

EviCore

By EVERNORTH®

2024

Utilization Management Program Description

EviCore by Evernorth



A handwritten signature in black ink that reads 'Tiffany Dubay'.

Tiffany Dubay

EviCore by Evernorth

Quality and Accreditation Senior Manager

Date: 3/30/2024

A handwritten signature in black ink that appears to read 'Eric J. Gratias'.

Eric J. Gratias, MD, FAAP

EviCore by Evernorth - Chief Medical Officer

Chair, Quality Management Committee

Date: 3/30/2024

SummaCare UMPC approved

5/2/2024

2024 Utilization Management Program Description

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INTRODUCTION TO EviCore BY EVERNORTH

Specifically designed with the size and scale to address the complexity of our healthcare system today and tomorrow, EviCore by Evernorth is committed to advancing healthcare management through evidence-based medicine. EviCore by Evernorth empowers the improvement of care by connecting patients, providers, and health plans with intelligent solutions to enable better outcomes. Health plans, requesting providers and rendering providers and/or facilities are EviCore's primary customer base. EviCore by Evernorth offers flexible plan designs, low-to-high touch options, quality reporting and trend management accompanied with solution-specific expertise. EviCore by Evernorth healthcare offers proven, diversified medical benefits management solutions that help our clients reduce costs while increasing the quality of care provided to their members. Relying on our team of specialized medical professional resources, extensive evidence-based guidelines, and advanced technologies, we ensure that each member receives the right care at the right time. EviCore by Evernorth is built with the size and scale to address the increasing complexity of today's healthcare system. Through our exceptional capabilities and an acute sensitivity to the needs of everyone involved, we harness healthcare's evolving demand and inherent change to better manage and optimize health benefits.

Overview

One of the cornerstones to the success of any Utilization Management (UM) program is its ability to ensure high quality care as well as effective, efficient, and timely utilization of healthcare services. Our utilization management services and programs are designed to serve individuals as well as specific groups of members. UM services provided by EviCore are administered in accordance with formal delegation agreements with our client health plans. EviCore by Evernorth recognizes health care providers are the key managers in the healthcare delivery system. Our philosophy is to support health care providers with expert consultation and tools to ensure members receive the best and most appropriate services possible at the most appropriate time in their individual care continuum. We believe our program provides guidance to deliver the most appropriate services to members at the appropriate level of care in a timely, effective, and cost-efficient manner:

- to continually improve the member's quality of care
- to utilize studies of patterns and utilization of services for improved member care and continuing education of the medical staff, administration, and consumer regarding healthcare cost containment
- to promote fair and consistent utilization management decision making
- to ensure consistency in authorization processing through application of nationally recognized clinical guidelines and adherence of UM policies and procedures
- to focus resources on a timely resolution of identified opportunities
- to educate medical providers and other health care professionals on appropriate and cost-effective use of healthcare resources
- to coordinate UM with quality improvement activities to support the ongoing monitoring of compliance with quality standards.

Who We Are

Historically, EviCore by Evernorth ("EviCore") has been the product of two leading providers of medical benefit management services that merged in 2015 (*CareCore National, LLC* and *MedSolutions, Inc.*) with *CareCore National, LLC*

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also owning *Landmark Healthcare, Inc.*, now referred to as *Landmark Healthcare, Inc. d/b/a EviCore MSK* (as of 2013). The merging of *CareCore National, LLC* and *MedSolutions, Inc.* enabled EviCore to leverage specific synergies in the healthcare sector and provide consumers with innovative solutions in benefit management. This unification helped to advance the collective commitment in containing healthcare costs in concert with increased quality outcomes for members, healthcare providers and payers alike. EviCore's corporate base resides in Franklin, Tennessee, with additional satellite offices in South Carolina, and Colorado, while providing service to members/providers in all fifty (50) states. In an effort to become an even more powerful tool in managing costs for patients and payers and reduce wasteful spending/overutilization, EviCore was acquired by *Express Scripts Holding Company* (NASDAQ:ESRX) on December 15, 2017.

Subsequently, on December 20, 2018, *Cigna Corporation* (NYSE: CI) acquired *Express Scripts* (EviCore's parent company). The combination of *Cigna* with *Express Scripts* integrated two complementary health care service companies, each with industry-leading cost trend capabilities that continue to deliver better care, expanded choice and drive down health care costs. In December of 2023, we transitioned to Evernorth visual identity (look and feel) and evolved our name and logo from "EviCore healthcare" to "EviCore by Evernorth". These acquisitions did not materially change EviCore, or its products and services. We continue to work in concert to effectively manage medical benefits for our clients and consumers.

EviCore is comprised of over 5,000+ employees including 1,200 clinicians. EviCore is empowered by a team of specialized medical professional resources:

- 500+ Medical Directors covering 60+ different specialties
- 1200 clinicians and growing with diverse specialties and experience
- Dedicated nursing and physician teams for various solutions
- 800,000+ providers engaged
- 100+ clients
- 100+ million lives covered
- 100,000+ Prior Authorization (PA) requests received daily
-

What We Do

EviCore by Evernorth

EviCore is a medical benefits management organization that offers best-in-class solutions to ensure patients receive optimal treatment at the right site of care by leveraging our team of medical professionals, evidence-based guidelines, and innovative technologies to deliver affordable care.

- Today, the rapid pace of medical innovation is creating an unsustainable rise in health care costs and making it challenging for some clinicians to keep up with the latest research and developments – often leading to unnecessary or inappropriate care.
 - More than two-thirds of physicians feel overwhelmed by the amount of information they need to keep up with. And, approximately 20% of medical care delivered today is unnecessary.
 - This unnecessary care can have serious impact on patients: inaccurate or incomplete diagnoses; ineffective treatments; false positives; exposure to unnecessary radiation; higher out-of-pocket costs.
- By keeping providers current on critical nuances in treatment procedures and clinical guidelines, EviCore fills knowledge gaps, which protects patients from receiving unnecessary – and potentially harmful – tests and treatments.

- We partner with clinicians to connect patients with the right treatment and providers who employ value-based care approaches to achieve better health outcomes sooner.
 - Our team of 500-plus board-certified physicians and ~1.2K clinicians cover 60-plus different specialties, working together to ensure the latest evidence-based guidelines are being used. Additionally, our physicians and clinicians review clinically complex cases to ensure patients receive the right care.
 - Today, we offer integrated solutions for key areas, including medical oncology, radiation oncology, oncology benefit management, precision medicine solutions, lab molecular, lab non-molecular, medical drug management, musculoskeletal solutions: surgical (spine and joint) and non-surgical (interventional pain, specialty therapies), home solutions, post-acute care, durable medical equipment, sleep, in-home primary care, cardiovascular, gastroenterology, and radiology.
 - EviCore currently works with over 100 payors, representing over 100M lives – approximately one in three Americans.
- We're working to seamlessly integrate our solutions with physicians' workflows, simplifying the authorization process so providers can spend less time on administration and more time with patients.

Our Solutions

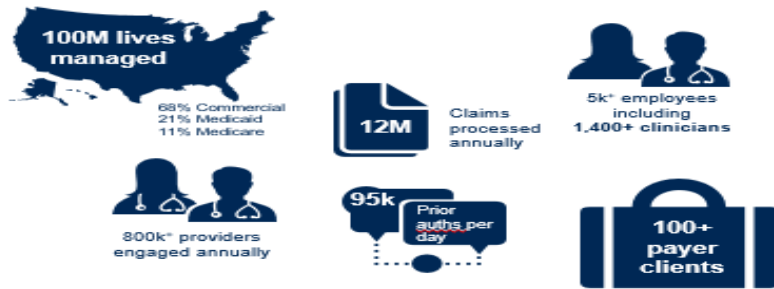
Our strength and breadth of Medical Benefit Management (MBM) expertise includes providing eleven (11) different comprehensive solutions: Radiology Program, Cardiac Imaging/Implantable Devices Program, Laboratory Management, Musculoskeletal Management, Radiation Oncology Management, Sleep Management, Medical Drug Management, Medical Oncology Management, Post-Acute Care Management, Gastroenterology Management program and the newest Evernorth FamilyPath Fertility Solution. This allows EviCore to continuously bring clients practical, innovative, and effective strategies that reduce costs while guiding providers and members to higher quality, evidence-based care.

Who We Serve

EviCore is enhancing outcomes through member, provider, and payer engagement benefiting all stakeholders in the pre authorization experience. EviCore serves the Commercial, Medicare and Medicaid health plan members spanning across the entire United States with business in each and every state. EviCore proudly services clients ranging in size from less than ten thousand (10,000) lives to greater than ten million (10,000,000) lives with provision of services across our eleven (11) comprehensive solution programs to more than one-hundred million (100,000,000) lives total.

eviCore Highlights

Addressing the complexity of healthcare for 25+ years



MISSION

It is the mission of EviCore's Utilization Management (UM) Program to improve the healthcare system through innovative medical benefits solutions by identifying the right care path to help enable the best outcomes for health plan members.

GOALS AND OBJECTIVES OF THE UTILIZATION MANAGEMENT PROGRAM

Utilization Management is performed to promote effective and efficient healthcare delivery and designed to evaluate the cost and quality of medical services delivered by healthcare providers. The goal of EviCore's UM program is to ensure appropriate utilization of services by securing the right study/treatment at the right time for the right member. This includes evaluation of both potential over and underutilization of services delegated to EviCore.

EviCore's objectives include, but are not limited to, the following:

- Create programs that evaluate:
 - medical necessity of covered services;
 - determination of benefit coverage;
 - appropriate utilization of services and adhere to the current standards of care.
- Provide fair and consistent UM decision-making
- Evaluate the consistency in applying the clinical guidelines by conducting inter-rater reliability (IRR) examinations and decision audits no less than annually.
- Conduct clinical peer review of all potential medical necessity non-certifications. Determinations for medical services, including advanced radiology, occupational, and speech therapy denial decisions, are performed by physicians. Adverse determinations for chiropractic, acupuncture, and massage therapy services are rendered to provide the most appropriate services to members at the appropriate level of care in a timely, effective and cost-efficient manner.
- Allocate resources on timely resolution of identified areas of opportunity.

COMMITMENT TO QUALITY

Each year, EviCore's executive leadership team establishes EviCore's common goals as an organization to ensure a seamless transition into the next year, to present clear objectives to all employees at all levels, and leverage our organizational synergies. The EviCore UM program contributes to the success of our priorities by relentlessly striving to empower the improvement of health care by connecting members, providers, and payers with intelligent, evidence-based solutions to enable better outcomes. This is achieved through effective and efficient healthcare delivery, ensuring appropriate utilization of resources, and providing continuous quality improvement.

PROGRAM RESOURCES & KEY PERSONNEL

The clearly defined organizational structure of the UM Program ensures that all participants are accountable for oversight and evaluation of EviCore services. This structure also promotes the necessary resources to support quick, coordinated, responses to identified quality issues. Key personnel responsible for the implementation and integration of utilization management activities include, but not limited to, the below:

Chief Medical Officer (CMO) - All services/programs offered at EviCore are overseen by EviCore's Chief Medical Officer who is a board-certified physician with a current, unrestricted medical license to practice medicine in a U.S. state or territory as a utilization review doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O). He/She is the designated senior clinical leader that is responsible for providing supervision, oversight and evaluation of all aspects of the UM program that is integrated within the Quality Management program. The CMO is individually responsible for clinical compliance within the UM program concerning clinical policy, quality, program development, review of UM cases, clinical guidelines and provider issues. The CMO is accessible to staff to provide guidance in all clinical aspects and, in addition, is responsible for the promotion of a positive relationship between EviCore clients and providers. He/She attends meetings with health plan medical directors and other officers as is required from time to time to report on and discuss issues. The Chief evaluates and recommends corrective actions concerning utilization trends, referral patterns, fraudulent medical practices and quality standards. EviCore's Chief Medical Officer also ensures the organization maintains qualified clinicians who are rendering decisions affecting consumers. Additionally, the EviCore CMO participates in the operations designed to foster business growth and development.

In summary, the senior level physician responsibilities include, but are not limited to:

- Setting UM policies
- Internal guideline/criteria review
- Supervising program operations
- Participates in staff training
- Review consistency of applying UM decision guidelines and implement corrective action(s) when needed
- Participating on the QM committee
- Evaluating the overall effectiveness of the UM program

Associate Chief Medical Officer(s) - Each service/program offered at EviCore is overseen by a designated EviCore Associate Chief Medical Officer (ACMO) who reports to the EviCore CMO and is a board-certified physician in their designated area of practice with a current, unrestricted medical license to practice medicine in a state or territory of the United States as a utilization review doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O.). The ACMO is the program clinical leader that is responsible for leading overall clinical program performance, including policy, clinical review decision, appeals, audits, and other clinical functions. Additionally, ACMO functions include, but not limited to:

- Evaluating utilization trends, referral patterns, fraudulent medical practices, quality standards, regulatory changes, program performance, and client feedback
- Overseeing clinical policy development for their applicable program and facilitate collaboration with other clinical programs at EviCore to ensure optimal process and content harmonization
- Participating as senior leadership in strategy, planning, and budgeting for their applicable program as well as in execution of annual program goals, accountable to the General Manager Services
- Ensuring their designated program maintains compliance with all CMS, NCQA, URAC, and other regulatory requirements and oversee program support to EviCore Audit teams.

Executive Medical Director - Each service/program offered at EviCore maintains a designated EviCore Executive Medical Director who reports to the program ACMO and is a board-certified physician in their designated area of practice with a current, unrestricted medical license to practice medicine in a state or territory of the United States as a utilization review doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O.). The Executive Medical Director is the program designee responsible for maintaining oversight of intraday activities of the applicable EviCore program and services. Executive Medical Director responsibilities include, but not limited to:

- Managing the day-to-day clinical activities of the applicable EviCore program
- Collaborating with leadership from Clinical Operations, Non-Clinical Operations, and Program Operations to support and promote optimal program functioning and identify opportunities for improvement
- Supervising and managing activities of the program Senior Medical Directors and Medical Directors to ensure effective and objective application of clinical guidelines, accurate determination of medical necessity, and efficient processing of clinical case review requests in accordance with legal and contractual obligations
- Supporting the development and maintenance of EviCore policies and procedures and criteria related to clinical certification
- Providing timely expert medical review of medical necessity requests for clinical services and renders a clinical opinion about the medical service under review, including post-decision reviews, when necessary to support timely completion of clinical services requests within the designated program.

Senior Medical Director - Each service/program offered at EviCore maintains a designated EviCore Senior Medical Director who reports to the program Executive Medical Director or ACMO and is a board-certified physician in their designated area of practice with a current, unrestricted medical license to practice medicine in a state or territory of the United States as a utilization review doctor of medicine (M.D.) or doctor of osteopathic medicine (D.O.). The Senior Medical Director is a critical intraday leader of the applicable EviCore program with responsibilities that include, but are not limited to serving as a coach, mentor, and/or clinical supervisor for the Medical Directors, serving as a Subject Matter Expert and first point of contact for Medical Directors who are seeking assistance with problematic case reviews.

Medical Director - EviCore Medical Directors are physicians who are board-certified in his/her designated area of practice with unrestricted license or certification to practice medicine or health profession in a state or territory of the United States. They review requests and are qualified to render a medical decision about the medical condition procedures and treatment under review, including a non-certification if the request does not appear to meet the guidelines and criteria. Physician reviewers who render final adverse determinations for medical services are currently board-certified by a specialty board approved by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists in the area of specialty in which they render their professional opinion. Medical Directors and Associate Medical Directors consider the needs of individual members and geographic availability of services in the local delivery system when applying the clinical guidelines or medical policy.

Clinical Peer Reviewer — A physician or other health care professional who holds an unrestricted license and is in the same or similar licensing category as the ordering provider, as typically manages or treats the medical condition under review. Clinical Peer reviewers can render decisions of non-certification for initial requests for services, conduct peer-to-peer conversations and uphold a decision on a reconsideration review. Clinical Peer Reviewers consider the needs of individual members and geographic availability of services in the local delivery system when applying the clinical guidelines or medical policy.

External Reviewer — In addition to the full-time EviCore Chief Medical Officer, Associate Chief Medical Officers, Executive Medical Directors, Senior Medical Directors, Medical Directors and Clinical Peer Reviewers, EviCore also uses

external physicians with clinical practice experience in appropriate specialties to assist, as needed, in the performance of medical necessity review as well as clinical guideline updates. They have a current, unrestricted license as a M.D. or D.O. and current board certification in an area of clinical expertise pertinent to the review request. External Reviewers are also trained in EviCore's use of clinical guideline criteria, as well as *URAC*, *Centers for Medicaid and Medicare (CMS)* and *NCQA* as it applies to EviCore's utilization management program.

Senior Vice President, Operations —The Senior Vice President (SVP) of Operations is the designated senior executive responsible for managing the organization's day-to-day functions using guidance, supervision, and leadership related to operational procedures necessary to meet regulatory and business objectives.

Vice President, Operations — The Vice President (VP) of Operations is the designated senior executive team member with responsibilities that include planning, directing, coordinating, and maintaining oversight of operations activities in the organization, ensuring development and implementation of efficient operations and cost-effective systems to meet current and future needs of the organization.

Senior Director, Operations — The Senior Director of Operations is the designated senior executive team member with responsibilities that include reviewing, analyzing, and evaluating business procedures. The Senior Director of Operations may also implement policies/procedures to improve day-to-day operations and maintains oversight of processes in an effort to reach goals set by departmental and company leadership.

Vice President, Clinical Operations — The Vice President of Clinical Operations (VP, Clinical Operations) is a registered professional nurse who maintains oversight of the resources and operations of the Utilization Management department and supports the clinical objectives of the utilization management program. He/She is responsible for the operational execution of the UM program under the direction of the Chief of Operations and Chief Medical Officer.

Senior Manager, Clinical Operations — The Senior Manager of Clinical Operations provides direct supervision for Clinical Supervisors and oversees the operations of clinical review requests from healthcare providers in accordance with contractual obligations and industry standards. He/She maintains knowledge of EviCore policies and procedures and criteria related to review. Additionally, the Senior Manager of Clinical Operations ensures cost effective management of personnel, resources and technology.

EviCore Compliance Officer — The EviCore Compliance Officer maintains oversight of EviCore corporate compliance activities that directly and indirectly affect quality and utilization management activities while providing direction of the EviCore compliance program as a whole. The Compliance Officer's functions include, but are not limited to, identifying and assessing areas of compliance risk while collaborating with executive management to effectively incorporate the compliance program within system operations and programs.

Legal Compliance Leadership — EviCore's Legal Compliance leaders are comprised of Directors and Managers who report to the Legal Compliance Senior Director/EviCore Compliance Officer and work collaboratively to ensure the compliance program effectively prevents and/or detects non-conformities with law, regulations, and organizational policies. Functions include, but are not limited to, identifying and assessing areas of compliance risk while collaborating with EviCore Operations leadership to effectively incorporate the compliance program within system operations and programs.

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Privacy Officer — The Privacy Officer is designated by the Compliance Committee to oversee EviCore’s privacy program and compliance with HIPAA, HITECH, and all other applicable privacy laws or regulations. The Privacy Officer reports to the Chief Compliance and Risk Officer.

Chief Information Security Officer —The senior-level executive responsible for aligning security initiatives with enterprise programs and business objectives, and ensuring that information assets and technologies are adequately protected. The Chief Information Security Officer serves an integral role in the *Quality Management Committee*.

Senior Director, Quality and Accreditation — The Senior Director of Quality and Accreditation is responsible for the coordination, development and evaluation of all outcome activities including, but not limited to, quality improvement and survey readiness with coordination of all survey activities to assure the organization maintains accreditation and certification with accrediting bodies. The Senior Director of Quality and Accreditation owns the execution of strategy and the operational direction of the accreditation department in addition to duties such as scheduling and recording of minutes for designated committees, as well as committee oversight for the Quality Management Committee.

Clinical Reviewers/Case Managers — The clinical review staff includes health care professionals who hold an active license or certificate from a U.S. state or territory and are trained in the use of utilization review guidelines to assess and screen requests for clinical services that may have been previously processed by clerical support staff to collect demographic data. Clinical reviewers function within their scope of practice that is relevant to the clinical service under review. They consider the needs of individual patients and geographic availability of services in the local delivery system when applying the clinical criteria. They have the authority to certify requests when the clinical information provided is consistent with the medical review guidelines, but do not have authority to non-certify a request. EviCore also utilizes offshore nursing staff (Registered Nurse/Licensed Practical Nurse) located in the Philippines to gather clinical information on a small subset of requests for services through EviCore, excluding appeals. Consistent with the domestic clinical reviewers employed by EviCore, offshore Clinical Reviewers do not have the authority to non-certify a request.

Senior Director of Chiropractic, Acupuncture and Massage Services —The Senior Director of Chiropractic, Acupuncture and Massage Services is a licensed chiropractor with primary responsibility for the operational oversight and clinical management of chiropractic, acupuncture and massage therapy programs.

Director, Non-Clinical Contact Center —The Non-Clinical Contact Center (NCCC) Director is responsible for the oversight and accountability of assigned Operations/Contact Center Teams. He/she provide direct leadership support and guidance to a team of Supervisors who assist in managing the Contact Center Agents, as well as ensures performance and other strategic objectives are met for the department.

Non-Clinical Support Staff —The non-clinical support staff objectives are to provide administrative, clerical support for the UM Program. Non-clinical support staff assess for completeness of information submitted, and collect and transfer demographic and eligibility data required for the clinical certification process. They can also collect structured clinical information in a focused screening process that does not require clinical review and/or clinical judgment. They have the authority to certify requests that successfully meet guidelines through EviCore’s structured review algorithms but are not permitted to non-certify any requests that are based upon medical necessity review.

Director of Provider Engagement — The Director of Provider Engagement is responsible for total relationship management and the overall provider experience acting as the key point of contact for providers fostering a culture of proactive and consultative provider relationship management, valued communication, impeccable service and provider satisfaction. At the strategic direction of the Chief of Operations, the Director of Provider Engagement will lead a comprehensive team that will own the provider relationship throughout the provider lifecycle, serving as a relationship

manager with provider entities, a liaison with client provider relations, and a conduit between providers and EviCore operations in order to identify, solve and avoid potential issues.

UTILIZATION MANAGEMENT PROGRAM INFRASTRUCTURE

EviCore's UM program is governed by the Health Services Quality Management Committee and granted authority by the Quality Management Committee (QMC). As mentioned above, EviCore offers eleven (11) innovative products/solutions. The UM program has a designated Chief Medical Officer (CMO) who is a board-certified physician and directly responsible for the oversight and management of the Utilization Review. Each select product/program has its own team comprised of licensed physicians serving as associate chief medical officer(s), medical directors or associate medical directors, certified and/or licensed clinical peer reviewers, registered nurses, licensed practical nurses, non-clinical staff and a wide array of support staff that make up a multidisciplinary team versed in collaborating to deliver a comprehensive yet individualized approach. The roles and responsibilities of the team members are delineated and defined within to prevent duplication of activities and further drive product efficiencies.

The Utilization Management Program Description is reviewed and renewed annually and defines the structure, goals, and objectives of the Utilization Management Program. It also summarizes policy, protocol, and the application of utilization management standards.

Governing Committees

Health Services Quality Management Committee (HS-QMC)

The mission of the committee is to promote the pursuit of quality excellence with a focus on systematic measurement, monitoring, and evaluation of operational and clinical performance with consistency, promotion, and implementation of strategies targeting improvement in the provision of care and services provided. Methodologies for measuring quality improvement include the PDCA (plan, do, check, act) or PDSA (plan, do, study, act) strategy, and/or the utilization of Lean Six Sigma principles and tools such as DMAIC (define, measure, analyze, improve, control) in support the delivery of safe, reliable and effective patient care services. Action plans are required to outline the identified area(s) in need of improvement, corrective action(s) to be taken, and the person(s) responsible for ensuring corrections within the timeframe identified for implementation.

Quality Management Committee

The Quality Management Committee (QMC) is comprised of both clinical and non-clinical representatives with oversight responsibility for activities associated with quality management, utilization management, and credentialing to ensure a well-integrated system that provides quality services to EviCore clients, members and providers. The Quality Management Committee, as delegated by the HS-QMC, provides the final approval to the UM Program content. The EviCore Chief Medical Officer retains responsibility for the overall operation of the QM program and serves as chair of the QMC with active participation and guidance. The CMO shall collaborate with fellow clinical peers when additional expertise is required in order to understand and improve an unfavorable outcome. In addition to the aforementioned members, the QMC also includes representatives from the Medical Director group, Medical Management group, Quality Services, UM Compliance and Audit, Appeals team, Consumer Engagement, Product Development, Client Management, Information Technology/Infrastructure, Legal/Compliance, and EviCore's Operations Excellence group. A health plan client representative may attend a QMC meeting upon notice. The QMC committee reviews the performance data and provides direction to the implementation of changes designed to continually improve program delivery. The QMC meets at least quarterly to assess and monitor key processes and associated metrics established through the **Key**

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Performance Indicators (KPI) (Attachment A). A quorum of at least fifty percent (50%) of the committee plus one (1) individual QMC member is required in order to conduct committee business. Each meeting agenda may include, but is certainly not limited to, the following:

- Status of annual QM/UM work plans
- Review of UM Key Performance Indicator (KPI) data with barrier assessment and intervention(s) formulation, as necessary
- Review of quality monitoring initiatives and progress on improvement projects
- Review of open Corrective Action Plans and strategies
- Review of vendor oversight performance and strategies for improvement
- Discussion of identified areas of opportunity involving quality of care

Quarterly QMC meeting minutes reflecting detailed discussion, decisions, actions, recommendations and meeting activities are recorded, maintained, and used internally for quality improvement purposes. The meeting minutes serve as a permanent record of QMC proceedings and are electronically signed by the QMC Chair upon approval.

Subsequently, they are then distributed to all appropriate EviCore administrators and maintained within EviCore QM/UM electronic folders for reference. The QMC is granted authority by EviCore's Compliance Committee with upward reporting to the EviCore Chief Executive Officer and parent company.

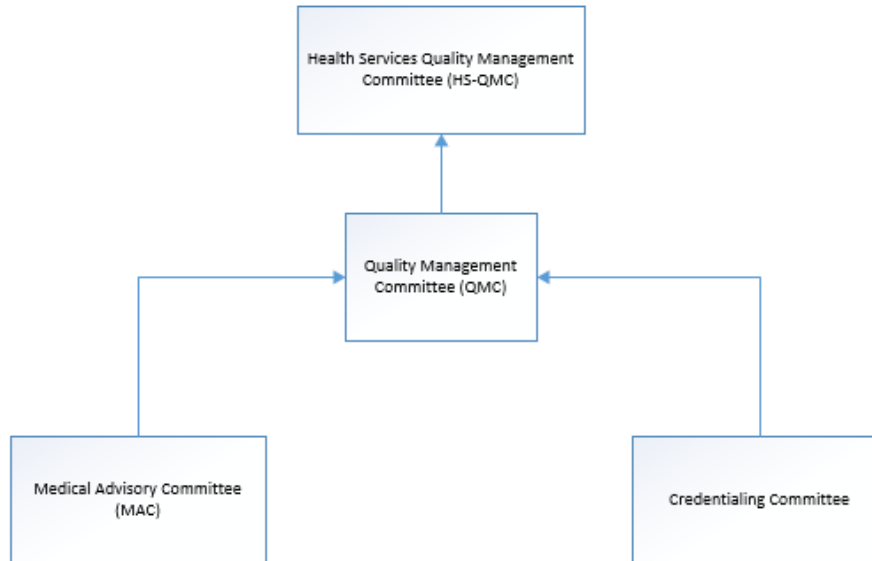
Medical Advisory Committee

The Medical Advisory Committee (MAC) is delegated responsibility for UM activities by the Quality Management Committee (QMC) that has final authority for all EviCore activities and for the execution of utilization review protocols and policies subject to review at the discretion of the QMC. Committee responsibilities include, but are not limited to, annual review of clinical guidelines across all programs/health plans, review and approval of newly developed clinical guidelines across all programs, review and approval of changes made to existing clinical guidelines across all programs, and acknowledgement of all health-plan specific clinical guidelines used in lieu of EviCore guidelines across all programs.

Credentialing Committees

The Credentialing Committee provides credentialing and re-credentialing of practitioners applying for participation and continuing participation in networks managed by EviCore and its subsidiaries. Additionally, the Credentialing Committee electronically reviews and determines a recommendation for second level provider appeals for utilization management denials. The committee establishes and maintains the policies and procedures related to credentialing activities include due process procedures and appeal hearings and ensures all policies/procedures are annually considered. The Credentialing Committee reports to the Quality Management Committee, is chaired by the applicable program Physician Team Captain with the co-chair licensed as a Doctor of Chiropractic and meets twice monthly.

eviCore healthcare Committee Structure 2024



SCOPE OF UTILIZATION MANAGEMENT PROGRAM

Prior Authorization Program

EviCore utilizes a prospective utilization management (UM) program (also referred to as a “prior authorization program”) as a key component in the overall strategy to align referring/ordering physicians and healthcare service providers in the provision of quality services to the member in an efficient and cost-effective manner contingent upon medical necessity.

The EviCore prospective utilization management program incorporates evidence-based clinical guidelines into a comprehensive approach to managing the utilization of advanced services. The results from a beneficial diagnostic exam will alter the physician’s clinical management of the member/enrollee’s disease process or will add confidence to the physician’s preliminary diagnosis.

The data collected as a result of the UM Program is analyzed and used by the Quality Management Program in developing and managing opportunities for enhanced delivery of services for the client health plans and consumers.

Radiology Program

EviCore’s Radiology Program delivers a superior, measurable impact regarding inappropriate advanced imaging utilization, quality of care, and overall reduction in expenditures by reviewing the appropriateness of advanced imaging requests against evidence-based clinical guidelines. The primary goal is to ensure patients receive the most appropriate evaluation based on their clinical presentations and diagnostic/treatment needs. The program reduces unnecessary radiation exposure and medically inappropriate use of intravenous contrast agent thus improving consumer safety.

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Modalities managed through this program include:

- Magnetic Resonance Images (MRI)
- Magnetic Resonance Angiograms (MRA)
- Positron Emission Tomography (PET) scans
- Computerized Tomography (CT) scans
- Computed Tomography Angiography (CTA)
- Nuclear Medicine

EviCore's Advanced Imaging program includes:

- *Prior Authorization*—Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *QPID Artificial Intelligence*—EviCore's industry-leading technology offers near-instant approval for healthcare providers who have demonstrated consistency in practicing within clinical guidelines. *QPID Artificial Intelligence* recognizes ordering patterns, applies robust evidenced-based clinical guidelines, and ensures the most appropriate imaging is performed at the right time for the right reason.
- *Claims Auditing and Payment* — This service ensures tests are coded and billed correctly.
- *Benchmarking and Reporting* — Measures provider/facility performance and makes relevant data available to payors through a variety of reports.

EviCore's Advanced Imaging guidelines are built on the foundation of nationally-accepted protocols, evidence-based clinical data, input from health plans, contributions from a panel of community physicians, and practicing clinicians from academic institutions. Our guidelines incorporate consensus/guideline statements from the following clinical specialty organizations and specialty societies:

- *American Academy of Family Physicians*
- *American Academy of Orthopedic Surgeons*
- *American College of Radiology*
- *National Comprehensive Cancer Network*

National resources reviewed include peer-reviewed literature such as:

- *American Family Physician*
- *European Journal of Emergency Medicine*
- *European Journal of Radiology*
- *Journal of Nuclear Medicine*
- *Journal of the American College of Surgeons*
- *Journal of the American Medical Association*
- *Magnetic Resonance Imaging Clinics of North America*

Ultrasound Management

EviCore's Ultrasound Management is encompassed within the Radiology Program and delivers a superior and measurable impact on utilization of ultrasound requests, quality of care, and overall reduction in expenditures by reviewing the appropriateness of ultrasound requests against nationally recognized clinical guidelines. The primary goal is to ensure patients receive the right tests based on their clinical presentations and diagnostic needs.

- *Prior Authorization* — Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *QPID Artificial Intelligence* — EviCore's industry-leading technology offers near-instant approval for healthcare providers who have demonstrated consistency in practicing within clinical guidelines. *QPID Artificial Intelligence* recognizes ordering patterns, applies robust evidenced-based clinical guidelines, and ensures the most appropriate imaging is performed at the right time for the right reason.
- *Claims Auditing and Payment* — This service ensures tests are coded and billed correctly.
- *Benchmarking and Reporting* — Measures provider/facility performance and makes relevant data available to payors through a variety of reports.

EviCore's Ultrasound guidelines are built on the foundation of nationally-accepted protocols, evidence-based clinical data, input from health plans, contributions from a panel of community physicians, and practicing clinicians from academic institutions. Our guidelines incorporate consensus/guideline statements from the following clinical specialty organizations and specialty societies:

- *American Academy of Family Physicians*
- *American Academy of Orthopedic Surgeons*
- *American College of Radiology*
- *American Institute of Ultrasound in Medicine*

National resources reviewed include peer-reviewed literature such as:

- *American Family Physician*
- *European Journal of Emergency Medicine*
- *European Journal of Radiology*
- *Journal of Nuclear Medicine*
- *Journal of the American College of Surgeons*
- *Journal of the American Medical Association*
- *Magnetic Resonance Imaging Clinics of North America*

Cardiac Imaging/Implantable Devices Program

EviCore's Cardiac Imaging program also entails the *Cardiac Implantable Devices* program (as described below). Cardiac Imaging ensures patients receive clinically appropriate cardiac imaging tests that contribute to timely diagnosis and care. The Cardiac Imaging Program reduces unnecessary radiation exposure and medically inappropriate use of cardiac diagnostic testing and invasive cardiac procedures. Results are achieved through decreased utilization of inappropriate cardiac imaging tests, redirection to less complex testing, reduced test duplication, and the elimination of high cost, poor quality studies that generate additional downstream cost and clinical risk. Also, by expanding the breadth of studies included, the program prevents providers from shifting from a managed modality to an unmanaged modality to avoid prior authorization requirements. The program addresses the following studies:

- Nuclear Cardiac (SPECT)

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- Transthoracic Echocardiography
- Transesophageal Echocardiography
- Stress Echocardiography
- CT for Coronary Calcium Scoring
- Coronary CTA
- Cardiac MRI
- Cardiac PET
- Cardiac SPEC
- Diagnostic Left Heart Catheterization
- Diagnostic Right Heart Catheterization

EviCore's Cardiac Imaging guidelines are built on the foundation of nationally-accepted protocols, evidence-based clinical data, input from health plans, contributions from a panel of community physicians, and practicing clinicians from academic institutions. Our guidelines incorporate consensus/guideline statements from the following clinical specialty organizations and specialty societies.

- *American College of Cardiology*
- *American Heart Association*
- *American Society of Nuclear Cardiology*
- *American College of Chest Physicians*

National resources reviewed include peer-reviewed literature such as, but not limited to:

- *American Journal of Cardiology*
- *Clinical Cardiology*
- *European Heart Journal*
- *International Journal of Cardiovascular Imaging*
- *Journal of the American College of Cardiology*
- *Journal of the American Society of Echocardiography*
- *Journal of Nuclear Medicine*
- *American Journal of Cardiology*

EviCore's Cardiac Imaging program includes:

- *Prior Authorization*— Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *QPID Artificial Intelligence* — EviCore's industry-leading technology offers near-instant approval for healthcare providers who have demonstrated consistency in practicing within clinical guidelines. *QPID Artificial Intelligence* recognizes ordering patterns, applies robust evidenced-based clinical guidelines, and ensures the most appropriate imaging is performed at the right time for the right reason.
- *Claims Auditing and Payment* — This service ensures tests are coded and billed correctly.
- *Benchmarking and Reporting* — Measures provider/facility performance and makes relevant data available to payors through a variety of reports.
- *Dedicated Cardiac Queue* — Reviews are performed by cardiac specialists including cardiologists and nurses who are experienced with the complexities of cardiac care.
- Specialized Pediatric Cardiac and Peripheral Vascular Disease (PVD) Guidelines

Cardiac Rhythm Implantable Devices

EviCore's Cardiac Rhythm Implantable Devices program identifies the clinical appropriateness of Permanent Pacemaker Implementation, Implantable Cardioverter Defibrillators (ICD) and Cardiac Resynchronization Therapy (CRT-D and CRT-P) implantation. Inappropriate implantation requests are a significant expense and carry serious patient risks including cardiac perforation, infection, and even death. Improved patient outcomes and increased savings result from reducing inappropriate procedures, reducing complications, and by providing evidence-based guidance to physicians.

EviCore's ICD program includes:

- *Prior Authorization* — Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *QPID Artificial Intelligence* — EviCore's industry-leading technology offers near-instant approval for healthcare providers who have demonstrated consistency in practicing within clinical guidelines. *QPID Artificial Intelligence* recognizes ordering patterns, applies robust evidenced-based clinical guidelines, and ensures the most appropriate imaging is performed at the right time for the right reason.
- *Benchmarking and Reporting* — Measures provider/facility performance and makes relevant data available to payors through a variety of reports.

EviCore's ICD guidelines are built on the foundation of nationally-accepted protocols, evidence-based clinical data, input from health plans, contributions from a panel of community physicians, and practicing clinicians from academic institutions. Our guidelines incorporate consensus/guideline statement from the following clinical specialty organizations, trials, and specialty societies:

• <i>The Multicenter Automatic Defibrillator Implantation Trial (MADIT and MADIT2)</i>	• <i>The American College of Cardiology</i>
• <i>The Sudden Cardiac Death in Heart Failure Trial</i>	• <i>The American Heart Association</i>
• <i>The Resynchronization/defibrillation for Ambulatory Heart Failure Trial</i>	• <i>The Heart Rhythm Society</i>
• <i>The Comparison of Medical Therapy, Pacing and Defibrillation in Heart Failure Trial</i>	• <i>The Cardiac Arrest Study Hamburg</i>
• <i>The Antiarrhythmic Versus Implantable Defibrillators Trial</i>	
• <i>The Canadian Implantable Defibrillator Study</i>	
• <i>The Sudden Cardiac Death in Heart Failure Trial</i>	
• <i>Immediate Risk Stratification Improves Survival Trial</i>	
• <i>The Multicenter Unstained Tachycardia Trial</i>	
• <i>Immediate Risk Stratification Improves Survival Trial</i>	
• <i>The Canadian Implantable Defibrillator Study</i>	
• <i>The Multicenter Unstained Tachycardia Trial</i>	

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- *The Resynchronization Reversers Remodeling in Systolic Left Ventricular Dysfunction Trial*

National resources reviewed include peer-reviewed literature such as:

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| <ul style="list-style-type: none"> • <i>American Heart Association Journal</i> • <i>New England Journal of Medicine</i> • <i>Journal of Cardiovascular Electrophysiology</i> | <ul style="list-style-type: none"> • <i>American Journal of Cardiology</i> • <i>Cardiac Electrophysiology Review</i> |
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Laboratory (Lab) Management

EviCore's Laboratory Management solution designed to improve quality of care, manage appropriate utilization of laboratory services as well as reduce inappropriate laboratory costs by enforcing >425 test-specific medical policies based on the most recent medical evidence. Prior authorization is performed on a strategic set of *Current Procedural Terminology (CPT)* codes and tests. In addition, significant reduction of inappropriate costs are obtained by leveraging thousands of lab-specific claims rules.

EviCore's Lab Management program includes:

- *Prior Authorization* — Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *QPID Artificial Intelligence*—EviCore's industry-leading technology offers near-instant approval for healthcare providers who have demonstrated consistency in practicing within clinical guidelines. *QPID Artificial Intelligence* recognizes ordering patterns, applies robust evidenced-based clinical guidelines, and ensures the most appropriate imaging is performed at the right time for the right reason.
- *Claims Auditing and Payment* — This service ensures tests are coded and billed correctly.
- *Benchmarking and Reporting* — Measures provider/facility performance and makes relevant data available to payors through a variety of reports.
- *Dedicated Laboratory Queue* — Reviews are performed by specialists who are experienced with the complexities of laboratory management.

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| <ul style="list-style-type: none"> • <i>American College of Medical Genetics</i> • <i>American Society of Clinical Oncology</i> • <i>American College of Obstetricians and Gynecologists</i> | <ul style="list-style-type: none"> • <i>American Heart Association</i> • <i>American Academy of Neurology</i> |
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The program addresses the following products:

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| <ul style="list-style-type: none"> • Large Carrier Screening Panels | <ul style="list-style-type: none"> • Pharmacogenomics | <ul style="list-style-type: none"> • Flow Cytometry |
| <ul style="list-style-type: none"> • Large Cancer Panels | <ul style="list-style-type: none"> • Cytogenetics and Microarray | <ul style="list-style-type: none"> • Molecular Infectious Disease |
| <ul style="list-style-type: none"> • Sequencing tests such as BRCA | <ul style="list-style-type: none"> • Immunohistochemistry | |

Musculoskeletal Management

EviCore's Musculoskeletal (MSK) Management program improves the quality and cost effectiveness of musculoskeletal services in innovative information technology, data management systems, evidence-based clinical pathways, and operational processes. The MSK program delivers a comprehensive suite of musculoskeletal solutions that focus on a patient-centered approach, promote evidence-based clinical decisions, and ensure the best outcome at the appropriate cost. EviCore's MSK Management offers clinical and administrative services. Our comprehensive program allows for the full spectrum of utilization and quality management based on these guidelines with services including utilization management and payment integrity. Our board-certified and specialized musculoskeletal clinical staff reviewers support the care review process using pathways that translate clinical guidelines into workflows supporting effective musculoskeletal care and holistic management of episodes of care. EviCore's MSK program includes:

- *Prior Authorization*— Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *Claims Studio*—This service appropriately applies all associated rules and edits for all the services we manage to ensure payment integrity.

EviCore's MSK evidence-based clinical criteria for the prior authorization of elective MSK procedures are developed by subject matter experts (SMEs) in the respective MSK specialties leveraging the highest level of evidence currently available published in peer-reviewed MSK professional journals. The MSK guidelines are internally reviewed by EviCore's MSK SMEs and by the EviCore Medical Advisory Committee. These clinical guidelines are externally reviewed by the medical policy teams of EviCore's clients and by national professional associations representing the various MSK specialties. Although the EviCore MSK clinical guidelines often align with the appropriate use criteria/clinical practice guidelines/coverage policy recommendations of these professional associations, these associations do not formally endorse EviCore's clinical guidelines.

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| • <i>American Academy of Neurology</i> | • <i>American Association of Hip and Knee Surgeons</i> |
| • <i>American College of Rheumatology</i> | • <i>American Pain Society</i> |
| • <i>American Association of Neurological Surgeons</i> | • <i>Spine Intervention Society</i> |
| • <i>American Academy of Orthopedic Surgeons</i> | • <i>American Academy of Orthopedic Surgeons</i> |
| • <i>American Society of Interventional Pain Physicians</i> | • <i>The American Orthopedic Society for Sports Medicine</i> |
| • <i>North American Spine Society</i> | • <i>American Physical Therapy Association</i> |
| • <i>American College of Occupational and Environmental Medicine</i> | • <i>American Occupational Therapy Association</i> |
| • <i>American Academy of Physical Medicine and Rehabilitation</i> | • <i>American Speech Language Hearing Association</i> |
| | • <i>American Society of Anesthesiologists</i> |

The program addresses the following products:

Interventional Pain Management

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- Epidural injections
- Facet joint injections
- Medial branch neurolysis
- Interventional pain procedure imaging
- Monitored anesthesia for interventional pain procedures

Spine and Large Joint Surgery

- Decompressions and fusions
- Arthroscopic, open, and joint replacement surgeries for the shoulder, hip, and knee

Specialized Therapy Management

- Physical
- Occupational
- Speech and language
- Chiropractic
- Acupuncture
- Massage

Radiation Oncology Management

EviCore's Radiation Oncology Management program promotes appropriate and cost-effective radiation treatment for our consumers by managing the appropriateness of modality, fractionation and image-guidance technology. Radiation Oncology guidelines are built on the foundation of nationally accepted protocols, evidence-based clinical data, input from health plans, and contributions from a Medical Advisory Board comprised of practicing Radiation Oncologists from academic institutions. Our guidelines incorporate consensus/guideline statements from the following clinical specialty organizations and specialty societies:

- *American Society for Radiation Oncology*
- *American Cancer Society*
- *American College of Radiation Oncology*
- *American College of Radiology*
- *NCCN® (National Comprehensive Cancer Network) Guidelines*
- *National resources reviewed include peer-reviewed literature such as:*
 - *International Journal of Radiation Oncology/Biology/Physics*
 - *Journal of Clinical Oncology*
 - *Journal of the National Comprehensive Cancer Network*
 - *Lancet Oncology*
 - *New England Journal of Medicine*
 - *Radiotherapy and Oncology*

Sleep Management

EviCore's Sleep program determines whether a requested sleep study is medically appropriate and can direct the member to convenient home testing options based on the patient's specific clinical indications. Members experience faster diagnosis and treatment resulting in lowered health risk, improved quality of life, and reduced expenditures.

- *Prior Authorization*— Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *QPID Artificial Intelligence*—EviCore’s industry-leading technology offers near-instant approval for healthcare providers who have demonstrated consistency in practicing within clinical guidelines. *QPID Artificial Intelligence* recognizes ordering patterns, applies robust evidenced-based clinical guidelines, and ensures the most appropriate imaging is performed at the right time for the right reason.
- *Claims Auditing and Payment* — This service ensures tests are coded and billed correctly.
- *Benchmarking and Reporting*—Measures provider/facility performance and makes relevant data available to payors through a variety of reports.

The program addresses the following products:

<ul style="list-style-type: none"> • Diagnostic Sleep Management 	<ul style="list-style-type: none"> • Treatment Sleep Studies 	<ul style="list-style-type: none"> • Continuous Positive Airway Pressure (CPAP) Equipment/supplies
<ul style="list-style-type: none"> • Wireless Sleep Monitoring Capabilities 	<ul style="list-style-type: none"> • Oral Sleep Appliances 	

Our guidelines are consistent with the *American Academy of Sleep Medicine* and the *Centers for Medicare and Medicaid Services*. EviCore’s Sleep guidelines are built on the foundation of nationally-accepted protocols, evidence-based clinical data, input from health plans, contributions from a panel of community physicians, and practicing clinicians from academic institutions. EviCore’s Sleep guidelines incorporate consensus/guideline statements from the following clinical specialty organizations and specialty societies.

- *American Academy of Sleep Medicine*
- *American College of Chest Physicians*

National resources reviewed include peer-reviewed literature such as:

	<ul style="list-style-type: none"> • <i>CMS Decision Memos</i>
<ul style="list-style-type: none"> • <i>Annals of Internal Medicine</i> 	<ul style="list-style-type: none"> • <i>Journal of Clinical Sleep Medicine</i>
<ul style="list-style-type: none"> • <i>Sleep</i> 	<ul style="list-style-type: none"> • <i>Current Opinion in Pulmonology</i>

Medical Drug Management

EviCore’s Medical Drug Management solution utilizes evidence-based guidelines to ensure clinically appropriate and safe use of non-oncology specialty drugs, guides drug administration to the lowest cost site of care, and ensures payment integrity of medical benefit billed claims. Our tools utilize flexible technology that improves operational efficiencies, captures necessary clinical information, and enables meaningful analysis and reporting. Providers receive coverage determination immediately upon completion of all relevant clinical information. The Medical Drug Management solution is designed primarily to manage specialty drugs covered under the medical benefit, however, we can work with clients to assume management of their drugs covered under the pharmacy benefit.

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EviCore's Medical Drug program includes:

- *Prior Authorization*— Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *QPID Artificial Intelligence*—EviCore's industry-leading technology offers near-instant approval for healthcare providers who have demonstrated consistency in practicing within clinical guidelines. *QPID Artificial Intelligence* recognizes ordering patterns, applies robust evidenced-based clinical guidelines, and ensures the most appropriate imaging is performed at the right time for the right reason.
- *Claims Auditing and Payment* — This service ensures tests are coded and billed correctly.
- *Benchmarking and Reporting* — Measures provider/facility performance and makes relevant data available to payors through a variety of reports.

Medical Oncology Management

EviCore's Medical Oncology solution incorporates treatment recommendations from the National Comprehensive Cancer Network (NCCN) Guidelines® via a proprietary Web-based decision support platform that covers all forty-four (44) cancer types supported by NCCN®. Recommended treatment options are based on each patient's individual clinical data and generally, choosing any one of the recommended options resulted in an immediate approval. Given patient variability and unique clinical circumstances, not all requested treatments will conform to NCCN Guidelines®. For those patients whose circumstances do not conform, EviCore's board-certified medical oncologists conduct a highly individualized clinical review of the requested treatment regimen. In the event that the requested regimen cannot be authorized/certified, EviCore will attempt to conduct a peer-to-peer discussion to examine alternative treatment options that are supported by published clinical evidence prior to issuing a non-certification. The result is very low non-certification rates of less than two (2) percent nationally. A single authorization is issued for all drugs in the primary regimen for a period of time sufficient to complete the entire course of treatment, or twelve (12) months in the case of metastatic disease where treatment may continue until progression. The program is designed to facilitate transparent representation of clinical guidelines, decision support through treatment recommendation, and creation of authorization records to facilitate claims payment in a format that minimizes the administrative burden on the ordering provider.

Post-Acute Care (PAC) Management

EviCore's Post-Acute Care (PAC) program coordinates, directs, and monitors the quality and cost effectiveness of health care resources. Utilization Management/Case Management (UM/CM) ensures that services are rendered in a timely manner, provided in the most appropriate setting and that services are planned, individualized, and evaluated for quality and effectiveness. The Care Coordinator aids in assisting the member's safe return to the community when appropriate or to the appropriate supervised care setting such as nursing facility or assisted living. The PAC Program works to assist the Health plan client in ensuring eligible members receive the most clinically-appropriate services in the most efficient manner possible, and to enhance consistency in reviewing cases by providing a framework for clinical decision making. Programs/solutions offered by EviCore PAC program includes:

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| • <i>Skilled Nursing Facility (SNF)</i> | • <i>Long-Term Acute Care (LTAC)</i> |
| • <i>Home Health Care (HHC)</i> | • <i>Transition of Care (TOC)</i> |
| • <i>Inpatient Rehab Facility (IRF)</i> | • <i>Durable Medical Equipment (DME)</i> |

PAC Facility Prior Authorization

EviCore promotes appropriate care and utilization through established procedures for applying criteria based upon the individual member medical necessity and community standards of care, thus minimizing administrative barriers for healthcare providers while promoting appropriate care. Prior authorization is required on PAC services to ensure timeliness and necessity/appropriateness of care. Case reviews are conducted telephonically, via fax referral, Allscripts, EviCore PAC portal or SFTP site. Prior authorization reviews are performed by clinicians who are licensed professionals with training and experience in UM. Potential non-certifications or cases requiring further review by a physician are facilitated to an EviCore Medical Director for review.

Transition of Care Management

EviCore provides transitional care management services, when delegated, with a focus on eligible members whose medical and/or psychosocial needs require moderate or high-complexity medical decision making during transitions in care. This transition in care may vary from an inpatient hospital setting to a lower level of care, including IRF, LTAC, SNF, and HHC or to the member's home or other community services. EviCore Care Coordinators assist with discharge planning as needed from PAC facilities to home to ensure the member has the appropriate support and services in the community for a safe transition home. EviCore's clinical staff perform assessments utilizing hospital medical records, patient/caregiver interview, and collaboration with hospital case management staff to recommend and coordinate services as needed.

Concurrent Review

Concurrent review is conducted onsite, via facsimile or telephonically as well as via EMR or PAC Facility. Registered Nurses, Licensed Practical Nurses, and Social Workers may conduct onsite or telephone-based concurrent review on all members admitted to inpatient rehabilitation facilities, skilled nursing facilities, and long term acute care facilities. The concurrent review process includes review of medical necessity, discharge planning, researching and coordinating alternatives to inpatient care, and care planning and assessments as indicated. In performing concurrent review, clinicians assess the member's progress (or lack of) and identified needs during each episode of care. Coordination of such needs prior to discharge help facilitate a smooth transition for the member between levels of care or home and to avoid unnecessary delays in discharge due to unanticipated needs of care. If a stay does not meet standard criteria, the case will be individually reviewed by the Medical Director and a determination rendered. Decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances requiring deviation from the norm.

EviCore's Post-Acute Care staff utilizes nationally recognized commercial criteria, which are objective, clinically valid, compatible with established principles of healthcare, and flexible. These criteria are used as general guidelines only to assess the quality of care and treatment, appropriateness, and/or in assigning length of certification authorized for a requested service. EviCore utilizes *Milliman Clinical Guidelines (MCG™)* criteria for clinical decision making in addition to CMS National and Local Coverage Determinations (NCDs/LCDs). In the application of these guidelines, consideration is given to the individual's age, comorbidities, complications, progress in treatment, psychosocial situation, and home environment when applicable, and special circumstances, which includes, but is not limited to, a member who has a disability, acute condition, or life-threatening illness.

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EviCore's PAC program includes:

- *Prior Authorization*— Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *Population Assessment & Member Risk Stratification* — EviCore obtains client claims, UM authorization, and demographic data prior to contracting to complete an in-depth analysis and identify opportunities to improve cost and quality of care by managing the post-acute care transition of care process. The analysis includes establishing a baseline of the population that includes the readmission rates within seven (7) and thirty (30) days, total cost of post-acute care and the episode of illness, trends by coverage category, age, ethnicity, and most frequent chronic conditions responsible for readmissions. Additional information on this process can be found in EviCore's policy and procedure titled *Assessment of Population and Risk Stratification (UM 0207)*.
- *Out of Network Care Coordination* — At the health plan's request, through delegation of out-of-network review, potential redirection to preferred providers will be attempted during the prior authorization process. Characteristics of the local delivery system and variables such as geographic access to appropriate services are discussed with the health plan and incorporated into the access plan.
- *Claims Auditing and Payment* — This service ensures tests are coded and billed correctly.
- *Benchmarking and Reporting* — Measures provider/facility performance and makes relevant data available to payors through a variety of reports.

Gastroenterology Management

EviCore's Gastroenterology solution ensures the appropriate use of endoscopic procedures and improves the quality of care by reducing the utilization of inappropriate endoscopies and colonoscopies through medical necessity reviews. Additionally, the program aids the member in identifying the most cost-effective sites of care for endoscopic procedures.

- *Prior Authorization*— Evidence-based guidelines are utilized to authorize imaging services. Providers have the option to consult specialized nurses, clinical peers and physicians on a case-by-case basis. This collaborative peer-to-peer approach is shown to improve practice patterns.
- *Site-of-Service Selection*—Improves the quality of care for the member by identifying the most cost-effective sites of care for endoscopic procedures.

The program addresses the following studies/procedures:

- Upper Gastrointestinal (GI) Tract Endoscopies
 - Esophagogastroduodenoscopy (EGD)
 - Capsule endoscopy
 - Endoscopic Retrograde Cholangio-Pancreatography (ERCP)
 - Enteroscopy
- Lower GI Tract Endoscopies
 - Colonoscopy
 - Sigmoidoscopy

Additional services offered through EviCore specific to the Gastroenterology Program include:

- Hospital outpatient surgery department
- Ambulatory surgery center

Our guidelines are built on the foundation of nationally-accepted protocols, evidence-based clinical data, input from health plans, contributions from a panel of community physicians, and practicing clinicians from academic institutions. EviCore's Gastroenterology guidelines incorporate consensus/guideline statements from the following clinical specialty organizations and specialty societies.

- *American Society of Gastrointestinal Endoscopy*
- *American College of Physicians*
- *American College of Gastroenterology*
- *American Gastroenterological Association*
- *US Multi-Society Task Force on Colorectal Cancer*
- *American Society of Anesthesiologists*
- *Canadian Association of Gastroenterology*
- *European Society of Gastrointestinal Endoscopy*
- *European Helicobacter Study Group*
- *European Society of Pathology*

Evernorth FamilyPath Fertility Solution

The Evernorth FamilyPathSM Fertility Solution combines fertility treatments and pharmacy care, access to expert fertility providers, and proactive patient support in a comprehensive solution that leads to simple, more cost-effective fertility-care decisions. Comprehensive cross-benefit coverage and integration drives down costs for patients and plans through management of effective fertility treatments and care networks. The FamilyPath fertility solution includes a range of benefit designs, management offerings, and medical network and engagement models to meet the needs of health plans, employers, and other groups seeking fertility benefit options. The goal of this comprehensive fertility management solution is to increase coverage and access for fertility services, to support consumers by helping to navigate through their fertility journey, and to do so in a clinically and fiscally responsible way for our clients.

Our comprehensive fertility solution includes the following fertility-specific components:

- Medical benefits and benefit management
- Network of specialists and labs
- Pharmacy benefit management
- Personal and digital member engagement with a team of Fertility Advisors
- FamilyPathSM digital app

The program addresses the following studies/procedures:

- Assisted reproductive services, including medical procedures, labs, and oral and injectable fertility medications.
 - Artificial insemination/intrauterine insemination (AI/IUI)
 - In vitro fertilization (IVF)
- Pre-implantation genetic testing
- Cryopreservation and storage of oocytes, sperm, and/or embryos

FamilyPathSM also provides optional referral programs for adoption and third-party reproduction/surrogacy. Please note that inpatient procedures and treatments for certain underlying medical conditions impacting fertility are not included.

Our guidelines are built on the foundation of nationally-accepted protocols, evidence-based clinical data, and contributions from both academic and community clinicians. The Evernorth FamilyPathSM guidelines incorporate consensus/guideline statements from the following clinical specialty organizations and specialty societies:

- *American Society for Reproductive Medicine (ASRM)*
- *American Urological Association (AUA)*
- *American College of Obstetricians and Gynecologists (ACOG)*

Behavioral Health Management

EviCore is not delegated behavioral health management services for any client. Should EviCore become delegated, EviCore will implement policy and procedures and have a designated behavioral healthcare program accompanied by appropriate behavioral healthcare practitioners involved in the implementation and evaluation of the behavioral healthcare aspects of the UM program.

PRIOR-AUTHORIZATION REQUEST PROCESS

Type of Requests

Pre-Service/Prospective – Service requested for review/authorization that has not been performed

Concurrent — Service requested for coverage of medical care or services made while a member is in the process of receiving the requested medical care or service(s)

Post-Service/Retrospective — Service requested for review/authorization that has already been performed

Appeal – Service has been reviewed and non-certified/denied in the Pre-Service or Retrospective review and a second review is being requested

Initiating a Request

Standard/Routine requests follow the normal pre-authorization process and timelines for completion. The request may be initiated via mail, a toll-free telephone number between the hours of 7AM – 7PM local time, a toll-free fax number or our secure website which is available twenty-four (24) hours per day, seven (7) days per week. Post service/retrospective requests will follow the standard/routine timelines for completion as the study/service has already been rendered.

Urgent/Expedited requests are initiated telephonically, fax and/or website, where applicable, and are dependent upon client/program. Urgent pre-service requests are defined as any request for medical care or treatment that must be approved, in whole or in part, prior to the member obtaining the medical care or service(s). Urgent pre-service or concurrent requests are clinically urgent requests to which the application of the time periods for making a routine or non-life threatening determination could result in the following:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse consequences without the care or treatment that is the subject of the request.

Therefore, the request is unable to follow the standard process and timeframes. Urgent requests that do not meet the urgent definition requirement will be downgraded by a Clinical Reviewer and documented in the case with the exception of Medicare requests. Urgent requests submitted via telephone, secure website, email, or fax for Medicare members will not be downgraded by EviCore.

Urgent Concurrent requests are urgent requests for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care (i.e., an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments). Concurrent review determinations are typically associated with inpatient care (continued stay review) or ongoing ambulatory care. Concurrent review determinations are based solely on the medical information obtained at the time of the review determination and the frequency of reviews for the extension of treatment is based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity. The urgent definition must be met in order to process a request under the urgent concurrent time frame. If urgency is not demonstrated, the request may be reclassified as pre-service or post-service and processed in accordance with the corresponding time frame.

Customer Expedited requests are for patient convenience and dependent upon EviCore client wishes. A Customer Expedited request may be submitted if the referring provider is located in close proximity to the imaging center, but the member lives a significant distance from the facility (sixty minutes/ sixty miles). If the study is not same-day, the routine pre-authorizing process should be followed. See EviCore Policy & Procedure *Clinical Certification of Services (UM 0045)* for additional details.

Emergency Services

Emergency services are necessary for medical conditions manifesting by acute symptoms of sufficient severity, such as pain, that in the absence of immediate medical attention, could reasonably expect to result in placing the member's health in serious jeopardy, serious impairment of bodily function or serious dysfunction of a body organ or part. Prior authorization for emergency services performed during an inpatient or emergency room visit do not require prior authorization in any EviCore program and are not managed by EviCore.

Accessibility

Prior authorization is required for claims payment of selected procedures or treatments as defined by the contract with each client health plan. To ensure that members, authorized representatives, providers, and facilities are provided timely access to appropriate utilization management staff, the EviCore Utilization Management Department is staffed Monday through Friday from 7:00am to 7:00pm in the member's local time zone and may be reached by mail, fax toll-free, toll-free phone or via secure website at www.evicore.com, which is available twenty-four (24) hours per day, seven (7) days per week. Clinical certification services may be extended for additional hours by contractual requirement or state law, as applicable (see EviCore's *Accessibility Policy (UM 0032)* for additional details). Requests performed during an inpatient or emergency room visit do not require prior authorization by EviCore for claims payment at this time. EviCore's Medical Directors and/or Clinical Peer Reviewers, as applicable and permitted, conduct reviews to render medical necessity determination for all requests that do not meet clinical guidelines based on initial screening and/or initial clinical review.

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If an emergent request is performed on an outpatient basis, clinical documentation from the requesting provider regarding the nature of the emergency may be requested for retrospective review in order to determine the nature of the emergency that precluded obtaining prior authorization and the medical appropriateness of the request performed.

EviCore offers twenty-four (24) hours per day/seven (7) days per week access to submit requests for prior authorization. Weekend, holiday and after-hour requests for these procedures will be processed on the website, faxed to the department, or recorded on the department's voicemail and will be processed in accordance with EviCore's *Accessibility Policy (UM 0032)*.

All Clinical Peer Reviewers are available for peer-to-peer discussions and can be accessed via the physician-line telephone prompt that is offered as part of each health plan toll free number and/or by conveniently accessing EviCore's website at www.evicore.com. Requests for discussion with a clinical peer may also originate through Customer Service or other service departments. Referring providers may request consultation with any medical director, the medical director who rendered a determination and/or a same/similar specialist or clinical peer with respect to the service under consideration. Requests for peer-to-peer discussion are responded to within one (1) business day. If the physician who rendered the determination on the request is not available to speak with the ordering practitioner, another appropriate clinical peer reviewer will be made available within one (1) business day of the request. Additional information may be found in EviCore's policies and procedures: *Accessibility (UM 0032)*, *Clinical Peer Reviewer Referral (UM 0030)*, and *Reconsiderations and Peer-to-Peer Discussions (UM 0031)*.

Linguistic and cultural accommodations are made for all members who need them:

- EviCore makes TDD/TTY (Telecommunications Device for the Deaf and Teletypewriter) services for the hearing and speech impaired via the member's health plan TDD/TTY telephone numbers. Landmark also provides a TTY line for hearing impaired individuals (888) 565-4236.
- Language assistance for non-English speaking/Limited English proficient (LEP) individuals to discuss utilization management services are provided by certified interpreters via EviCore's vendor, *CQ Fluency*, and is free of charge.
- Dedicated staff, including the Landmark Member Advocate, are available to speak with visually impaired members or members who are unable to read English and will assist as necessary through the UM or grievance process. Visually impaired members will be provided large print materials and grievance forms upon request.
- Written communications, such as UM determination letters, are translated for non-English speaking members upon request as required by law or contract.

Reviewing a Request

Service requests initiated telephonically are entered into the EviCore electronic case management system by non-clinical staff that collect demographic information and structured clinical information via algorithms/pathways. Requests that are not systematically authorized/certified will be forwarded onto a licensed Clinical Reviewer for initial Clinical Review. The non-clinical staff in no way interprets nor evaluates a request for medical necessity.

Clinical Reviewers assess the entirety of clinical information submitted with the request in accordance with evidence-based clinical guidelines to determine if the requested service(s) can be authorized/certified or if enough clinical information has been received for the Medical Director, or Clinical Peer Reviewer where appropriate, to make an accurate and valid determination. If it is determined that there is insufficient clinical present, the request may be pending in accordance with the client health plan, state and federal guidelines in order to capture the missing information. Attempts to obtain the clinical information are performed via phone and/or fax for a specified amount of time/number of attempts in accordance with client, state and federal agreement. Failure to receive the needed

information in the given timeframe will result in the request being sent to an EviCore Medical Director, or Clinical Peer Reviewer where appropriate, for medical necessity review with any/all clinical information in the case, and a medical decision will be rendered. Only a Clinical Peer or Medical Director may issue an adverse determination.

Determination and Notification of Request

The determination of the request is communicated verbally to both the provider and member in accordance with health plan guidelines and state/federal requirements. Verbal notice may be completed utilizing one of EviCore's automated notification systems and/or a live, non-clinical agent. Regardless of the method used, the post-determination right of a peer-to-peer conversation along with any other additional post-decision review options is provided in accordance with health plan contract and applicable state and federal guidelines (reference EviCore policy and procedure *Notification of Clinical Certification- Approved and Adverse Determinations [UM 0118]* and *Non-Certification of Request for Services [UM 0029]*). Additionally, the decision is also communicated to both the member and provider via written notice in accordance with client, state/federal requirements and additional review options, as applicable to client/business, detailed in the written notice of determination (see EviCore Policy & Procedure *Notification of Clinical Certification- Approved and Adverse Determinations [UM 0118]* and *Non-Certification of Request for Services [UM 0029]*).

Appealing an Adverse Determination

There may be instances where a member, member's representative, or physician is not satisfied with the review decision. EviCore has established policies and procedures for responding to grievances and appeals (see EviCore Policy & Procedure *Appeals EviCore [UM 0209]* and/or applicable state addendum or *Medicare Appeals-Utilization Management [UM 0209-Medicare UM]*, as applicable). Appeal procedures are designed to provide a full and fair process for responding to member requests to reconsider a decision they find unacceptable regarding their care and service. The client retains all responsibility for formal appeals processing unless all or part of the appeal process is delegated to EviCore. The appeal function may or may not be delegated for the programs that EviCore administers. The scope of appeal delegation is defined in the agreement with the client. When requested from the health plan, EviCore will make available the entire clinical documentation file related to the adverse determination within one (1) business day of receipt of request, unless otherwise agreed upon timeframes exist. Appeals processing is a formal and distinct process separate from peer-to-peer and reconsideration options designed by clients to meet their individual needs and are designed to provide a full and fair process in responding to member requests for additional review/reconsideration. Appeals delegated to EviCore must be submitted via telephone, fax, website, email, or mail (or as determined by client) within one hundred eighty (180) calendar days of initial adverse determination (or as determined by client) and may be initiated by the physician, member, member's designee or the requested facility (upon request of the member). The timeframe for appeal submission may be shorter where defined by regulatory requirement or longer where required by health plan contract (see EviCore's specific Appeal Addendums per state). The appeal process commences upon receipt of a valid appeal request and documented in EviCore's electronic database.

EviCore will conduct appeals within the timeframes that are reasonable for the type of appeal and may expedite (accelerate) a standard appeal review upon request.

- A pre-service appeal is a request to change an adverse determination for care or service that the organization must authorize, in whole or in part, in advance of the member obtaining the care or service(s).

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- An expedited appeal is available for pre-service authorizations upon request when the urgent/expedited criteria have been established and evident. Requests for expedited/urgent appeal review are permitted to be downgraded to the standard/routine priority should the clinical information fail to necessitate urgency/lack evidence of meeting the urgent definition above, and dependent upon plan type and/or state regulation requirements.
- All other pre-service appeals will be processed under standard priority.
- A post-service appeal is a request to change an adverse determination for care or service(s) that have already been received by the member. EviCore does not process post-service appeals under the expedited priority; post-service appeals are processed as routine/standard priority.
- An external appeal is a request for an independent, external review of the final adverse determination (FAD or internal appeal determination) made by the organization through its internal appeal process.

If EviCore is delegated decisions about coverage for an ongoing course of treatment, before the end of the period of time or number of treatments previously approved, the member will have continued coverage pending the outcome of an internal appeal.

Internal EviCore appeal policies are available upon request to the member, authorized representative, the ordering and/or rendering provider. EviCore will not retaliate or take any discriminatory action with respect to a member or a healthcare provider that is intended to penalize the member, member's authorized representative, or the member's healthcare provider for initiating an appeal, dispute resolution, or judicial review of an adverse determination.

Appeal Review

Once the appeal is initiated and priority of the appeal established, it follows the same review process as an initial request with review of all relevant documentation considered (including the information that was relied upon for the previous decision). EviCore ensures that all delegated appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in the decision. Therefore, if an appeal cannot be authorized/certified at the clinical reviewer level, it is reviewed by a Medical Director/physician who was not involved in the initial adverse decision (nor a subordinate) and who has the same or similar specialty as typically manages the medical condition, procedure or treatment as mutually deemed appropriate. Additionally, the appeal reviewer must be located in a state or territory of the United States while conducting the appeal review and must also be currently board certified (if applicable) by: a specialty board approved by the *American Board of Medical Specialties* (doctors of medicine); or the *Advisory Board of Osteopathic Specialists* from the major areas of clinical services (doctors of osteopathic medicine); or the *American Dental Association's (ADA)* specialty boards or *American Board of General Dentistry (ABGD)*; or the *American Board of Podiatric Surgery (ABPS)* or the *American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)*.

For every appeal the appeal reviewer accepts, they attest that they have the scope of licensure that typically manages the medical condition under review and that they have current, relevant experience and/or knowledge to render a determination for the request under review.

Appeal Determination and Notification

Written notification for all appeal decisions will be issued to the member, the authorized member representative, the ordering provider or the facility rendering the service. The determination of an appeal is communicated verbally as well to the provider and/or member according to health plan guidelines, applicable accreditation standards, and state/federal regulation requirements. Reversals of non-certification determinations are issued within the same timeframes and include a valid authorization number as well as an approval date. EviCore implements a decision to

overturn an adverse decision by approving the request in the electronic data base. The verbal notice advises of the final determination along with any applicable additional options for review including peer-to-peer consultation and/or further appeal options consistent with health plan contract and applicable state/federal requirements. These options are also detailed in the written notice and accompanied with other required information per regulatory requirements (see EviCore's Policy & Procedure *Appeals EviCore [UM 0209]*).

All records related to appeals are maintained in accordance with enterprise policy and procedure *Global Records Management Policy (RM.00.0)* and EviCore's *Appeals EviCore (UM 0209)* policy. EviCore's electronic database system maintains a register of first level, second level, and external appeals containing the below:

- General description of the reason for the appeal
- Date the appeal was received
- Date of each review/review meeting
- Resolution at least level of appeal
- Date of resolution at each level
- Name of the aggrieved person for whom the appeal was filed

Timeliness			
<u>Request Type</u>	<u>Decision Standard</u>	<u>Verbal/e-Notification</u>	<u>Written Notice</u>
Standard Pre-Service	<p>Within 2 business days of receipt of necessary information, not to exceed 15 calendar days from receipt of request</p> <p>*Within 14 calendar days from receipt of request for Medicare/Medicaid</p>	<p>Within 2 business days of receipt of necessary information, not to exceed 15 calendar days from receipt of request</p> <p>*Within 14 calendar days from receipt of request for Medicare/Medicaid</p>	<p>Within 2 business days of receipt of necessary information, not to exceed 15 calendar days from receipt of request</p> <p>*Within 14 calendar days from receipt of request for Medicare/Medicaid</p>
Urgent Pre-Service	<p>Within 24 hours of receipt of necessary information, not to exceed 72 hours of request</p>	<p>Within 24 hours of receipt of necessary information, not to exceed 72 hours of request</p>	<p>Within 24 hours of receipt of necessary information, not to exceed 72 hours of request</p>
Urgent Concurrent Review	<p>Within 24 hours from receipt of request</p> <p>*Within 72 hours from receipt of request for Medicare/Medicaid</p>	<p>Within 24 hours from receipt of request</p> <p>*Within 72 hours from receipt of request for Medicare/Medicaid</p>	<p>Within 24 hours from receipt of request</p> <p>*Within 72 hours from receipt of request for Medicare/Medicaid</p>
Retrospective Review	<p>Within 30 calendar days from receipt of request</p>	<p>Within 30 calendar days from receipt of request</p>	<p>Within 30 calendar days from receipt of request</p>
Appeal	<p>Within 30 calendar days from</p>	<p>Within 30 calendar days from</p>	<p>Within 30 calendar days from</p>

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Standard	receipt of valid request	receipt of valid request	receipt of valid request
Appeal Urgent	Within 72 hours from receipt of valid request	Within 72 hours from receipt of valid request	Within 72 hours from receipt of valid request

*The above timelines are general; specific timelines are based upon requirements of applicable state laws, standards and health plan requirements with most stringent requirement being followed per EviCore.

Consumer Engagement/SmartChoice Program

EviCore provides individual members the information they need to make informed treatment decisions through our *SmartChoice* program. This program empowers members to control their imaging facility choices by choosing from convenient imaging locations based on a preferred geographic area that are part of their chartered network. *SmartChoice* serves as an EviCore outreach service to educate members on their procedures and options. In addition, EviCore acts as a concierge to the members by providing transparency into the quality of facilities, cost of services, as well as scheduling of appointments. Our Advanced Imaging program contains two (2) aspects:

Prior Authorization

- Evidence-based guidelines are utilized to authorize imaging services
- Once a request has been deemed authorized/approved, members are provided with the aforementioned concierge services above

Site of Care Self-Referral

- Client-provided member information is received and proactive outreach is initiated

Members are provided with the aforementioned concierge services above.

Clinical Guidelines/Evidence-Based Decision Making

Evidence-based medicine is the conscientious and judicious use of reliable, well tested, clinically reliable medical data in rendering decisions about the care of individual patients. The practice of evidence-based medicine typically means integrating clinical expertise with the best available external clinical evidence from systematic research.

EviCore's clinical guidelines are documents that define the clinical indications for all services in all programs where EviCore is contracted to provide benefit management and clinical certification for coverage. The clinical guidelines serve as the basis for the clinical review algorithms/pathways. Additionally, they are objective, clinically valid, parallel to established principles of healthcare and yet flexible enough to allow deviations from the norm to accommodate individual circumstances and the local delivery system (see EviCore policy and procedure *Guidelines [UM 0021]* for additional details). To ensure appropriate determinations of medical appropriateness for clinical services are adjudicated, development of clinical guidelines with involvement from appropriate healthcare providers with current knowledge relevant to the material under review is executed. Additionally, the guidelines are based on current evidence-based medical principles, evaluated at least annually and updated as necessary by the appropriate approval authority, and accessible to members and providers as appropriate and upon request.

EviCore has developed and maintains evidence-based clinical guidelines to evaluate each of our programs. The guidelines are based on nationally accepted protocols, clinical evidence, and actual experience with health plans. The guidelines are not intended to supersede or replace sound medical judgment but facilitate the identification for the most appropriate procedure/treatment given the enrollee's clinical condition. Our evidence-based guidelines are in keeping with best medical practice as supported by clinical literature. EviCore clinical guidelines are based on domestic

and international research of the appropriate specialty-based scientific literature, and incorporates guideline statements from leading clinical specialty organizations but not limited to:

- *American College of Radiology (specifically, their Appropriateness Criteria);*
- *American College of Cardiology and the American Heart Association;*
- *Kerr L. White Institute for Health Services Research (Emory School of Medicine);*
- *American Academy of Orthopedic Surgeons*
- *Intersocietal Accreditation Commission*
- *American Board of Sleep Management*

Medical review determinations are rendered by UM staff members. A licensed clinical peer or medical director or other licensed, delegated, physician renders all adverse medical decisions. EviCore ensures that all licensed employees who make medical necessity-based coverage decisions, and those who supervise them, base their determinations only on the appropriateness of care. The process of utilization management does not include any bonus or other incentive for denials of medically necessary services and are not based directly on the utilization of services.

To ensure EviCore does not engage in unnecessary repetitive contacts with provider/consumers to obtain information relevant to the request, when conducting routine prospective and retrospective utilization review, all reasonable efforts are made to gather only the information necessary to authorize a request. Providers are not routinely required to numerically code diagnosis (es) or procedure codes in order to be considered for clinical certification and medical records are not routinely requested for all patients; only when there is difficulty in making a review determination or as otherwise required. Prospective and concurrent certification determinations are based solely on the medical information obtained at the time of the review determination. As such, retrospective review determinations are based solely on the clinical information available to the requesting provider at the time the service was rendered. All information relevant to the clinical certification request is considered when a determination is rendered and is maintained in the electronic record including documentation of the original request and any negotiation and/or agreement to accept an alternative clinical service, along with all verbal exchanges and related written correspondence.

Every year, EviCore's panel of expert physician reviewers conduct a formal and stringent review of all EviCore clinical guidelines with updates and recommendations as appropriate. Re-drafts and updates to the guidelines are performed by a team of in-house medical directors knowledgeable in their specific program guidelines.

Clinical guidelines adopted for EviCore use that are externally created, such as commercial criteria (i.e., *NCCN [National Comprehensive Cancer Network]*, *CPGs [Clinical Policy Guidelines]*, or *MCG™*) are reviewed annually and/or as changes are made by the commercial proprietor and approved for use by the applicable program Team Captain and EviCore CMO. Commercial criteria liaisons within EviCore are responsible for continually monitoring the commercial criteria for revisions, communicating applicable updates to EviCore program Team Captains and ultimately to the MAC and QMC for review/approval/execution.

These drafts/executive summaries of revisions/changes are then sent for review and comment by our expert panel comprising the Medical Advisory Committee (MAC), all of whom are practicing clinicians and acknowledged experts in their relevant fields and pertinent specialties. The clinical guidelines are also reviewed and approved by the designated council or committee of the health plan to ensure continued compliance and relevance to the defined goals and objectives. Upon approval, the EviCore clinical guidelines are posted internally, published to the EviCore website for

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external-facing clients and distributed to interested health plans and applicable regulatory agencies. An executive summary of changes to all guidelines are posted to the EviCore website with redlined versions outlined prior to actual deployment of updates. This allows greater transparency in the provider population and a more holistic view of alterations in guidelines with ample time for adjustment.

Clinical guidelines approved for use are forwarded to the applicable EviCore team who updates the automated pathways/algorithms for the clinical data collection application as necessary. Upon completion of criteria revision integration, the system changes are reviewed and tested by the program Physician Lead(s) and/or designees to validate the accuracy and consistency with criteria. Upon successful testing, the updated pathway/algorithm is deployed into the “live” production environment. Changes to the criteria and pathways/algorithms are communicated to all applicable clinical staff by the program Physician Lead(s) and/or designee.

Archived copies of previous versions of all EviCore and health plan-specific utilization criteria for all programs are maintained in the EviCore systems to be retrieved and released as deemed necessary. Additional details surrounding the management of EviCore’s clinical guidelines and EviCore’s Medical Advisory Committee processes can be found respectively in EviCore’s internal policies titled *Guidelines (UM 0021)* and *EviCore Medical Advisory Committee (QM 0282)*.

EviCore Policy & Procedure

EviCore maintains established protocols for the development, revision, editing, and implementation of policies and procedures at least annually. In accordance with enterprise policy *CIG.GEN.001 Compliance Department Policy Development and Retention* and EviCore’s *Annual Review of EviCore Program Documents [UM 0210]* and regulatory requirements, all EviCore policies and procedures are reviewed for applicable updates and amendments in order to reflect the organization’s most current practice. Once revisions are approved by the responsible department leader/approval authority and effectuated, the policies are then sent to the Quality Management Committee (QMC) for review, suggestions and approval for use. Department supervisors/managers remain responsible throughout the year for distributing the policies/procedures to those employees, consultants, and independent contractors with follow through on implementation and/or communication plan of any new, revised or retired policy applicable to their department. The most updated version of policies and procedures remain current and accessible to all impacted employees, consultants, and independent contractors throughout the year via the internal enterprise intranet site, “Iris”. EviCore maintains a fluid master list of policies and procedures that encompass pertinent dates such as date of revision, date of effectuation, approval authority, and date of QMC approval.

Evaluation of New Technology

EviCore evaluates the inclusion of new technology and the new application of existing technology in its benefit plan, including medical procedures, pharmaceuticals and devices in order to keep pace with the evolution of healthcare and ensure our consumers have equitable access to safe and effective care. New developments in clinical services may take the form of entirely new imaging technologies, drug therapies, devices or novel applications of existing technology. Such changes are evaluated for clinical efficacy and safety by the Chief Medical Officer (as applicable)/Associate Chief Medical Officer and issue a policy amendment (as appropriate) or have the material distributed to members of EviCore’s Medical Advisory Committee (MAC). Review of information from appropriate government regulatory bodies, published scientific journals, relevant specialists and/or other applicable sources is gathered and distributed to the MAC members who then recommend acceptance or rejection of the new technology based upon its best assessment of the evidence presented. Committee feedback and recommendations are communicated to the interested clients with implementation of any policy/process changes related to new technology contingent upon agreements with the client and are subject to their approval. EviCore does not manage any behavioral healthcare products at this time and, therefore, does not review

new technology/changes in technology in relation to behavioral healthcare. EviCore's policy and procedure *Evaluation of New Technology (UM 0134)* provided further details of EviCore review of new technology.

NCQA Accreditation

The *National Committee for Quality Assurance (NCQA)* is a private, not-for-profit organization dedicated to improving health care quality. The organization is frequently referred to as a "watchdog" for the managed care industry with a mission to improve the quality of health care by generating useful, understandable information about health care quality to help inform consumer and employer choice. NCQA also generates information and feedback that help physicians, clients and others to identify opportunities for improvement and make changes enhancing the quality of patient care. As such, EviCore has achieved compliance with the rigorous clinical quality and service standards of NCQA for the last twenty-two (22) years (both entities included) with the use of best practices within our UM and QM programs. This distinction reflects EviCore's continued commitment to providing the highest quality of services.

URAC Accreditation

URAC, an independent, nonprofit organization, is well known as a leader in promoting health care quality through its accreditation and certification programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. URAC's mission is to promote continuous improvement in the quality and efficiency of health Utilization Management through processes of accreditation and education. EviCore continues to demonstrate commitment to quality as evidenced by our continued URAC accreditation status since 2001 and commended for promoting quality health services.

UM Work Plan

Each year, EviCore develops its plan of initiatives to improve clinical service quality through collaborative efforts. This process is outlined in the annual UM Work Plan, along with individual project plans which support the work plan and provide detailed goals that are tracked and reported throughout the year. Also included in the EviCore UM Work Plan are the target dates of completion along with actual completion dates, allowing EviCore to maintain an aim of focus and assess progress. The work plan is reviewed and approved annually by the Quality Management Committee with membership designed to promote inter-departmental cooperation in addressing efficiency and quality opportunities across all EviCore business activities.

Consumer Safety & Stakeholder Involvement

Improving the culture of safety within healthcare is an integral component in preventing or reducing errors and improving overall healthcare quality for the consumers we serve. Strategies to address consumer protection and safety necessitates partnership, vigilance, and collaboration across the continuum of care to identify solutions to consumer safety issues. As such, EviCore continually maintains at least one Quality Improvement Project (QIP) pertaining to consumer safety aimed at avoiding undesirable results or situations for our consumers as they are a vital factor contributing to positive health outcomes. Additional procedures and efforts in identifying and resolving consumer

safety issues are outlined in EviCore policies *Consumer Safeguard Mechanisms (QM 0111)* and *Quality of Care Concern Reporting (QM 0183)*.

Diversity, Equity and Inclusion in the Work Place

Within the enterprise, we aim to foster an inclusive culture that leverages the strength of diversity to serve our customers and patients, enhance employee engagement and empowerment, and drive organization success. To achieve this goal, it is important that our workforce reflects the 1 in 3 Americans that we touch so that we can best meet and anticipate their needs. Not only do we want to attract and create a workforce that reflects that, we want EviCore to be a place where people can bring their true selves to work and grow their careers here. As such, EviCore maintains guidance for establishing diversity, equity, and inclusion Employee Resource Groups (ERGs), employee-led groups formed around common interests, etc. and designed to provide a space and place for people of similar backgrounds or interests to come together. Please reference EviCore's *Guidebook for Establishing Diversity & Inclusion Employee Resource Groups* found on the internal EviCore intranet.

Diversity: The collective mixture of differences and similarities that include individual and organizational characteristics, values, beliefs, preferences, and behaviors. The factors that make up diversity are limitless. Examples include race, gender, national origin, age, sexual orientation, disability, and veteran status, just to name a few.

Equity: The quality of being fair and impartial

Inclusion: The achievement of a work environment in which all individuals are treated fairly and respectfully, have equal access to opportunities and resources, and can contribute fully to the organization's success.

Crisis Calls

EviCore places high importance on ensuring mechanisms are in place to respond on an urgent basis to situations that pose an immediate threat to the health and safety of our consumers. In accordance with the organization's internal policy (*Consumer Safeguard Mechanisms [QM 0111]*), EviCore maintains specific work flows and processes to be executed upon the discovery of a Crisis Call, encompassing both behavioral health as well as medical health crises. Crisis Call procedures are maintained within the EviCore intranet for ease of access including note templates and scripting to aide in the event of an emergency. Annual mandatory training for applicable staff is also completed to ensure EviCore employees are well-versed and knowledgeable on Crisis Call procedures.

Business Continuity and Disaster Recovery

EviCore exercises a combination of preventative and recovery controls/processes, including disaster and emergency response procedures, to reduce the risk of loss of confidentiality, integrity, and availability of services. As such, a contingency plan (commonly called a business continuity plan) is maintained within EviCore with documented disaster and emergency recovery strategies. Internal testing is completed annually, and as necessary, taking reasonable steps to ensure up-to-date procedures are maintained and effective based upon plan assessment and testing results. Thereafter, the plan is reviewed with recommended revisions, as necessary, to address any issues identified in the testing of the disaster recovery plan. For additional details on EviCore's business continuity and disaster recovery process, please refer to EviCore policy/procedure *evi-IT-118 Contingency Plan*.

Delegation Oversight

The tracking and trending of client satisfaction with EviCore services is primarily achieved through the collection and analysis of annual health plan audit data as well as intermittent meetings with the client conducted throughout the year on an agreed upon cadence. EviCore participates in various audits with clients over the course of the year, including

pre-delegation, annual delegation, URAC monitoring, CMS Data validation and Clinical Decision Making, state regulatory, and state market conduct examinations. Additionally, EviCore partners with our clients to perform individual focused audits for specific areas of client interest. Those audits range from weekly to monthly and cover such items as turnaround times, case processing and documentation, appeal processing, policy and procedure updates, letter template review and updates as well as denial rationale readability. All audit findings are addressed through the corrective action plan process and remediation steps put in place to correct any identified findings as deemed necessary.

Hard copy and electronic files are provided for off-site evaluation by the health plans performing internal *CMS*, *URAC*, *NCQA* and state regulatory compliance audits. EviCore's staff frequently attend the *CMS* audits either in-person or virtually in order to provide direct client support. Health plan clients are also provided secure direct access to EviCore's electronic certification database for ad hoc evaluation of EviCore's utilization management process. The substantial file review compliments on-site visits and serves as an internal auditing tool that promotes the proactive identification of training opportunities and/or process improvements.

EviCore Vendor Oversight

EviCore only delegates specified activities to entities that have demonstrated capability to adequately carry out those functions in a compliant manner, have the mechanisms to document their activities, and produce associated reports. EviCore evaluates this ability prior to delegation as well as on a continual basis throughout the delegation and remains accountable for vendor oversight and performance assessment as evidenced in EviCore's policy *Vendor Oversight (QM 0400)*.

The EviCore pre-delegation review consists of a vendor risk assessment, conducted by the Vendor Oversight Manager in conjunction with Information Technology (IT) Security, and determines which assessments are to be completed. The level of assessment for pre-delegation is dependent upon whether the vendor/delegated entity will be performing a UM function or not. Once all pre-delegation evaluation(s) have been completed and EviCore Quality Management Committee (QMC) review and approval obtained, EviCore and the approved delegate execute the written delegation agreement (DA) that is compliant with regulatory requirements, *URAC* and *NCQA* standards, as applicable, as well as EviCore requirements.

EviCore evaluates the delegate's performance and quality of functions carried out during the Vendor Oversight Committee (VOC) meetings as well as the Quality Management Committee (QMC) meetings. Presentation of objective and measurable performance data (as applicable) are reviewed, analysis for trends and/or barriers and formulation of identified corrective action as deemed necessary. Vendors are required to provide specific performance reports as outlined in the delegation agreement, but never less than twice annually.

On no less than an annual basis, EviCore completes an oversight audit via desktop and/or onsite, as determined by EviCore and dependent upon the service provided. The evaluation assesses the vendor's performance in accordance with contractual agreements, and *NCQA/URAC/CMS/HITRUST* standards, where applicable. During a desktop review, if the need is established, the Vendor Oversight Manager or identified proxy may establish the necessity of an onsite evaluation or an electronic review via satellite or Internet using the outlined audit criteria. EviCore reserves the right to conduct audits at any time, and in the event concerns are identified during a desktop review, a follow up on-site audit may occur.

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Delegation is defined as “a formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform the function, it may not delegate the responsibility for ensuring that the function is performed appropriately” —NCQA 2024 UM-CR-PN Standards. “The process by which the organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate” —URAC Health plan Standards.



Regulatory Compliance

The Utilization Management Program operates continually and fluidly in concert with the EviCore Compliance Division to administer the corporate compliance plan and maintain current utilization licenses with utilization review (UR) business being conducted in every state.

In accordance with EviCore’s *Formal Training Care Management Staff policy (UM 0101)*, EviCore ensures that all clinical and non-clinical UM staff receive formal training in EviCore policies and procedures as well as URAC, NCQA, federal and state regulations in addition to being adequately prepared to conduct their assigned utilization review function in the utilization management unit at time of hire and annually thereafter.

EviCore maintains a sophisticated and comprehensive corporate compliance and ethics program designed to prevent violations with applicable laws and regulations, and to promptly detect and correct issues. EviCore’s Compliance Program includes extensive compliance related education and training for members of its Workforce to effectively integrate compliance into the Company’s corporate culture. Throughout 2024, EviCore conducts staff training for new and existing employees, achieving 100% completion rate. Required training is delivered primarily through e-learning modules via our Training Platform, or for select audiences through instructor-led sessions, or hard copy training decks via an attestation process.

Required training provides an enterprise-wide awareness of key legal, regulatory, and ethical principles for members of EviCore’s workforce. In addition to Corporate Compliance training, a select group of employees received supplemental training, tailored specifically to their assigned program.

EviCore is committed to managing its compliance obligations using sophisticated tools that assure both certainty in execution and verification of training completion. EviCore’s Human Resources (“HR”) platform provides regular data feeds to the internal Training Platform, allowing for automatic and timely assignment of Required Training. Upon training assignment for Employees, the Training Platform automatically sends an initial email notification and

subsequent periodic reminder notifications on Required Training assignments. To monitor the training program, EviCore generates completion reports in a specified cadence with judicious communication to people leaders for prompt follow up with individuals who have not completed their assigned training within the specified due date.

Enterprise compliance training for existing employees, includes but is not limited to:

- Code of Ethics and HIPAA Privacy Training
- General Compliance & Combatting Fraud, Waste, and Abuse Training
- Information Security
- Safety in the Workplace
- Workplace Harassment Training

Enterprise compliance training for newly employed individuals, includes but is not limited to:

- Code of Ethics
- Privacy Awareness
- General Compliance & Combatting Fraud, Waste, and Abuse Training
- Information Security
- Safety in the Workplace
- Workplace Harassment Training
- Overview of Records Management

Select employees complete role based training, includes but not limited to:

- Anti-Bribery and Anti-Corruption Training
- Economic Sanctions
- URAC NCQA Review
- Medicare Part C Organizational Determination
- Complaints Process
- Your Role in Telephone Communications Awareness
- Office Workstation Ergonomics Training
- Cultural Competency
- Workplace Violence Awareness

EviCore staff (clinical and nonclinical) who engage with members and/or providers on the telephone also complete annual training on *Handling a Crisis Call* to ensure they are adequately prepared to facilitate such.

Process for Assessing Performance

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As noted in Attachment A, EviCore's Key Performance Indicators (KPI) of quality are focused on the interactions between requesting/rendering healthcare providers/members and EviCore clinical/non-clinical staff members during all phases of the UM process from the time of service request until case closure. Priority is established for metrics surrounding service delivery and includes, but is not limited to:

- *Call Center Performance Scores*
 - *Average Speed of Answer (ASA)*
 - *Call Abandon Rate (ABN)*
 - *Average Handle Time (AHT)*
- *UM Initial Determination Values*
- *UM Reconsideration Determination Values*
- *UM Medicare Reopen Determination Values*
- *UM Appeal Determination Values*
- *Clinical/Non-Clinical Quality Assurance Values*
- *Complaints & Grievances- Volumes, TAT and Trends*
- *Inter-Rater Reliability (IRR) Scores*
- *Clinical Decision Accuracy (CDA) Scores*
- *Provider Satisfaction, as delegated*
- *Member Satisfaction, as delegated*

Additional indicators of quality may be established by each group or department directly involved with the delivery of UM services and reported to the QMC according to objective and measurable goals and reported with analysis of identified trends and barriers. Any identified aberrant data is discussed and may precipitate process improvement initiatives with additional monitoring and re-evaluation as applicable.

KPI DESCRIPTORS AND BENCHMARKS

Call Center Performance Scores

Telephone access performance scores are comprised of the *ASA*, average *ABN*, and *AHT* measurements and help to ensure EviCore, as an organization, is performing at or above the industry/regulatory standards and client expectations. Data is collected within each category on a monthly basis and delineated by EviCore platform, Clinical vs Non-Clinical departments and in some instances, by product/client. The results are then presented quarterly to the QMC with trends and deviations from goal discussed, barriers to meeting goals identified and actions for improvement formulated and implemented. Subsequent months of data re-measurement enable the ability to evaluate the efficacy of the interventions in place and re-evaluate plans for action. Please reference the **Attachment A** titled ***Key Performance Indicators of Quality*** for details/goals.

UM Initial Determination Values

UM initial determination values measure the turnaround time (TAT) from time of case initiation to time of determination, notice and closure. The average TAT of initial review requests are measured on a monthly basis and delineated by EviCore platform with further characterization based upon the priority status of the case (urgent vs. standard reviews) allowing EviCore to pinpoint areas of opportunity based upon case type. The results are then presented quarterly to the QMC with trends and deviations from goal discussed, barriers to meeting goals identified and actions for improvement formulated and implemented. Subsequent months of data re-measurement enable the ability to evaluate the efficacy of the interventions and re-evaluate action plans. Please reference the **Attachment A** titled ***Key Performance Indicators of Quality*** for details/goals.

UM Reconsideration Determination Values

UM reconsideration determination values measure the turnaround time (TAT) from time of reconsideration request to time of determination/notice and closure of the reconsideration review. The volume of reconsideration requests along with average TAT of reconsideration review requests are measured on a monthly basis and delineated by EviCore platform with further characterization based upon the priority status of the case (urgent vs. standard reviews) allowing EviCore to pinpoint areas of opportunity based upon case type. The results are then presented quarterly to the QMC with trends and deviations from goal discussed, barriers to meeting goals identified and actions for improvement formulated and implemented. Subsequent months of data re-measurement enable the ability to evaluate the efficacy of the interventions and re-evaluate action plans. Please reference the **Attachment A** titled **Key Performance Indicators of Quality** for details/goals.

UM Appeal Determination Values

UM appeal requests can be received from the member and/or provider and facilitation of appeal is dependent upon the delegation agreement with that particular EviCore client. UM appeal determination values measure the turnaround time (TAT) from time of receipt of request for appeal to time of determination/notice and closure. For those appeals in which EviCore is delegated, the average TAT for requests for appeal are measured on a monthly basis and delineated by EviCore platform, further differentiated by the line of business (Medicare vs Non-Medicare) and priority status (urgent vs. standard vs post-service). This allows EviCore to pinpoint areas of opportunity based upon case type. The results are then presented quarterly to the QMC with trends and deviations from goal discussed, barriers to meeting goals identified and actions for improvement formulated and implemented. Subsequent months of data re-measurement enable the ability to evaluate the efficacy of the interventions and re-evaluate action plans. Please reference the **Attachment A** titled **Key Performance Indicators of Quality** for details/goals.

UM Medicare Reopen Determination Values

UM Medicare reopen determination values measure the turnaround time (TAT) from time of a valid reopen request to time of determination, notice, and closure of the reopen review. The volume of reopen requests along with the volume of reopen requests that actually met the criteria to be reopened and the associated average TAT is measured on a monthly basis and delineated by EviCore platform with further characterization based upon the priority status of the case (urgent vs. standard reviews) allowing EviCore to pinpoint areas of opportunity based upon case type. The results are then presented quarterly to the QMC with trends and deviations from goal discussed, barriers to meeting goals identified and actions for improvement formulated and implemented. Subsequent months of data re-measurement enable the ability to evaluate the efficacy of the interventions and re-evaluate action plans. Please reference the **Attachment A** titled **Key Performance Indicators of Quality** for details/goals.

Clinical & Non-Clinical Quality Assurance Values

Quality Assurance (QA)/Process Audit values measure the quality of case processing for all staff performing UM functions to ensure services are delivered in an accessible, appropriate, pleasant and safe fashion. Reviews are performed by a dedicated resource team and are applicable to both Clinical and Non-Clinical and differentiated by EviCore department. The results of the QA reviews are then presented quarterly to the QMC with trends and deviations

from goal discussed, barriers to meeting goals identified and actions for improvement formulated and implemented. Subsequent months of data re-measurement enable the ability to evaluate the efficacy of the interventions and re-evaluate action plans as needed. Please reference the **Attachment A** titled *Key Performance Indicators of Quality* for details/goals.

Inter-Rater Reliability (IRR) Scores

The IRR test assesses the appropriateness and consistency of medical guideline application and decisions by all EviCore staff that perform clinical review and/or render utilization review determinations. The IRR exams are created from real case scenarios and process questions, with an average of twenty (20) questions per exam. Additionally, the IRRs may be focused on specific areas of concern identified with deficiencies as evidenced by the Quality Assurance/Process Audit reviews. The Clinical Reviewer IRR requires the agent to indicate whether the request satisfied the medical necessity guidelines/authorization or if second level (clinician) review is indicated. Additionally, the clinical reviewer must indicate what specific medical guideline was utilized in order to make their determination. The Physician Reviewer/Clinical Peer Reviewer IRR exams are created, as well, from actual case scenarios and requires the reviewer to indicate whether or not the request satisfies the medical necessity criteria. They are expected to indicate the proper adjudication of the case, the correct reviewing clinical guidelines and the most appropriate denial rationale, if indicated. If trends or issues in relation to work processes are identified, non-clinical agents may also be required to complete an IRR examination to assess their knowledge and consistency. Clinical IRR exams are conducted quarterly and deemed mandatory for each applicable agent. The results of exams are tabulated and presented to the QMC each quarter. Any individual receiving a score of less than the established EviCore goal will receive remedial training and the IRR test re-administered to the agent in accordance with EviCore policy Interrater Reliability Assessment (QM 0114). Inter-Rater results are reported to interested health plans and other appropriate EviCore committees for review, discussion and implementation of intervention as deemed necessary. Please reference the **Attachment A** titled *Key Performance Indicators of Quality* for details/goals.

Complaints & Grievances

Complaints may be received from multiple points of entry at EviCore. Once received, complaints are recorded, tracked and used to identify trends and opportunities for improvement, if so delegated by the EviCore client. EviCore employs a dedicated resource team to manage the complaint resolution process and determine whether the nature of the complaint requires formal investigation and response. Complaint investigation includes a description of the complaint, findings identified during the investigation and any actions to be taken as a result of the research. Complaint volume, trends and resolutions are reported quarterly to the QMC and to the appropriate regulatory entity or respective client, as applicable per contractual obligation with discussion and implementation of intervention as deemed necessary. Please reference the **Attachment A** titled *Key Performance Indicators of Quality* for details/goals.

Provider Satisfaction Scores

Provider Satisfaction scores serve as a means to monitor and evaluate the level of satisfaction with EviCore UM processes. The Provider Satisfaction surveys are designed to assess what services provided by EviCore are important to referring providers and identify opportunities for quality improvement initiatives in the delivery of benefit management programs. For the 2024 year, the enterprise vendor, *Verint EFM*, will be utilized to conduct healthcare provider surveys in an effort to further align the organization and leverage existing capabilities. Where applicable, surveys capture a statistically significant, random sample of referring providers who were recently in contact with the certification review programs. Satisfaction results are reported to the QMC, which may recommend corrective actions for satisfaction levels found to be below established thresholds with results reported to interested contracted health plans. Please reference the **Attachment A** titled *Key Performance Indicators of Quality* for details/goals.

Member Satisfaction Scores

Member Satisfaction scores serve as a means to monitor and evaluate the level of satisfaction with EviCore UM processes from the consumer perspective. Satisfaction with services is measured by formal survey conduction and/or assessing member complaints and appeals. As delegated, member satisfaction surveys are conducted among members receiving services through EviCore's Customer Service department and/or through the SmartChoice program to assess EviCore's processes and identify opportunities for quality improvement. Member surveys are either conducted by third party vendors at defined intervals throughout the year in accordance with said vendor scheduling and policy or managed internally by EviCore. The surveys capture a statistically significant, random sample of members who were recently in contact with the certification review programs. Satisfaction results are reported to the QMC, which may recommend corrective actions for satisfaction levels found to be below established thresholds with results reported to interested contracted health plans. Member satisfaction surveys are managed in accordance with EviCore's internal policy titled *Member Satisfaction (QM 0093)*. Please reference the **Attachment A** titled **Key Performance Indicators of Quality** for details/goals.

METHODOLOGY FOR IMPROVEMENT

When an opportunity to improve the UM program delivery process is identified, improvement initiatives are developed within the appropriate investigative framework. Using that framework and its supporting analytical tools, initiatives are implemented according to the nature and complexity of the variance. Methods used to address quality improvement initiatives include, but not limited to:

- Deming's Plan-Do-Check-Act/Plan-Do-Study-Act Cycle of Quality Improvement
- Department-initiated activities
- Workgroups (single department or cross-functional)
- Internal Corrective Action Plan (CAP)
- Operations Excellence (COE)
- Fully-chartered Lean Sigma Projects
- Quality Improvement Projects (QIPs)

EviCore Future

Moving quickly into the new year, the 2024 priorities and objectives were established as a roadmap to continue EviCore's success. The 2024 priorities are similar in some ways but different in others from the historical corporate priorities. EviCore's goals continue to reflect our desire to consistently pursue certain cornerstones of our success but also reflect new ideas and/or new priorities on how to succeed.

- A. Support the 2024 enterprise priorities to:
 - i. Communicate the value EviCore provides; Focus on growth and retention of clients; Look at UM with a holistic approach; Connect the various EviCore solutions
- B. Continue to engage all EviCore departments for identification and collaboration of quality improvement activities;
- C. Continue to proactively monitor and analyze key performance indicators with implementation of interventions, as deemed necessary, to aberrant data/trends;
- D. Maintain national utilization review licensing, appropriate same-state physician licensing, and compliance plans for all other regulatory requirements to support expanding business;

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- E. Maintain compliance with CMS and state regulations as well as URAC and NCQA accreditation standards;
- F. Complete quality initiative objectives and identified work group goals;
- G. Develop improvement initiatives in response to internal and external customer service metrics to increase overall satisfaction with EviCore programs and promote consumer safety;
- H. Continue to advance health literacy with continued focus and alignment of plain language utilized in member communications.