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 certain Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma, and Texas.

Which members will eviCore healthcare manage for the outpatient radiology 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 June 1, 2017, eviCore will manage selected radiology services for BCBS.

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.evicore.com. 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.

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 6:00 a.m. to 6:00 p.m., Monday through Friday. The phone number is 855-252-1117. The web portal is available for access 24/7.

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

- Member's name, date of birth, plan name and plan 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

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

You can check the authorization via the portal at www.evicore.com or via phone at 855-252-1117.

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.

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

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.

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

How long is an authorization valid?

Authorizations are valid for forty-five (45) calendar days. If the service is not performed within 45 days from the issuance of the authorization, please contact eviCore healthcare.

Can I request more than one OB ultrasound at once?

Up to a maximum of 2 OB ultrasound procedural codes (76813 & 76805) may be auto approved upon notification to eviCore healthcare, providing they are appropriate codes and diagnosis for the woman's current gestational age.

What information is needed when submitting a request for OB ultrasound?

Please include the patients gestational at the time the requested OBUS CPT codes(s) will be performed, any prior OBUS that have been done (include the CPT code, date and results), and the patients prenatal record.

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 radiology services in urgent situations only, treatment may be started without preauthorization, however the treatment must meet urgent/emergent guidelines.

Will eviCore be processing claims for BCBS?

No, eviCore will only manage prior authorization requests. 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.

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