eviCore healthcare Radiation Therapy 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 certain Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma, and Texas.

Which members will eviCore healthcare manage for the outpatient Radiation Therapy services program?
eviCore will manage services for:

- Blue Cross and Blue Shield (BCBS) Medicare members located in the states listed above.
- BCBS Medicaid members located in Illinois and Texas

What is the relationship between BCBS and eviCore healthcare?
Beginning in June 1, 2017, eviCore will manage select radiation therapy services for BCBS.

What procedures will require prior authorization?
Radiation therapy services: Complex (77307), 3D Conformal, Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT), Brachytherapy, Hyperthermia, Proton Beam Therapy, Intensity-Modulated Radiation Therapy (IMRT), Neutron Beam Therapy, Radiopharmaceuticals

How can I initiate a prior authorization request?
The preferred, most efficient method is to initiate a request online at www.evicore.com. You may also initiate requests via phone at 855-252-1117.

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, Monday through Friday local time. For auth requests originating from Texas hours of operation are 6 am to 6 pm central time Monday through Friday and between 9 am-noon central time on Saturdays, Sundays, and legal holidays. The web is available 24/7.

What are the elements of the Radiation Therapy Program?
The main component of the Radiation Therapy Program is prior authorization for all radiation therapy services.

Who is administering the Radiation Therapy Program, and what is the programs intent?
eviCore healthcare will be administering the outpatient radiation therapy prior authorization program. The program's purpose is to ensure that radiation therapy services provided to our members are consistent with national guidelines, and reflected in eviCore healthcare's Radiation Therapy Clinical Guidelines.

What medical providers will be affected by this agreement?
We require prior authorizations when the participating physician's office, hospital outpatient or

freestanding facility provides the services. It is the responsibility of the performing facility to confirm that the rendering physician completed the prior authorization process for radiation therapy.

What information will be required to obtain a prior authorization?

- Member or Patient's Name, Date of Birth, and health plan ID number
- Ordering Physician's name and NPI number
- Ordering Physician's Telephone and Fax number
- Radiation Therapy Facility's Name, Telephone and Fax number

You can obtain a worksheet of required information for eviCore healthcare's Radiation Therapy Program at the following link:
https://www.evicore.com/resources/pages/providers.aspx?solution=Radiation%20Therapy#ReferenceGuidelines

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

The most efficient way to obtain preauthorization for urgent requests is via phone, as an immediate approval can be obtained. Please contact eviCore healthcare directly at 855-252-1117, indicating the request is urgent. For outpatient radiation therapy in urgent situations only, treatment may be started without preauthorization, however the treatment must meet urgent/emergent guidelines.

If a patient is undergoing treatment before the start of the program on June 1, 2017, will the treatment need authorization?

For treatments already underway, please refer to BCBS at this time.

If the simulation occurred, but the treatment begins after June 1, 2017, will it need authorization?

Yes, we require prior authorization for treatments that are scheduled on or after June 1, 2017.

Where can I see eviCore healthcare's radiation therapy coverage criteria?

You can see eviCore healthcare's clinical guidelines on radiation therapy at:
https://www.evicore.com/resources/pages/providers.aspx?solution=Radiation%20Therapy#ReferenceGuidelines

Once I ask for a prior authorization, how long will it take to get a decision?

eviCore healthcare is committed to reviewing all requests and giving case decisions within fourteen (14) calendar days of receiving all necessary clinical information with an exception of Texas Medicaid that will be processed within 3 calendars days.

Do I need a separate prior authorization number for each service code requested?

eviCore healthcare will assign one authorization number per treatment plan with a decision for medical necessity.

Can I get prior authorization for multiple sites of therapy, for the same patient, at the same time?

When medically necessary, you can get a prior authorization for multiple sites of therapy.

What if I don't obtain prior authorization?

Claims may be denied if you don't obtain prior authorization or approval.

What if I don't agree with eviCore healthcare's clinical code determination?

Please contact eviCore healthcare. You can schedule a peer-to-peer discussion with an eviCore healthcare board certified radiation oncologist.

If the patient needs more treatment (such as a recurrence of disease or a change in clinical condition), do I have to call eviCore healthcare for a new prior authorization?

Yes, the prior authorization is only valid for the treatment plan requested by the physician. If the patient needs a different or changed treatment plan, we require a new prior authorization. If you need to change the plan during the course of treatment, contact eviCore healthcare. You can discuss the new treatment plan and ask to adjust the existing authorization.

If the patient starts radiation therapy treatment at one facility and changes to another during a course of treatment, is a new prior authorization required?

Yes. If a new physician group is treating the patient, a new treatment plan will likely be followed. Please call eviCore Healthcare to discuss the changed facility as a new prior authorization number may be required.

Where should I send claims once I provide services?

Send all claims as you would normally to BCBS. Pre-Certification and Pre-Service approval is not a guarantee of payment of benefits.

Medicare: Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions of your Certificate of Benefits booklet and/or Summary of Benefits.

Medicaid: For services to be paid by Blue Cross and Blue Shield, members must be eligible for Medicaid at the time of treatment. Payment depends on the amount allowed for the treatment. It also depends on a review of supporting records. Other terms and limits of your plan may also apply.

Can only the provider ask for authorizations?

A representative of the physician's staff can ask for authorization. This could be someone from the clinical, front office or billing staff, acting on behalf of preferred provider organization (PPO).

Does eviCore healthcare employ physicians other than radiation oncologists to review prior authorization requests?

Only radiation oncologists review authorizations for radiation therapy treatment when medical review is required.

How will all parties be notified if the prior authorization has been approved?

Ordering and rendering providers will receive written notification via fax and urgent requests via phone. You can also validate the status using the eviCore provider portal at www.evicore.com or by calling eviCore healthcare at 855.252.1117. Members will be notified in writing by mail and urgent requests via phone.

What information about the prior authorization will be visible on the eviCore healthcare website?

The authorization status function on the website will provide the following information:

- Prior Authorization Number/Case Number
- Status of Request
- Cancer Type
- Site Name and Location
- Prior Authorization Date
- Expiration Date

If a prior authorization is not approved, what follow-up information will the referring provider receive?

For Medicaid BCBS IL & TX members, the referring provider will receive a denial letter that contains the reason for denial as well as Reconsideration and Appeal rights and processes. A reconsideration allows providers the chance to provider additional information to support the request and includes the opportunity to request a Peer-to-Peer discussion with an eviCore Medical Director to review the decision.

For Medicare BCBS members, the referring provider will receive a denial letter that contains the reason for denial as well as Appeal rights and processes. Please note that after a denial has been issued for a Medicare member, no changes to the case decision, such as a reconsideration, can be made. Speaking with an eviCore Medical Director is for educational purposes only

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.

If the office does not have web access, how can a provider verify that a study has been authorized?

If the office does not have web access, you can call eviCore at 855-252-1117.

What are the parameters of an appeals request?

eviCore will manage 1st level appeals. An authorized representative, including a provider, acting on behalf of a member, with the member's written consent may file an appeal on behalf of a member. A member patient authorization form must be completed for all first level appeals. Appeal rights are detailed in coverage determination letters sent to the providers with each adverse determination. Appeals must be made in writing within 120 calendar days and 30 calendar days for IL Medicaid unless the request involves urgent care, in which case the request may be made verbally. eviCore will respond within 30 calendar days, and 15 business days for IL Medicaid requests.

Where should first-level appeals be sent?

Appeals must 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