Authorization FAQs for therapy and physical medicine services

1. What are eviCore's available Treatment Plans and how do I know which one to send?

Several versions of eviCore's Treatment Plan are available in order for you to report pertinent information based on the patient's primary condition:

- Standard Therapy Treatment Plan - Orthopedic conditions except for the hand/forearm
- Hand Therapy Treatment Plan - Hand, wrist, and elbow conditions
- Lymphedema Management Treatment Plan - Lymphedema
- Neurological Rehabilitation Treatment Plan - Adult and pediatric neurological and developmental conditions
- Vestibular Rehabilitation Treatment Plan - Vestibular and dizziness conditions

When you submit a request electronically, the selection of the proper Treatment Plan form is automated based on the primary diagnosis entered at the beginning of the form. For example, if you enter lymphedema as the primary diagnosis, the e-Form will prompt you to complete the Lymphedema Management Treatment Plan.

If you fax your Treatment Plan, select the form that best fits the patient's primary condition. eviCore will not return a Treatment Plan to you because it does not "match" the patient's primary diagnosis. However, use of the proper form will help ensure that you provide the most relevant information to the clinical peer reviewer.

- e-Forms: Login to the provider portal at www.LMHealthcare.com
- Fax: (888) 565-4225

2. What do I do if I entered the wrong primary ICD code?

The e-Form changes dynamically based on the primary ICD code. Up until the point you submit the e-Form, you can adjust the diagnosis. If your adjustment changes the version of the Treatment Plan to be completed, your responses to the "global" fields (those applicable to every version) will be retained. The e-Form will not retain any responses you entered in the dynamic fields.

For example, you start filling out the Standard Therapy Treatment Plan, and then change the ICD code to one that triggers the Hand Therapy Treatment Plan. The global fields (e.g. Date Current Objective Findings Obtained) will be retained because they are always applicable. However, your condition-specific responses (e.g. spinal ROM) will not be retained since they are not applicable to every Treatment Plan. If your change in diagnosis does not change the version of the Treatment Plan (e.g. from one hand ICD code to another hand ICD code) all of your responses will be retained.

If you need to change the primary ICD code for a previously submitted Treatment Plan, please call eviCore. You will not be required to complete a different version of the Treatment Plan on an already submitted authorization request and/or for an existing authorization.

3. Can I use my own forms when requesting authorization for therapy or physical medicine services?

No. To ensure that clinical peer reviewers receive the necessary and complete information, and to make consistent clinical determinations, we only accept requests submitted on an eviCore Treatment Plan. When submitting paper forms, be sure to complete every section. Treatment Plans with incomplete sections or references such as "See attached" in lieu of completing items on eviCore's form will be returned to the requesting provider for resubmission.

4. Am I required to complete the Revised Patient Specific Functional Scale (PSFS)?

The Revised PSFS section is included and required on all Therapy Treatment Plan submissions, regardless of your UM Category. Enter the scores that the patient gives you in the Revised PSFS section of your Treatment Plan.

The initial PSFS should be completed at the start of care. Record the patient's limited functional activities (a minimum of three) and scores exactly as stated by the patient. Throughout the episode, ask the patient to score the same activities each time you submit a Treatment Plan requesting continuing care. You may include additional activities as the patient progresses in treatment.

5. How do I send supporting clinical documents to be considered in eviCore's review determination?

In most cases, the newly revised Standard Therapy Treatment Plan or a special-condition Treatment Plan provides our clinical peer reviewers with the information they need to make a determination. If our clinical peer reviewers are unable to make a determination, they will suspend your request and send you a letter outlining the supporting documentation needed. E-Forms do not support attachments and do not allow additional provider comments.

6. How do I report joint range of motion and strength findings?

When you submit a request electronically, the e-Form will prompt you to report findings for each joint that you indicate. If you fax your request, you must include the Supplemental Joint Form if you have more joint findings to report than will fit on the Treatment Plan. The Treatment Plan and the Supplemental Joint Form must be faxed to eviCore together.

On the Standard Therapy Treatment Plan, report primary joint findings on the Treatment Plan form. If you have additional joints to report, select the "Multiple joints" checkbox and complete the Supplemental Joint Form.

For the Lymphedema Management, Neurological Rehabilitation, and Vestibular Rehabilitation Treatment Plans, *all* joint findings must be documented on the Supplemental Joint Form. For these cases, select the "Supplemental Joint Form attached for extremity ROM/strength" checkbox on the Treatment Plan form.

7. How do I report joint strength on the e-Form if the range of motion is within normal limits?

If you report that a joint is within normal limits, you cannot enter strength findings. Therefore, do not check "WNL" if you have strength findings to report. Instead, enter your strength findings

and at least one passive range of motion measurement, even if that measurement is within normal limits.

8. How do I report bilateral findings on the Hand Therapy Treatment Plan?

Submit bilateral hand requests electronically. The e-Form will prompt you to report findings for each hand. Bilateral findings will be reported on the completed version of your Hand Therapy Treatment Plan as a two-page document.

If you are unable to submit electronically, you may fax your additional findings along with your completed Treatment Plan.

9. How far in advance can I submit a Treatment Plan?

Submit Treatment Plans no more than 7 days prior to the proposed Start Date. Requesting care too far in advance does not allow you to report up-to-date examination findings. For a surgical patient, hold your request until 7 days before the proposed Start Date of post-operative treatment.

The "Date current objective findings obtained" field on the Treatment Plan should be within 7 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.

10. Is it okay to use non-specific diagnosis codes?

No. Always use the most specific ICD codes available. It is to your advantage to code as specifically as possible as some codes are identified as more complex cases with higher risk adjustment factors. Proper specific coding will affect your Risk-Adjusted Visits per Episode (RAVE) and will result in more accurate reporting on your PPS.

11. Can I include 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 Blue Care Network process for all DME.

12. How do I print a copy of my completed e-Form?

All submitted e-Forms are available on the provider portal in a print-friendly format. eviCore transfers the information you provide to a PDF document for you to view and print for your records. You will be prompted to print the Treatment Plan after it's been submitted electronically.

13. How quickly will eviCore review my Treatment Plan and how can I track the status?

eviCore will typically review your Treatment Plan and respond with a determination within three business days. You may check the status of a Treatment Plan review online by logging in to the provider portal. Select "Patient Status" from the menu to access the Treatment Plan inquiry feature.

Or, call eviCore at (877) 531-9139.

14. How will I be notified of eviCore's review determination?

Written notifications of clinical review determinations are provided online. Select "Patient Status" from the menu to access the Treatment Plan inquiry feature. Click the "View Letters" button to download review determination documents.

We will also fax or mail you a copy of each letter.

15. What is an Approved Time Period?

The Approved Time Period is the period of time (duration) to use authorized visits. Visits must be spread through the Approved Time Period to avoid a gap in care at the end of that 30-day period.

16. Why are Approved Time Periods limited to 30-days?

Medical necessity authorizations for a 30-day timeframe allow the patient to learn exercises and the provider to assess the patient's response to treatment. If additional care is required, updated clinical information must be submitted on a new Treatment Plan.

17. What do I enter as the "Start Date for This Treatment Plan"?

The "Start Date for this Treatment Plan" will be the first visit of the new Approved Time Period if treatment is authorized. For your initial request, this date should be the first visit that requires authorization. For continuing care requests, this date should be after the end date of the previous Approved Time Period. Do not enter the first date of the patient's treatment episode unless this is the patient's first visit for this episode of care.

18. Can I change the Start Date of an authorization?

You may change the Start Date up to 7 calendar days prior to the original Start Date of an authorization, provided that the adjustment does not cause it to overlap with another Approved Time Period. Contact eviCore at (877) 531-9139 to request the adjustment. The Start Date of an authorization cannot be adjusted to a later date.

19. How do I extend the End Date of an authorization?

Date extension requests are not required as long as they occur within the benefit period. If your patient has an unlimited benefit and needs more than the 120 days that were initially loaded in the system, please submit a date extension request. Download the Date Extension Request form and fax it in or contact eviCore at (877) 531-9139 to request the adjustment.

20. Can I request more treatment after my Approved Time Period expires?

Yes. If you believe a patient will require treatment after the Approved Time Period expires, submit an updated Treatment Plan to request continuing care. Keep in mind that Treatment Plan periods cannot overlap. Therefore, be sure the Start Date of your request for continuing care is after the End Date of your previous authorization.

21. How do I request a reconsideration for more treatment within an existing Approved Time Period?

If the member has a setback or complication, you may request additional care within an existing Approved Time Period. To do so, you must submit a new Treatment Plan with updated clinical findings.

If your Treatment Plan is being submitted electronically, you will be prompted to modify the Start Date to a date after the existing Approved Time Period ends, or to request additional care within the existing Approved Time Period.

- If you modify the Start Date, your request will be reviewed for a new Approved Time Period.
- If you request care within the existing Approved Time Period, you will be required to enter additional information that describes the patient's progress since the previously submitted Treatment Plan and explains why visits were not spread over the Approved Time Period. If additional treatment is approved, it will be granted only within the same date range as the existing Approved Time Period.

If you fax a Treatment Plan with a Start Date that is within an existing Approved Time Period, eviCore will either review the Treatment Plan for a new Approved Time Period or consider additional care within the existing Approved Time Period. When considering additional care within the existing Approved Time Period, we will send you a Request for Information (RFI) letter if medical necessity cannot be established. The RFI letter will include a form titled, “Request for Additional Treatment Within an Existing Authorization Period.” Complete the form to describe the patient’s progress since the previously submitted Treatment Plan and explain why visits were not spread over the Approved Time Period. Return the form to eviCore along with a copy of the RFI letter. Incomplete forms will be returned for completion.

If additional treatment is approved within an existing Approved Time Period, you will receive a replacement determination letter with the same date range as the existing Approved Time Period and an increase to the total number of visits approved. If a new Approved Time Period is established you will receive a determination letter containing the number of visits approved for the new time period.

22. What is a Request for Information (RFI)?

eviCore responds to an authorization request with an RFI letter when additional information is needed to make a review determination. When you receive an RFI, send a copy of the RFI letter back to eviCore with the requested information. The RFI letter will state the time frame during which you are required to respond. Following are some common causes for RFI's and tips to help you avoid them:

- Sufficient objective clinical information is not included on the Treatment Plan, or the information provided is greater than 7 days before the requested Start Date. If you have been treating the patient over that period of time, the clinical findings may have changed.

  Tip: Be sure that the Treatment Plan reflects objective clinical information that is no greater than 7 days old, and that it includes all significant changes in function, motion, strength, pain, and edema.

- Your requested Start Date is prior to the End date of an existing Approved Time Period. Visits were used too quickly.

  Tip: Spread the authorized visits over the approved duration to avoid gaps in care.

- The diagnosis code used is nonspecific and we are unable to determine what condition the treatment is for.

  Tip: Use the most specific diagnostic code available to describe the patient's condition. On the request, indicate any recent surgeries affecting that part of the body and whether you are treating the left or right side of the body.

23. Is a new Treatment Plan required if a patient has surgery on the body part being treated with therapy or physical medicine services?

Yes. If a patient has surgery on the body part being treated with therapy or physical medicine services, and treatment is required post-surgery, submit a new referral to initiate a new episode of care. After you receive authorization for the new episode of care, submit an updated Treatment Plan request.

24. How do clinical peer reviewers decide on the number of visits they authorize?

eviCore's clinical peer reviewers use proprietary Clinical Practice Guidelines and available evidence to decide the number of visits authorized for each request. Clinical peer reviewers take into account the complexity and severity of a member's condition when rendering a clinical review. See the Utilization Management Guide for a detailed description of the review determination process.

23. What determines medical necessity?

Treatment is medically necessary when required to achieve a specific diagnosis-related goal that will (i) significantly improve impaired neurological and/or musculoskeletal function stemming from a congenital anomaly or (ii) restore neurological and/or musculoskeletal function that was lost or impaired due to an illness, injury or prior therapeutic intervention. "Significant" is defined as a measurable and meaningful increase (as documented in the patient's record) in the patient's level of physical and functional abilities that can be attained with short-term treatment, usually within a two to three month period. In addition the treatment includes the following:

- Must include a home management program
- Must require the skills of a therapist/chiropractor due to the level of complexity and sophistication of the patient or the care being delivered.
- Must have an expectation that the condition will improvement significantly in a reasonable period of time.
- In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function.
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

30. What is "a reasonable period of time?"

"Reasonable" is defined as the number of visits necessary to improve or restore neurological or musculoskeletal function required to perform normal activities of daily living, such as grooming, toileting, feeding, etc. Therapy or physical medicine services for maintenance, defined as activities that preserve present functional level and prevent regression, are not covered.

All therapy/physical medicine services delivered must be skilled and directed at restoring function. If the patient does not have a reasonable expectation of achieving significant improvement in a reasonable and predictable period of time, therapy/physical medicine services are not a covered benefit. “Significant” is defined as a measurable and meaningful increase (as documented in the patient's record) in the patient’s level of physical and functional abilities.

32. May I call in to request authorization?

No. Treatment Plans must be either completed online via eviCore’s secure web site or faxed utilizing eviCore’s Treatment Plan to (888) 565-4225.

33. What if I forget to submit a request for authorization until after I have delivered care?

Retrospective authorization requests occur when all requested visits for a member have already been provided. Fax a copy of all applicable documents (i.e., Treatment Plan, evaluations and reassessments, daily progress notes, outcomes assessments, flow sheets) for the services provided. If information is missing, medical necessity cannot be determined and visits will not be authorized for those dates of service.

34. How do I appeal services not approved as medically necessary?

You may appeal the authorization determination; the review determination letter provides appeal information. Or, you may speak directly with a eviCore clinical peer reviewer. To discuss your case, call eviCore’s customer service number (877) 531-9139 and ask to speak with a clinical peer reviewer.

35. Who do I call to verify member benefits?

Member benefits can be verified by following the normal Blue Care Network process for verifying eligibility and benefits.

36. Where do I submit claims?

Submit claims directly to Blue Care Network.