eviCore healthcare Radiology/Cardiology 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 Scott & White Health Plan members.

Which members will eviCore healthcare manage for the outpatient radiology/cardiology services program?

eviCore will manage services for:

- Commercial Fully Insured
- Commercial Self-Funded
- Medicare Advantage

What is the relationship between Scott & White Health Plan and eviCore healthcare?

eviCore will manage selected radiology services for Scott & White Health Plan for dates of service on or after August 1, 2018 and cardiology services effective September 1,2018. Providers can begin submitting prior authorization requests for radiology services to eviCore healthcare on July 27, 2018 and cardiology request beginning August 17, 2018.

How can I initiate a prior authorization request?

The SWHP Provider Portal is the quickest, most efficient way to obtain an authorization. Log onto - **https://portal.swhp.org/ProviderPortal/#/login,** click on the **eviCore link** to initiate a case, view case/authorization details, verify eligibility, and more.

Providers can also obtain prior authorization 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 8:00 p.m.

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 8:00 p.m., Monday through Friday. The phone number is 888-209-5762. The web portal is available for access 24/7.

What information is needed in order to get approval for radiology/cardiology 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 on the portal at www.evicore.com, or via phone at 888-209-5762.

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/cardiology services?

eviCore healthcare is committed to reviewing all requests and giving case decisions within fourteen (14) calendar days of receipt of your request for Medicare Advantage and within three (3) calendars days for commercial members. In order to ensure timely decision making, it is important that you provide all clinical documentation supporting services(s) being requested. Notifications are faxed to the ordering provider and mailed to the member. Denial notifications are not sent to the facility.

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

For commercial members, the referring provider will receive outreach prior to receiving a denial letter that will contain the reason the request has been recommended for denial. During this outreach a physician consult may be scheduled if needed to allow the opportunity to request a Physician-to-Physician discussion with an eviCore Medical Director, at which point any additional details can be offered for consideration when making a final decision. Please note that due to state mandated time frames you will have one (1) business day to schedule the physician consult.

For Medicare members, the referring provider will receive outreach prior to receiving a denial letter that will contain the reason the request has been recommended for denial. During this outreach a physician consult may be scheduled if needed to allow the opportunity to request a Physician-to-Physician discussion with an eviCore Medical Director, at which point any additional details can be offered for consideration when making a final decision. 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 after a denial is rendered is for educational purposes only.

Are retrospective requests accepted?

Radiology and Cardiology retrospective requests can be initiated by contacting eviCore at 888-209-5762 and requesting a retro auth. This must be done within seven (7) calendar days of the date of service. Requests will be reviewed and decisions made based on medical necessity/urgency of service.

How long is an authorization valid?

Authorizations are valid from the date of the preauthorization request up to forty-five (45) calendar days of approval notice. If the service is not performed within 45 days from the issuance of the authorization, which will be the date the request was initiated, please contact eviCore healthcare.

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 888-209-5762, indicating the request is urgent. For outpatient radiology/cardiology 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 Scott & White Health Plan?

No, eviCore will only manage prior authorization requests. Pre-Certification and Pre-Service approval is not a guarantee of payment of benefits.

What are the parameters of an appeals request?

Medicare: All requests for Medicare appeals will be managed by Scott and White Health Plan. Appeal rights are detailed in coverage determination letters sent to the providers with each adverse determination. You can also refer to the Scott and White provider manual for details on how to submit a request for reconsideration.

Commercial: eviCore will manage 1st level **fully insured** appeals. An authorized representative, including a provider, acting on behalf of a member can request an appeal. Appeal rights are detailed in coverage determination letters sent to the providers with each adverse determination. Appeals must be made in writing within 180 calendar days unless the request involves urgent care, in which case the request may be made verbally. eviCore will respond within 30 calendar days.

Where should fully insured commercial 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