eviCore healthcare Medical Oncology Program
Frequently Asked Questions

Which members will eviCore healthcare manage for the Medical Oncology program?
eviCore will manage preauthorization services for Health Alliance's commercial and Medicare Advantage members.

How do providers initiate a preauthorization request?
Providers in the Health Alliance network will access eviCore through YourHealthAlliance.org for providers. Out-of-network providers must fax 1-800-540-2406 or call 1-844-303-8452 with preauthorization requests.

Is it possible for the provider to be both the ordering and rendering provider?
Yes.

How long does it take to initiate a preauthorization request using the website?
If all necessary clinical questions are completed and appropriate clinical information is submitted, you may receive an immediate decision. If further review is needed then eviCore will make a decision within two business days of receiving all clinical information.

What are the hours of operation for the call center?
eviCore healthcare's preauthorization call center is available from 7:00 a.m. to 7:00 p.m. local time, Monday through Friday at 1-844-303-8452. The web portal is available for access 24/7.

What information is required to obtain approval for preauthorization requests?
- Member or Patient's Name, Date of Birth, and Health Plan ID Number
- Ordering provider name, National Provider Identifier (NPI), Tax Identification Number (TIN), fax number
- Place of service
- Rendering facility's name, NPI, TIN, street address, fax number
- Service being requested: Requested drug(s)/HCPCS 'J' code and name (brand and/or generic)
- All relevant clinical notes

Relative diagnosis and medical history including:

- Signs and symptoms
- Results of relevant test(s)
- Relevant medications
- Working diagnosis/stage
- Patient history including previous treatment

How do providers check the status of a preauthorization request?
Network providers can check the authorization status by accessing eviCore via YourHealthAlliance.org for providers or by calling 1-844-303-8452. Out-of-network providers must call 1-844-303-8452 to check the status of an authorization.

What does the authorization number look like on the authorization approval?
The authorization number will begin with the letters "EV," followed by a seven-digit number—EV7777777.

How will eviCore notify members and ordering providers of approvals/denials?
Written notices will be sent to the member as well as the ordering provider(s).

Will the rendering facility be notified of determinations?
The facility will not receive notification of the determination. It is imperative that the facility verify that authorization was obtained before rendering services.

How do providers schedule a peer-to-peer consultation?
Providers must call 1-844-303-8452 to schedule a peer-to-peer consultation. Additionally, this program allows Post-Decision Review requests for 14 calendar days after the date of service.

How will expedited/urgent requests be handled?
When a service requiring authorization is medically urgent, the provider must call 1-844-303-8452. Urgent requests are defined by National Committee for Quality Assurance (NCQA) 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. Expedited or urgent requests must contain a provider's attestation that urgent services are necessary. Once all information is provided, eviCore can typically process expedited or urgent requests within 24 hours.

How do urgent requests initiated via phone get entered into the system?
Urgent requests are entered into the system in the same method as non-urgent requests. However, they are flagged as urgent and are reviewed within a shortened time frame.

How does a provider verify credentialing status?
Verify your credentialing status with Health Alliance. Contact the Contracting and Provider Services department at 1-800-851-3379, ext. 4668, or email PSC@healthalliance.org.

How does a provider join the Health Alliance provider network?
To join the Health Alliance provider network, visit YourHealthAlliance.org and create an account as a Prospective Provider.

How do providers check the eligibility of a member?
Member eligibility can be verified via YourHealthAlliance.org for providers.

How does eviCore determine if a provider is in-network?
Health Alliance provides eviCore a list of all participating providers daily. Participation status can be verified via YourHealthAlliance.org for providers. Providers can also contact Health Alliance's Customer Service department at 1-800-851-3379.

How does as a provider file a formal complaint?
Provider complaints should be submitted to Health Alliance by phone at 1-800-851-3379, ext. 4668, or via email at PSC@healthalliance.org.

How do providers appeal a preauthorization denial?
All appeals will be handled by Health Alliance and must be submitted in writing. Instructions to appeal the preauthorization decision are in the denial letter. The request must include the:

- Member name
- Member ID number
- Reason for appeal
- Any evidence to support the request for appeal

How do providers access the eviCore system?
Providers in the Health Alliance network will access the eviCore system through YourHealthAlliance.org for providers. Out-of-network providers must call 1-844-303-8452 or fax 1-800-540-2406 to request a preauthorization.

Can a provider check the status of a pending preauthorization request other than by phone?
Providers in the Health Alliance network may check the status of a pending request online through YourHealthAlliance.org for providers. Out-of-network providers must call 1-844-303-8452 to check the status of a pending request.

Will eviCore allow a "future date" on preauthorization requests?
Yes.

Will preauthorizations obtained and approved by Health Alliance prior to the eviCore go-live date still be valid?
Yes.

What are the elements of the Medical Oncology Program?
The main component of the Medical Oncology Program is prior authorization for all primary injectable chemotherapeutic agents billed under the medical benefit and used in the treatment of cancer as well as select supportive agents in combination with the chemotherapy. The program also includes newly approved chemotherapy services.

What procedures will require preauthorization?
Refer to the list of HCPCS codes on the implementation site that require preauthorization: https://www.evicore.com/healthplan/Health_Alliance. Note that newly approved chemotherapy agents not on this list and used for the treatment of cancer do require preauthorization.

What medical providers will be affected by this agreement?

All physicians who perform pre-selected oncology related injection/infusion procedures are required to obtain a preauthorization for the drugs prior to the drugs being administered in an office or outpatient setting. Physicians and facilities who render oncology related injection/infusion procedures within the scope of this protocol must confirm that preauthorization has been obtained, or payment for their services may be denied.

What is the most effective way to get authorization for urgent oncology requests?

The most efficient way to obtain preauthorization for urgent requests is via phone, as an immediate approval can be obtained. Please contact eviCore healthcare directly at 1-844-303-8452, indicating the request is urgent.

What is the process to follow for urgent preauthorization requests if eviCore healthcare is not available?

Note that preauthorization is not required for drugs provided in an emergency room, observation, or urgent care setting. Chemotherapy is rarely administered on an urgent basis, however supportive drug therapies that may meet urgent criteria can be submitted through the website and will receive immediate approval.

If a patient is undergoing treatment before the start of the program on 6/1/17, will the treatment need authorization?

- If a patient has already started treatment prior to June 1, 2017 any existing authorizations obtained through Health Alliance will remain valid through the expiration date on the original authorization. No additional authorization is required through eviCore..
- If a patient is being treated with a drug that did not require PA through Health Alliance, but does require PA through eviCore, a request must be submitted through eviCore.
- If a new drug is introduced into a treatment regimen, that would also require an eviCore approval.

What happens if the provider's office does not know the treatment regimen that needs to be ordered?

The caller must be able to provide either the drug name or the HCPCS code in order to submit a request. eviCore will assist the physician's office in identifying the appropriate code based on presented clinical information and the current HCPCS code(s)provided.

Where can I see eviCore healthcare's medical oncology coverage criteria?

You can see eviCore healthcare's clinical guidelines on medical oncology at https://www.evicore.com/solution/pages/medicaloncology.aspx.

Once I ask for a preauthorization, how long will it take to get a decision?

When a preauthorization is initiated online and the request meets criteria, the service will be approved immediately, and a time stamped approval will be available for printing. If the non-urgent request does not meet criteria or requires additional clinical review, a determination should be made within 2 business days upon receipt of all necessary clinical information to process a medical necessity review.

How long will the preauthorization approval be valid?

The length of time for which an oncology preauthorization will be valid will vary by request ranging from approximately 8 – 14 months, depending on the severity of the cancer. When a preauthorization number is issued for a treatment regimen, the requested start date of service will be the starting point for the period in which the course of treatment must be completed. If the course of treatment is not completed within the approved time period, or if there is a drug change in the regimen, then a new preauthorization number must be obtained.

Is a separate authorization needed for each drug ordered?

No. A single authorization number will cover the entire primary treatment regimen for the length of treatment (up to 14 months depending on the treatment selected). The eviCore system will collect the clinical data needed and provide a list of recommended regimens (single agent and multi-agent) from which to select. Providers may also custom build a regimen by selecting from a list of all drugs covered in the program. In either case, the entire regimen must be provided at the time the authorization is requested. Supportive therapies (anti-emetics, GCSFs, ESAs, etc.) do require a separate authorization that can be obtained at the same time the primary treatment request is submitted or at any other time as needed. If a new drug is needed at a later date, a new authorization will be needed for the complete regimen to be used from that date forward.

Who should request preauthorization in cases where a Primary Care Physician refers a patient to a specialist who determines that the patient needs cancer treatment including a drug that requires preauthorization?

The physician who orders the drug should request the preauthorization. In this case, it would be the specialist.

If a preauthorization number is still active and a patient comes back within the time for follow up and needs an additional infusion of the authorized drug, will a new preauthorization number be required?

No. If the infusion is needed during the timeframe in the preauthorization, the preauthorization will cover additional infusion services of the authorized drug.

What happens if a service is rendered despite an authorization denial?

The Medical Oncology Review Program is a preauthorization program that includes a medical necessity determination for the requested treatment regimen. Coverage for treatment regimens that are not medically necessary will be denied as not covered. Failure to comply with any preauthorization protocol may result in an administrative claim denial.

In the event of an adverse determination can the provider request a clinical review?

A Peer to Peer physician discussion can be conducted anytime during the determination and up to 14 calendar days after the determination. However, after a determination has been made the decision cannot be changed and the peer to peer discussion is for educational purposes only. Instructions on how to initiate a Peer to Peer will be listed on the denial letter. eviCore will attempt to conduct a Peer to Peer prior to issuing a denial in order to discuss alternate treatment options.

Are any drug modifications allowed under the Medical Oncology preauthorization program?

Yes. Any modifications to the authorized drug treatment regimen will require a new authorization in order for the entire regimen to be used from the date of the modification moving forward.

Is preauthorization required when using a covered drug to treat a non-cancer diagnosis?
Not through the Medical Oncology program. Non-cancer diagnosis are managed under the Specialty Drug Program.

If a denial occurs because of a coding mistake can I resubmit the claim?
Yes, if the mistake is administrative (related to coding) then a claim can be resubmitted as long as preauthorization remains in effect and the procedure on the claim is medically necessary.

If the patient starts a medical oncology regiment at one facility and changes to another during a course of treatment, is a new preauthorization required?
Yes. If a new physician group is treating the patient, a new preauthorization should be obtained..

Where should I send claims once I provide services?
Send all claims as you would normally to Health Alliance.

Can only the provider ask for authorizations?
A representative of the physician's staff can ask for authorization. This could be someone from the clinical staff, front office, or billing staff acting on behalf of the referring physician.

What information about the preauthorization will be visible on the eviCore healthcare website?
The authorization status function on the website will provide the following information:

- Preuthorization Number/Case Number
- Status of Request
- Cancer Type
- Site Name and Location
- Preuthorization Date
- Expiration Date

How will all parties be notified if the prior authorization has been approved?
Referring providers will be notified of the prior authorization via fax. Both providers can validate a prior authorization by using the eviCore website or by calling eviCore Customer Service. Members will be notified in writing. The facility will not receive a notification.

If a preauthorization is not approved, what follow-up information will the referring provider receive?
The ordering provider will receive a denial letter by mail that contains the reason for denial as well as appeal rights and processes. Please note that after the denial has been issued for a Commercial member, the referring provider may request a Peer-to-Peer discussion with an eviCore Medical Director to review the decision. Please note that after a denial has been issued for a Medicare member, no changes to the case decision can be made. Speaking with an eviCore Medical Director is for educational purposes only.

What is the format of the eviCore healthcare authorization number?

An authorization number is (1) one Alpha character followed by (9) nine numeric numbers. For example: A123456789.

If the office does not have web access, how can a provider verify that a study has been authorized?

If the office does not have web access, you can call eviCore at 1-844-303-8452.