eviCore healthcare
Utilization management programs
Frequently asked questions

Who is eviCore?
eviCore is a specialty medical benefits management company that provides utilization management services for health plans. EviCore's evidence-based healthcare solutions support the medical provider community in managing service quality, cost and competence to ensure patients receive appropriate care for necessary services and achieve better health outcomes.

How does the eviCore program work?
The ordering provider should contact eviCore prior to the service being scheduled and performed. The request may be immediately processed or additional information may be requested. Response time for medical necessity review does not begin until all pertinent information has been received.

In most cases, when all of the required information is provided at the time of the initial request, a decision will be made and communicated to the requesting provider within one business day. Online prior authorization requests with all appropriate information are generally provided in real time. Procedures are in effect to accommodate medically urgent requests.

How can the provider submit requests to eviCore healthcare?
There are three ways to submit prior authorizations for advanced imaging and musculoskeletal services, including:

- Web: www.eviCore.com (preferred method)
- Phone: 844-303-8451
- Fax: 800-540-2406

The web portal provides 24/7 access to submit or check on the status of your request. The portal also offers additional benefits:

- Speed – Requests submitted online require half the time (or less) than those taken by telephone. They can often be processed immediately.
- Efficiency – Medical documentation can be attached to the case upon initial submission, reducing follow-up calls and consultation.
- Real-time access – See real-time status of a request.
- Patient history – See existing and previous requests for a member.

Since providers already have access to eviCore's provider portal, will they need to create a new account specific to Moda?
No. eviCore provider portal accounts are universal and may be used across all payers.

What are eviCore's hours of operation?
eviCore is available from 7 a.m. to 7 p.m., Monday through Friday. eviCore is not open on the following holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day, and the day after Thanksgiving
- Christmas Day

Providers may submit prior authorization requests to eviCore online or via fax 24-hours a day, seven days a week, excluding planned downtime for system maintenance.

What happens if a provider makes a prior authorization request outside of eviCore's normal business hours?
If a provider leaves a telephone voice message requesting a prior authorization outside of eviCore's hours of operation, including weekends and holidays, eviCore will respond within one business day.

For urgent case, eviCore provides Medicare weekend coverage. Registered nurses are available Saturday and Sunday from 8 a.m. to 5 p.m. EST, with on-call nurses available outside of these weekend hours. eviCore also manages expedited appeals with nurses Saturday and Sunday from 10 a.m. to 4 p.m. EST. For additional coverage, eviCore has an on-call group available during high call volumes.

What is eviCore's process to make an update on an existing authorization?
All updates to an authorization must be made by calling 844-303-8451. Post-decision update requests that require clinical review will be allowed up to 60 calendar days following the date of service.

How long is an authorization period?
Once a prior authorization for advanced imaging is approved by eviCore, it is valid for 90 calendar days.

For musculoskeletal therapies, approved prior authorizations are valid for 60 days.

For musculoskeletal spine and joint programs, approved prior authorizations are valid for 45 days.

Can a provider extend an authorization period?
No. Date extensions are not permitted. For example, if services are not rendered within the 45 day authorization period, a new authorization will be required.

If an urgent care or outpatient office has an urgent need, is the ordering provider required to obtain an authorization for an urgent case anytime, including evenings and weekends?
Yes. Urgent procedures must be requested by calling 844-303-8451 and indicated that the request is for **medically urgent care**. All urgent requests must meet the NCQA medically urgent criteria, which is defined as conditions that are a risk to the patient's life, health, ability to regain maximum function, or the patient is having severe pain that requires a medically urgent procedure.

If clinical documentation is needed, then a determination will be processed within 24 to 48 hours of receiving all required information. A medical necessity review is **not required** for inpatient observation and emergency department studies.

Important note: Requests submitted by web portal and fax are treated as standard requests. **Urgent requests must be made by telephone ONLY.**

Are there options if the initial request is not approved?
Yes. Rest assured that if the initial request is denied, there are other opportunities members can take to get a prior authorization request approved. The two options for providers include:

- **A reconsideration review:** A reconsideration review can be requested if there is additional clinical information available without the need for the provider to participate in a discussion.
- **A peer-to-peer discussion:** A peer-to-peer discussion can be requested and will be scheduled with an eviCore medical director. The requesting provider, nurse practitioner or physician assistant can conduct the peer-to-peer with the medical director. During the conversation, the reason for the denial will be discussed and additional information can be provided to support the medical necessity of the request. The ordering provider will be notified at the end of the peer-to-peer discussion if the denial is overturned or upheld. A reconsideration review and a peer-to-peer discussion can be requested by calling 844-303-8451 up to and including the date of service.

  Members may use the appeal process outlined in their Member Handbook.

Will members who have been authorized for services under AIM during the transition month/period be honored by eviCore?
Yes. Open authorizations will be honored and providers will not need to get a new authorization for the same service with eviCore.

What is the impact of failing to obtain medical necessity certification from eviCore?
If eviCore has not deemed services are medically necessary, claims will be denied.

If a claim from a contracted provider is denied the provider will be responsible for the costs of the services provided and the member will be held harmless.

For non-contracted providers, services performed without a required prior authorization will be denied. If a pre-authorization is denied, the member will be responsible for the costs of the services provided.

What is a retrospective request?
A retrospective request is the process of submitting a required prior authorization request after an imaging procedure or service has already been scheduled.

Are retrospective requests allowed?
In Alaska, all retrospective requests are allowed.

In Oregon, the answer will vary on whether the provider is contracted or non-contracted with Moda:

- For contracted providers, retrospective prior authorization requests will not be allowed. Providers must submit a prior authorization request. If they don't, or don't get approval, the provider will be responsible for the costs of the services provided.
- For non-contracted providers, services performed without a required prior authorization may be denied. If a pre-authorization is denied, the member will be responsible for the costs of the services provided. However, the responsible party will vary based on the line of business and group. For more information, contact customer service or account services.

What happens when a member sees non-contracted provider?
When a member sees a non-contracted provider, the provider must submit and obtain a prior authorization. If services are performed without a required prior authorization, or if the prior authorization is denied, the member may be responsible for the full cost of the service provided. For more information, contact customer service or account services.

Will eviCore be processing claims for Moda Health?
No.

What clinical guidelines will be used to make a determination of medical necessity?
Clinical guidelines are available to view online at www.evicore.com.

Who should the provider contact for medical necessity review questions?
If you have additional questions about the medical necessity review program, please email eviCore's Client Services team at clientservices@evicore.com or call 844-303-8451.

Advanced Imaging (Radiology/Cardiology)

How does the advanced imaging program work?
For routine scans, the ordering physician should contact eviCore prior to the study being scheduled and performed. The request may be immediately processed or additional information may be requested. eviCore will provide a response within two (2) business days for standard requests and 24 hours not to exceed 72 hours for urgent requests. Response time for medical necessity review does not begin until all pertinent information has been received.

What services are managed through eviCore's advanced imaging program?

- CT, CTA
- MRI, MRA
- PET
- Diagnostic Heart Catheterization (DHC)
- Cardiac Imaging
- Cardiac CT
- Cardiac MRI
- Cardiac PET
- Nuclear Stress Testing
- Echo Stress Testing

Medical necessity review is **not required** for inpatient, observation and emergency department studies.

What would happen if in the process of doing a scan and the radiologist or rendering physician feels an additional study is needed?
The radiologist or rendering physician should proceed with the study. After the scan, they should contact eviCore to submit an updated request before notifying the patient's referring physician of the additional test.

What happens if approval has been granted for a CT with and without contrast, but the radiologist determines that the contrast is not necessary?
The facility or the referring physician's office staff should call eviCore at 844-303-8451 to update the code on the authorization.

Will providers be able to perform diagnostic exams in the office?
Yes. As long as the appropriate authorization is requested and received and the procedure is within the scope of practitioner's license.

What information is required when requesting authorization for the advanced imaging program?

- Patient's name, address and DOB
- Member ID/Health plan ID
- Ordering provider and facility name
- Ordering provider and facility tax ID
- Ordering provider and facility NPI
- Address, phone, fax
- Requested test(s) CPT code(s)

Musculoskeletal – Pain, Joint, Spine

What services are managed through the interventional pain management, spine and joint surgery program?

- Interventional pain management
- Spine surgery in outpatient setting
- Joint surgery in outpatient setting

Will eviCore grant approval for a series of injections?
No. eviCore will never authorize a series of injections. eviCore requires a separate pain management prior authorization request for each date of service. A patient's response to previous injections administered will often times determine if a subsequent injection is necessary. Information in the office notes may help avoid processing delays.

What information is required when requesting authorization for the musculoskeletal program?

- Patient's name, address, DOB
- Member ID
- Diagnosis/ICD10 code
- Date of initial evaluation
- Date of onset of the condition requiring treatment
- Co-morbidities
- Objective physical examination findings
- Type and duration of treatment to be performed

Specialty Therapy Services

What services are managed through the Specialty Therapy Services program?

- Physical therapy/ Occupational therapy/ Speech therapy
- Alternative Care
    - Chiropractic
    - Massage therapy
    - Acupuncture

For authorizations regarding intensive outpatient rehabilitation for the treatment of autism spectrum disorder or neurodevelopmental conditions, please contact Moda Health for authorization.

What information is required when requesting authorization for specialty therapy services?

- Patient's name, address and DOB
- Member ID
- Diagnosis/ICD10 code
- Date of initial evaluation
- Start date of treatment plan
- Date of onset of the condition requiring treatment
- Objective physical examination findings
- Recent signs and symptoms
- Motion and strength measurements
- Limitations

How does the provider place a prior authorization for services under the physical medicine and therapy program?

A medical necessity review isn't always required for all services. In cases when a medical necessity review is not required, the prior authorization is a two-step process that includes a notification and a treatment request.

The notification and a treatment request may be submitted by the servicing practitioner or their office staff. The preferred method to submit the notification information is online at www.eviCore.com. Online submissions are available 24/7. Notifications can also be submitted by calling 844-303-8451 between 7 a.m. and 7 p.m., Monday through Friday.

What is a notification?
A notification is the initial authorization request submitted to eviCore to inform Moda Health that a member is starting care. A reference number is issued to authorize the initial visits. The notification includes patient demographic information, and allows for claims payment. The number of visits varies based on each therapy. They include:

- Physical therapy / Occupational therapy – 6-10 visits
- Speech Therapy – 6 visits
- Chiropractic – 6 visits
- Massages / Acupuncture – 6 visits

What is the notification process?
All physical medicine/therapy practitioners may submit a notification within seven days of the initial evaluation. They may also need to submit a treatment request to obtain authorization for the treatment episode. Below is the notification process:

- Within seven (7) days of service (before or after service), providers should submit a notification that the member is starting care.
- An eviCore pre-authorization approval may be instant or may require medical review.
- Medical review is completed within two (2) days.
- Standard authorization periods are for 30 days.

What is the difference between a notification and a prior authorization?
A notification is to inform eviCore and Moda that a member will be starting care for a specific condition.

How many visits will eviCore approve when the provider submits a notification?
The initial authorization is based on the average number of visits used for the type of service being requested.

- Acupuncture and massage therapy notifications are generally allowed a four-visit episode of care.
- Chiropractic notifications are generally allowed a six-visit episode of care.
- Physical therapy/occupational therapy notifications are generally allowed a six to 10-visit episode of care.
    - Qualifying conditions (e.g. post-operative) can entitle additional visits
- Speech therapy notifications are generally allowed a six-visit episode of care.

When a provider submits a notification, will they know if a treatment request is also required?
Yes. After your initial submission, eviCore will prompt you to complete a treatment request if one is required at the time you submit your notification.

What is a treatment request? (treatment authorization vs. prior authorization)
After the initial approved episode of care is exhausted, a treatment request is the process of submitting clinical information for a condition-specific medical necessity review when an episode requires additional visits.

Transitioning to eviCore

What happens to pending prior authorizations with AIM Specialty?
For groups that currently have AIM, request for treatment must be placed through eviCore for dates of service beginning **April 1, 2017**. Authorizations with AIM prior to April 1, 2017, will remain valid.

Will Moda continue to utilize AIM Specialty Health for other services?
No. For groups that currently have AIM, effective **April 1, 2017** all prior authorizations for advanced imaging and musculoskeletal services must be placed through eviCore.

When did eviCore start accepting prior authorization requests?
eviCore began accepting prior authorizations starting **March 27, 2017**, for services scheduled for April 1, 2017, and after.