information, the request may be denied.

## Changes to partial-approval determination letters

The partial-approval letters have been revised to provide clearer information, including the number of authorized visits and the care duration. Member letters follow the same format as the provider letters. The member letters include an assurance that additional visits may be requested after the member completes the existing duration of care.

## Tips for avoiding a request for information

A request for information is sent when medical necessity cannot be determined because:

- **PROBLEM:** Objective clinical information is not included on the treatment plan request or the clinical information provided is greater than seven days old. (If you have been treating the member over that period of time, the objective findings may have changed.)

  **TIP:** Be sure the treatment plan:

  - Reflects objective clinical information that is no more than seven days old
  - Includes significant changes in function, motion, strength, pain and edema

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## Tips for avoiding a request for information (continued)

A request for information is sent when medical necessity cannot be determined because:

- **PROBLEM:** You are requesting visits prior to the end of the prior authorization. The visits were used too quickly without an explanation as to why the member required a greater intensity of care.

  **TIP:** Explain in the treatment plan the reasons the patient needs to be seen more frequently than was specified in the authorization. Be sure to document complications or setbacks that may have occurred. If necessary, you may fax your fully completed updated treatment plan and attach additional information.

- **PROBLEM:** The diagnosis code used was nonspecific and eviCore is unable to determine what condition the treatment will address.

  **TIP:** Use the most specific diagnostic code available to describe the member's condition. Also, indicate whether you are treating the left or right side of the body, if the member has had treatment in the past for the same body region.

- **PROBLEM:** You are requesting authorization for additional visits before using your six-visit waiver.

  **TIP:** Submit a request for additional visits if medically necessary after the fifth visit. Include the progress made since the start of care.

## Time frame for responding to a request for information

Providers must submit requested information to eviCore within seven days of the date on the information request letter or services will be administratively denied. eviCore is required to close the request within the time frames established by Blue Care Network.

Providers may reopen the case by submitting the requested information to eviCore as soon as possible.

## General tips about referrals

- Indicate recent surgeries that affect the primary condition (type of surgery and date) in the Provider Communication section on e-referral.
- Identify the side of the body affected (left or right) in the Provider Communication section in the e-referral system.
- Botox®, steroid, epidural and other injections do not initiate a new episode of care.
- Avoid nonspecific diagnosis codes on the referral. If these codes must be used, indicate the body part in the Provider Communication section in the e-referral system.