Radiology and Cardiology Management

Provider Orientation Session for Aetna

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Agenda

- Program Overview
- Submitting Requests
- Prior Authorization Outcomes, Special Considerations, Post Decision Outcomes
- Site of Care Enhancement (Radiology)
- Provider Portal Overview
- Additional Provider Portal Features
- Provider Resources
- Q & A

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Program Overview

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Aetna Prior Authorization Services

eviCore healthcare (eviCore) began accepting prior authorization requests on September 15, 2015.

The **Radiology Site of Care** enhancement for Fully Insured members begins December 1, 2021.

Prior authorization applies to the following services:	Prior authorization does **NOT** apply to services performed in:
• Outpatient	• Emergency Rooms
• Diagnostic	• Observation Services
• Elective / Non-emergent	• Inpatient Stays

It is the responsibility of the ordering provider to request prior authorization approval for services. Providers should verify member eligibility and benefits on the secured provider log-in section at: https://apps.availity.com/availity/web/public.elegant.login

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Applicable Memberships

Prior Authorization is required for Aetna members who are enrolled in the following lines of business/programs:

- **Medicare (Aetna Next Generation)**
- **HMO**
- **PPO**

Radiology Site of Care medical necessity review (effective 12/1/2021) is applicable to the following lines of business:

- **Commercial Fully Insured Members**

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Services Requiring Prior Authorization

Radiology Advanced Imaging Services:

- CT, CTA
- MRI, MRA
- PET, PET/CT

Cardiology Advanced imaging and diagnostic services

- Stress Testing
  - Myocardial Perfusion Imaging (SPECT & PET)
  - Stress Echocardiography
- Cardiac CT & MRI
- Echocardiography; Transthoracic, Transesophageal
- Diagnostic Heart Catheterization

To find a **complete list** of Current Procedural Terminology (CPT) codes that require **prior authorization** through eviCore, please visit: https://www.evicore.com/resources/healthplan/aetna

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Submitting Requests

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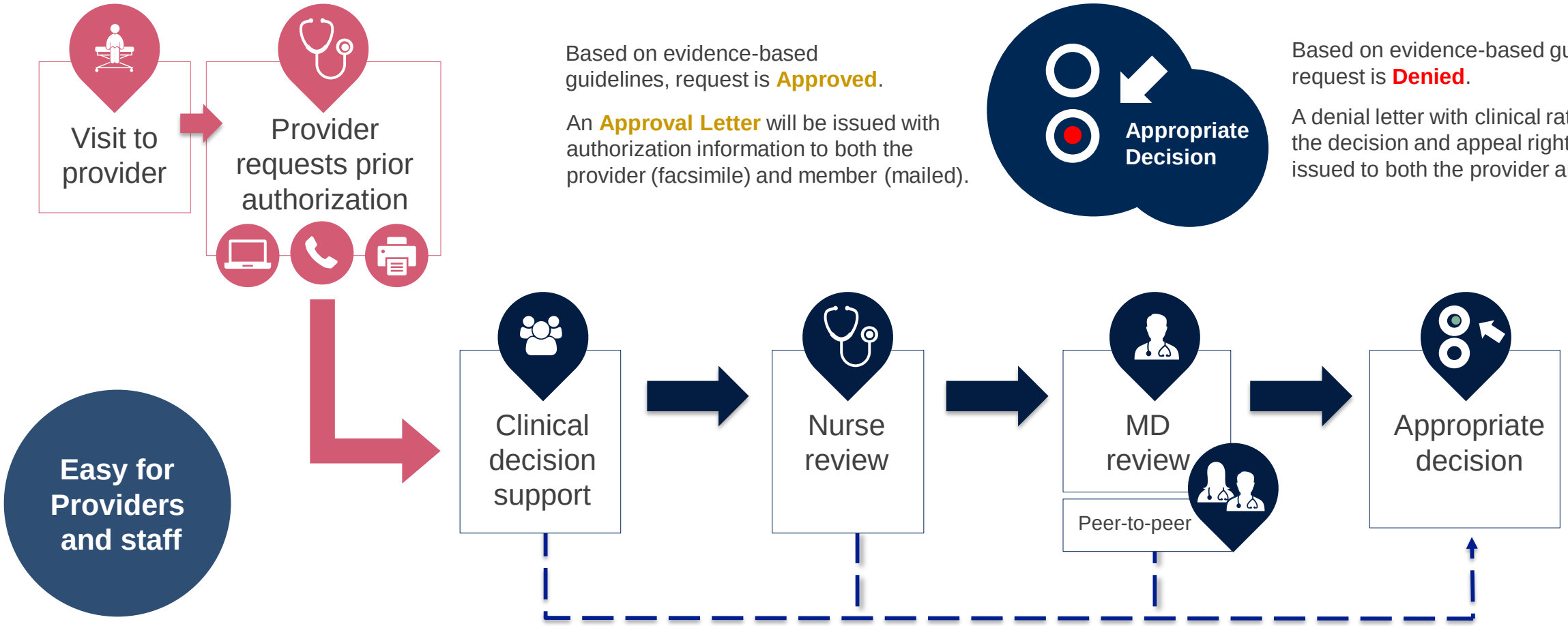
Utilization Management – the Prior Authorization Process



Based on evidence-based guidelines, request is **Approved**.

An **Approval Letter** will be issued with authorization information to both the provider (facsimile) and member (mailed).

Appropriate Decision

Based on evidence-based guidelines, request is **Denied**.

A denial letter with clinical rationale for the decision and appeal rights will be issued to both the provider and member.

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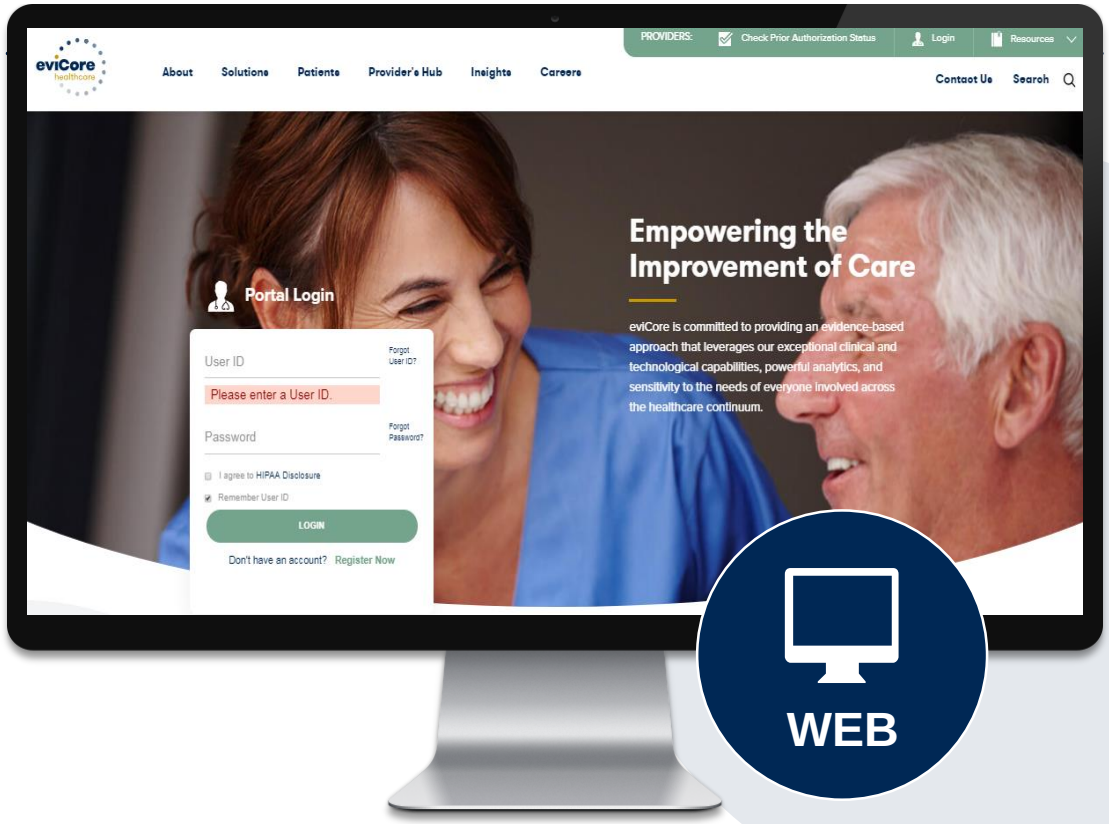
Methods to Submit Prior Authorization Requests

eviCore Provider Portal www.eviCore.com (preferred)

- **Saves time**: Quicker process than phone authorization requests
- **Available 24/7**: You can access the portal any time and any day
- **Save your progress**: If you need to step away, you can save your progress and resume later
- **Upload additional clinical information**: No need to fax in supporting clinical documentation, it can be uploaded on the portal to support a new request or when additional information is requested
- **View and print determination information**: Check case status in real-time
- **Dashboard**: View all recently submitted cases
- **Duplication feature**: If you are submitting more than one prior authorization request, you can duplicate information to expedite submittals



Phone Number:
888.622.7329
Monday through Friday
7am – 7pm local time

Fax Number:
844.822.3862
PA requests are accepted via fax and can be used to submit additional clinical information

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Information needed for Prior Authorizations

To obtain prior authorization on the very first submission, the provider submitting the request will need to gather four categories of information:

1. Member
- ID
- Member name
- Date of birth (DOB)

2. Referring (Ordering) Physician
- Physician name
- National provider identifier (NPI)
- Phone & fax number

3. Rendering Facility
- Facility name
- Address
- National provider identifier (NPI)
- Tax identification number (TIN)
- Phone & fax number

4. Supporting Clinical
- Pertinent clinical information to substantiate medical necessity for the requested service
- CPT/HCPCS Code(s)
- Diagnosis Code(s)
- Previous test results

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Insufficient Clinical – Additional Documentation Needed

Additional Documentation to Support Medical Necessity

If during case build all required pieces of documentation are not received, or are insufficient for eviCore to reach a determination, the following will occur:

A Hold Letter will be faxed to the Requesting Provider requesting additional documentation	The Provider must submit the additional information to eviCore	eviCore will review the additional documentation and reach a determination
The Hold notification will inform the provider about what clinical information is needed as well as the date by which it is needed.	Requested information must be received within the timeframe as specified in the Hold Letter, or eviCore will render a determination based on the original submission.	Determination notifications will be sent

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Pre-Decision Options: Medicare Members

I've received a request for additional clinical information. What's next? There are three ways to supply the requested information to eviCore for review:

- eviCore will notify providers telephonically and in writing before a denial decision is issued on Medicare cases
- Additional clinical information must be submitted to eviCore in advance of the due date referenced
- Additional clinical information should be submitted to eviCore for consideration per the instructions received, clinical can be **faxed** to 844.822.3862 or **uploaded** directly into the case via the provider portal at **www.eviCore.com**
- Alternatively, providers can choose to request a **Pre-Decision Clinical Consultation** instead of submitting additional clinical information. This consultation can be requested via the eviCore website (see slide 48 for instructions).
- The Pre-Decision Clinical Consultation must occur prior to the due date referenced
- If the additional clinical information is faxed/uploaded, that clinical is what is used for the review and determination. The case is not held further for a Pre-Decision Clinical Consultation, even if the due date has not yet lapsed
- Once the determination is made, notifications will go out to the provider and member, and status will be available on **www.eviCore.com**

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Prior Authorization Outcomes, Special Considerations, and Post Decision Options

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Prior Authorization Outcomes

- **Approved Requests -** Authorizations are typically valid for 90 days from the date of the date of initial request
- **Denied Requests -** Based on evidence-based guidelines, if a request is determined as inappropriate, a notification with the rationale for the decision and post decision/ appeal rights will be issued
- **Partially Approved Requests –** In instances where multiple CPT codes are requested, some may be approved and some denied. In these instances, the determination letter will specify what has been approved as well as post decision options for denied codes, including denied Site of Care (if applicable).

Notifications

- Authorization letters will be faxed to the ordering physician
- Web initiated cases will receive e-notifications when a determination is made
- Members will receive a letter by mail
- Approval information can be printed on demand from the eviCore portal: **www.eviCore.com**

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Special Considerations

Retrospective (Retro) Authorization Requests

- Must be submitted within 14 calendar days from the date of services
- Retro requests submitted beyond this timeframe will be administratively denied
- Reviewed for clinical urgency and medical necessity
- Retro requests are processed within 30 calendar days
- When authorized, the start date will be the submitted date of service

Urgent Prior Authorization Requests

- eviCore uses the NCQA/URAC definition of **urgent**: when a delay in decision-making may seriously jeopardize the life or health of the member
- Can be initiated on provider portal or by phone
- Urgent cases are typically reviewed within 72 hours

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Special Considerations, continued

Alternative Recommendation

- An alternative recommendation may be offered, based on eviCore's evidence-based clinical guidelines, if the originally requested study does not meet guidelines
- The ordering provider can accept the alternative recommendation during case build, and the recommended study will be approved instead of the original requested one
- If the alternative recommendation is not accepted and the case is denied, providers still have up to 3 days to accept the alternative recommendation, either on the web portal or via phone
- If the alternative recommendation is not accepted within the allotted timeframe a reconsideration of the denial can be requested

Authorization Update

- If updates are needed on an existing authorization, you can contact eviCore by phone
- If the authorization is not updated and a different facility location or CPT code is submitted on the claim, it may result in a claim denial

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Post-Decision Options

My case has been denied. What's next?

Your determination letter is the best immediate source of information to assess what options exist on a case that has been denied. You may also call eviCore at **888.622.7329** to speak to an agent who can provide available option(s) and instruction on how to proceed.

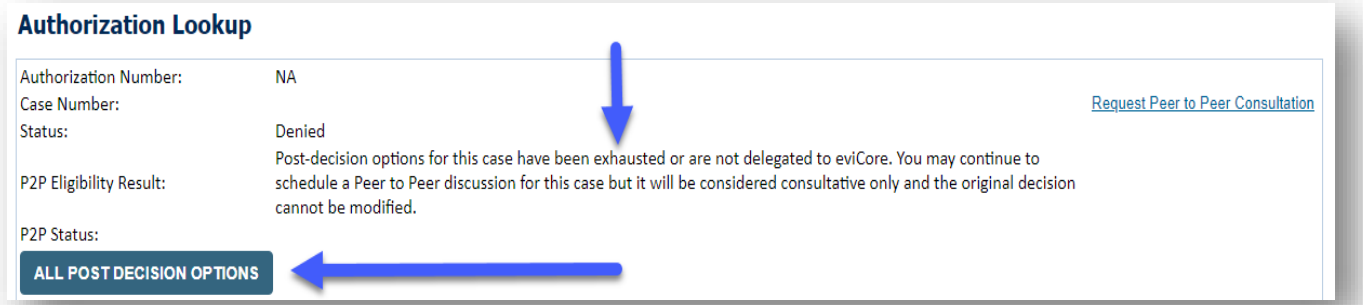
Alternatively, select 'All Post Decisions' on www.eviCore.com , under the authorization lookup function, to see available options.

Reconsiderations

- In some instances, additional clinical information provided in a reconsideration request may be sufficient for an approval
- Medicare cases are not eligible for Reconsideration
- Reconsiderations must be requested before an appeal is submitted
- Reconsiderations can be scheduled via the online eviCore portal, through the Authorization Lookup feature on www.eviCore.com , there is more information on how to schedule these in the Portal Overview section below (slide 53)

Appeals

- eviCore will not process first-level appeals



Clinical Consultations – Medicare Cases

- Providers can request a Clinical Consultation with an eviCore physician to better understand the reason for denial
- Once a denial decision has been made on a Medicare case the decision cannot be overturned via Clinical Consultation, this conversation is educational only

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Site of Care – Fully Insured Commercial Membership

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Site of Care Enhancement

What is changing?

For membership included in site-of-care program there will be a separate medical necessity review for **both**:

- The requested procedure

  AND

- The requested site of care

- The enhanced review will automatically be included in case build for these members.
- During case build, the clinical criteria for using a non preferred facility must be selected in order to proceed, and will be reviewed for medical necessity.

If any part of the case is denied (procedure and/or site of care) the overall case status will be denied.

Both the site-of-care and the procedure must be approved or any claims associated with the request will be denied.

More detailed training on the Site of Care Program can be found on the Aetna Provider Resource page: https://www.evicore.com/resources/healthplan/aetna-resources?solutionid=E0C4A52C-6112-49E1-82D0-278E2BFFECDF#solutiondocs

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Provider Portal Overview

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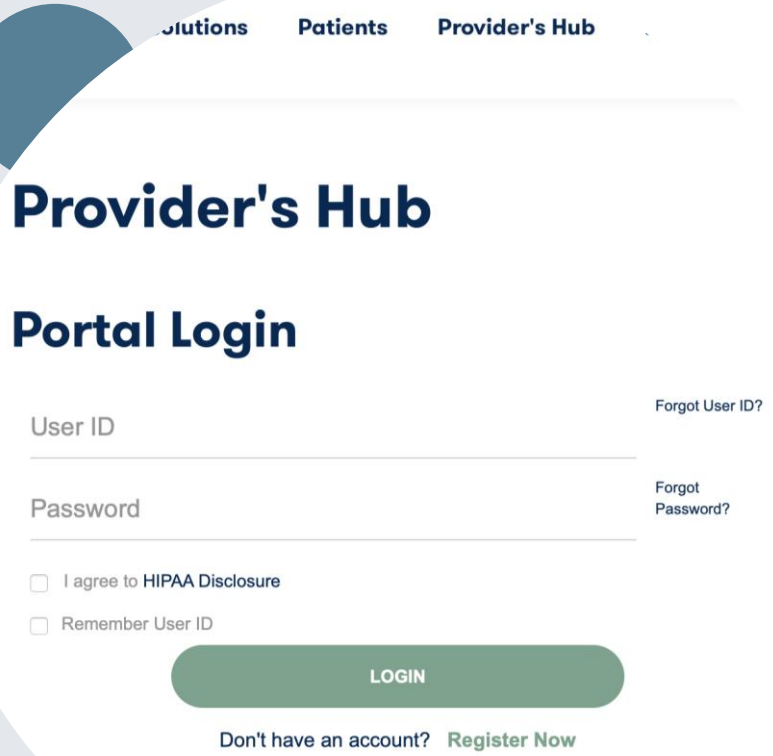

Portal Compatibility

The eviCore.com website is compatible with the following web browsers:

- Google Chrome
- Mozilla Firefox
- Internet Explorer 9, 10, and 11

You may need to disable pop-up blockers to access the site. For information on how to disable pop-up blockers for any of these web browsers, please refer to our Disabling Pop-Up Blockers guide.

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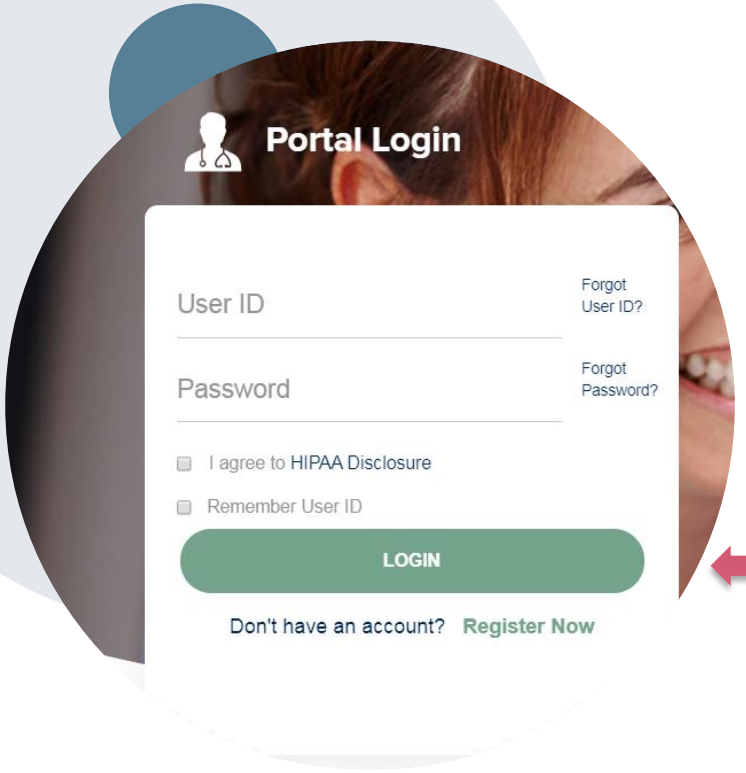
eviCore healthcare Website



Visit www.evicore.com

Already a user?

If you already have access to eviCore's online portal, simply log-in with your User ID and Password and begin submitting requests in real-time!

Don't have an account?

Click "Register Now" and provide the necessary information to receive access today!

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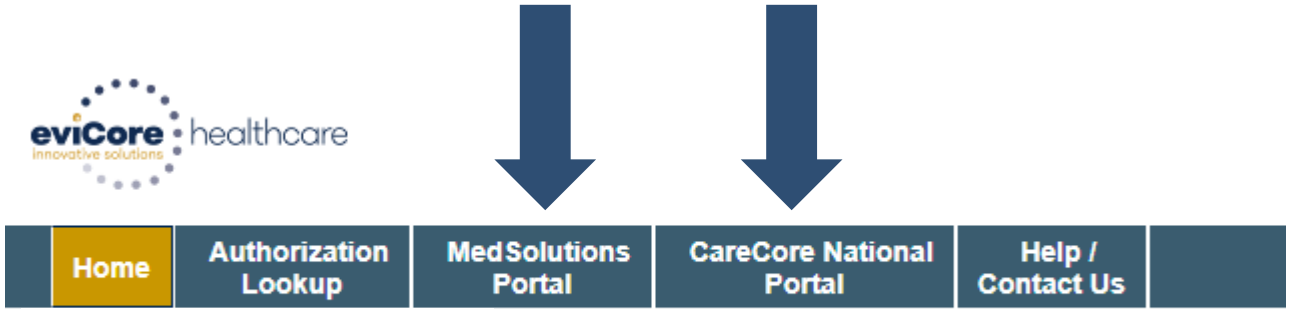
Platform Migration, effective 11/24/2021

- Starting November 24, 2021, all Aetna requests must be submitted through the CareCore National portal at **www.eviCore.com**, instead of the MedSolutions Portal.
- If a provider has an existing login, the same credentials are used for both portals and a new account does not need to be created.
- Authorizations requested prior to November 24 can continue to be viewed on the MedSolutions portal, but new Radiology requests must be created on the CareCore portal, as outlined below.



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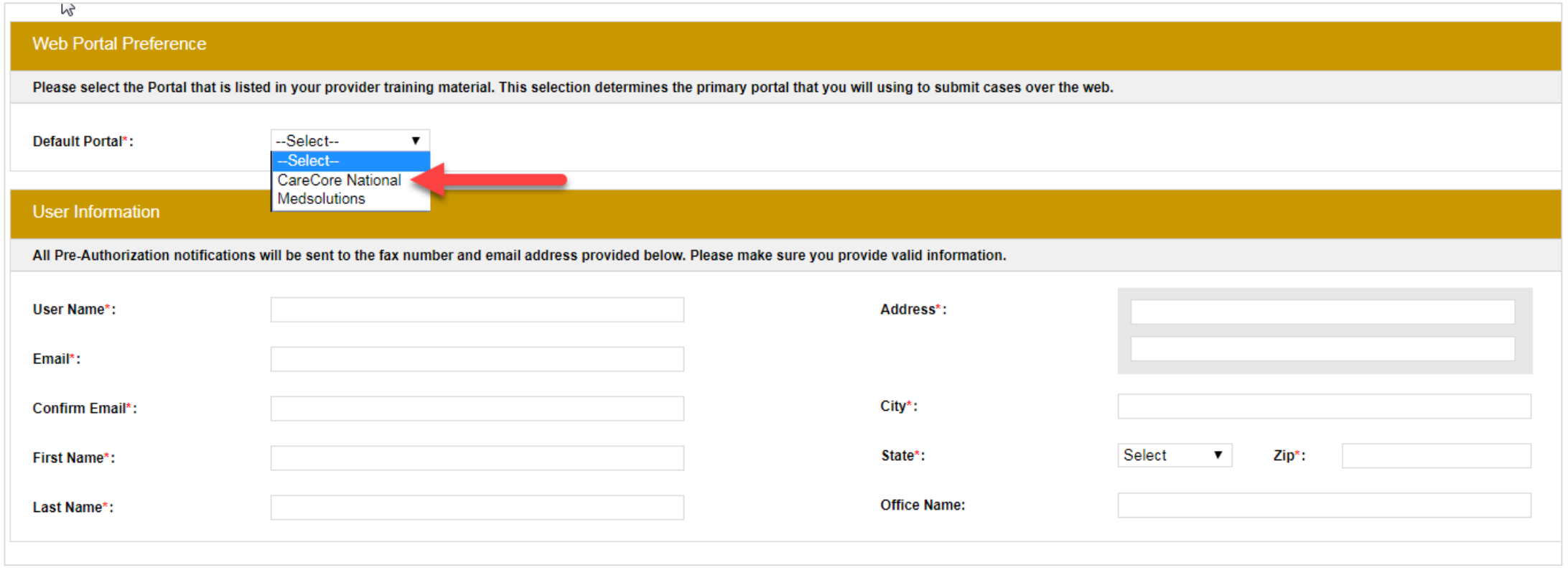
Creating An Account



- Select CareCore National as the Default Portal, complete the User Information section in full, and Submit Registration.
- You will immediately be sent an email with a link to create a password. Once you have created a password, you will be redirected to the log-in page.

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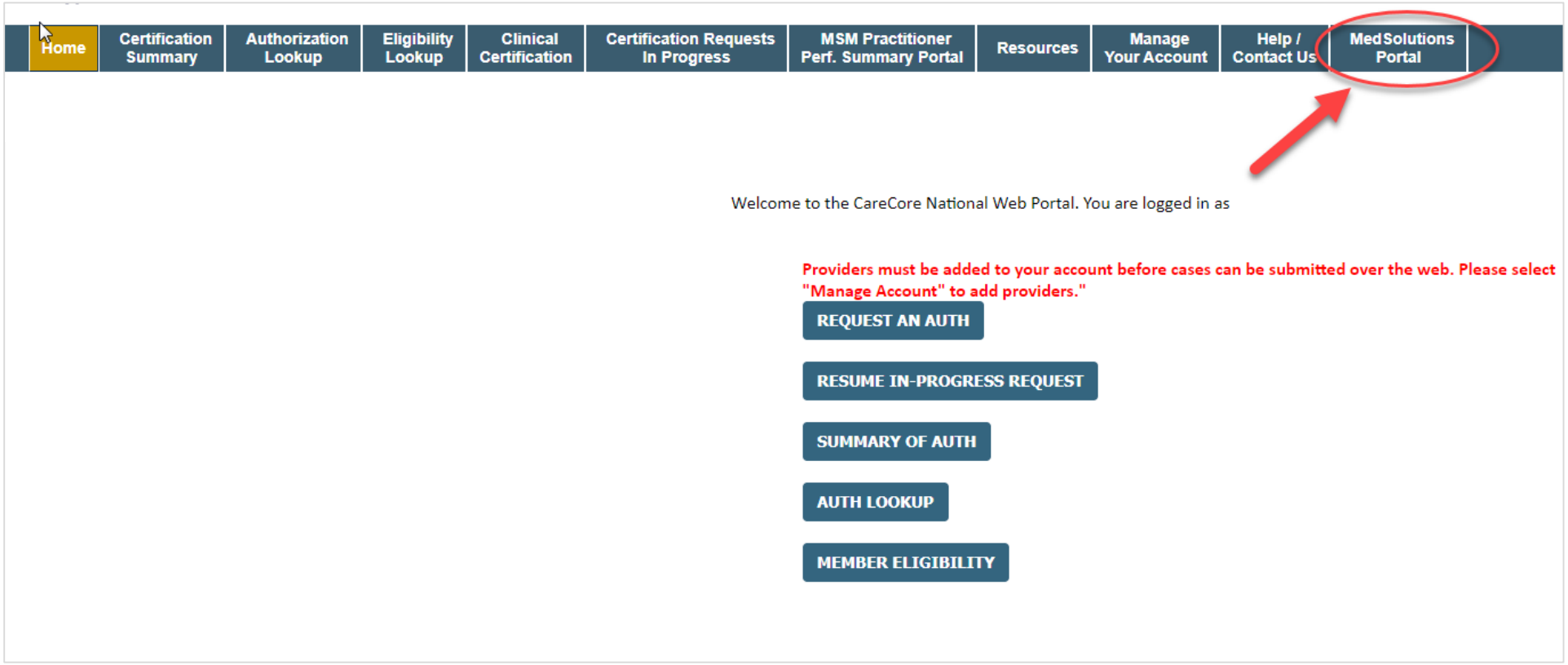
Welcome Screen



Note: You can access the MedSolutions Portal at any time without having to provide additional log-in information. Click the MedSolutions Portal on the top-right corner to seamlessly toggle back and forth between the two portals.

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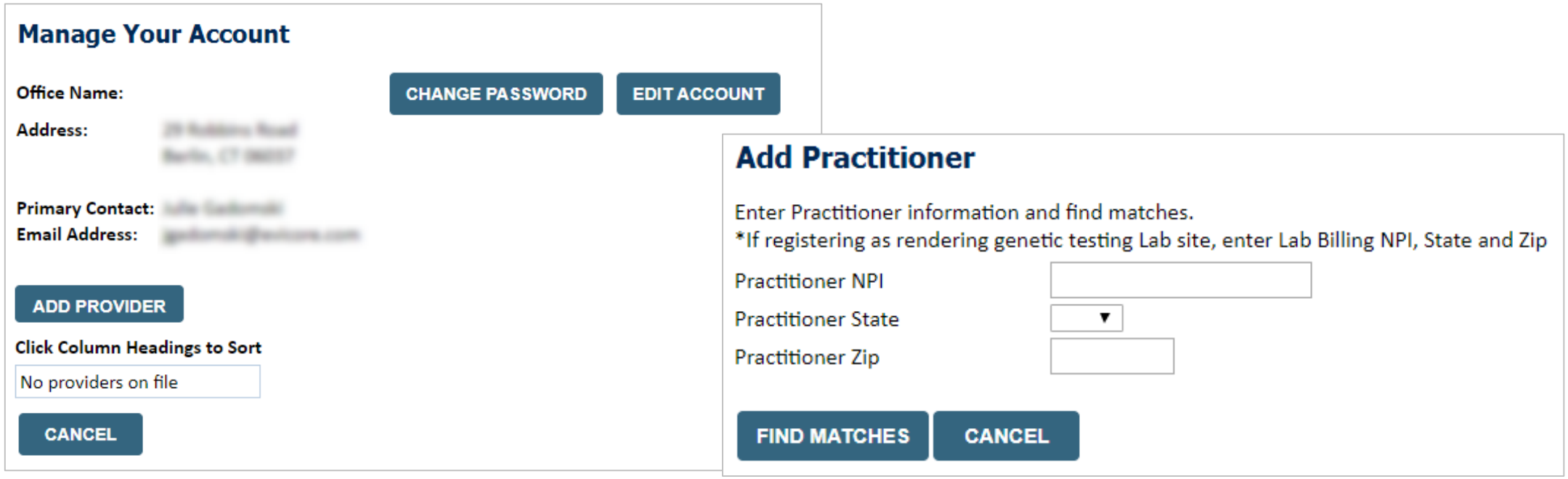
Add Practitioners



- Select the "**Manage Your Account**" tab, then the **Add Provider**
- Enter the NPI, state, and zip code to search for the provider
- Select the matching record based upon your search criteria
- Once you have selected a practitioner, your registration will be complete
- You can also click "**Add Another Practitioner**" to add another provider to your account
- You can access the "**Manage Your Account**" at any time to make any necessary updates or changes

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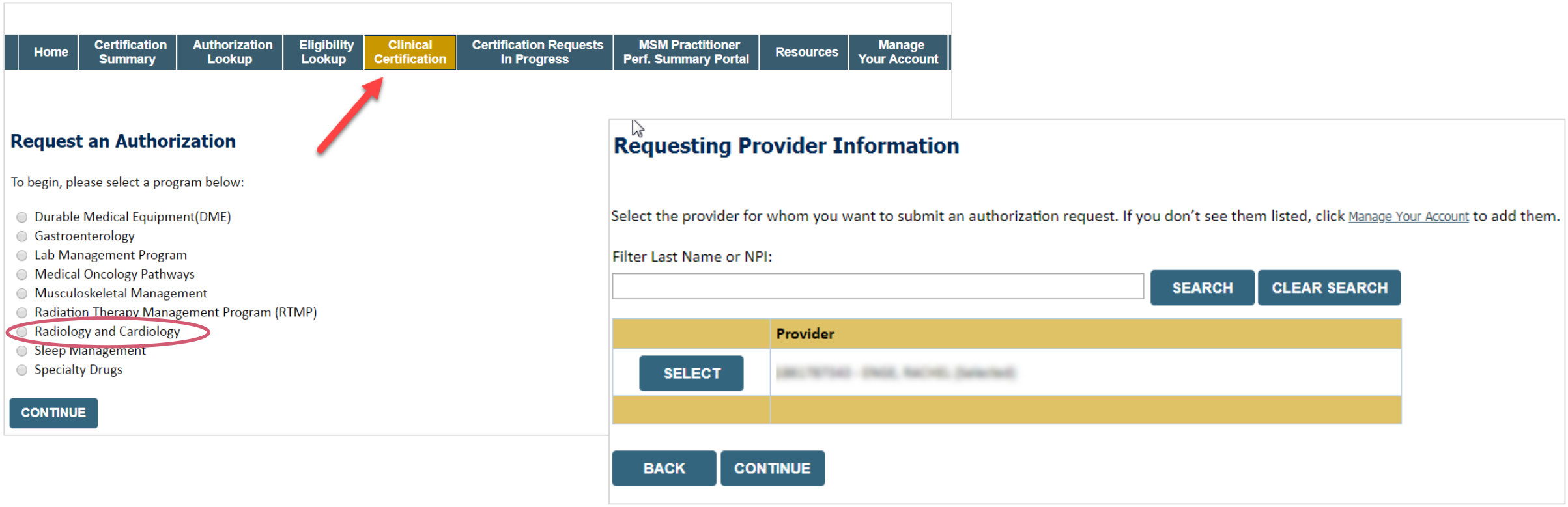
Initiating A Case



- Choose Clinical Certification to begin a new request
- Select the appropriate program
- Select "Requesting Provider Information"

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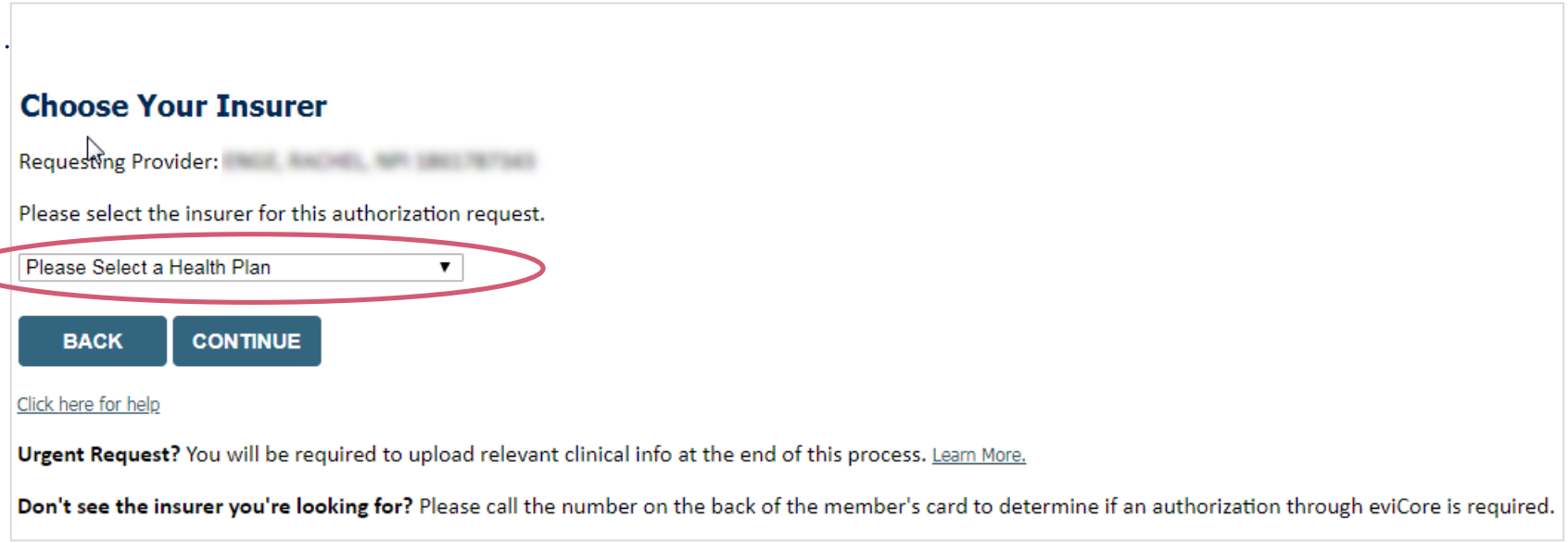
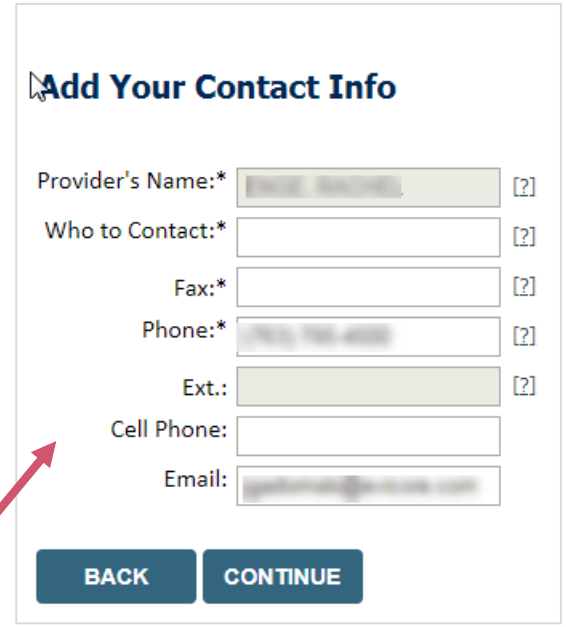
Select Health Plan & Provider Contact Info





- Choose the appropriate Health Plan (Aetna) for the request
- Once the plan is chosen, select the provider address in the next drop-down box
- Select CONTINUE and on the next screen Add your contact info
- Provider name, fax and phone will pre-populate, you can edit as necessary
- By entering a valid email you can receive e-notifications

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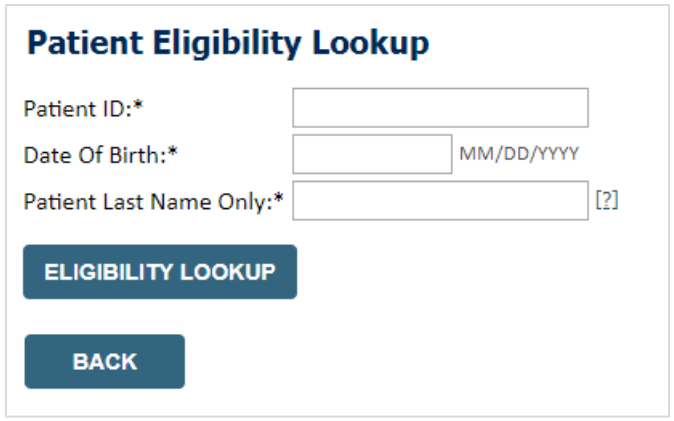
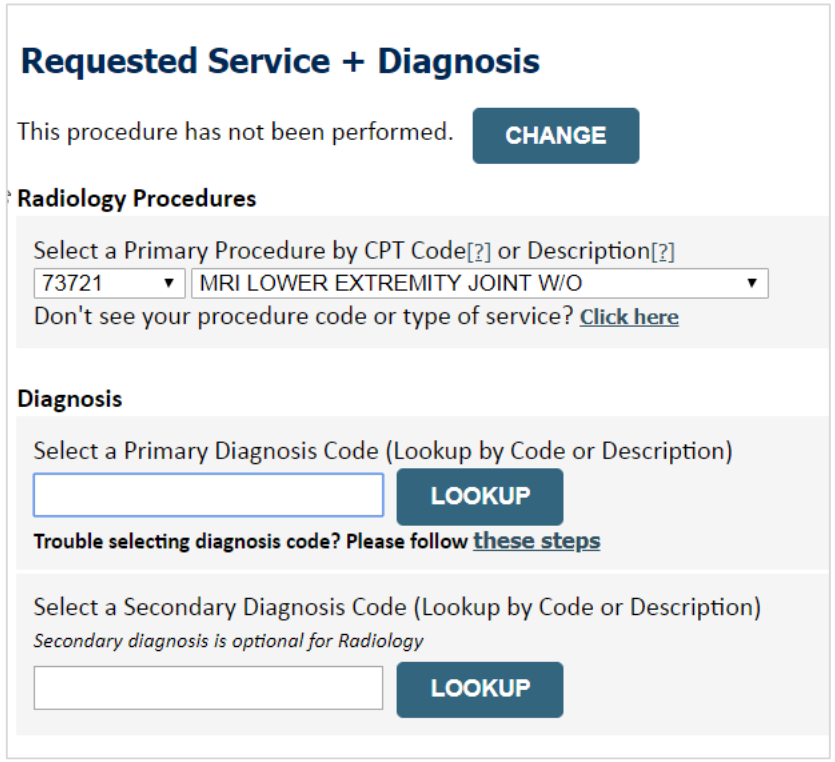
Member & Request Information





- Enter the member information, including the patient ID number, date of birth, and last name. Click Eligibility Lookup
- Next screen you can enter CPT code & diagnosis code

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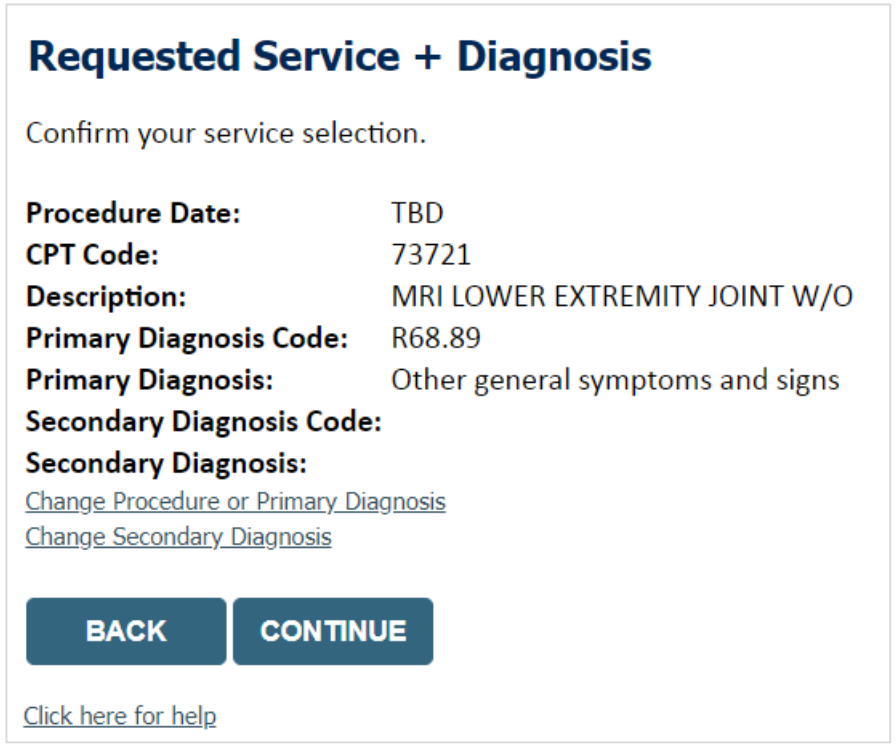
Verify Service Selection



- Verify requested service & diagnosis
- Edit any information if needed by selecting Change Procedure or Primary Diagnosis
- Click continue to confirm your selection

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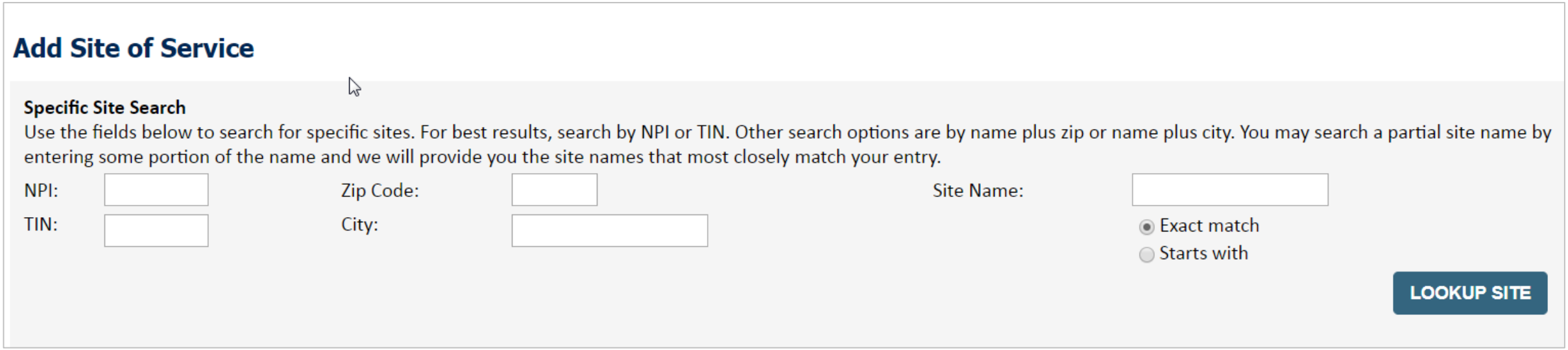
Site Selection

Start by searching NPI or TIN for the site where the procedure will be performed. You can search by any fields listed. Searching with NPI, TIN, and zip code is the most efficient.



- **Select the specific site where the testing/treatment will be performed.**

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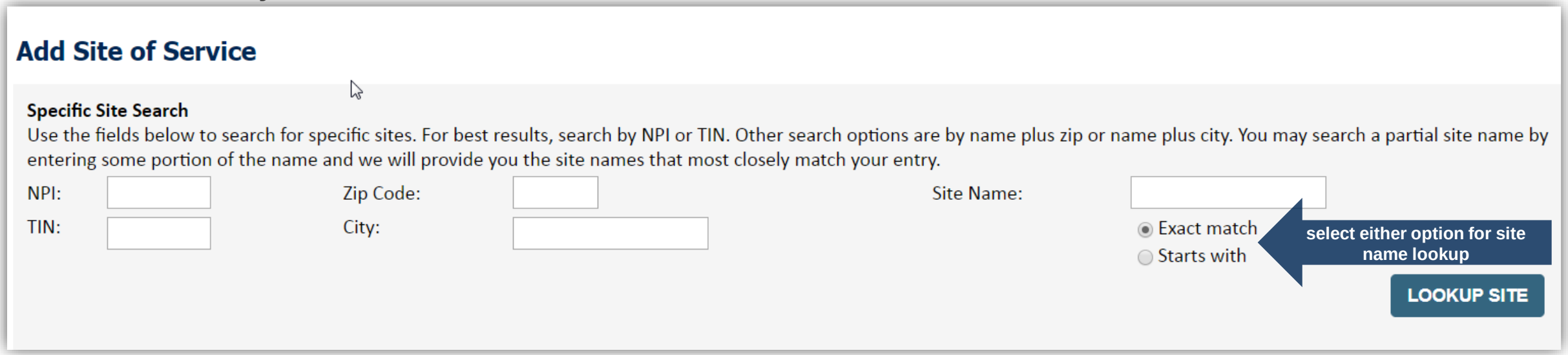
Site of Care – Radiology requests (if applicable)

- During the site selection portion of the prior authorization process, search NPI or TIN for the site where the procedure will be performed. You can search by any fields listed. Searching with NPI, TIN, and zip code is the most efficient, and using 'Starts With' rather than 'Exact Match' can be used if you don't have the full site name.

- Enter the search criteria, and select 'Lookup Site' to search for the specific site where the testing/treatment will be performed.

- Selection of an outpatient facility will move the case forward to the clinical collection portion of the prior authorization process, consistent with the current Aetna site selection process. **Selection of a hospital based setting will prompt the user to select a different facility**.



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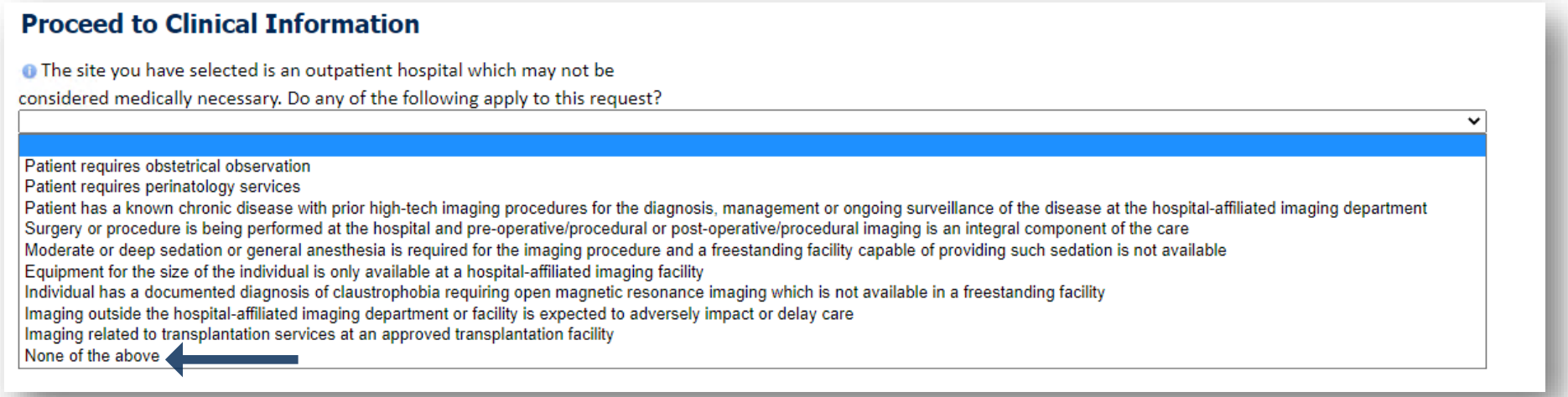
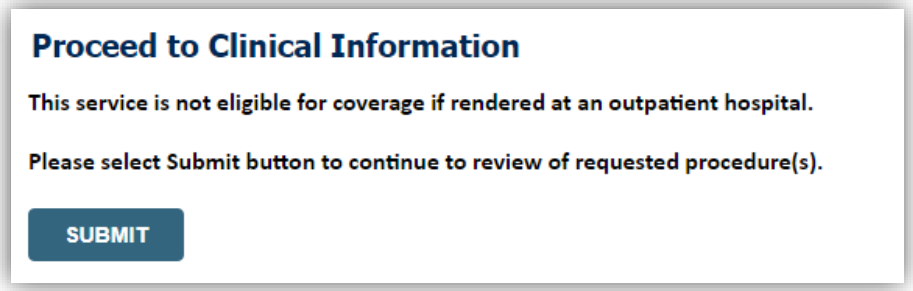
Site of care – clinical criteria for nonpreferred site

- If a non preferred site is selected, you will be prompted to enter the clinical criteria for using a non preferred facility.



- The appropriate clinical criteria must be selected from the drop-down menu. If none apply, then select '**None of the above**'. If 'None of the above' is selected, you will receive a popup letting you know that the procedure(s) requested are not eligible for coverage at the non preferred site. You will still proceed through clinical collection to determine the medical necessity of the procedure itself, separate from Site of Care.

- More detailed information on the Radiology Site of care program can be found here: https://www.evicore.com/resources/healthplan/aetna-resources?solutionid=E0C4A52C-6112-49E1-82D0-278E2BFFECDF#solutiondocs



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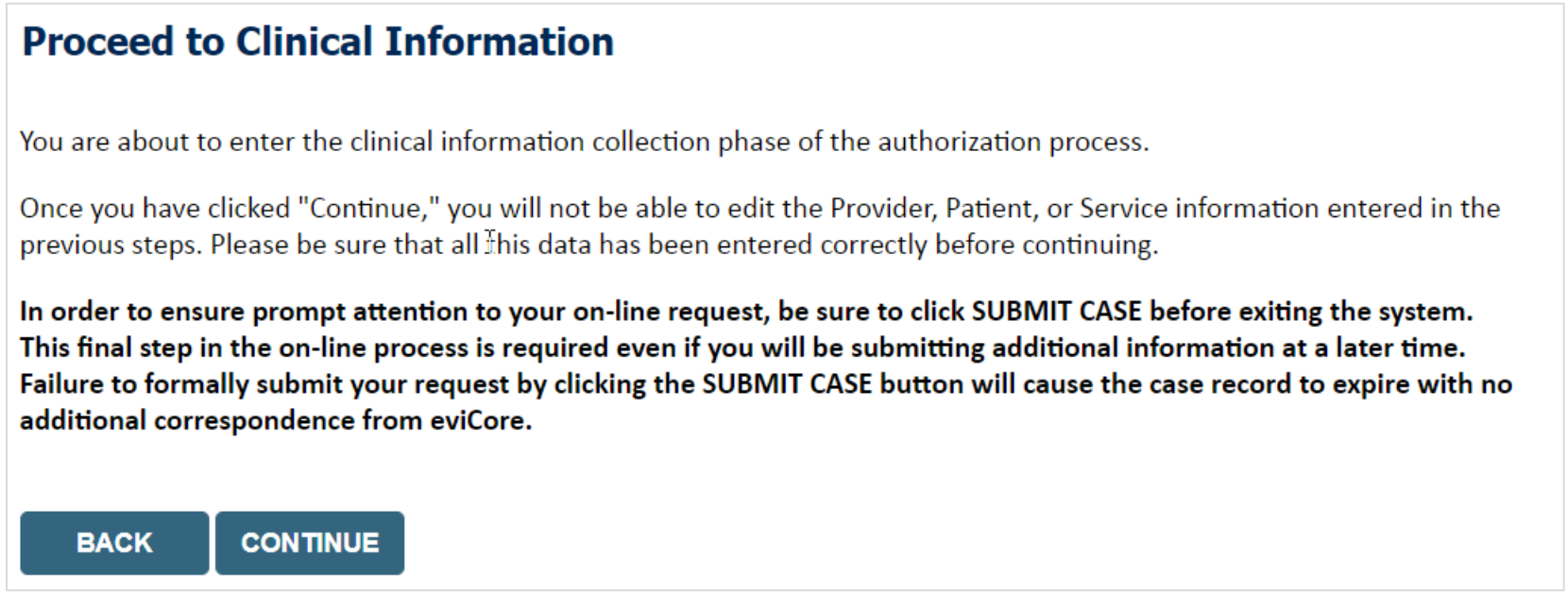
Clinical Certification



- **Verify that all information is entered and make any changes needed**
- **You will not have the opportunity to make changes after this point**

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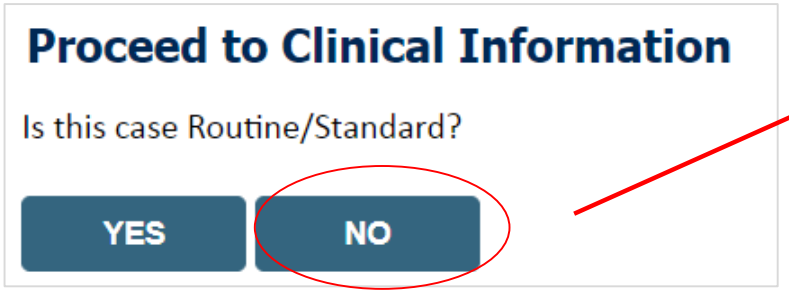
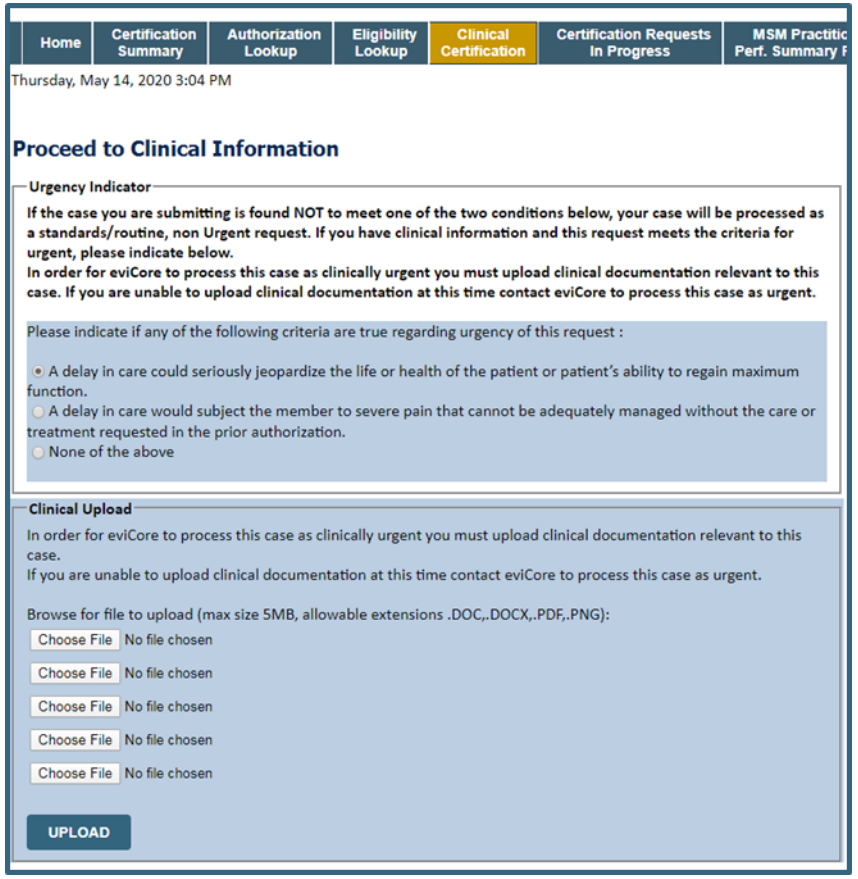
Standard or Urgent Request?

- If your request is urgent select **No**
- When a request is submitted as Urgent, you will be required to upload relevant clinical information
- If the case is standard select **Yes**
- You can upload up to FIVE documents in .doc, .docx, or .pdf format – max 5MB document size
- Your case will only be considered Urgent if there is a successful upload





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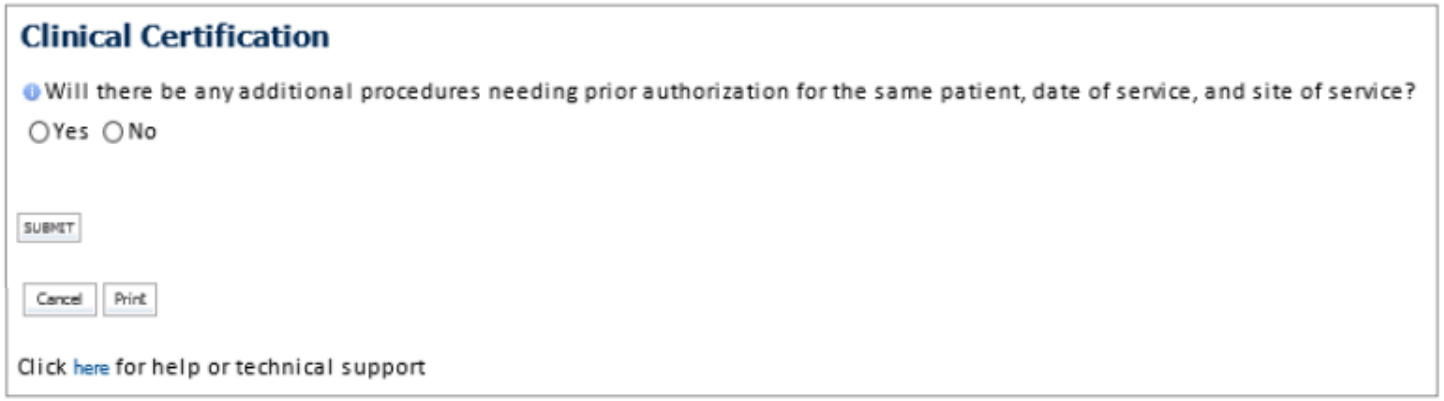
Requesting Multiple CPT Codes

After you indicate the case urgency of the case, you will be asked about additional procedures. All CPT codes must be for the same program (Radiology).



- **Select YES to add Additional CPT codes.**
- **Enter one CPT at a time and select SUBMIT after each one.**

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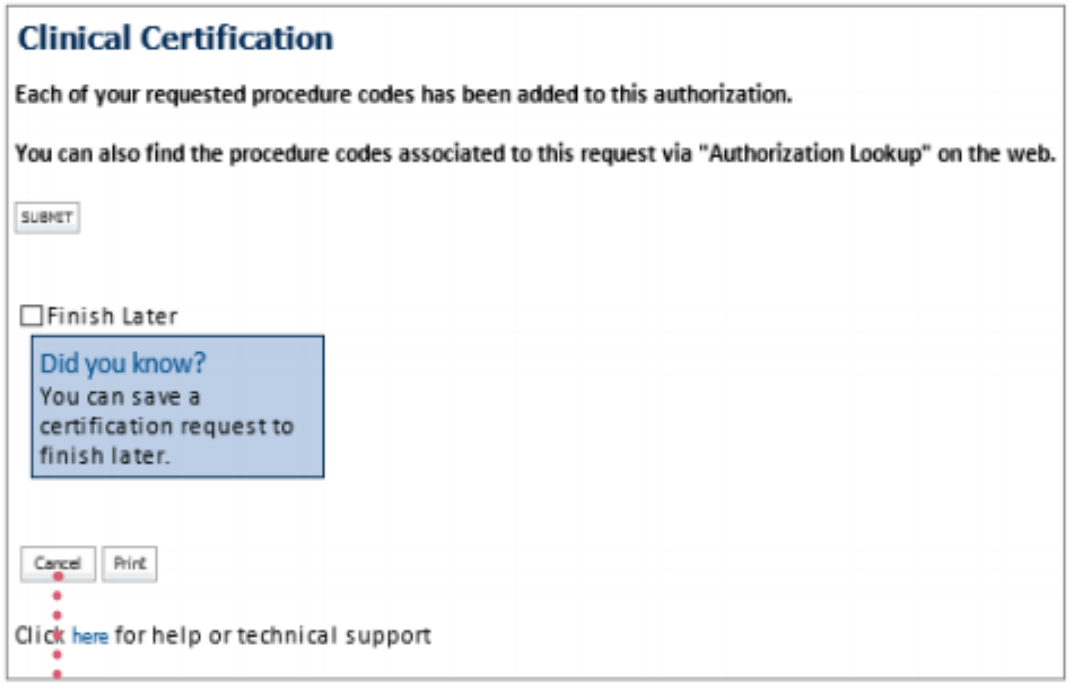
Requesting Multiple CPT Codes



CAREFUL
Selecting CANCEL will not save or submit any of the info you've just entered.

If the CPT code does not pass validation, an onscreen message will inform you that the code is either out of scope, has been requested already, or requires the creation of a separate authorization. If the CPT code has been added, an on screen message will display.

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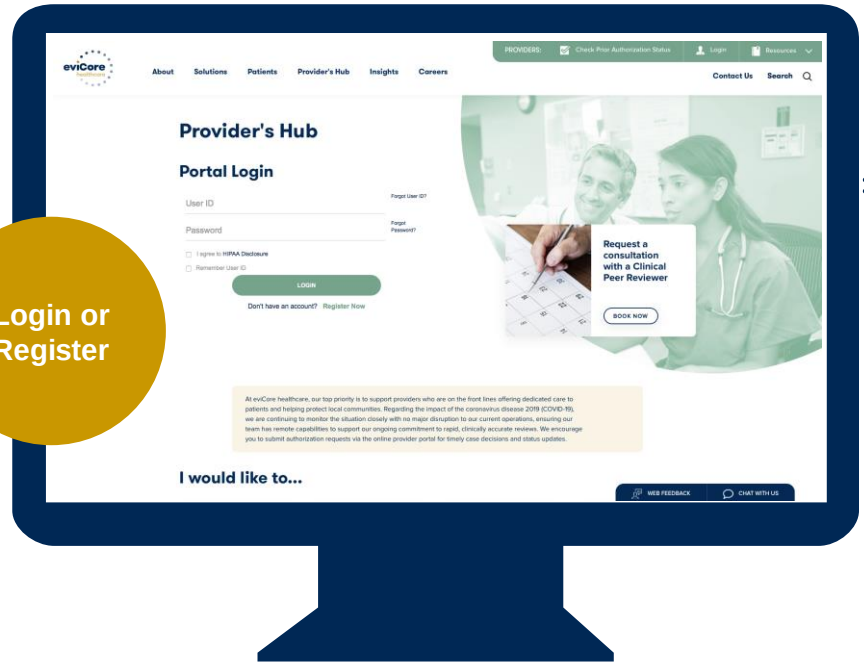
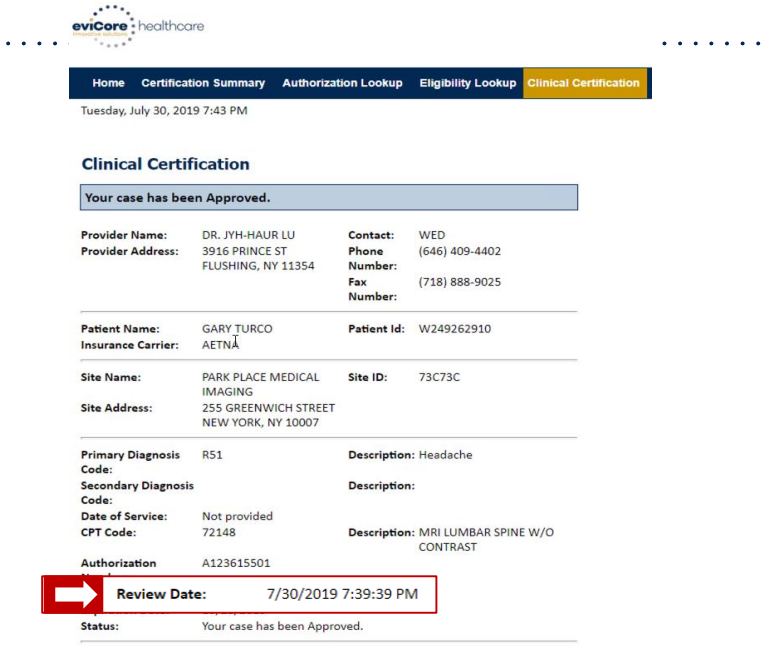
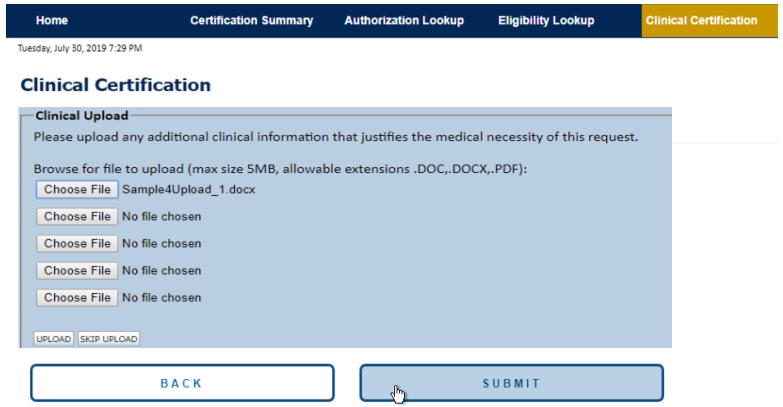
Improved Provider Experience: Real-time Approval or Clinical Documentation Upload



Login or Register

Real-time Decision or Clinical Upload





***In some circumstances, you may be asked to complete a series of clinical questions which may result in an immediate approval or a request for clinical upload**

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Clinical Certification

Why am I no longer seeing the clinical survey questions when I submit a prior authorization request on some of my requests?

Enhanced Process

- Clinical survey questions may populate based upon the information provided. *However…*
- For some radiology cases, the experience may be different due to enhancements we are making in the system.
- We have been able to replace clinical surveys with a new faster and streamlined process.
- These enhancements will reduce submission time and improve turnaround times.
- If the case is not approved in real-time based on the clinical information, you will be asked to submit the member's medical record supporting the request for services.
- You will be prompted to upload clinical at that time, or you can choose to send it in at a later time – a delay in providing clinical will cause a delayed case decision.

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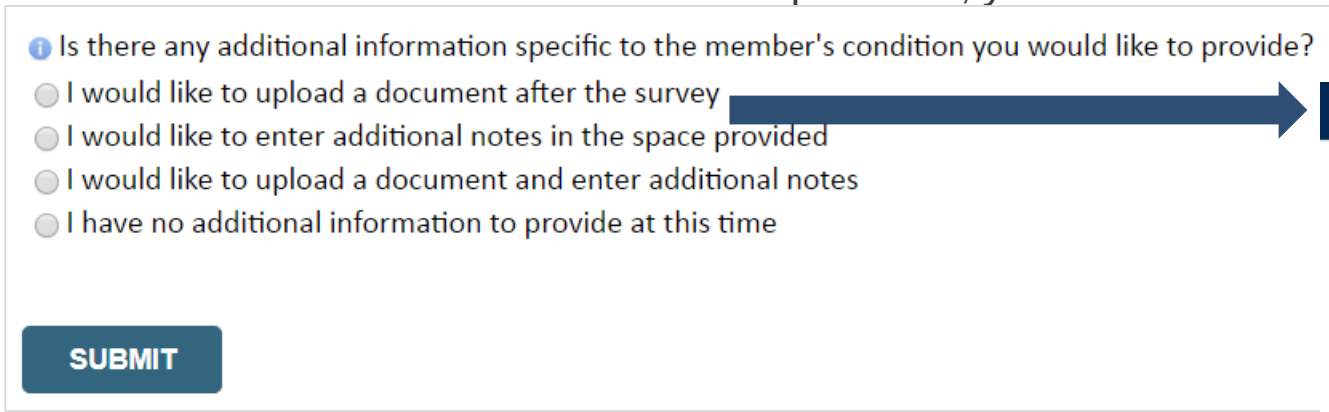
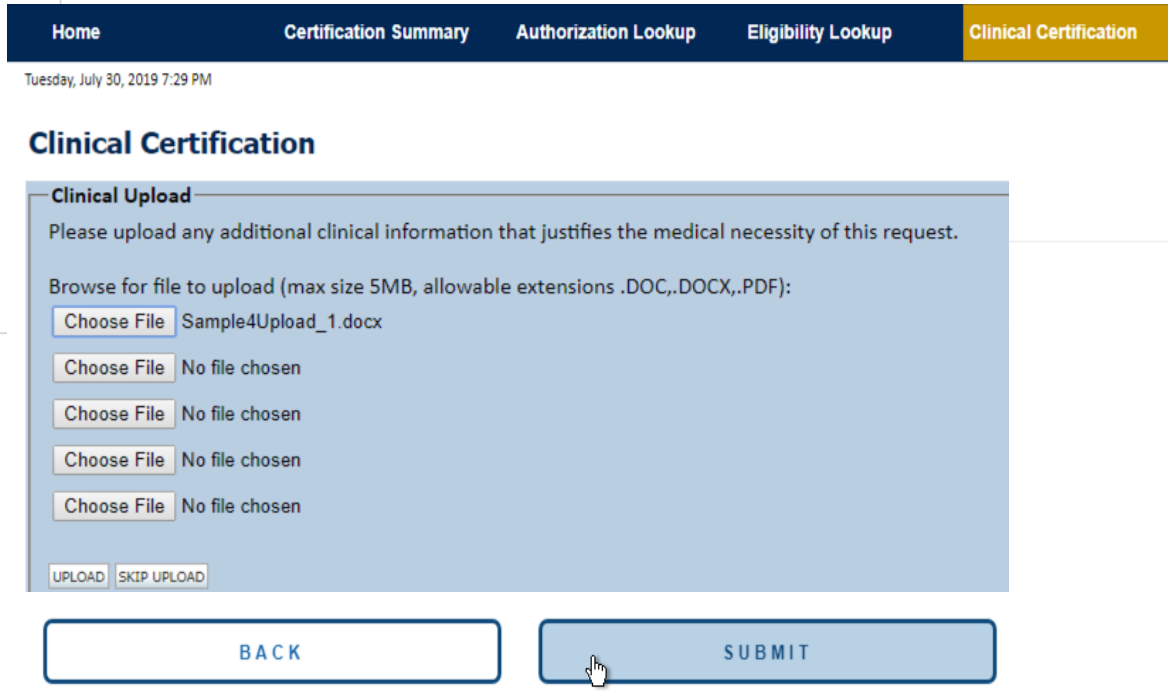
Request for clinical upload

If criteria are not met based on clinical questions, you will receive a similar request for additional info:





Tips:

- Upload clinical notes on the portal, to avoid any delays (e.g., by faxing)
- Enter additional notes in the space provided only when necessary
- Additional information uploaded to the case will be sent for clinical review

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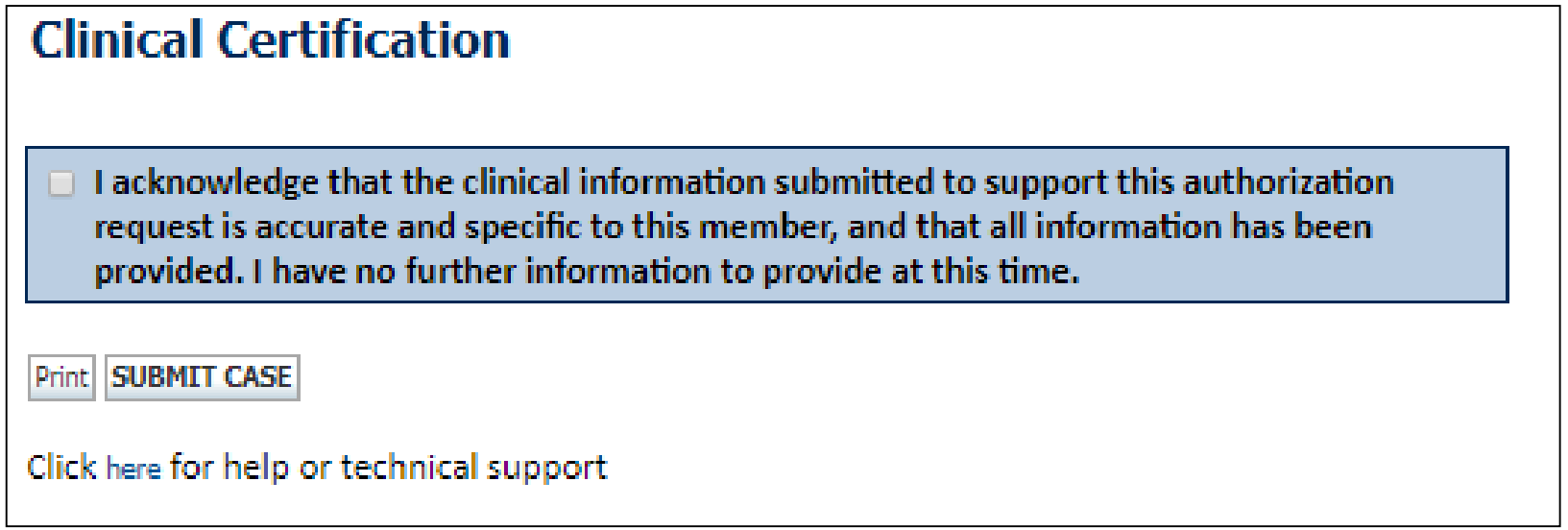
Finalizing the Case Submission



Acknowledge the Clinical Certification statements, and click "Submit Case"

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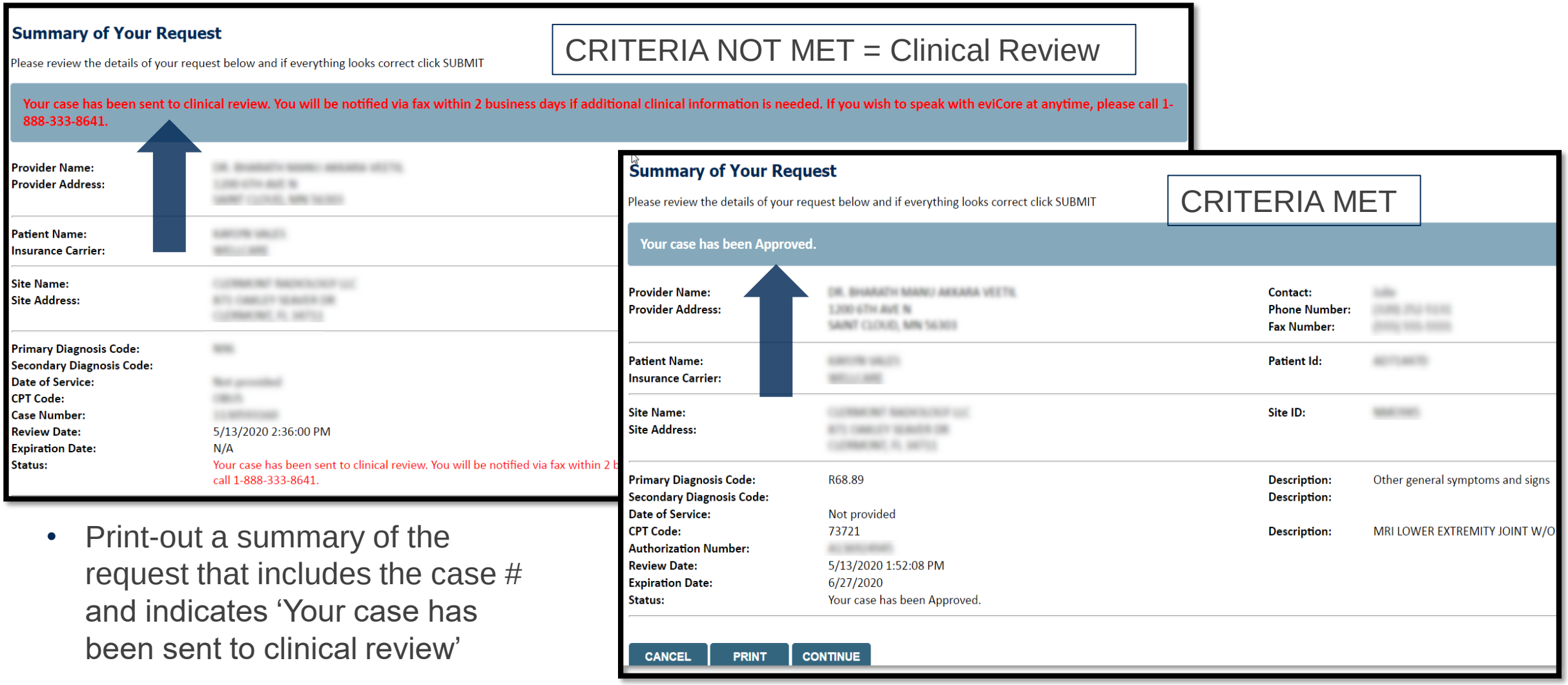
Next Step: Criteria met OR Criteria not met



- Print-out a summary of the request that includes the case # and indicates ‘Your case has been sent to clinical review’

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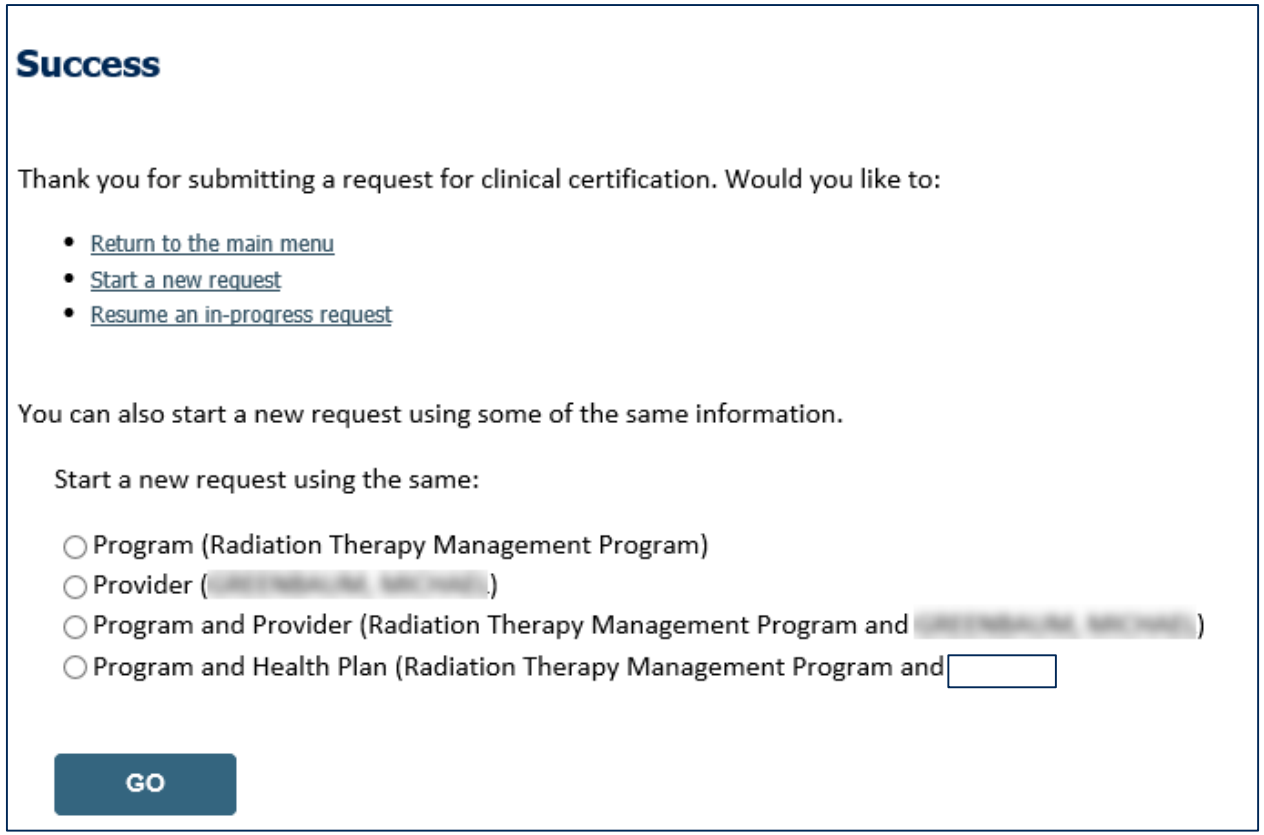
Duplication Feature

- Once a case has been submitted, the Duplicate feature allows a new request to be started using some of the same information
- This eliminates entering duplicate information and allows multiple cases to be built efficiently
- Time saver!



Additional Provider Portal Features

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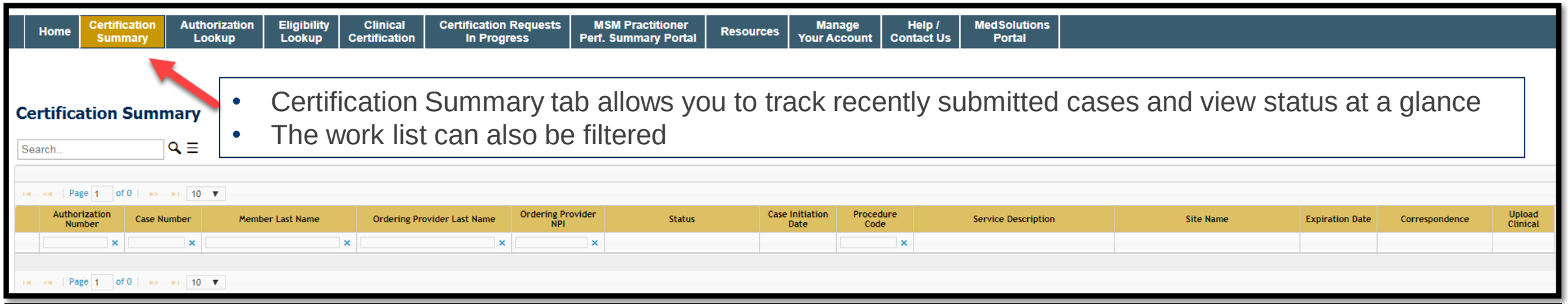
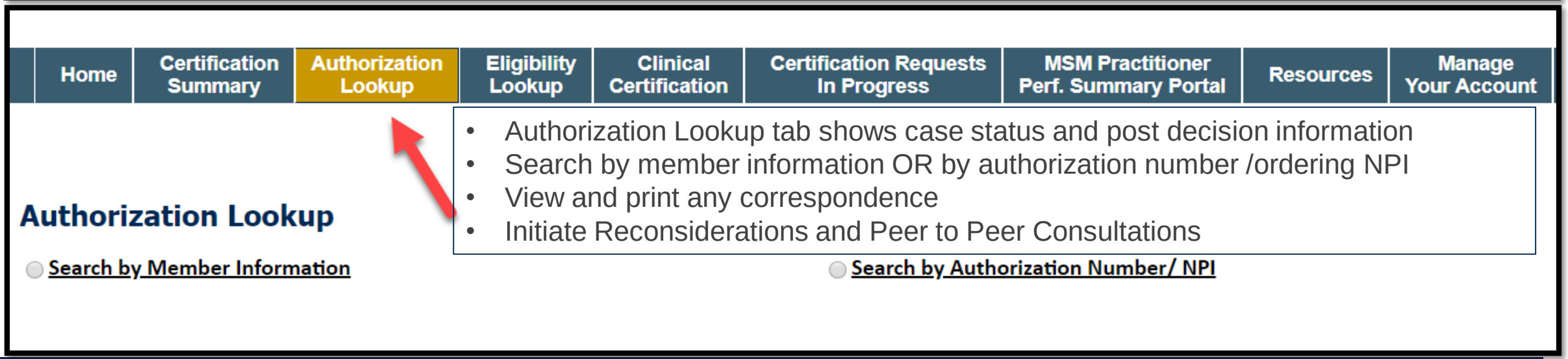
Certification Summary / Authorization Lookup

The top ribbon menu has several helpful features :



- Certification Summary tab allows you to track recently submitted cases and view status at a glance
- The work list can also be filtered



- Authorization Lookup tab shows case status and post decision information
- Search by member information OR by authorization number /ordering NPI
- View and print any correspondence
- Initiate Reconsiderations and Peer to Peer Consultations

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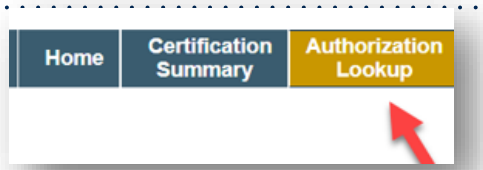
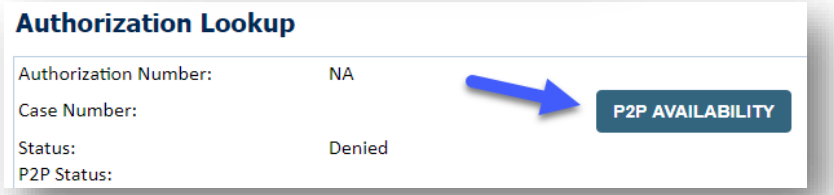
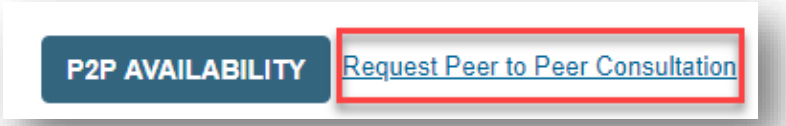
How to schedule a Peer to Peer Request

- Log into your account at www.evicore.com
- Perform Authorization Lookup to determine the status of your request.
- Click on the “P2P Availability” button to determine if your case is eligible for a Peer to Peer conversation:

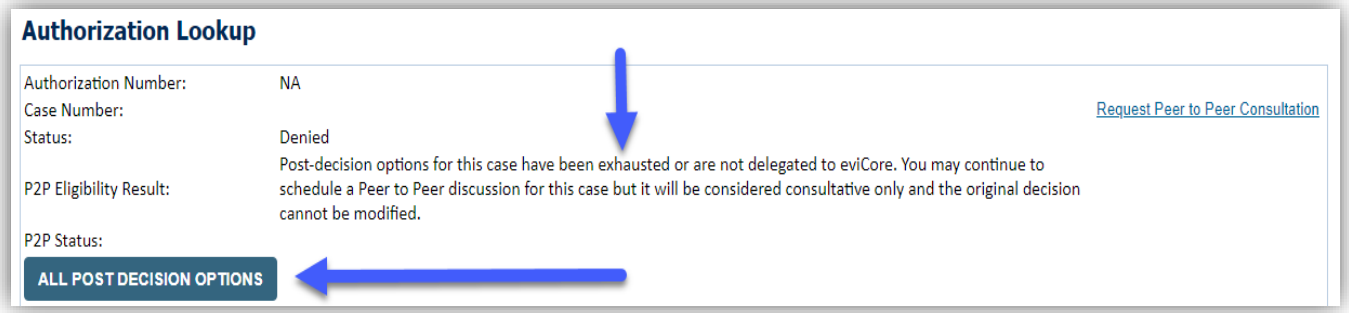




- If your case is eligible for a Peer to Peer conversation, a link will display allowing you to proceed to scheduling without any additional messaging.



- Pay attention to any messaging that displays. In some instances, a Peer to Peer conversation is allowed, but the case decision cannot be changed. When this happens, you can still request a Consultative Only Peer to Peer. You may also click on the “All Post Decision Options” button to learn what other action may be taken.
- Once the “Request Peer is selected, you will be transferred to our scheduling software via a new browser window.



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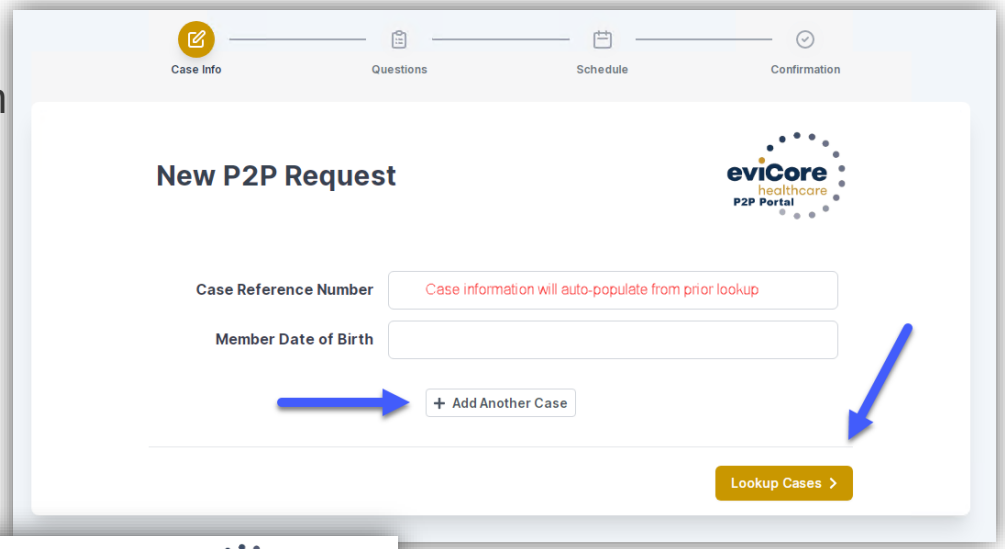
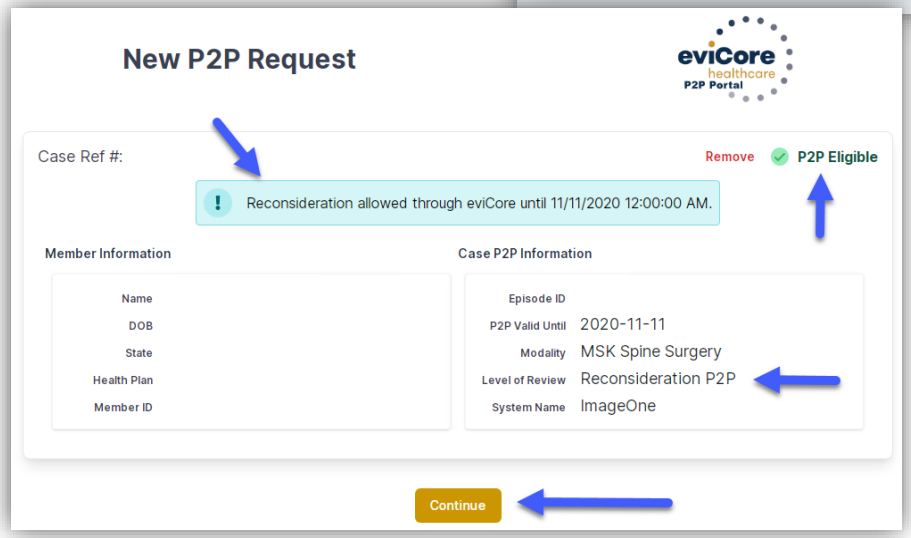
How to Schedule a Peer to Peer Request

- Upon first login, you will be asked to confirm your default time zone.
- You will be presented with the Case Number and Member Date of Birth (DOB) for the case you just looked up.
- You can add another case for the same Peer to Peer appointment request by selecting “Add Another Case”
- To proceed, select “Lookup Cases”



- You will receive a confirmation screen with member and case information, including the Level of Review for the case in question. Click Continue to proceed.



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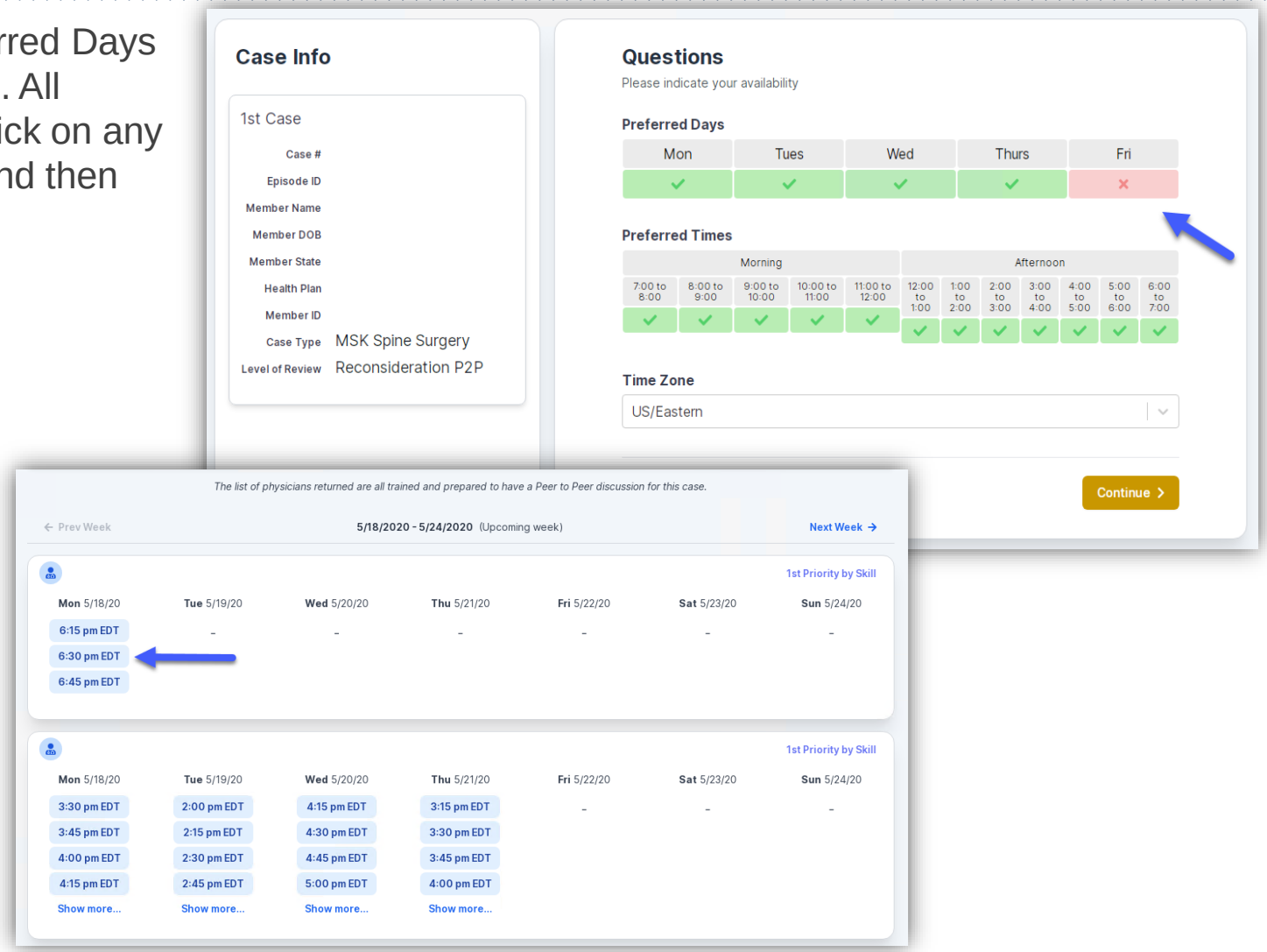
How to Schedule a Peer to Peer Request

- You will be prompted to identify your preferred Days and Times for a Peer to Peer conversation. All opportunities will automatically present. Click on any green check mark to deselect the option and then click Continue.

- You will then be prompted with a list of eviCore Physicians/Reviewers and appointment options per your availability. Select any of the listed appointment times to continue.



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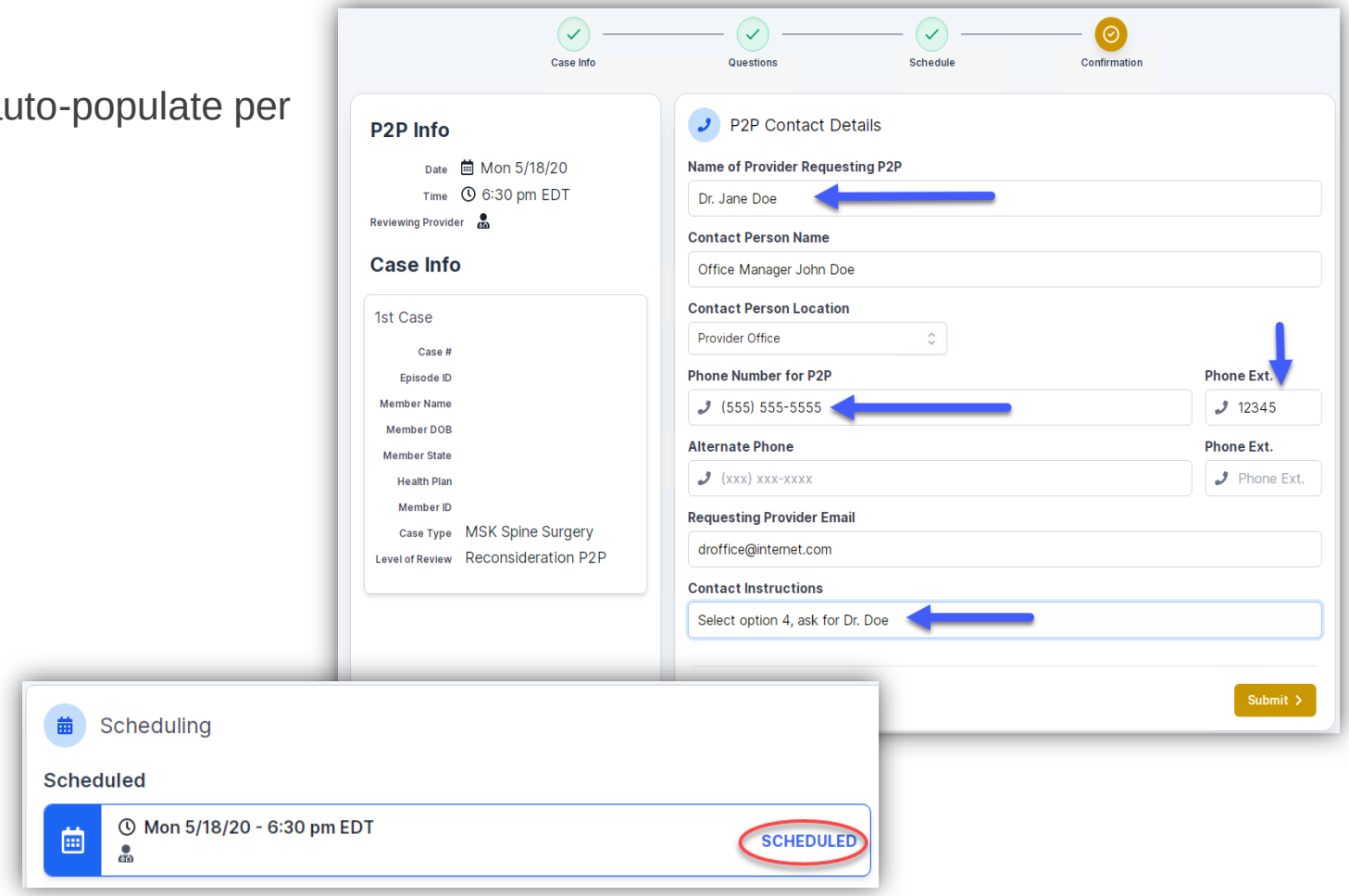
How to Schedule a Peer to Peer

Confirm Contact Details

- Contact Person Name and Email Address will auto-populate per your user credentials
- Be sure to update the following fields so that we can reach the right person for the Peer to Peer appointment:
  - Name of Provider Requesting P2P
  - Phone Number for P2P
  - Contact Instructions

- Click **submit** to schedule appointment. You will be presented with a summary page containing the details of your scheduled appointment.



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Canceling or Rescheduling a Peer to Peer Appointment

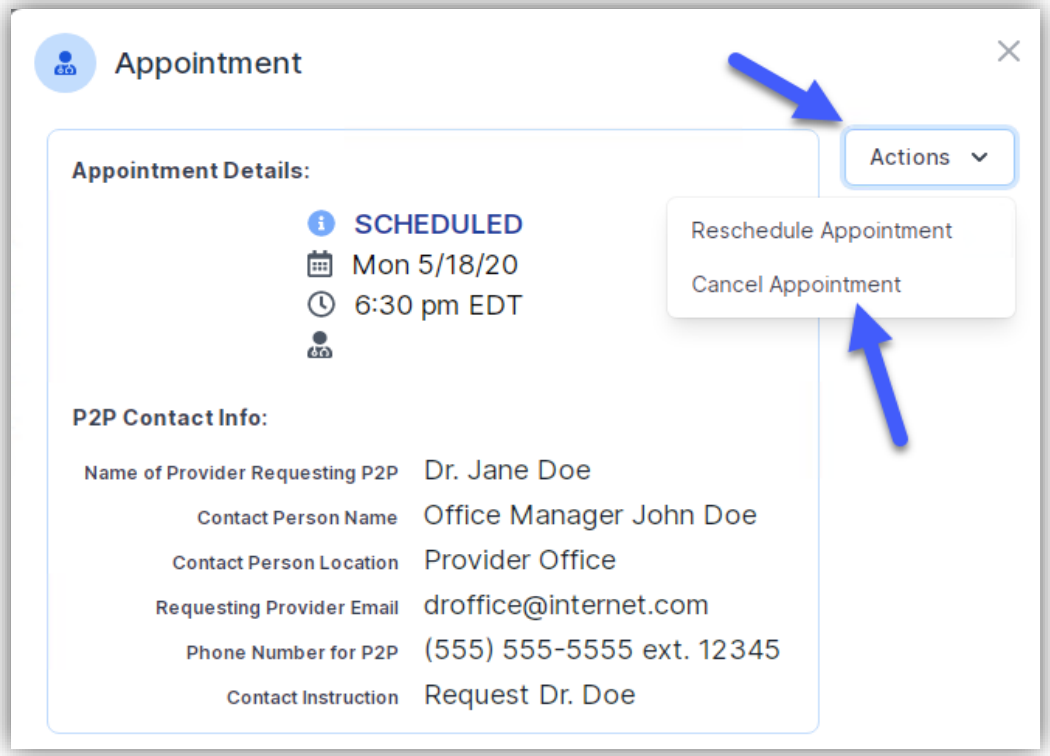
To cancel or reschedule an appointment

- Access the scheduling software per the instructions above
- Go to “My P2P Requests” on the left pane navigation.
- Select the request you would like to modify from the list of available appointments
- Once opened, click on the schedule link. An appointment window will open
- Click on the Actions drop-down and choose the appropriate action

  If choosing to reschedule, you will have the opportunity to select a new date or time as you did initially.

  If choosing to cancel, you will be prompted to input a cancellation reason

- Close browser once done



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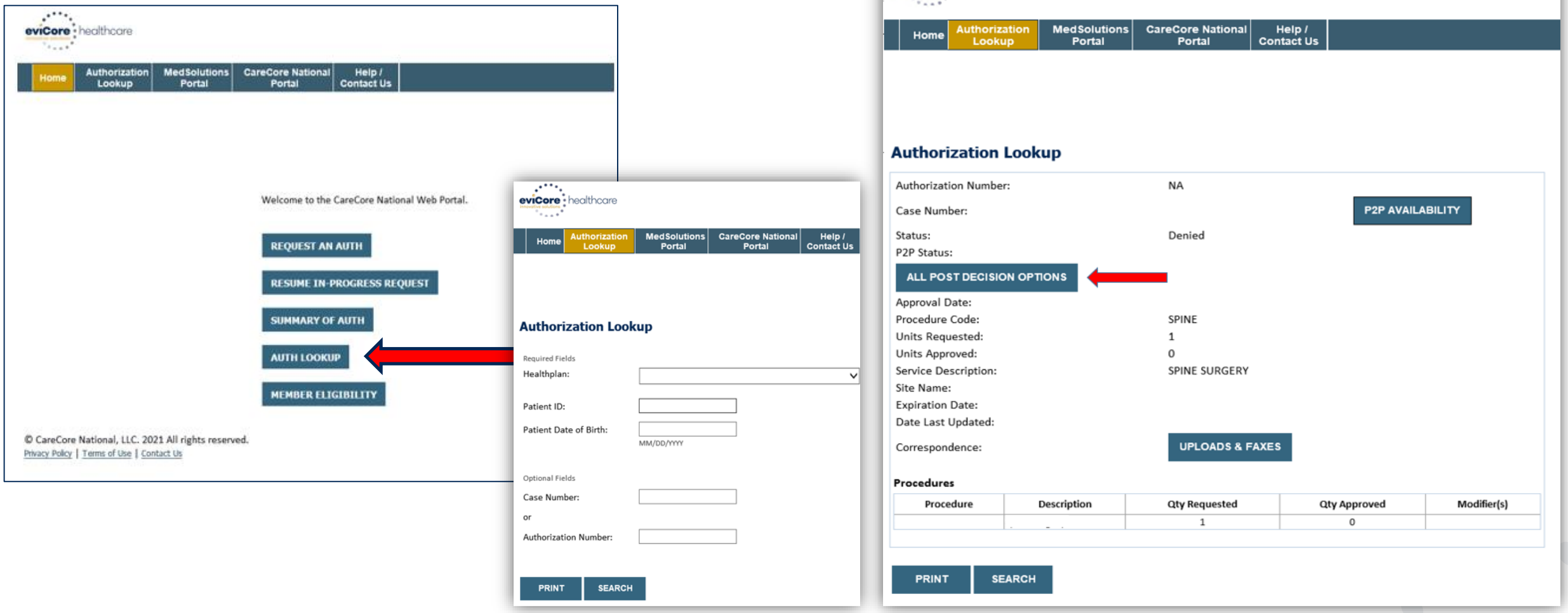
eviCore Reconsideration Review Process on the Web

- Select “Auth Lookup” from the main menu, then enter health plan and patient information or authorization number
- When the authorization summary displays, select ‘All Post Decision Options’ to see if the case is eligible for Reconsideration or Appeal



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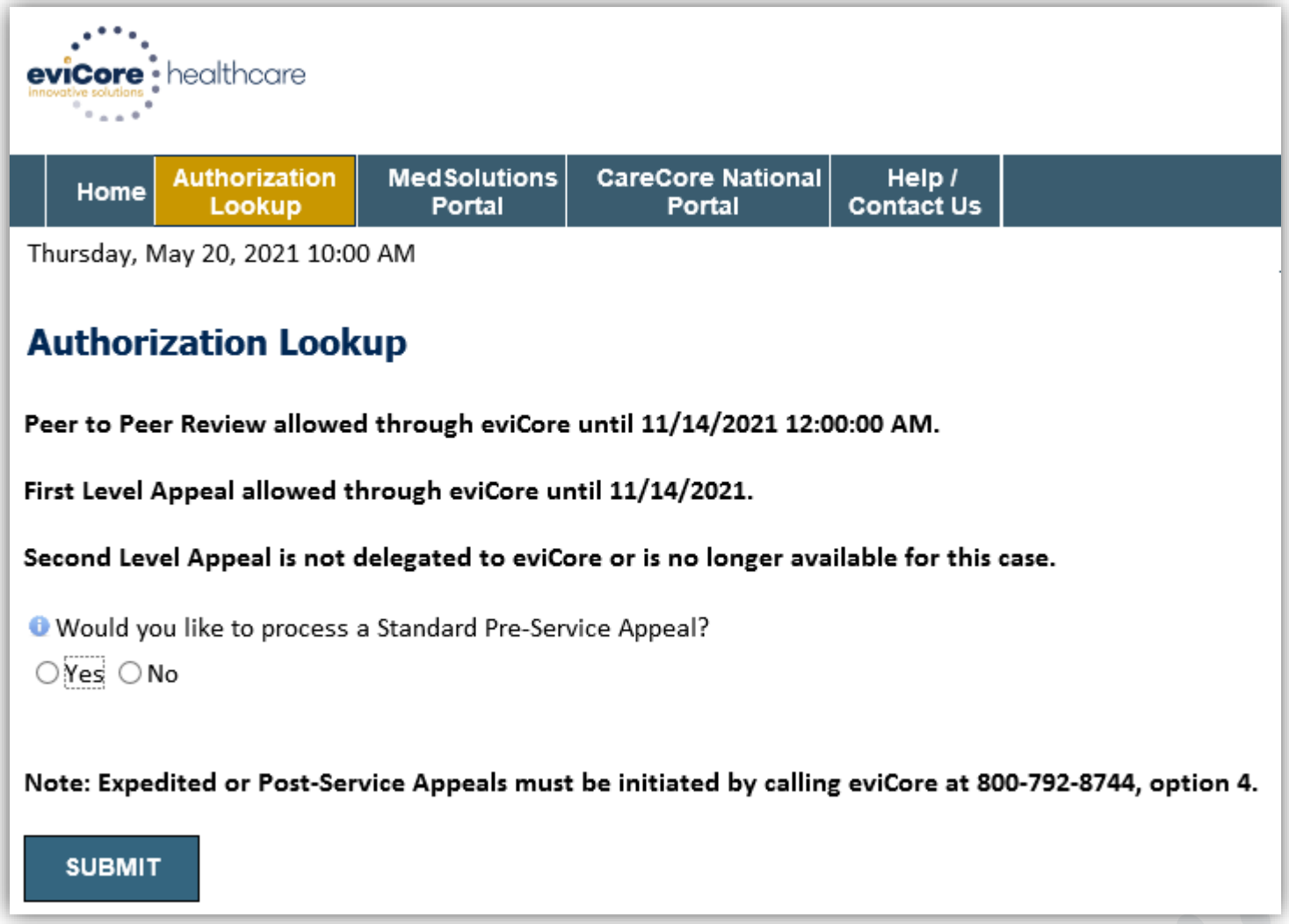
eviCore Reconsideration Review Process on the Web (cont.)

- If a reconsideration or first level appeal is delegated through eviCore, the user will see the following question at the bottom of available appeal options
- User can answer “Yes” to move forward
- If the user answers “No” an appeal or reconsideration will not be started and the following notation will be placed on the case: Post Decision Review process opened and abandoned by Web User. Case will not proceed to Reconsideration or Appeal review at this time.
- Note: Select ‘No’ to go back to schedule a Peer-to-Peer



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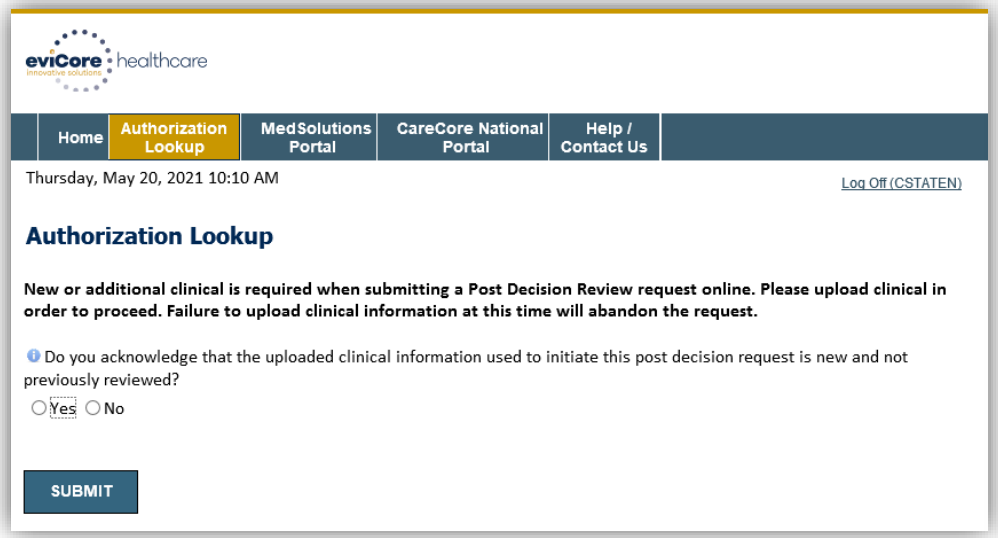
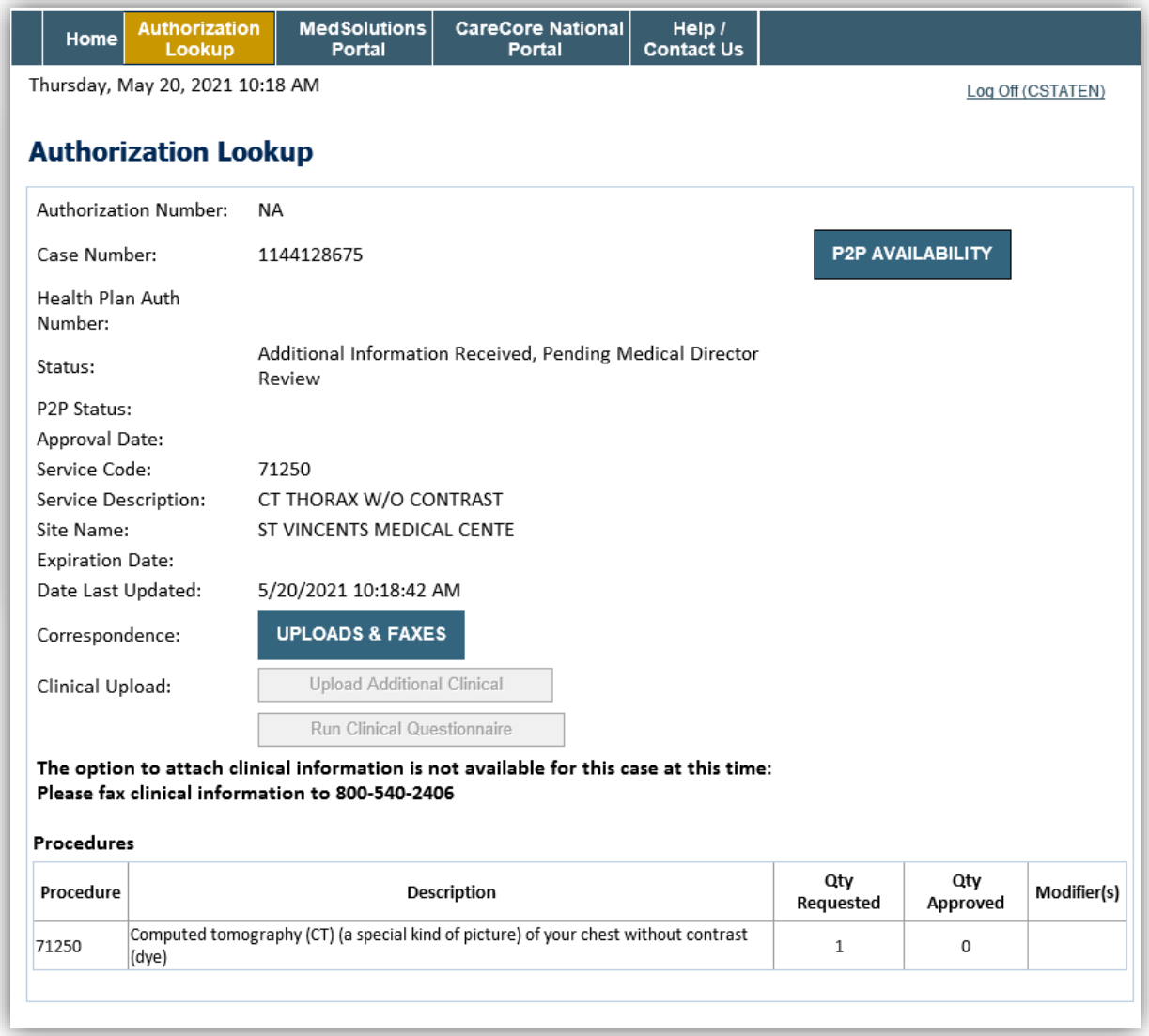
eviCore Reconsideration Process on the Web (cont.)

- New or additional clinical documentation is required; Failure to upload new or additional clinical documentation will cancel the request



- After the post decision review is initiated, the user will return to the authorization lookup
- Status will be updated to show additional information was submitted and pending review
- A determination will be faxed to the provider



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Provider Resources

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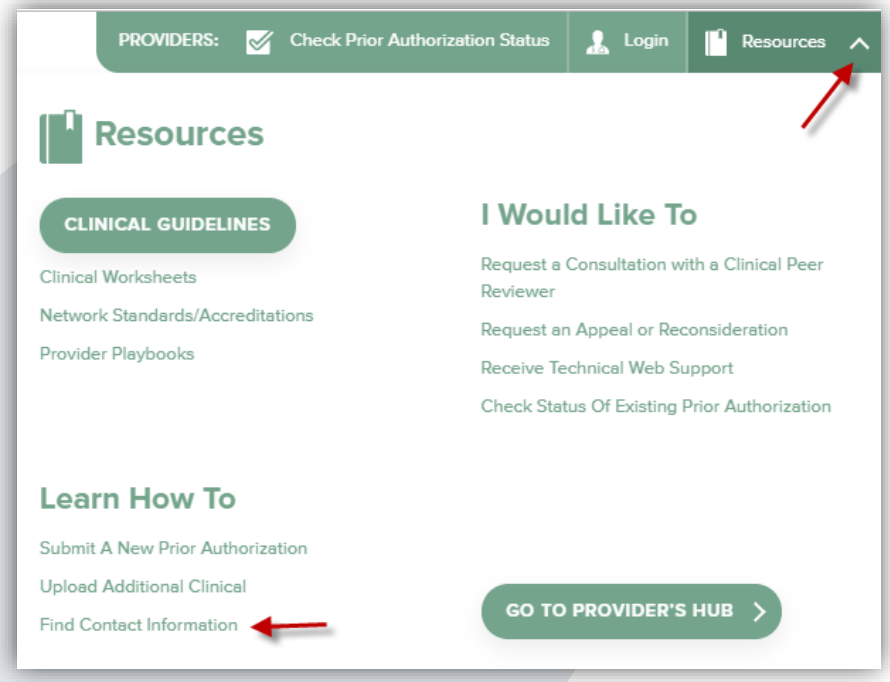

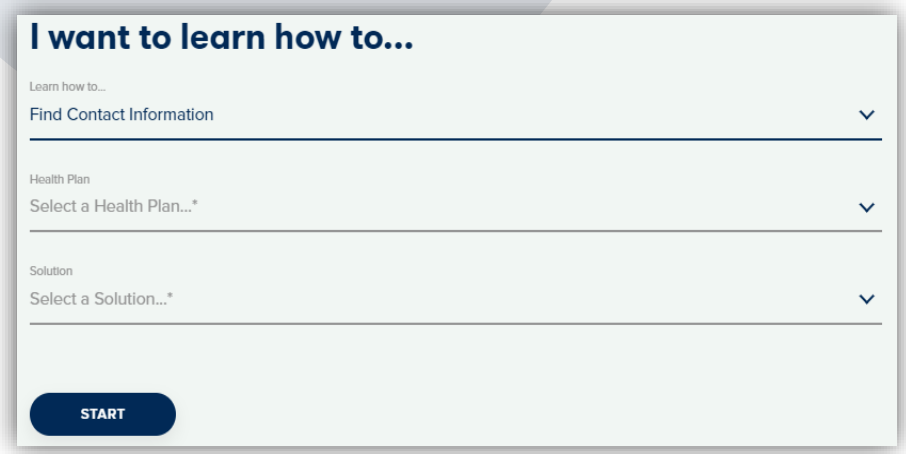

Provider Resources

Prior Authorization Call Center – 888.622.7329

- Call center hours are 7am – 7pm Monday-Friday local time

Web-Based Services and Online Resources

- Important tools, health plan-specific contact information, and resources can be found at **www.evicore.com**
- Select the **Resources** to view Clinical Guidelines, Online Forms, and more.

Provider Resource Page

https://www.evicore.com/resources/healthplan/aetna

Web Support

- The quickest, most efficient way to request prior authorization is through our provider portal. Our dedicated Web Support team can assist providers in navigating the portal and addressing any web-related issues during the online submission process.
- To speak with a Web Specialist, call (800) 646-0418 (Option #2) or email portal.support@evicore.com

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eviCore Provider Support Teams

Client and Provider Services

Dedicated team to address provider-related requests and concerns including:

- Questions regarding Accuracy Assessment, Accreditation, and/or Credentialing
- Requests for an authorization to be resent to the health plan
- Consumer Engagement Inquiries
- Eligibility issues (member, rendering facility, and/or ordering physician)
- Issues experienced during case creation
- Reports of system issues

How to Contact our Client and Provider Services team

Email: ClientServices@evicore.com For prompt service, please have all pertinent information available. When emailing, make sure to include the health plan in the subject line with a description of the issue, with member/provider/case details when applicable.

Provider Engagement team

You can find a list of Regional Provider Engagement Managers at **www.eviCore.com** → Provider's Hub → Training Resources

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Provider Newsletter

Stay Updated With Our Free Provider Newsletter

eviCore's provider newsletter is sent out to the provider community with important updates and tips. If you are interested in staying current, feel free to subscribe:

- Go to eviCore.com
- Scroll down and add a valid email to subscribe
- You will begin receiving email provider newsletters with updates

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Provider Resource Review Forums

The eviCore website contains multiple tools and resources to assist providers and their staff during the prior authorization process.

We invite you to attend a Provider Resource Review Forum, to navigate www.eviCore.com and understand all the resources available on the Provider's Hub. Learn how to access:

- eviCore's evidence-based clinical guidelines
- Clinical worksheets
- Check-status function of existing prior authorization
- Search for contact information
- Podcasts & Insights
- Training resources

How to register for a Provider Resource Review Forum?

You can find a list of scheduled **Provider Resource Review Forums** on www.eviCore.com → Provider's Hub → Scroll down to eviCore Provider Orientation Session Registrations → Upcoming

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Thank You!

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