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General information

EviCore by Evernorth[®] manages prior authorizations and benefit limits for the following services and members:

- Physical, occupational and speech therapy services by therapists for Blue Care Network commercial members and BCN Advantage members
- Physical medicine services by chiropractors and by athletic trainers for BCN commercial members

EviCore's management of prior authorizations includes requests for both initial and follow-up visits, for both contracted and noncontracted providers.

Note: For BCN commercial members with a diagnosis of autism:

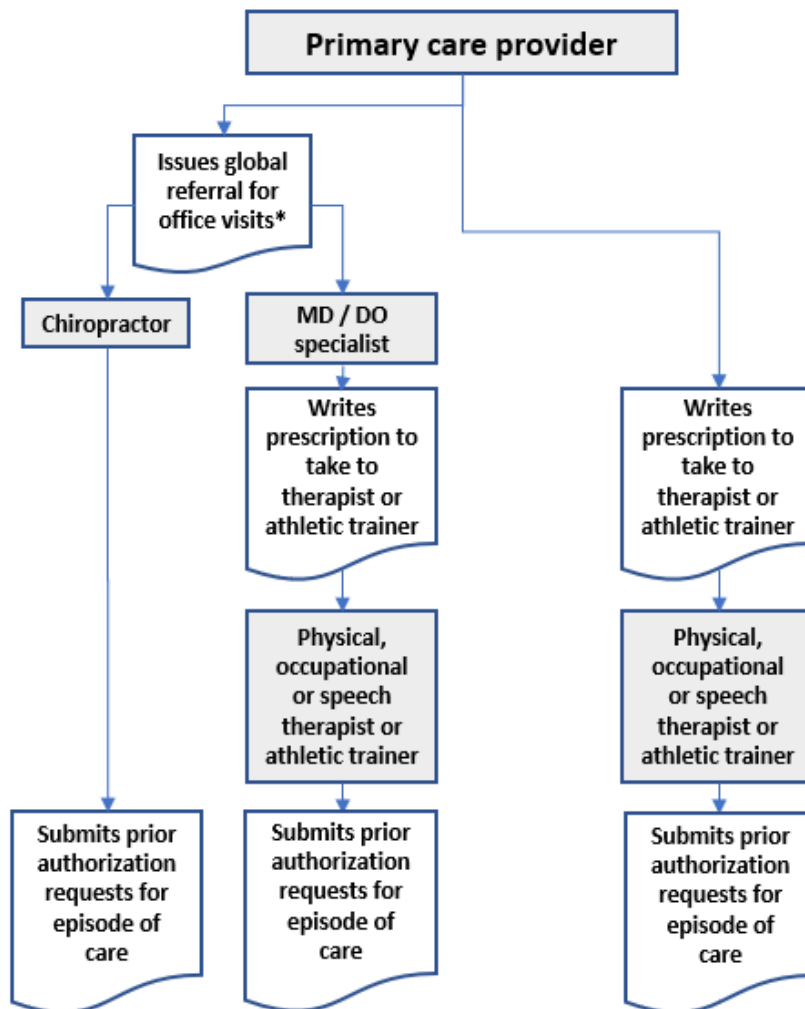
- For dates of service on or after Jan. 1, 2024, prior authorization isn't required for members of any age.
- For dates of service before Jan. 1, 2024, prior authorization is required for members 19 years of age and older.

The guidelines in this document apply mainly to services that require prior authorization by EviCore. For information about services that require prior authorization by BCN, refer to "Which therapy requests must be submitted to BCN through the e-referral system?" on Page 13.

Global referrals and prior authorizations

How does the global referral and prior authorization process work?

The schematic below shows the options for making global referrals and submitting prior authorization requests.



*No global referral is required for BCN Advantage members or for members with a point-of-service plan. A global referral is required only when a BCN commercial member has a primary care provider based in the East or Southeast region or has a plan with a designated provider network that the chiropractor or specialist doesn't belong to. Otherwise, the chiropractor or the other providers shown here can initiate the prior authorization request with the primary care provider's approval.

How should referring providers write the prescription?

When referring a member for physical, occupational or speech therapy from a therapist or for physical medicine services from an athletic trainer, the referring provider may write the prescription for “evaluate and treat.”

Writing the prescription in this way allows the therapist or athletic trainer to:

- Plan upcoming visits in line with the progress the member makes
- Work with the member in establishing a treatment plan based on both medical necessity and the member’s anticipated response to treatment over a period of time

Note: The treatment plan should include the proposed frequency and duration necessary to achieve the expected outcomes.

Which visits require prior authorization?

Initial evaluations don’t require prior authorization.

To determine which procedure codes require prior authorization, check the document titled [Procedure codes for which providers must request prior authorization](#).

Which settings does the prior authorization requirement apply to?

For services that require prior authorization, the requirement applies to the following BCN-participating settings that provide services for BCN commercial and BCN Advantage members:

- Freestanding diagnostic facilities
- Outpatient hospital settings
- Ambulatory surgery settings
- Provider offices

How do I submit prior authorization requests for therapy services?

Therapists, chiropractors and athletic trainers who request prior authorization for therapy or physical medicine services must:

1. Check the member’s eligibility and benefits and the provider’s status. For information on how to do that, refer to the section titled “Checking a member’s eligibility and a provider’s status” on Page 14.
2. Submit a prior authorization request to EviCore for an episode of care. Do the following:
 - Submit the prior authorization request for treatment only after the initial evaluation is done so that the clinical information learned during the evaluation can be used to complete the prior authorization request. This will help expedite the request.

- Submit separate prior authorization requests for each type of treatment the member needs — physical, occupational and speech therapy from a therapist or physical medicine services from a chiropractor or athletic trainer — and for each new episode of care.

Notes:

- Therapists, chiropractors and athletic trainers who practice within a group should use their group's NPI as the servicing site.
- Prior authorization requirements for PTs and OTs vary based on their category assignment. See the "Information about EviCore category assignments for PTs and OTs" section on Page 9 for more information.
- Prior authorization requests submitted by chiropractors for physical medicine services must be separate from requests submitted for manipulation services:
 - Prior authorization requests for physical medicine services must be submitted to EviCore.
 - Prior authorization requests for manipulation services must be submitted to BCN.

For medically urgent prior authorization requests, see the "How can I submit prior authorization requests for medically urgent services?" section on Page 8.

For additional information about the process of submitting prior authorization requests for initial and follow-up services to EviCore, see the "Submitting prior authorization requests" section of the [Services reviewed by EviCore for Blue Cross and BCN](#) document.

What criteria does EviCore use in reviewing prior authorization requests?

EviCore's qualified licensed clinical peers review all treatment plans submitted by providers. When making determinations on prior authorization requests, EviCore:

- Reviews the benefits as defined in the health plan certificates for the services requested
- Uses EviCore's proprietary clinical practice guidelines as the basis for their clinical rationale. These guidelines are developed by content experts and practicing clinicians and are reviewed annually. To view the guidelines, see the following pages on bcbsm.com:
 - For commercial members: [Services That Need Prior Authorization](#)
 - For Medicare Advantage members: [Medicare Advantage Prior Authorization](#)
- For PTs and OTs, uses category assignments to determine the information that must be submitted with the request. For additional details, see the "Information about EviCore category assignments for PTs and OTs" section on Page 9.

EviCore's judgments about treatment frequency and duration are based on the following:

- Severity of the clinical findings

- Presence of complicating factors
- Natural history of the condition
- Expectation of functional improvement
- Need for skilled therapy or physical medicine services

Judgments about frequency and duration require continuous assessment and modification based on patient progress and response to treatment.

Discharge from treatment may be considered appropriate when one of these conditions is present:

- Reasonable functional goals and expected outcomes have been achieved.
- The caregiver and the member can continue management of symptoms with an independent home program.
- The member is unable to progress toward outcomes because of medical complications or psychosocial factors.
- Services become routine and repetitive in nature, indicating they are not of a skilled nature.
- The member is no longer objectively demonstrating benefit from treatment.

What information do I need to submit through the EviCore provider portal?

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 a prior authorization request through the EviCore provider portal, answer the questions that are presented to you within the portal.

Note: PTs and OTs with a category A assignment may have fewer requirements. See the "Information about EviCore category assignments for PTs and OTs" section on Page 9 for more details.

What can I do to speed up the prior authorization process?

Here are tips to speed up the prior authorization process:

- Complete the evaluation before you submit the prior authorization request. You don't need authorization to perform the evaluation.
- Don't send the physician referral with the prior authorization request. It isn't necessary.
- Submit requests through the EviCore provider portal. When you submit requests for prior authorizations through the provider portal or by phone, the requests are eligible for real-time decisions.
- Use the worksheets at [evicore.com](https://www.evicore.com)* while you prepare to submit prior authorization requests.
- Complete all relevant questions on the worksheet/pathway. If you submit a prior authorization request with incomplete or insufficient information, EviCore will have to contact you, which will delay the decision on the request.
- Report patient-reported functional outcome measure scores. The clinical worksheets identify the scores you must 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 in the provider portal 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 prior authorization request is more than 15 days in the past, EviCore will treat it as a retroactive request. Include the following information for retroactive 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 prior authorization requests:

- **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 "Information about EviCore category assignments for PTs and OTs" on Page 9.

How do I establish medical necessity?

Providers must establish medical necessity for the initiation of treatment by objectively documenting any or all of the following, as applicable, using a validated tool whenever possible and reporting the scores on the EviCore treatment plan form:

- Level of impairment or significant functional limitations
- Deficits in strength or motion
- Pain-limiting function
- Altered neurological signs

EviCore works with the therapist or physical medicine provider to ensure that the member receives medically necessary treatment.

Where can I find EviCore's clinical worksheets — the ones I need to submit when I fax a prior authorization request?

To learn how to access EviCore's clinical worksheets, see the "Finding the EviCore fax forms for these services" section of the [Services reviewed by EviCore for Blue Cross and BCN](#) document.

How can I submit prior authorization requests for medically urgent services?

Submit urgent requests (requests for which you need an expedited determination) through the EviCore provider portal or by calling EviCore.

For information about accessing the EviCore provider portal and for EviCore phone numbers, see the "Submitting prior authorization requests" section of the [Services reviewed by EviCore for Blue Cross and BCN](#) document.

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.

If EviCore requests additional clinical information, how long do I have to provide it?

When EviCore receives prior authorization requests with incomplete clinical information, they'll 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 commercial members:** If EviCore doesn't receive the requested information within 10 days, they'll process the prior authorization request based on the information originally provided.
- **For BCN Advantage members:** EviCore manages prior 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.

How can I correct or change a request already submitted?

To correct or change a prior authorization request already submitted, call EviCore at 1-855-774-1317.

Don't try to correct or change a request using the EviCore provider portal.

Information about EviCore category assignments for PTs and OTs

What are EviCore category assignments and which providers are affected?

EviCore assigns **physical and occupational therapists** to a category based on physical therapy visits per episode. They do this by retroactively reviewing physical therapy claims from a one-year period. The categories are:

- **Category A:** When submitting prior authorization requests, providers need to submit limited information about the patient's condition. EviCore approves the request for a block of visits over an extended duration. The provider determines the number of visits that are medically necessary within the approved time period. Authorizations are valid for 180 days.
- **Category B:** When submitting prior authorization requests, providers need to submit additional information, which varies based on the patient's age and condition and the type of request (initial or continuing). The number of visits EviCore approves varies based on the patient's condition, severity, complexity and response to treatment received. EviCore determines the length of time for which authorizations are valid.

Important: For hospitals or outpatient therapy centers that bill both physical and occupational therapy using the same NPI, the assigned category establishes the review requirements for both physical and occupational therapists. This is true even though the category is based only on physical therapy claims and occupational therapists aren't assigned to a category.

To view documents related to PPSs and categories, go to [EviCore's Blue Care Network Provider Resources page](#).^{*} On that page, click the *Solution Resources* tab, click *Musculoskeletal* and then click the link for the appropriate document.

Click this link...	To open this document...
<i>Blue Care Network PT Categorization Frequently Asked Questions</i>	<i>Physical Therapy Practitioner Performance Summary and Provider Category FAQs</i>
<i>Blue Care Network Practitioner Performance Summary and UM Categories</i>	<i>Practitioner Performance Summary and Utilization Management Categories</i>

When does EviCore release category assignments?

EviCore releases practitioner performance summaries with updated categories twice a year. The category assignment from the report is effective two months following the release of the report.

Report is released	Category assignment is effective
First business day of February	April 1
First business day of August	Oct. 1

How do I view my category assignment?

You can view practitioner performance summaries, which include your category assignment, through the EviCore provider portal. To do this:

1. Log in to Blue Cross and BCN's provider portal (availability.com^{*}).
2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.
3. Click the *EviCore Provider Portal* tile in the Applications tab.
4. In the EviCore provider portal, select *Practitioner Performance Summary* from the main menu.
5. Select the health plan (*Blue Care Network*) and a provider. Only providers you've added to your EviCore web user account are available to select.
6. Click *View PPS*. The dashboard will open in a new tab.
7. Click the *UM Category* tab.

The EviCore provider portal displays the results of the most recent claims analysis and the key performance benchmarks EviCore used to determine your category.

How can I request reconsideration of a category B assignment?

If you believe there were circumstances that adversely affected your category assignment, you can request reconsideration within 15 days from the date on which EviCore published the new practitioner performance summary.

Submit the request for category reconsideration through the Practitioner Performance Summary area of the EviCore provider portal.

Information about the outcome of a prior authorization request

How can I check the status of a prior authorization request?

Once EviCore has made a determination on the prior authorization request, the therapist, chiropractor or athletic trainer can view the number of visits authorized on EviCore's secure provider portal. The total number of visits may be authorized at one time, or additional visits may be authorized as needed. The referring provider doesn't need to be involved in this process.

You can check the status of a prior authorization request through the EviCore provider portal or by calling EviCore.

For information about accessing the EviCore provider portal and for EviCore phone numbers, see the "Submitting prior authorization requests" section of the [Services reviewed by EviCore for Blue Cross and BCN](#) document.

How will EviCore notify providers and members of the determination made on a prior authorization request?

EviCore will send written notification of the determination made on a prior authorization request — whether it's an approval or a denial — to the requesting provider and to the member. All requests are assigned a nine-digit number preceded by the letter A.

For approved requests, EviCore:

- Sends written notification to providers by fax
- Posts the notifications in EviCore's provider portal

Each notification includes two elements:

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

The member's visits must be spread through the authorized duration to avoid a gap in care at the end of the time period (duration). If the member has a setback or complication, additional visits may be requested before the authorized time period is over. An updated treatment plan must be submitted with this request and must include objective clinical findings and a detailed explanation of the reasons for the early request for additional visits. Without this information, the request will be denied.

Note: The benefit duration is the period of time included in the member's contractual benefit; it isn't the same as the authorized duration. 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

Notes for therapists and athletic trainers:

- When EviCore approves a prior authorization request for therapies, they authorize a certain number of visits for each type of therapy. The physical, occupational and speech therapy visits EviCore approves on the authorization can be provided on the same day or on separate days.
- EviCore authorizes therapy treatment but doesn't authorize specific procedure codes. In the EviCore provider portal, providers select the therapy type (MSMOT, MSMPT or MSMST). Providers must submit a separate prior authorization request for each therapy type and EviCore makes a determination on each prior authorization request submitted.

Important: All therapists, chiropractors and athletic trainers are constrained by the limits of the member's benefits, including the number of visits and the duration of treatment. The visits are allocated and coordinated among therapists and chiropractors based on medical necessity so as not to exceed the member's benefit limits.

For denied requests, providers:

- May request a copy of the clinical criteria or clinical judgment used in making a determination by sending a request, along with a copy of the determination letter, to the address shown in the denial letter.
- Must file an appeal if they want to have the request reviewed again. Refer to "How can I appeal a prior authorization request that was denied?" later in this document.

More information about prior authorization requests

How long is an authorization valid?

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

- If none of the authorized services are performed within the time indicated, you should withdraw the case. Each authorization has a specific duration of time to provide the approved services.
- If only some 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. For information about accessing the EviCore provider portal and for EviCore phone numbers, see the "Submitting prior authorization requests" section of the [Services reviewed by EviCore for Blue Cross and BCN](#) document.

How can I request a peer-to-peer review (consultation) of a prior authorization request that was denied?

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 evicore.com*
2. Click either *Providers* or *Resources* at the upper right. Click *Request a Consultation with a Clinical Peer Reviewer*, under the "I Would Like to" heading.
3. Make the appropriate selection in the Program field.
4. Select *Blue Care Network* from the Health Plan drop-down.
5. Complete the rest of the fields.
6. Click Next and follow the prompts.

You'll receive an email message 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.

Notes:

- For BCN commercial members, a peer-to-peer review may result in a reconsideration and a change in the decision on a prior 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 to a decision on an authorization.

Will EviCore retroactively review authorization requests if I didn't submit an authorization prior to providing services?

EviCore will review retroactive authorization requests if they are submitted within 365 days of the date on which the services were 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.

Which therapy requests must be submitted to BCN through the e-referral system?

Submit the following therapy requests to BCN through the e-referral system (and not to EviCore):

- Therapies provided by skilled nursing facilities

Note: For therapies provided by SNFs for patients in a Basic bed, submit an outpatient prior authorization request:

- For the place of service, select “Off Campus Outpatient Hospital.”
- For the procedure code, enter ****97110** for physical therapy, ****97535** for occupational therapy or ****92507** for speech therapy. Enter only these codes regardless of the actual physical, occupational or speech therapy service to be performed.
- For the servicing provider/servicing facility, enter the name of the skilled nursing facility providing the therapy.
- Enter data into the other fields.
- Submit separate requests for different therapy types (physical, occupational and speech).
- Stand-alone orthotic splints
- Stand-alone massage therapy

Checking a member’s eligibility and a provider’s status

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

Before you submit a prior authorization request, you should check the member’s eligibility and benefits through our provider portal. Follow these steps:

1. Log in to availity.com*
2. Select *Patient Registration* on the menu bar.
3. Select *Eligibility and Benefits Inquiry* and follow the prompts.

How can I verify that I’m a contracted provider for BCN commercial and BCN Advantage?

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

How can I join the BCN commercial or BCN Advantage provider network if I’m not already participating?

You can enroll with BCN by visiting bcbsm.com/providers. Click *Join Our Network* and then click [Enroll now](#). Follow the instructions on the page that opens.

How does EviCore determine whether a provider is in network?

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:

1. Log in to our provider portal (availity.com*).
2. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources (Blue Cross and BCN)*.
5. Select *Products* in the top menu bar.
6. Select *BCN*. The document is under the “General product information” heading.

Appeals of denied prior authorization requests

How can I appeal a prior authorization request that was denied?

Providers who are contracted with BCN should follow these guidelines:

- **BCN Advantage.** BCN-participating providers who disagree with a determination related to medical necessity or medical appropriateness made by EviCore for a BCN Advantage member should follow BCN’s process for standard or expedited appeals, which is outlined in [Utilization Management](#) chapter of the *BCN Provider Manual*; look in the “Appealing utilization management decisions”.
- **BCN commercial.** BCN-participating providers who disagree with a determination related to medical necessity or medical appropriateness made by EviCore for a BCN commercial member should follow EviCore’s process for standard or expedited appeals. In general, providers should follow the instructions in the denial letter when submitting standard appeal requests for BCN commercial members to EviCore. Refer to the additional information described in the table.

Appeal type	Information
Standard	<ul style="list-style-type: none"> • The appeal must be submitted to EviCore within 180 calendar days of the date noted on the written denial notification. • Requests are to be in writing and must include additional clarifying clinical documentation to support the request. • EviCore notifies the provider of the decision within 30 calendar days of receiving all necessary information. This decision is final.

Appeal type	Information
Expedited	<ul style="list-style-type: none"> • An expedited appeal may be requested by a practitioner when circumstances require that a decision be made in a short period of time because a delay in making the decision may acutely jeopardize the life or health of the member. • Retroactive appeals (when service has already been provided to the member) won't be considered for an expedited appeal. • Requests for expedited appeals may be initiated verbally for decisions regarding precertification of urgent care and concurrent cases that result in denial. • EviCore notifies the provider of the decision within 72 hours of receiving the request. This decision is final.

Providers who are not contracted with BCN and who disagree with a determination made by EviCore should follow BCN's process for standard or expedited appeals. Specific instructions for submitting the appeal are included in the denial letter. Information on BCN's provider appeals process is found in the [Utilization Management](#) chapter of the *BCN Provider Manual*; look in the "Appealing utilization management decisions".

How does EviCore make decisions on BCN commercial appeals?

Appeals related to BCN commercial members that are handled by EviCore are reviewed as follows:

- BCN commercial appeals from therapists related to physical, occupational or speech therapy and from athletic trainers related to physical medicine services are reviewed by an EviCore physician.
- BCN commercial appeals from chiropractors related to physical medicine services are reviewed by an EviCore chiropractor.

For all BCN commercial provider appeals, the individual at EviCore who made the original denial determination isn't the same individual who makes the appeal decision.

Claims

Where do I submit claims for services authorized by EviCore?

Submit therapy claims for BCN commercial and BCN Advantage members in the same ways you submit other claims.

See the following chapters in the *BCN Provider Manual*:

- The Claims chapter for information on submitting claims for BCN commercial members. To access this chapter:
 1. Log in to our provider portal (availity.com*).

2. Click *Payer Spaces* on the menu bar.
 3. Click the BCBSM and BCN logo.
 4. Click the *Resources* tab.
 5. Scroll down and click *Provider manuals*.
 6. Click *BCN commercial and BCN Advantage*.
 7. Click the link to open the Claims (billing) chapter.
- The [BCN Advantage chapter](#) for information on submitting claims for BCN Advantage members

What happens if EviCore authorizes evaluation and treatment dates at the same time and the claim shows an evaluation date that occurs before the first treatment date?

EviCore may authorize the evaluation and treatment dates at the same time — on the same date and in the same prior authorization request. Keep reading to learn how those dates are handled when EviCore receives a claim that shows an evaluation date that occurs before the date of the first treatment visit.

All therapy services, including both the evaluation and treatment visits, must be covered by the date span specified in the prior authorization request. Providers should enter both the evaluation and the treatment visits on the same prior 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 prior authorization. If you're requesting prior authorization before treatment begins, complete the evaluation and then submit the prior authorization request within seven days of the evaluation date. The start date on the prior 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 you need to change the treatment start date.

- 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. However, the date span on the modalities line remains unchanged. This way, the evaluation claim can be paid and the member is afforded the full date span for their treatments.

How are visits counted when two or more types of therapy are provided on the same day?

When a member receives two or more types of therapy on the same day, each type of therapy counts as one visit. For example, if the member received physical therapy and occupational therapy on the same day, this would be counted as one physical therapy visit and one occupational therapy visit — for a total of two visits used against the benefit limit when the claim is processed.

When EviCore approves a prior authorization request for therapies, they authorize a certain number of visits for each type of therapy. The physical, occupational and speech therapy visits EviCore approves on the authorization can be provided on the same day or on separate days.

What information do providers need to include on the claim?

When submitting therapy claims, providers must include the following:

- Professional claims: Appropriate procedure code and therapy modifier
- Facility claims: Appropriate therapy revenue code and procedure code

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

You don't need to report the nonpayable functional limitation G codes and their applicable modifiers.

Additional information

How does EviCore monitor and report on utilization?

Under their agreement, BCN and EviCore collaborate to establish evidence-based clinical practice standards that help ensure the best possible outcomes for members.

EviCore monitors the utilization of each therapist, chiropractor and athletic trainer using evidence-based practice standards and compares their performance to BCN peer performance standards. EviCore uses these data to work with therapists, chiropractors and athletic trainers to increase the use of efficient best practice patterns, as appropriate.

Note: EviCore reports utilization data to physical therapists (only) on a regular basis in the form of Provider Performance Summary reports. Physical therapists can also access this information at evicore.com* at any time through EviCore's secure provider portal.

How does BCN educate members about outpatient rehabilitation benefits, including medical necessity requirements and limits on number of visits?

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 doesn't guarantee approval of a request for all 60 visits by EviCore. 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, 2024, to Aug. 17, 2024. The benefit is exhausted after Aug. 17, 2024.

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

Can members opt out of reporting some of their rehabilitation visits to EviCore?

Members can't opt out of reporting rehab visits. They must report all outpatient rehab visits. Reporting some visits and not others isn't an option.

For 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 to use benefits for treatment during the summer and want to opt out of reporting visits during the other times of the year, but this is not allowed.

What can providers do to limit their financial liability when they know there will be issues with prior authorization or reporting?

As a provider, you want to limit your liability if one of the following is true:

- You know the prior authorization for the services won't be approved.
- The member's benefits don't include the services you provide.
- The member is about to or has exhausted his or her benefits.
- The member chooses to opt out of reporting visits to BCN.

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

How do I file a complaint?

Submit the complaint to EviCore at clientservices@evicore.com.*

Do members have any options for virtual therapy?

Members who have coverage through BCN commercial self-funded groups that purchase the Virtual Muscle and Joint Health program also have access to personalized virtual exercise therapy through Hinge HealthTM. This program is intended to complement care provided by in-person providers and physical therapists.

Participation in this program doesn't count toward any in-person benefit limits. Members can use the Virtual Muscle and Joint Health program along with traditional in-person physical therapy, physical medicine or osteopathic manipulation treatment.

For more information on the Virtual Muscle and Joint Health program, see the document titled [PT, OT, ST, and physical medicine services by chiropractors and athletic trainers: For virtual exercise therapy and prior authorization determinations](#).

Contact information

Who can I call with questions?

Contact us with questions related to physical, occupational and speech therapy or physical medicine services as follows:

- For prior authorization or treatment questions, call EviCore's Client & Provider Services department at 1-855-774-1317.
- For claims issues, call Blue Cross / BCN Provider Inquiry. To identify the phone number, visit the [For Providers: Contact Us](#) webpage and make the pertinent selections.

*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 not responsible for its content.

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