eviCore healthcare Radiology Program

Frequently Asked Questions

Who is eviCore healthcare?

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for Priority Health. We have had a relationship with eviCore since 2017.

What is the re-launch date of the Radiology Program?

Beginning September 5, 2018, clinical information will be required for prior authorization based on certain CPT codes.

What procedures will require prior authorization?

Please refer to the list of CPT/HCPCS codes that require prior authorization at the following link: https://www.evicore.com/healthplan/priorityhealth.

Which members will eviCore healthcare manage for high-tech radiology services?

eviCore will manage authorizations for Priority Health Commercial, Medicaid and Medicare members.

How can I initiate a prior authorization request?

The quickest, most efficient way to obtain prior authorization is through the 24/7 self-service web portal at www.priorityhealth.com/provider. Log into your provider account then click "Auth Request". When a case is initiated on the web portal and meets clinical criteria, a real-time authorization may be received. Prior authorization can also be obtained via phone at 844-303-8456.

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

Urgent requests can be requested on the web portal at www.priorityhealth.com/provider or by calling eviCore healthcare directly at 844-303-8456 indicating the request is urgent. For high-tech radiology services in urgent situations only, treatment may be started without prior authorization; however, the treatment must meet urgent/emergent guidelines.

What are the criteria for a clinically urgent request?

All urgent requests must meet the NCQA medically urgent criteria which are defined as conditions that are a risk to the patient's life, health, ability to regard in maximum function, or the patient is having severe pain that required a medically urgent service. Urgent requests can be initiated on the web portal or telephonically. Most requests will receive a real-time approval, however if further clinical review is needed, then a determination will be made within 24 hours for Medicare and Medicaid members and 72 hours for the Commercial membership after receiving complete clinical information.

Is it possible for the physician to be both the referring and the rendering provider?

Yes. This is allowed under the program guidelines.

What are the hours of operation for the prior authorization department?

eviCore healthcare's prior authorization call center is available from 7:00 a.m. to 7:00 p.m. Eastern Time, Monday through Friday. The phone number is **844-303-8456**. The web portal is available for access 24/7.

Who can request a prior authorization?

A representative of the ordering physician's staff can ask for authorization. This could be someone from the clinical, front office or billing staff, acting on behalf of the ordering physician.

What information is needed in order to get approval for radiology services?

- Member's name, date of birth, plan name and Priority Health member ID number
- Ordering physician's name, National Provider Identifier (NPI), Tax Identification Number (TIN), fax number
- Place of service
- Rendering facility's name, NPI, TIN, street address, fax number
- Service being requested (CPT codes and diagnosis codes)
- All relevant clinical notes; imaging/X-ray reports, patient history, physical findings

Are there guides that can assist me with the types of clinical questions that will be asked when initiating a prior authorization request?

Yes, eviCore has online forms available to assist representatives with the authorization process. The online forms can be at the following link: https://www.evicore.com/healthplan/priorityhealth, click on "eviCore Online Forms & Resources" and select *Radiology* from the Solution dropdown. The forms are designed as fax forms but can be used as a tool to understand the types of clinical questions that will be asked during the case creation.

If additional clinical information is requested during my initial prior authorization creation, can I upload it on the web portal?

Yes, five documents can be uploaded in either PDF or Word format and must be less than 5MB. There is also a box which can be used to free text supporting clinical information such as family history, test results, symptoms, physical findings, office notes etc.

I go through the web portal and answer all questions but do not receive a real-time approval. I am asked to upload clinical information and after the notes are uploaded I receive an approval without going to clinical review. Why do I have to upload the notes if the request will be approved?

eviCore will ask for additional information because the case could not be approved via the clinical pathways. The additional information is ingested by our analytic algorithms and can be used to help reach an approval without the need for clinical review.

Who would I contact if the facility, member or provider information cannot be found in the web portal?

A representative of the ordering physician's staff can contact eviCore's call center by calling 844-303-8456**.**

How do providers check for the authorization status of a member?

To check the status of an authorization, you may contact eviCore at 844-303-8456 or go to "Request an authorization" at www.priorityhealth.com.

- Log on to the Priority Health website
- Click on Auth request
- Follow the steps and click "Go to eviCore"
- At eviCore's toolbar, choose Authorization Look-up on the top left
- Fill in the requested information and submit

What is the turnaround time for prior authorization requests?

All requests are processed within two (2) business days after receipt of all necessary clinical information. If a case is pended for additional information, once the information is received a decision will be made within two (2) business days.

How will eviCore contact the ordering provider when there is incomplete clinical information provided with a prospective request for authorization?

If a prior authorization request where clinical information provided is insufficient to render a decision, eviCore will pend the case and make outreach attempts to obtain the necessary information. eviCore will make four (4) outreach requests for Medicare members: one (1) fax and three (3) phone attempts over the course of fourteen (14) calendar days. eviCore will make one (1) fax outreach attempt to the ordering provider for Commercial and Medicaid members to obtain the necessary clinical information.

What clinical guidelines are used when eviCore makes a medical necessity determination?

The clinical guidelines can be found at the following link: https://www.evicore.com/healthplan/priorityhealth, click on “eviCore Clinical Guidelines” then select *Cardiology & Radiology* from the Solution dropdown.

What is the process for an alternative recommendation by eviCore?

In cases where a request cannot be approved, eviCore may offer an alternative recommendation. If the ordering physician accepts an alternative recommendation the original requested study will be withdrawn and the new study will be approved.

What is the format of the eviCore healthcare authorization number?

An authorization number is (1) one alpha character followed by (9) nine numeric numbers, and then the CPT code of the procedure authorized. For example: A123456789. All approved requests will be faxed to the ordering and rendering providers and mailed to the member. You can also view authorizations in the Authorization Look-up tool once you have logged into eviCore from your priorityhealth.com account.

How will members be notified of approvals and denials for radiology services?

Written approval and denial notices will be sent to the member as well as the requesting provider(s).The denials will be faxed to the ordering provider and mailed to the member. For

Medicare members, once a service has been denied, an appeal must be filed in order to have the request re-reviewed. Appeal instruction will be provided on denial notifications. There are denial instructions at the end of this document for your review.

How will the rendering facility be notified of medical necessity determination?

The ordering and rendering providers will receive written notification of an approval. Denial letters will not be sent to the facility.

What are my options when a prior authorization request is denied?

Commercial and Medicaid membership: There are two options after requested services are denied – either a reconsideration review or a peer-to-peer discussion, which can be requested within 14 days from the date of denial. If additional clinical information is available without the need for a provider to participate, a reconsideration review can be requested by phone. If additional clinical information is available but there is a need for participate peer-to-peer review, the physician, nurse practitioner or physician's assistant may speak with an eviCore medical director with the same specialty expertise. Please refer to the peer-to-peer frequently asked questions document on the resource site or the quick reference guide for market specific phone numbers.

Medicare membership: eviCore will reach out to providers to let them know that the case will be denied in order to allow for a pre-decision consultation prior to the denial being issued. If the consultation does not take place or the information shared during the consultation does not cause the case to meet medical necessity criteria, the case will be denied. The referring and provider will receive a denial letter that contains the reason for denial as well as Appeal rights and processes. In this population, please note that after a denial has been issued, no changes to the case decision can be made as the Center for Medicare and Medicaid Services does not allow changes after the determination of a case. Speaking with an eviCore Medical Director is for educational purposes only. You may file a first level appeal with Priority Health.

Does Priority Health have Reconsideration Requests?

Yes, for **Commercial and Medicaid members only**. Additional clinical information can be provided without the need for a provider to participate within **14 business days** following the date of the determination.

Do we have the ability to ask for a Peer-to Peer consultation?

Yes and this is now called a Clinical Consultation request. It can only be requested for **Commercial and Medicaid members**. You must request this within **14 business days** following the date of determination. We ask that you log on to the Implementation page https://www.evicore.com/healthplan/priorityhealth and click on Request a Clinical Consultation. You will be asked to fill in some demographic information and the date and time you want to be contacted by one of our Medical Directors.

How long is an authorization valid?

Authorizations are valid for ninety (90) days. If the service is not performed within 90 days from the issuance of the authorization, please contact eviCore healthcare.

Our office prior authorized high-tech radiology without contrast, and during the service, it was decided to add contrast. Do we need a new auth?

When it comes to tests with/without contrast, as long as the code authorized falls into the same test grouping, we would accept the original authorization. There's no need for a new auth to be completed.

For example – if code 71250 was prior authorized, but the test performed and billed was 71270 – we would link the auth and pay the claim without requiring the provider to update the PA with eviCore.

- 71260 Computed tomography, thorax; with contrast material(s)
- 71250 Computed tomography, thorax; without contrast material
- 71270 Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections.

What is the process to update a CPT code or a facility on an authorization?

Authorization updates can be made by calling eviCore at 844-303-8456. Post-decision updates requests that do not require clinical review can be made at any time, providers do not need to contact eviCore to down code contrast. eviCore will accept post-decision updates that require clinical review up to and including the date of service. The ordering physician and member can request facility changes on an authorization.

Does eviCore approve cases retrospectively if no authorization was obtained before the service?

Retrospective requests must be initiated by phone within **120 calendar days** following the date of service for Commercial membership or within **30 calendar days** following the date of service for Medicaid membership. No retrospective request will be allowed for Medicare membership. In many instances, the services must have been urgent and medically necessary. Please have all clinical information relevant to your request available when you contact eviCore healthcare.

What are the parameters of an appeals request?

eviCore will manage only 1st level provider appeals for Commercial members only. Appeal rights are detailed in coverage determination letters sent to the providers with each adverse determination. Appeals must be made in writing unless the request involves urgent care, in which case the request may be made verbally.

How do initiate a first-level provider appeal?

Appeal rights will be included in the denial letter. Appeals may be submitted by mail, fax or email to:

Mail: eviCore healthcare
Attn: Clinical Appeal Dept.
400 Buckwalter Place Blvd
Bluffton, SC 29910

Fax: 866-699-8128

E-mail: Appealsfax@evicore.com

Toll Free Phone: (800)792-8744 ext. 49100 or (800)918-8924 ext. 49100