Medical Oncology Management
Provider Orientation
Corporate Overview
100M Members Managed Nationwide

Comprehensive Solutions

- The industry’s most comprehensive clinical evidence-based guidelines
- 4k+ employees including 1k clinicians
- Engaging with 570k+ providers
- Advanced, innovative, and intelligent technology

Headquartered in Bluffton, SC
Offices across the US including:

- Lexington, MA
- Colorado Springs, CO
- Franklin, TN
- Greenwich, CT
- Melbourne, FL
- Plainville, CT
- Sacramento, CA

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Comprehensive Solutions

End-to-End Solution on a single integrated platform

Radiology
Cardiology
Musculoskeletal
Sleep Management
Medical Oncology
Specialty Drug
Radiation Therapy
Lab Management
Post-Acute Care
Medical Oncology Solution Experience

- 8 years’ experience – since 2007
- 3 regional and national clients
- Extensive national footprint
- 14M total membership
  - 11.75M Commercial membership
  - 252+k Medicare membership
  - 11k Medicaid membership
- 400+ average cases built per day
Service Model
The Client Provider Operations team is responsible for high-level service delivery to our health plan clients as well as ordering and rendering providers nationwide.

**Client Provider Operations**

- **Client Provider Representatives**
  - Client Provider Representatives are cross-trained to investigate escalated provider and health plan issues.

- **Client Service Managers**
  - Client Service Managers lead resolution of complex service issues and coordinate with partners for continuous improvement.

- **Regional Provider Engagement Managers**
  - Regional Provider Engagement Managers are on-the-ground resources who serve as the voice of eviCore to the provider community.
Why Our Service Delivery Model Works

One centralized intake point allows for timely identification, tracking, trending, and reporting of all issues. It also enables eviCore to quickly identify and respond to systemic issues impacting multiple providers.

Complex issues are escalated to resources who are the subject matter experts and can quickly coordinate with matrix partners to address issues at a root-cause level.

Routine issues are handled by a team of representatives who are cross trained to respond to a variety of issues. There is no reliance on a single individual to respond to your needs.
Our Clinical Approach
Clinical Staffing

Multi-Specialty Expertise
- 250 Medical Directors covering 28 different specialties
- 800 nurses with diverse specialties and experience
- Dedicated nursing and physician specialty teams for various solutions

Specialty-Based Routing
- Allows clinically complex cases to automatically route to a specific queue, based on clinical specialty for review
- Ensures greater accuracy of decision-making across the many clinical disciplines

- Family Medicine
- Internal Medicine
- Pediatrics
- Sports Medicine
- OB/GYN
- Cardiology
- Nuclear Medicine
- Radiation Oncology
- Sleep Medicine
- Oncology/Hematology
- Orthopedic
- Chiropractic
- Pain Mgmt / Interventional Pain
- Physical Therapy

- Medical Genetics
- Pathology
- Surgery
  - General
  - Thoracic
  - Cardiac
  - Neurological
  - Otolaryngology
  - Spine
- Radiology
  - Musculoskeletal
  - Neuroradiology
Our Medical Oncology Solution *is* Evidence Based

National Comprehensive Cancer Network® (NCCN)

26 of the World’s Leading Cancer Centers Aligned

Inclusive of 44 cancer types

Represents 97% of all cancers

Continually updated

eviCore Pathways
Medical Oncology Pathway Experience

More than 98k authorizations since June 2015, resulting in 98.5% clinically appropriate treatments

- Immediate approval for 70%
- Remainder resolved in average of 6 hours
- 1.3% non-certification
- Appeal rate is less than 1%

Graph showing:
- 70% Immediate Approval
- 28.5% Approved after P2P or Redirection
- <1.5% Pended or Denied

EviCore data on file
**Summary**

**What types of Drugs are included?**
- Injectable Chemotherapy billed through the Medical Benefit
- Drugs covered under this program, but being used to treat NON-cancer conditions are NOT part of this program, but may require PA. Contact the number on the ID card to confirm requirements.

**What is covered in my authorization?**
- All inscope drugs that were entered as part of a regimen – there are no partial approvals.
- The HCPC codes associated with the approved drugs
- The time period indicated on the authorization (8-14 months)
- The Authorization is not for a specific dose or administration schedule. *However, billing in excess of the appropriate # of units or frequency of administration for a drug may result in claims denial.*

**How often do I need to update my authorization?**
- When the authorization time has expired.
- When there is a change in treatment including new or different drugs.
- NOT when dosing changes
- NOT if an approved drug is no longer used

**What about drugs billed through Pharmacy?**
- Pharmacy drugs (typically orals) will need to be ordered an approved through the pharmacy and PBM as you are doing today.
- When selecting a regimen that contains orals drugs, those drugs will not be included in your final authorizations.
Medical Oncology Prior Authorization Program for Prominence Health Plan
eviCore began accepting requests on October 24, 2016 for dates of service November 1, 2016 and will now expand this to include southern Nevada’s HMO/POS/PPO membership effective April 1, 2018.

It is the responsibility of the ordering provider to request prior authorization approval for services.

**eviCore Prior authorization applies to services that are:**

- Outpatient
- Elective/non-emergent

**eviCore Prior authorization does not apply to services that are performed in:**

- Emergency room
- Inpatient
- 23-hour observation
Prior Authorization Required:

- All primary Injectables chemotherapy billed under the medical benefit

To find a list of CPT (Current Procedural Terminology) codes that require prior authorization through eviCore, please visit:

Applicable Membership

Authorization is required for Prominence Health Plan members enrolled in the following programs:

- Commercial HMO
- Commercial PPO
- Commercial POS

Members who do not require prior authorization:

- Medicare
Prior Authorization Requests

How to request prior authorization:

[Image of a computer screen with a website URL and a phone number]

**WEB**

[www.evicore.com](http://www.evicore.com)

Available 24/7 and the *quickest* way to create prior authorizations and check existing case status

Or by phone:
844-224-0495
7:00 a.m. to 7:00 p.m. local time
Monday - Friday
Medical Oncology Solution Defines a Complete Episode of Care

Disease-Specific Clinical Information
- Diagnosis at onset
- Stage of disease
- Clinical presentation
- Histopathology
- Comorbidities
- Patient risk factors
- Performance status
- Genetic alterations
- Line of treatment

2-5 minutes to enter a complete case
Needed Information

Member
Member ID
Member name
Date of birth (DOB)

Referring/Ordering Physician
Physician name
National provider identifier (NPI)
Tax identification number (TIN)
Fax number

Rendering Facility
Facility name
National provider identifier (NPI)
Tax identification number (TIN)
Street address

Requests
Patient’s clinical presentation.
Diagnosis Codes.
Disease-Specific Clinical Information.
Patient’s intended treatment plan

If clinical information is needed, please be able to supply:

• Prior tests, lab work, and/or imaging studies performed related to this diagnosis
• The notes from the patient’s last visit related to the diagnosis
• Type and duration of treatment performed to date for the diagnosis
Prior Authorization Outcomes

Approved Requests:
- All requests are processed within 2 business days after receipt of all necessary clinical information
- Authorizations will vary by request ranging from approximately 8 – 12 months

Delivery:
- Faxed to ordering provider and rendering facility
- Mailed to the member
- Information can be printed on demand from the eviCore healthcare Web Portal

Denied Requests:
- Communication of denial determination
- Communication of the rationale for the denial
- How to request a Peer Review

Delivery:
- Faxed to the rendering provider and rendering facility. Texas providers will also receive a verbal denial
- Mailed to the member
Prior Authorization Outcomes

Reconsiderations

• Additional clinical information can be provided without the need for a physician to participate
• Must be requested on or before the anticipated date of service

Peer-to-Peer Review:

• If a request is denied and requires further clinical discussion for approval, we welcome requests for clinical determination discussions from referring physicians. In certain instances, additional information provided during the consultation is sufficient to satisfy the medical necessity criteria for approval.
• Peer-to-Peer reviews can be scheduled at a time convenient to your physician
Special Circumstances

Appeals

- eviCore Healthcare will be delegated for first level member and provider appeals.
- Requests for appeals must be submitted to eviCore within 180 days of the initial determination.
- A written notice of the appeal decision will be mailed to the member and faxed to the provider.
- Second level appeals will be managed by a third party assigned by the state, please contact Prominence.

Retrospective:

- Retro Requests must be submitted with 3 business days following the date of service. Requests submitted after 3 business days will be administratively denied.
- Retros are reviewed for clinical urgency and medical necessity. Turn around time on retro requests is 30 calendar days.

Outpatient Urgent:

- Contact eviCore by phone to request an expedited prior authorization review and provide clinical information.
- Urgent Cases will be reviewed with 72 hours of the request.
Web Portal Services
eviCore healthcare website

- Point web browser to evicore.com
- Click on the “Providers” link
- Login or Register

Providers Delivering Medical Solutions That Benefit Everyone.
Creating An Account

To create a new account, click Register.
Select a Default Portal, and complete the registration form.
Review information provided, and click “Submit Registration.”
Accept the **Terms and Conditions**, and click “Submit.”
You will receive a message on the screen confirming your registration is successful. You will be sent an email to create your password.
Create a Password

Your password must be at least (8) characters long and contain the following:

- ✔️ Uppercase letters
- ✔️ Lowercase letters
- ✔️ Numbers
- ✔️ Characters (e.g., ! ? *)
To log-in to your account, enter your **User ID** and **Password**. Agree to the HIPAA Disclosure, and click “Login.”
Account Overview
Welcome Screen

Welcome to the CareCore National Web Portal. You are logged in as:

**Providers must be added to your account before cases can be submitted over the web. Please select “Manage Account” to add providers.”**

- Request a clinical certification/procedure
- Resume a certification request in progress
- Look up an existing authorization
- Check member eligibility

Providers will need to be added to your account prior to case submission. Click the “Manage Account” tab to add provider information.

**Note:** You can access the MedSolutions Portal at any time if you are registered. Click the MedSolutions Portal button on the top right corner to seamlessly toggle back and forth between the two portals without having to log-in multiple accounts.
Click the “Add Provider” button.
Enter the Provider’s NPI, State, and Zip Code to search for the provider record to add to your account. You are able to add multiple Providers to your account.
Once you have selected a practitioner, your registration will be completed. You can then access the "Manage Your Account" tab to make any necessary updates or changes.

You can also click "Add Another Practitioner" to add another provider to your account.
Adding Practitioners

Select the matching record based upon your search criteria.
Case Initiation
Initiating A Case

- Once registered, providers are granted access to the web portal.

- After logging into your account, a welcome screen provides options. Choose “request a clinical certification/procedure” to begin a new case request.
Select the **Program** for your certification.
Select the **Practitioner/Group** for whom you want to build a case.
Choose the appropriate **Health Plan** for the case request.
Enter the **Providers’s name** and appropriate information for the point of contact individual.
New patients are registered or current patients are selected from the drop down list.
The Patient History Screen becomes the hub for all future requests or data relating to this patient. This includes a record of previous requests for services through eviCore, authorization numbers and dates, and clinical summaries based on the information provided through the request process.
Clinical Details

Patient ID:
Patient Name:

What is the anticipated start date of treatment? [ ] MM/DD/20YY

Clinical Certification

This procedure will be performed on 7/1/2016. [CHANGE]

Medical Oncology Pathways

Select Drug Classification[?] or Description[?]

CHEMO □ CHEMOTHERAPY □

Primary Chemotherapy and Supportive drugs must be entered as separate requests.

Diagnosis

Diagnosis Code: D48.1
Description: Neoplasm of uncertain behavior of connective and other soft tissue
Change Diagnosis
If the ordering provider will not be billing for the drugs, you will have the opportunity to enter the rendering site information. Verify all information entered and make any needed changes prior to moving into the clinical collection phase of the prior authorization process. You will not have the opportunity to make changes after that point.
The Clinical Pathway begins with the selection of the cancer type. This will dictate the questions that will be asked in the following screens. All cancer types covered by NCCN are available as well as an “Other” option for rare cancers not addressed by NCCN.
Clinical Pathway

The user will be asked a series of questions necessary to generate the recommended treatment list for the patient being treated. A typical traversal will have between 5 and 12 questions based on the complexity of the cancer. The system will dynamically filter to only the minimum number of questions needed to complete the review.

Clinical Certification

Active (Symptomatic) Myeloma requires one or more of the following symptoms (prior to start of therapy):

- Calcium elevation (greater than 11.5 mg/dL)
- Renal insufficiency (creatinine greater than 2 mg/dL)
- Anemia (hemoglobin less than 10 g/dL or 2 g/dL less than normal)
- Bone disease (lytic or osteopenic)
- Repeated infections, amyloidosis, or hyperviscosity

Most recent entry for this patient: None

- Clinical Presentation:
  - Smoldering (asymptomatic)
  - Active (symptomatic)
All NCCN recommended treatments are displayed as well as an option to submit a custom treatment plan by selecting the individual drugs that will be administered. All of the drugs in the selected regimen that require an authorization will be automatically included if approved.
Approval

Clinical Certification

Your case has been sent to Medical Review.

Provider Name:  
Provider Address:  
Contact:  
Phone Number:  
Fax Number:  

Patient Name:  
Insurance Carrier:  
Patient Id:  

Site Name:  
Site Address:  
Site ID:  

Diagnosis/ICD-10 Code:  
Date of Service:  
HCPCS Code(s):  
Drug(s):  

Description: MALIGNANT NEO COLON NOS  
39263  
OXALIPLATIN (ELOXATIN)  

Authorization Number:  
Review Date:  1/19/2015 4:11:36 PM  
Start Date:  2/2/2015  
Expiration Date:  9/30/2015  
Status: Your case has been Approved.

- Selection of a recommended regimen will result in immediate approval of all drugs in the requested regimen with an authorization time span sufficient to complete the entire treatment.

- No further action is needed unless the treatment needs to be changed due to disease progression or other clinical factors.
Custom Treatment Plans

Custom Treatment plans can be submitted for any case where the provider does not want to use a recommended regimen. Drugs are selected from a drop down list and the user has the opportunity to attach or enter supporting information for the request.
Custom Treatment Plans

Clinical Certification

Your case has been sent to Medical Review.

Provider Name: [Redacted]
Provider Address: [Redacted]
Contact: [Redacted]
Phone Number: [Redacted]
Fax Number: [Redacted]

Patient Name: [Redacted]
Patient Id: [Redacted]
Insurance Carrier: [Redacted]

Site Name: [Redacted]
Site ID: [Redacted]

Diagnosis/ICD-10 Code: 15190, 39042
Date of Service: 1/19/2015
HCPCS Code(s): [Redacted]
Description: MALIGNANT NEO COLON NOS
Drug(s): 5-FLUOROURACIL (5FU; ADRUCIL), BRENNUXIMAB-VEDOTIN (ADCETRIS)

Case Number: [Redacted]
Review Date: 1/19/2015 4:57:01 PM
Expiration Date: [Redacted]
Status: Your case has been sent for Medical Review.

- Custom plans are reviewed by an eviCore medical oncologist to determine if the request is clinically appropriate. Factors such as rare conditions, toxicity issues, or comorbidities may result in approval.
- If the request is not able to be approved, the eviCore Oncologist will request a peer-to-peer to discuss alternate treatment options that meet evidence based guidelines prior to issuing a denial. The goal is to eliminate the need for denials when acceptable alternatives are available.
- All reviews are completed within 48 hours of receiving complete clinical information.
Once a case has been submitted for clinical certification, you can return to the Main Menu, resume an in-progress request, or start a new request. You’re even able to indicate if any of the previous case information will be needed for the new request.
Authorization look up
Eligibility Look Up

New Security Features Implemented

- Cardiology Eligibility: Medical necessity determination required.
- Radiology Eligibility: Precertification is required.
- Radiation Therapy Eligibility: Medical necessity determination required.
- Sleep Management Eligibility: Medical necessity determination required.

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Provider Resources
Provider Resources: Pre-Certification Call Center

7:00 AM - 7:00 PM (Local Time): 844-224-0495

- Obtain pre-certification or check the status of an existing case
- Discuss questions regarding authorizations and case decisions
- Change facility or HCPC Code(s) on an existing case
Provider Resources: Web-Based Services

www.evicore.com

To speak with a Web Specialist, call (800) 646-0418 (Option #2)

- Request authorizations and check case status online – 24/7
- Web Portal registration and questions
- Pause/Start feature to complete initiated cases
- Upload electronic PDF/word clinical documents
Provider Resources: Client Provider Operations

clientservices@evicore.com

- Eligibility issues (member, rendering facility, and/or ordering physician)
- Questions regarding accuracy assessment, accreditation, and/or credentialing
- Issues experienced during case creation
- Request for an authorization to be resent to the health plan
Provider Resources: Implementation Document

Provider Enrollment Questions Contact Prominence Health Plan at (775) 770-9300

Prominence Health Plan Implementation Site:


- HCPC code list of the procedures that require prior authorization
- Health Plan quick reference guide
- NCCN.org for clinical guidelines
- Web User Guide

Medical Oncology Tools & Criteria

Thank You!