eviCore healthcare FAQ

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.

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

1. **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.
2. **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 at any time, up to and including the date of service.

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

As a member, will authorized 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. This decision only affects Moda's payment. The decision to access care remains with the member and physician.

If a claim from a contracted provider is denied, the provider will be responsible for the cost of the service provided and you will be held harmless.

For non-contracted providers, services performed without a required prior authorization will be denied. If a pre-authorization is denied, you will be responsible for the cost of the service provided. eviCore's decision only affects claims payment. The decision to access care remains with the member and physician.

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 performed.

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, you will be responsible for the costs of the services provided. For more information, contact customer service or account services.

As a member, what happens if I see a non-contracted provider?
If you see 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, you may be responsible for the full cost of the service provided. For more information, contact customer service.

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

Advanced Imaging (Radiology/Cardiology/Ultrasound)

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
- Ultrasound (for OEBB members, this goes into effect Oct. 1, 2017)

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

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

Specialty Therapy Services

What services are managed through the Specialty Therapy Services program?

- Physical therapy/ Occupational therapy/ Speech therapy
- Alternative Care
    - Chiropractic
    - Acupuncture
    - Massage therapy (if covered by your policy)

What is a notification?

A notification is the initial authorization request submitted to eviCore to inform Moda Health 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.

What is the notification process?

All physical medicine/therapy practitioners must 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 you are 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 you 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 chiropractic notifications are generally allowed an initial six-visit episode of care.
- Massage therapy notifications are generally allowed an initial six-visit episode of care if covered by your policy. Please check your Member Handbook for details.
- 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 an initial six-visit episode of care.

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?

Requests 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. Effective **April 1, 2017** all prior authorizations for advanced imaging and musculoskeletal services must be placed through eviCore.

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