Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

eviCore healthcare

Tips about eviCore authorizations

For BCN HMO℠ (commercial) and BCN Advantage℠ members

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This document explains the elements of an authorization. It provides tips for requesting authorizations and explains the time frame for responding to requests from eviCore for additional information.

Elements of an authorization

For eviCore healthcare®, the treatment authorization for BCN members includes two elements:

- The number of visits authorized
- The period of time (duration) in which the 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. For example:

- An authorized duration of 60 consecutive days allows unlimited visits over 60 consecutive calendar days
- An authorization of 15 visits per medical episode per plan year allows 15 visits to be spread over the entire benefit year

Visits must be spread throughout the authorized duration to avoid a gap in care at the end of the time period (duration).

If a member has a setback or complication, the provider may request additional visits before the authorized time period is over; however, the treating therapist must submit updated/current clinical information to eviCore for review. Without this information, the request may be denied.

Tips for requesting an authorization

- Complete the evaluation before you submit the authorization request. You don't need authorization to perform the evaluation.
- Don't send the physician referral with the authorization request. It isn't necessary.
- Use the worksheets at www.eviCore.com* while you prepare to submit authorization requests.

- Consider submitting requests through the eviCore web portal. When you submit requests for authorizations through the web portal or by phone, the requests are eligible for real-time decisions.
- Complete all relevant questions on the worksheet/pathway. If you submit an authorization request with incomplete or insufficient information, eviCore will have to contact you, which will delay the decision on the authorization request.
- Report patient-reported functional outcome measure scores. The clinical worksheets identify the scores you will have to report.

  Note: The scores you must report are specific to the tools used to complete the evaluation. Don't substitute scores that a patient reported based on questions in a different reporting tool.
- When you answer all questions that are presented on the web or asked by phone, eviCore doesn't typically require additional clinical information. If they need more information, eviCore will contact you.

  Note: You don't need to attach a fax or upload documents unless the member's condition is more complicated than a typical patient with the same condition.
- Use the most specific diagnosis code available to describe the member's condition, including whether the condition is bilateral or whether it affects the right or left extremity.
- If the start date for the authorization request is more than 15 days in the past, eviCore will treat it as a retrospective request. Include the following information for retrospective requests:
  - The dates of service on which you provided care
  - The daily notes for each date of service
  - The date of and the findings from the initial evaluation
  - Progress notes, if applicable

- When submitting requests, be sure to select the same site or location of service that is assigned to your utilization management category. When submitting authorization requests for BCN members:
  - Physical therapists in outpatient therapy centers and hospitals: Search by the facility's Organization National Provider Identifier.
  - Independent physical therapists and physicians: Search by your individual NPI.

  You can find more information about your Practitioner Performance Summary and assigned utilization management category in the eviCore Physical Therapy Practitioner Performance Summary and Provider Categories FAQs document*.

Time frame for responding to requests for information

When eviCore receives authorization requests with incomplete clinical information, they will place the request on hold while they request and then wait to receive the missing information. To avoid processing delays, respond promptly to all requests for information.

- **For BCN HMO members:** If eviCore doesn't receive the requested information within 10 days, they will process the authorization request based on the information originally provided.
- **For BCN Advantage members:** eviCore manages authorization requests with insufficient clinical information according to Centers for Medicare & Medicaid Services guidelines. They'll reach out to the provider by phone and fax to request the required information. If the provider doesn't respond within 12 days, eviCore will process the request based on the information originally provided.

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're required to let you know we're not responsible for its content.

eviCore healthcare oversees outpatient physical, occupational and speech services for BCN members delivered by independent physical therapists, outpatient therapy providers and physician practices. eviCore also oversees physical medicine services for BCN members delivered by chiropractors. eviCore is an independent company that does not provide Blue Cross or Blue Shield products or services and that is solely responsible for the products or services it provides.