Narrative Survey Comments

(Possible action items are highlighted for further discussion)

What suggestions do you have for further reducing administrative burden?

eviCore Process suggestions/ issues

eviCore increases burden and questions the PT's clinical judgement. The corePath process is an improvement but still burdensome and intrusive.

- Focus on outcomes not visits.
- If you add up all the minutes it takes in this drowning sea of paperwork, patients would even get more PT time.
- Allow PTs to send their notes to be reviewed.
- If a specific clinic is over utilizing therapy then they can be audited and penalized rather than taking visits from patients that actually need therapy and clinics who only treat as medically necessary.
- The program is not working as well or as efficiently as might be reported by eviCore.
- Eliminate program and not require auth approval.

Modify/Change eviCore

General suggestions given by providers to improve eviCore that do not fit in the other categories.

- Just be able to fax or upload evaluations and progress notes
- Just follow Medicare guidelines.
- Avoid having EviCore process authorization requests for Med B services in the Long Term Care/SNF setting. Or create a simplistic form or request evaluations for auth. Much of the information required on the form could be found on the evaluation itself. There should be different forms for actual outpatient settings vs. LTC/SNF settings due to our varying populations.
- Have a place on the form for clinical input, measurement box for objective data, area to express progress or difficulties/setbacks, approve more than 1-2 visits on follow up and allow the client to utilize their benefits.
- We have not seen the additional questions that were discussed in informational sessions the end of last year to see how these will affect our ability to complete the authorization process in a timely fashion. I have looked at the website as well for the updated resources with the additional information that would be needed to effectively complete the process, but didn't find them.
- Scan form in, then therapist contacts eviCore, it is reviewed with therapist on the call.
- Improve the turn- around. Some cases have taken 14 days

Time Consuming

The eviCore process takes away time that providers could be spending with patients. Despite being encouraged to use the online system, providers still are required to call and talk with BCBSM or eviCore.

Additional staff members will need to be hired simply to complete these authorizations therefore increasing clinic costs. Creating a better connection between eviCore and BCN will decrease time spent by providers fixing these communication errors.

- Stop making me add a bunch of redundant information that should already be in the system. - Grant a reasonable number of visits for a given condition so that we don't have to keep re-submitting
- Consolidate questions/process. Have the leaders of this process tied going through it themselves? Might help to see that every case is different.
- Keep things standardized (in terms of information needed) and time efficient (reduce redundancy).
- Why would you push us towards using the website when we still need to call and wait on the phone to find out # visits are authorized? Now this takes 2x as long. When this rolls out to all BCBSM plans in July we will need to hire another staff member just to do auths.
- It is limiting patient care and time consuming administratively.
- Completing authorizations takes away from time I could spend treating patients and puts an extra burden on our administrative and support staff. It increases clinic costs and is frustrating for patients to be unable to use their outpatient therapy benefits.
- Change the forms to be less time consuming. Bring physical therapists on board to create forms that are treatment area specific. One form for total knee replacement, rotator cuff surgery, etc.
- Approve more visits at a time. Approving 1-3 visits at a time causes a huge administrative burden. Also, there is a HUGE disconnect between Evicore/Corepath and BCN with claims processing. We get many denials stating there was no auth. We produce authorization from Evicore/Corepath and have to put hours of time in only to find out that BCN did not have the same information as Evicore/Corepath. We are the ones taking the time to fight these denials when the systems between the two companies need to be better interfaced to avoid these issues.
- Every time we talk to someone, they give us different answers to the same questions. Your staff all needs to be on the same page. The information you ask for in the forms are very redundant-just read the evaluation/progress note that we send in for the information. I am getting worn out from all of the unnecessary required paperwork. It takes away from the most important part of my job, patient care!!!
- Eliminate need for the DASH functional questionnaire which is very time consuming and redundant of the functional questions on our evaluation. Even though it usually takes less than 10 min to perform the Evicore process for auth that is 10 min. therapists are not spending with their patients, which is sometimes 25% of their scheduled time. I would also reduce the number of questions on the auth form as this information is on the initial evaluation which can be sent to Evicore.

Online System more efficient

Providers indicate the online questions are inconsistent with the paper forms. The online system is slow, not always clear or complete and asks repetitive questions. In a corporation with multiple clinics, all clinics should have access to the online system to increase efficiency. Responses are not immediate as promoted by eviCore.

- It would be much more efficient if the worksheet completed by the PT was aligned with the online request. If the wording was the same online as it is on the form, and if there could be a reference to the question on the form it would enable support staff to complete the online request without asking assistance.
- It would be nice if the sheets that we print off to obtain information would more closely follow the questions asked on the website.

- Some indexes we use are not in your system.
- Work on streamlining the online portal so it is more efficient and very clear for clinicians to choose the proper link to obtain auth for PT visits.
- The system is slow and needs to be fixed. Improve the hand request clinical forms so we can move faster on the web portal.
- Improve consistencies on the website, it is unknown with what questions/results you may get
- Have the questions on the form match questions online. Give more visits for patients especially when they start 6 or 8 as it's not enough. Make the process less time consuming and require less clinical information. The forms & entering on line is too time consuming.
- Website asks repetitive questions, same answers are input into several screens
- We are supposed to be getting an immediate response when doing the requests online, but we are only seeing the immediate response about 2/3 of the time. The new corePath guidelines take more time away from the therapists being able to see patients because the questions are more clinical in nature and cannot always be handled by the office staff who are assisting in getting the authorization requests.
- If a facility has multiple locations, allow ALL locations to submit online. Apparently only the main clinic is allowed to do so and filling out the form or calling is SO MUCH MORE time consuming!!!
- We have never had an opportunity to request a specific number of visits. It would be nice if the paper intake form more closely followed the on-line submission screens. Going through web-denis to get to Evicore site is extra time. Should be able to go back screens if data needs to be changed/error was made. Cannot do that for every screen. Would prefer page at end with ALL data when auth is approved (currently doesn't have visits AND units, patient name/DOB/auth number, date range, etc all in 1 place). Would like to consistently get the box/screen near the end that asks for additional information. Probably only get that box/screen 20% of the time.

Easier for office staff to complete

The forms have to be completed by providers the majority of the time because the questions are clinical. The office staff does not always know how to respond and thus asks the providers multiple questions. If the paper forms were more reflective of the online forms, office staff would have an easier time completing the process on the web.

- Suggest printable forms that accurately reflect what information is needed to complete the authorization request. These forms could then be given to the therapist at the patients visit so the necessary information can be obtained. The completed forms can then be given to office staff to submit auth request.
- It is unclear why if notes are given support staff must still fill in measurements.
- Administrative staff are no longer able to call to get the auth, the PT has to take time out of their busy day to call because the questions asked cannot be answered by support staff.
- Issue paper templates that can be filled out by the therapist and then entered in to the computer by the support staff.
- It would be much more efficient if the request worksheet completed by the PT aligned with the online request. If the wording was the same online as it is on the form, and if there could be a reference to the question on the form it would enable support staff to complete the online request without seeking assistance.
- Very pleased with the new Evicore Corepath! :) - Suggestions on making Landmark for Blue Care Network, the same as the new Evicore Corepath authorization would be wonderful! That is where the burden on

administrative time is now (Landmark), having to call for case ID then filling out an online form that the Physical Therapist should be doing, because if it is not filled out completely, you have to go back to them to ask questions continually it seems & any questions that occur when filling out the form online, if it's time consuming getting answers from the Physical Therapist, you get kicked out & have to start over...Very frustrating!

- We are supposed to be getting an immediate response when doing the requests online, but we are only seeing the immediate response about 2/3 of the time. The new corePath guidelines take more time away from the therapists being able to see patients because the questions are more clinical in nature and cannot always be handled by the office staff who are assisting in getting the authorization requests.

Professionals make the decisions

Providers are responsible for patient care and their decisions should not be influenced by an insurance company or even another PT who has not seen or examined the patient. Medical necessity is better determined by providers, not someone with no medical experience. Patient presentation is often misunderstood by eviCore/BCBSM.

- What type of data are you gathering from corePath? The physician, PT and patient should decide on the care they are receiving, not the insurance company. You have heard this before, I know.
- Trust the clinician to do their professional job.
- Acknowledge therapist input!
- Monitoring of units causes burden on the care team. Changes create poor patient satisfaction as they are told they will have less care that day. If same frequency of units are delivered then visit number is reduced. Patient are confused and concerned about their benefit and who is determining Medical necessity in conflict with their physician and therapist.
- Trust our clinical judgement! I would rather they look into how many visits are needed for specific diagnoses and grant that amount initially and then have us request authorization for extenuating circumstances. Example.... Achilles tendon repair. We know that they are going to need months of rehab. I would rather they give us 24 visits to start and then request additional visits after the 24. TKA - we should be granted 12 visits and then request further visits afterwards. I think that everyone should be granted a minimum of 10 visits to line up with the Medicare documentation.
- Get rid of authorizations all together and allow the physical therapist to make sound judgement on how long to keep patients in therapy. If a specific clinic is over utilizing therapy then they can be audited and penalized rather than taking visits from patients that actually need therapy and clinics who only treat as medically necessary.
- Let the health care providers be responsible for directing care. Not some nurse reading forms and using data bench marks to decide on appropriate auth of visits.
- Go by our initial plan of care visits that the Dr. and the PT deem medically necessary.
- Go with doctor and therapist recommendations.
- Let PT and doctors determine what is right for patients.
- The clinicians seeing the patients should be the ones deciding how many visits are warranted for each specific patient, not relying on algorithms that don't take individual responses to surgery/injury into account.
- Go back to letting the professionals make decisions based on the patient individual case, not algorithms. Everyone is different and responds differently.

- BCBSM could allow the providers to determine medical necessity through sound clinical judgement without the use of a utilization management company. They could use an audit process instead. The less number of people between a provider and a patient, the better.

- Evicore/path-core needs to line up with visits allowed per insurance carrier. Patient will call and hear from insurance they have 30 visits, however path/evicore will only allow 16, than the Dr and patient get upset with PT. If the PT sees the patient more they get penalized; however the PT knows what the patient needs not a computer program. Peer to peer review will take more time out of a PT day when instead we could be helping patients.

- The form allows for reduced admin time spent, however, all clinical justification options have been replaced with check boxes and does not adequately reflect patient presentation.

Direct login with less information required

Logging into the system especially for second authorizations requires too much provider and patient information. The system should automatically remember this to save providers/admins time.

- Don't require me to enter my name & fax # every time. My fax # has not changed in 15 years. I shouldn't have to enter my NPI then select my clinic then confirm it when I only have one clinic, tied to my NPI.

- Able to log directly into Evicore would be an immediate improvement, along with ability to enter less information for choosing the patient.

- Quick login, patients info saved from initial eval so just edits can be made on second auths, and more visits given for each auth, so I don't have to keep sending them out and doing re-evals each visit

- Reducing demographic information.

- Authorization letter is fully faxed. When provider information is changed in the portal, it should be remembered and followed. (i.e. we prefer to use our EMR fax number, but eviCore does not allow for editing the information so that the eviCore system maintains the new information) For second authorization requests, no one should have to fill out more than the patient name and ID number - the system should just be an "upload" process and submit.

- Need a much quicker log in process! need to grant visits from therapist and doctor orders, not on a cookbook system

- Make forms actually applicable to patient conditions. We should not have to fill out demographics. Give appropriate number of visits from the get go so we are not wasting our time and can actually serve patients.

Change visit requirements, focus on outcomes & clinical reasoning

eviCore does not respect clinical reasoning regarding the appropriate amount of visits. Calling to change this is burdensome. The system does not consider case complexity and too few visits are authorized. They should be more focused on patient outcomes and not the number of visits. Additionally authorization should not be required for the first 5-12 visits.

- Authorize more visits upfront at a greater frequency to improve patient dysfunction at a more rapid pace

- Actually basing visits on the complexity of the case and not just the same amount for everyone.

- First authorization should be secure 3x a week for 4 weeks, then reauthorization for additional. Average visits per patient tends to be 12-14

- Increase initial visit count to 10 and eliminate supplementary form, produce a single form global submission

- Insurance companies need to quit practicing medicine.

- Patients want to be treated based on the evaluation and judgement of their medical provider.
- If you add up all the minutes it takes in this drowning sea of paperwork, my patients would even get more of my time.
- Trust your providers, focus on outcomes not visits.
- Base the authorization of visits on therapist clinical reasoning and not give out some arbitrary number of authorized visits based on financial reasons.
- Authorize more visits. What progress do you expect to see when you authorize 1-3 visits? There is also a time factor as well. You authorize 1-3 visits for the time frame of one month. The majority of clients are treated 2-3 times per week. Without authorization we can't see the clients so there is a delay in treatment.
- The people reviewing the cases are paying no attention whatsoever to the setting the patient is in. We request therapy for residents of a skilled nursing facility and we are denied the number of requested visits stating the patient can do a home exercise program...THEY LIVE IN A SNF! How can they do a HEP?!? Very poor reviewing of requests. Are the people doing the initial review even clinical at all?
- Allow therapist to use their judgment to complete 6-8 PT sessions without requiring authorization; direct access allows up to 10...so why not evicore?
- In post op care, please consider providing more visits up front when we realize these more complicated patients will require prolonged PT
- As it seems standard to give 6 initial visits, no need for authorization the first 6 visits and then start the process if needed
- As a category A provider there should be no need to complete online prior authorization for visits.
- Questions 7 and 12 ask about requested number of visits -- where is there a place to request a certain number of visits? This option never comes up. We are just assigned visits with no input from the therapist.
- I don't find the process a burden. Having to call Evicore to change the authorization to what was requested on my forms to insure they will be covered and the patient doesn't get a bill is the burden.
- Outcome measures better reflect the impairment/condition and provide a section that allows for therapists to specifically enter how many visits requested.
- Authorize more visits to start. Give more visits at first or second request.
- Don’t require any auth for the first 6 visits and then ask for functional information based on patient's condition.
- Give the required visits that was ordered by physician on the original prescription
- Let therapists do the job they were trained to do and eliminate the need for authorizations. The authorization process takes the clinical judgment away from the therapist, makes more work for the therapist, and puts the patient’s healthcare in the hands of someone sitting in a cubical that has never examined the patient.
- Have the questions on the form match questions online, give more visits upfront-6 or 8 is not enough for the therapists to start with; too much clinical information is needed, forms & entering on line is too time consuming.
- Trust our clinical judgement! I would rather the look into how many visits are needed for specific diagnoses and grant that amount initially and then have us request authorization for extenuating circumstances.

Example…. Achilles tendon repair. We know that they are going to need months of rehab. I would rather them give us 24 visits to start and then request additional visits after the 24. TKA - we should be granted 12 visits and then request further visits afterwards. I think that everyone should be granted a minimum of 10 visits to line up with the Medicare documentation

- Approving more visit at initial and second requests to deliver continuous and uninterrupted care and less time filling out request forms.

- Be realistic about the amount of care needed to restore function. Adding unit limits really limits clinical options and forces another layer of clinical tracking and administrative burden. It is hard to put on a form all the variables needed to paint a picture of the patient in front of us and these arbitrary limits stifle progress. We typically get 4 units a visit on initial auth and drop to 3 on second auth with no consideration given to patient involvement.

- Authorization of visits need to reflect clinical findings of each patient

- Authorizations of adequate visits after initial evaluation

- Authorize after 12 visits period. Have more pleasant representatives answer the phone when you have to call to provide information. They are RUDE!!

- Quick login, patients info saved from initial eval so just edits can be made on second auths, and more visits given for each auth, so I don't have to keep sending them out and doing re-evals each visit

- Give the therapists the amount of visits they ask for on the initial evaluation. It is unrealistic to treat a patient with 6 visits per month, 2 x per week for 3 weeks when you can't ask for more until the 4th week is causing delays in patient care. Scheduling them only 1x per week doesn't get them enough education and skilled intervention to take care of their injury or illness. This method of reimbursement is inefficient and causes longer healing time for the patient, frustration and possible early discharge because the PT doesn't want the hassle of all the paperwork and waiting to see if we get 2 more visits.

- Authorize more visits at the onset of care which reflects an accurate ability for the therapist to treat a patient without being directed and hung up by ridiculous and redundant paperwork.

- Give us a better outline why patients that need continued care and slow progress and one time you will give 2 visits and then others you will give us 6-8. No great change in overall objective measures. Just seems a little inconsistent.

- Authorize more visits on second authorization--needing to frequently fill out paperwork every 1-4 visits is very time consuming, especially for patients requiring a high frequency of visits for their diagnosis. Also, the forms list minimal functional assessments/objective measures to represent patient status, which thus requires the clinician to fill out a lot of information in the comments section to communicate patient status.

- Give patients eval plus 10 visit from the start, be more strict with visits after that point unless post-surgical

- Have a place on the form for clinical input, measurement box for objective data, area to express progress or difficulties/setbacks, approve more than 1-2 visits on follow up and allow the client to utilize their benefits.

- Trust the MD and PT suggestion for number of visits. PT rehab is the least expensive and most effective conservative care. Stop limiting it so severely!

- One thing that has changed from 2017 is that we are not being given the opportunity to receive additional visits for a 2nd or 3rd auth when the end date has not been reached. Most times our patients are given 1-3 visits in a 2nd or 3rd auth to be used in a month. That is less than 1 visit a week. In actuality POCs signed by doctors are stating they should be seen 2 x a week for a total of 8 visits a month. The denial letter gives us the choice to start a new auth beginning after the end date of the current auth or our PTs need to appeal the previous auth. This is not helping our patients as they back slide in their treatment when not being seen for 2 - 2/12 weeks. It is also not time efficient for our therapist who have to take time away from patients

to handle lengthy appeals. Last year some of our PTs were on hold for 30 - 45 mins waiting to speak with someone and still didn't get an answer over the phone. Will the appeals process be the same for them?

- Stop making me add a bunch of redundant information that should already be in the system. - Grant a reasonable number of visits for a given condition so that we don't have to keep re-submitting
- Let patients have access to medically necessary physical therapy benefits that they pay for each month in premiums and reduce interruptions in care.
- Approve more visits at initial evaluation.
- It would be helpful if you authorize 12 visits initially for surgical patients. They can progress through the first post-op month, and useful information can be provided to you for additional visit requests.
- I wish they would authorize at least 12 sessions initially for neuro patients
- Allow patients access to medically necessary care! They pay the money so let them use their benefits! Let us Physical Therapists do our job in helping patients get their life back.
- Authorize more visits initially to reduce paperwork and disruptions in care.
- Start reward program for therapist who shows better result in short time. It will save BCBS money and therapist will be happy to work with patients. Reduce paperwork. Give correct and timely information to therapist so that they collect deductible and co pay in timely fashion. Finally, educate the patient about deductible and copay. Tell them it is part of their contract which thy must honor. Many patients are "runaways".
- Approve more visits at a time. Approving 1-3 visits at a time causes a huge administrative burden. Also, there is a HUGE disconnect between Evicore/Corepath and BCN with claims processing. We get many denials stating there was no auth. We produce authorization from Evicore/Corepath and have to put hours of time in only to find out that BCN did not have the same information that Evicore/Corepath did. We are the ones taking the time to fight these denials when the systems between the two companies need to be better interfaced to avoid these issues.
- It would be beneficial to still be able to start an authorization for the initial request before the patient is seen without having clinical information so we can have their visits approved.
- Let therapists make the judgements on number of visits up to 10-12 visits prior to requesting authorizations- I would rarely have to request.
- Respect the therapists request, stop over managing it; stop choosing profit over people's well-being!
- EviCore needs realistic algorithms based on the actual needs of patients and actual number of visits required to meet the patient's needs rather than on their arbitrary numbers that are published nowhere in the literature and that they won't share because they say they are proprietary information. Approving a more appropriate number of visits at the initial auth would reduce administrative burden and be better for the patient.
- Automatically authorize post op patients 10-20 visits based on surgery
- Grant a more reasonable number of visits initially (more than 6). 2. Accept our plan of care documentation as support for the need for care. 3. Grant authorization for 15 visits or 20 visits prior to having to request further authorization.
- Need a much quicker log in process! need to grant visits from therapist and doctor orders, not on a cookbook system
- More realistic initial authorizations with more visits authorized.

- The patient should be allowed the number of visits per the contract that they are paying for. PPO plans do not require authorization.
- Re-introduce waiver of visits for initial authorization request so practitioners don't have to be involved.
- Approve of 8 visits non-op. 12 visits post-op and let the clinical record speak from there if further visits are needed. Quit rationing PT care.
- All patients could be given an automatic waiver of possibly 6 visits without any submission of information. BCN eviCore grants 6 visits for PT and 8 for OT. But, the difference also is that the initial authorization for services and one visit is authorized by BNC first and then the care is transferred to eviCore. There is not a two-step process with the Medicare Plus Blue population so maybe this is not possible.
- Make forms actually applicable to patient conditions. We should not have to fill out demographics. Give appropriate number of visits from the get go so we are not wasting our time and can actually serve patients.
- Authorize more visits initially. Less paperwork and burden for patients and PT. I have seen many patients become frustrated while waiting for more authorization
- Let the Therapists determine the visits needed
- Improve consistency in authorization numbers among similar cases including surgical cases
- Go back to the way visits were authorized in 2016, prior to evicore. Listen to your consumers. Abide by the script issued by the PHYSICIAN and recommended by the evaluating physical therapist. Stop managing your consumers like an HMO when they are paying for a PPO plan. Increase window to request additional visits from 2 days to 10 days. Make peer to peer reviews count for something, not just guiding the PT to an appeals process that will likely be denied regardless.

Peer to peer review

Providers had mixed reports on peer to peer review.

- Easier setup for peer to peer reviews if necessary
- Peer to peer review will take more time out of a PT day when we could be helping patients.

Improvement

Providers have noticed some improvements in the new eviCore corePath system.

- Feel this has been a significant improvement
- Very pleased with the new Evicore Corepath! :) - Suggestions on making Landmark for Blue Care Network, the same as the new Evicore Corepath authorization would be wonderful! That is where the burden on administrative time is now (Landmark), having to call for case ID then filling out an online form that the Physical Therapist should be doing, because if it is not filled out completely, you have to go back to them to ask questions continually it seems & any questions that occur when filling out the form online, if it's time consuming getting answers from the Physical Therapist, you get kicked out & have to start over...Very frustrating!

Better customer service

Providers/admins are frustrated with the poor customer service. The wait times on the phone are excessive and evicore phone staff tend to be rude and disinterested in assisting. The staff are often unhelpful, unable to answer provider/admin questions and do not get back with callers within 24 hours.

- Develop a culture of positive influence at your organization. Empower and train your staff to help providers help your customers utilize their benefit. More often, my admin staff complain of evicore staff being rude on phone w/ a nasty tone and one of "we really don't want to help you".
- The wait time to talk to someone could be less.
- Have a full process in place that is consistent and have appropriate training for eviCore staff to empower them to assist as needed with questions
- Every time we talk to someone, they give us different answers to the same questions. Your staff all needs to be on the same page. The information you ask for in the forms are very redundant-just read the evaluation/progress note that we send in for the information.
- Be more open to listening to us.
- Have more pleasant representatives answer the phone when you have to call to provide information. They are RUDE!!
- Suggestion box to report frustrations more readily
- It is not time efficient for our therapist that have to take time away from patients to handle lengthy appeals. Last year some of our PTs were on hold for 30 - 45 mins waiting to speak with someone and still didn't get an answer over the phone. Has the appeals process been improved?
- Trying to get to someone vs the automated system takes the longest. Also, there should be a better way to give more information if there are co morbidities, a lot of time it is spent speaking to non- medical staff who ask for frequent spelling of terms, don't understand what we are trying to say, etc.
- Would love to input the patient's information and upload a Progress Letter and have them get back with us in 24 hrs.

No suggestions currently

Providers did either not provide suggestions or did not feel they had enough information.

- Just wanted to clarify that we are barely into February so request for second authorizations are currently minimal
- I don't have suggestions now. When we are in Group A, we are separated from the process because we have fewer imposed restrictions. If/when we get bumped back to Group B, we will deal with it on a daily basis.
- No suggestions at this time since I have not had to do one yet.

Is the corePath process more time efficient than the eviCore program in 2017?

Faster than eviCore

corePath is more efficient than eviCore specifically in authorization for patient care and functional form scores.

- It does allow us to get authorization almost instantaneously once we complete the authorization process. It is great that we are able to schedule patients follow up sessions while they are still in the clinic.
- Using the functional form scores (as imperfect as they are) is faster and makes more sense than entering ROM and strength scores.

- It has its pros and cons but overall I think it is better. There are definitely a few areas where improvement can be made though.
- It is very similar but the turn-around is a little faster
- Much better! :) Thank you!
- Yes, but it may also be related to the fact that we are now Category A instead of B

Takes longer than eviCore

Providers think corePath takes longer than eviCore because the forms are different, phone call authorizations do not match online forms, errors in the system, and limited visit approval.

- Authorizations via phone are taking longer with fewer visits authorized, eviCore support staff unable to assist in helping clinical support staff in answering questions over the phone, eviCore staff unable to elaborate on why certain number of visits are authorized.
- For the first authorization (after evaluation), we previously just had to enter the basic information (first page of the form). Now some diagnoses require us to enter more than the basic information.
- There have been issues on a daily basis with some of the approvals that I receive back from Evicore, and I have had to call on a daily basis to get them fixed. I've put the correct NPI, TIN, Facility, Start date and Depts on the forms, and they come back approved for different depts., different start dates, and a different NPI. I had 4 patients in one day that I spent over an hour on the phone trying to fix.
- No because they keep changing processes. You call to get information and they cannot help you or tell you what you are missing or what you should have done differently. They only read a preset script, when questions veer off they don't know how to answer correctly. This seems to take up more of our time than prior.
- Still labor intensive and takes therapy staff away from patient care.
- Therapists have to complete paperwork multiple times and billing has to determine which paperwork. It is inefficient and too specific and they always approve 6 visits anyway, so it doesn't seem to be effective.
- Visits are approved in smaller doses over a longer period of time making the need to fill more forms out less efficient overall
- Have had lots of problems in the new year.
- A bit less time efficient. The details about the authorization are provided to us a few days later after gaining authorization via the portal. We have called multiple times, with no assistance, because the fax that is sent to us is only a cover sheet. We have to have processes in place to log in and find authorizations to have the details that are within the authorization letter. eviCore does not seem to care that they have a glitch in their system that faxes the authorization letter to providers.
- The amount of time I've spent on this already is horrendous. Don't have time for this when I am supposed to be helping people. PLEASE do something about this
- It takes longer to complete and patients are left waiting for care, and frequently cancel visits secondary to uncertainty of insurance coverage.
- Definitely not. We do not know what questions the new system is going to ask. There needs to be a template questionnaire to print out for each body part area that the therapists can fill out so that the office staff has all the information necessary to complete the authorization. In 2017 the eviCore program had a form that went through all the questions that will be asked. Now we don't know what will be asked once we

get into the authorization screen online. Sometimes we do not have the necessary info because we didn't know that question would be presented.

- Website does not give visits. Go through process online and then need to call to figure out authorized visits. Questions asked on website are now completely different from what is asked over phone (phone still asking motion, pain, strength, etc. as they were in 2017).

No Change

Providers do not notice any difference between corePath and eviCore as the information required is still repetitive and lengthy taking away from patient care.

- They have not really changed anything in the initial process.
- I don't notice a big change, but I have only done about 5-10 this year so far.
- Same
- Same
- It's the same.
- Same
- Same amount of difficulty and same scrutiny with number of authorized visits.
- Same repetitive demographic info is being requested. And why do we need to continue to fill in date of initial eval and date of onset? Those don't change. A whole page asking if we are fabricating a splint or only giving HEP? We never do this.
- Both programs are time consuming. Not friendly to therapist
- I have not noticed any changes in the program
- They seem the same.
- Neither are time efficient
- They're both about the same.
- Neither are good.
- Zero
- Takes about the same amount of time. It's really going to be a problem when all of my patients with Blue Cross require these authorizations. An average of 10 minutes per patient multiplied by at least 50% of my caseload generates an incredible amount of paperwork and time spent away from treating patients.
- None of it is efficient in my opinion.

Better, but still takes too long

Providers think that the forms are easier to fill out and authorizations come quicker. However, the forms are not all inclusive and additional narratives are required to support the patient case. Re-authorizations, disputing visits and multiple forms continue to make the process time consuming.

- The form is more general, which is less time consuming to fill out, but then does not accurately portray the needs of my patients. I frequently find myself having to spend significant time writing a narrative to explain why continuation of care is needed, because the form itself does not indicate it.

- Its better, but needs to be free of PT time and less tedious/time consuming so it does not take away from patient care. Every additional or longer form takes away from patient care and costs the clinic more money without extra reimbursement.

- It is more efficient in the fact that we receive initial authorizations quicker, but we are still spending an enormous quantity of time on entering all the information, requesting frequent re-authorizations, and disputing a low number of visits approved with peer-to-peer reviews. Overall, corePath is still hurting patients just as much as eviCore has.

Other

Provider input that does not fit a particular theme.

- The biggest problem is the length of time to log in twice needlessly!

- Just authorize more visits at a time!

- Your staff need to be more consistent; it isn't uncommon to be denied by one representative only to resubmit to another rep and be granted additional or original service auth (what the heck is going on there?) Insurance carriers see tot be looking to save money by creating additional layers of red tape, and time consuming processes designed to create a "gotcha" event where therapists in clinics, hospitals are penalized / denied payment for services rendered in good faith.

- There have been issues between BCBS and eviCore regarding patient eligibility...specifically information flowing from BCBS to eviCore