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Prior Authorizations for Oncology Services
Frequently Asked Questions (FAQ)

Health Partners Plans (HPP) has expanded its partnership with eviCore healthcare to review prior authorizations for medical oncology and chemotherapy services beginning July 1, 2018, for Health Partners (Medicare), and October 1, 2018, for Health Partners (Medicaid). This is referred to as the Medical Oncology Review program in this document.

This partnership with eviCore will allow providers to access eviCore's experts as well as their nationally recognized evidence-based guidelines and criteria. The program is designed to improve quality of care and patient safety while ensuring the provision of clinically appropriate care to HPP patients in a timely manner. This document is a resource for providers to use to answer common questions about the program.

Q: What are the elements of the Medical Oncology Review program?
A: The Medical Oncology Review program consists of prior authorization medical necessity determinations for all primary injectable agents used in the treatment of cancer as well as select supportive agents in combination with the chemotherapy. The program also includes newly-approved chemotherapy agents that are used for the treatment of cancer.

Q: What is the effective date of the program?
A: The effective date of the Medical Oncology Review program administered by eviCore healthcare is July 1, 2018, for Health Partners Medicare and October 1, 2018, for Health Partners (Medicaid).

Q: Which medical oncology procedures will require a prior authorization?
A: Refer to the list of HCPCS codes that require prior authorization. This can be found on eviCore's website at **https://www.evicore.com/healthplan/healthpartnersplans**. Check the HPP website, as the program may be modified or updated. Note that newly approved chemotherapy agents not on this list and used for the treatment of cancer do require prior authorization.

Q: Which providers will be impacted by this program?
A: All physicians who perform pre-selected oncology-related injection/infusion procedures are required to obtain a prior authorization for services prior to the service being rendered 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 prior authorization has been obtained, or payment for their services may be denied.

Q: Do medical oncology services performed in an inpatient setting at a hospital or emergency room setting require prior authorization?
A: Prior authorization is required for inpatient chemotherapy or oncology services provided in an inpatient hospital setting. Medical oncology services in an emergency room setting—like all ER services—does not require prior authorization.

Q: What is eviCore's website?
A: **www.evicore.com**

Q: How can a provider request a prior authorization through eviCore?
A: There are two options:

1. Visit **www.evicore.com** and login via the "Ordering Provider Login" after completing a free registration. It is possible to obtain immediate authorization decisions if the evidence-based criteria are met.
   OR
2. Call eviCore toll free at **888-444-6178**.

Q: What are eviCore's hours of operation?
A: eviCore's call center hours are from 7:00 a.m. to 7:00 p.m., Monday through Friday, Eastern Standard Time.

Q: What information will be required to obtain a prior authorization?
A: The required information includes:

- Member or patient's name, date of birth, and health plan ID number
- Ordering physician's name and NPI number
- Ordering physician's telephone and fax number
- Facility's name, telephone and fax number
- Requested drug(s) (HCPCS 'J' code and name (brand and/or generic))
- Relative diagnosis and medical history including:
    - Signs and symptoms
    - Results of relevant test(s)
    - Relevant medications
    - Working diagnosis/stage
    - Patient history including previous therapy

If initiating the prior authorization by telephone, the caller should have the medical records available.

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

Q: What is the process that providers will follow if eviCore is not available when they need to obtain a prior authorization?
A: Our online authorization initiation system at **www.evicore.com** is available 24 hours per day, 7 days a week.

Q: How long will the prior authorization process take?
A: When a prior authorization is initiated online and the request meets criteria, the regimen 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 two business days upon receipt of all necessary clinical information to process a medical necessity review.

Q: What happens when the online system does not provide an immediate authorization?
A: eviCore will review and issue an authorization if the requested regimen meets the established evidence-based criteria. All other requests will be sent to an eviCore medical director for review and determination. All decisions should be made within two business days for non-urgent requests once complete clinical information is received. All determination decisions will be sent in writing to the member and ordering providers and rendering provider and facility, if available.

Q: How can providers indicate that the procedure is clinically urgent?
A: Urgent requests should be made by calling eviCore's toll-free number at **888-444-6178**. The provider must notify the eviCore clinical reviewer that the test is "Urgent" and demonstrate medical necessity by providing the appropriate clinical documentation. Urgent care decisions will be made when following the standard timeframe could result in seriously jeopardizing the member's life, health or ability to regain maximum function. Note that for in-scope services rendered in settings other than the ER, observation, or urgent care, a physician or other health care professional may request a prior authorization on an urgent or expedited basis in cases where there is a medical need to provide the service sooner than the conventional prior authorization process would accommodate.

Q: What is the process to follow for urgent prior authorization requests if eviCore is not available?
A: Note that prior authorization is not required for drugs provided in an ER, 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.

Q: If a patient is undergoing treatment before the start of the program on July 1, 2018, will the treatment need authorization?
A: Health Partners Medicare members must receive prior authorization for dates-of-service beginning July 1, 2018, from eviCore healthcare. All medical oncology services requests submitted prior to July 1 will continue to be handled by Optum Oncology.

For Health Partners (Medicaid) members who are undergoing treatment before the transition to eviCore healthcare on October 1, 2018, all medical oncology services requests must be submitted to HPP pre-certification by calling **1-866-500-4571**, **prompts 2, 3**

Q: What information will be available through the provider portal located on eviCore's website?
A: The authorization status function on the eviCore provider portal will provide the following information:

- Prior authorization number (available 30 minutes after number is issued)/Case number/date
- Status of request
- Cancer type
- Site name and location (If available)
- Expiration date

Q: How will providers be notified of the prior authorization review decision?
A: Referring providers will be notified of the determination via fax. If fax is not available, the notice will be sent via USPS. Rendering providers can validate the prior authorization determination through eviCore's website at **www.evicore.com** or by calling eviCore Customer Service at **888-444-6178**. Written notification is provided upon request if the rendering provider contacts eviCore Customer Service. Members will be notified in writing of any adverse determinations.

Q: What is the format of the eviCore's authorization number?
A: An authorization number is one (1) alpha character followed by (9) nine numeric numbers. *For example: A123456789.*

Q: How can the eviCore criteria be viewed?
A: The eviCore medical oncology program is a direct reflection of the NCCN guidelines. These guidelines are available for public view at **NCCN.org**.

Q: How long will the prior authorization approval be valid?
A: The length of time for which a prior authorization will be valid will vary by request ranging from approximately 8 to 14 months. When a prior authorization 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 prior authorization number must be obtained.

Q: If a prior authorization 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 prior authorization number be required?
A: No. If the infusion is needed during the timeframe in the prior authorization, the prior authorization will cover additional infusion services of the authorized drug.

Q: Are any drug modifications allowed under the Medical Oncology Prior Authorization program?
A: 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.

Q: If the patient starts a medical oncology regimen at one facility and changes to another during a course of treatment, is a new prior authorization required?
A: Yes. If a new physician group is treating the patient, a new treatment plan will likely be followed. Therefore, a new prior authorization number must be requested.

Q: Is a separate authorization needed for each drug ordered?
A: No. A single authorization number will cover the entire 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. 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.

Q: Who should request prior authorization 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 prior authorization?
A: The physician who orders the drug should request the prior authorization. In this case, it would be the specialist.

Q: In the event of an adverse determination can the provider request a clinical review?
A: A pre-decision consultation is available for Medicare members. If your case requires further clinical discussion for approval, we welcome requests for clinical determination discussions from referring physicians. In certain instances, additional information provided during the pre-decision consultation is sufficient to satisfy the medical necessity criteria for approval. However, if the request is denied, the decision is final and cannot be overturned. Call eviCore at **888-444-6178** for a pre-decision consultation.

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

Q: What happens if a service is rendered despite an authorization denial?
A: The HPP Medical Oncology Review program is a prior authorization 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 under the member's benefit plan because services that are not medically necessary are not covered under HPP. Failure to comply with any prior authorization protocol may result in an administrative claim denial.

Q: What are the parameters of an appeals request?
A: For Health Partners Medicare members, eviCore healthcare will not be delegated for first level provider appeals. For Health Partners (Medicaid) members, eviCore will manage first level provider appeals for Medicaid plans after the transition to eviCore on October 1, 2018. In both cases, the appeal process is included in the determination letter.

Q: Is a prior authorization determination a guarantee of payment?
A: No. As a member's eligibility can change, this is only a medical necessity determination. Medical necessity determinations are provided based on the patient eligibility data as it appears in the benefit funds' eligibility system when the request is made, and is not a guarantee of payment.

Q: Is provider education and training available?
A: Yes. Visit the implementation website at **https://www.evicore.com/healthplan/healthpartnersplans** for updates and announcements including educational webinars on submitting prior authorization requests. Additional tools and resources can be found on eviCore's website at **www.evicore.com**.

Q: What is eviCore's contingency plan in the event of a power outage?
A: eviCore has multiple customer service centers in varying geographical locations, which allows eviCore to continue providing support even if one location experiences a power outage. For example, if calls directed to one location were to suffer a power outage, the calls would automatically be routed to another service center so that the service would be seamless to the caller.

Q: Do you need to bill with a HCPCS code?
A: Yes, the HCPCS code must be present on the bill. Billing requirements are not changing for oncology services.

Q: Does an NDC code need to be present on the bill?
A: Yes, if a payment is based upon a HCPCS code, such as a J-code or Q-code, the drug must be submitted with the NDC code along with the units dispensed.

Q: Do units need to be present on the bill?
A: Yes, please include the proper number of units dispensed on the bill.

Q: Should "waste" be billed?
A: Yes, waste must be included and the appropriate modifier must accompany the HCPCS code.

Q: When authorizations are expired, does a new authorization need to be created?
A: Yes, once the authorization has expired, please follow eviCore's procedure to submit a new authorization.