Radiation Oncology Frequently Asked Questions (FAQs)

What is the Holistic Treatment Plan Review of the Radiation Oncology Program?

EviCore relies on information about the patient's unique presentation and physician's intended treatment plan to authorize all services from the initial simulation through the delivery of the last fraction of radiation.

- Providers specify a diagnosis rather than request individual CPT codes
- Diagnosis and treatment plan compared to the evidence-based guidelines developed by our Medical Advisory Board
- If request is authorized/covered or partially authorized/covered, then the treatment technique and number of fractions will be provided
- For questions about specific CPT codes that are included with each episode of care, please reference the EviCore Radiation Therapy Coding Guidelines located online: Radiation Oncology | EviCore by Evernorth
- Correct coding guidelines are based on ASTRO/ACR Radiation Therapy coding resources.

Which Radiation Oncology modalities and procedures require prior Authorization?

All Radiation Therapy treatment plans for both cancerous and non-cancerous diagnosis require authorization.

Radiation Therapy Procedures include:

- Complex isodose technique (77307)
- 2D & 3D Conformal
- Intensity-Modulated Radiation Therapy (IMRT)
- Image-Guided Radiation Therapy (IGRT)
- Stereo-tactic Radiosurgery (SRS)
- Stereo-tactic Body Radiation Therapy (SBRT)
- Brachytherapy
- Radiopharmaceuticals
- Hyperthermia Proton Beam Therapy
- Neutron Beam Therapy

The authorization will include all necessary non-clinical modalities

- SIM
- Planning
- Devices
- Imaging
- Physics
- Management

Refer to the complete list of procedure codes that require prior authorization on Network Health WI Provider Resources | EviCore by Evernorth.

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Which providers are impacted by this program?

It is the responsibility of the performing facility to confirm that the referring physician completed the prior authorization process for Radiation Therapy services. Verification may be obtained via the EviCore healthcare website or by calling 855-727-7444.

Important: Authorization from EviCore does not guarantee claim payment. Services must be covered by the health plan, and the members must be eligible at the time services are rendered. Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless. Please verify the member's eligibility with the health plan.

Do services performed in an inpatient setting at a hospital or emergency room setting require prior authorization?

No. Radiation Oncology ordered through an emergency room treatment visit, while in an observation unitor during an inpatient stay does not require prior authorization.

How do I check the eligibility and benefits of a member?

Member eligibility and benefits should be verified on Provider Resources | Network Health before requesting prior authorization through EviCore.

How do I request prior authorization through EviCore healthcare?

Providers and/or staff can request prior authorization in one of the following ways:

1. **Web Portal (preferred)** The EviCore portal is the quickest, most efficient way to request prior authorization and is available 24/7. Providers can request authorization by visiting www.EviCore.com

2. **Call Center EviCore**'s call center is open from 7 a.m. to 7 p.m. local time. Providers and/or staff can request prior authorization and revise existing cases by calling 855-727-7444

3. **Fax option** While not preferred, providers and/or staff may submit a request for prior authorization to 855-774-1319

What information is required when requesting prior authorization?

When requesting prior authorization, please ensure the proprietary information is readily available:

Member

- First and Last Name
- Date of Birth
- Member ID

Ordering and Rendering Provider

- First and Last Name
- National Provider Identification (NPI) Number
- Tax Identification Number (TIN)
- Phone and Fax Number

Relative diagnosis and medical history including:

- Signs and symptoms
- Results of prior relevant test(s) including imaging studies
- Relevant medications
- Working diagnosis/stage
- Patient history including type and duration of previous therapy

How to avoid inappropriate denials when services are appropriate?

Services that are deemed appropriate are those that follow clinical and/or medical necessity guidelines. If a provider follows guidelines that govern clinical and/or medical necessity criteria, but still experiences high denial rates, the reason may be due to clinical information missing from the case request.

Where can I access EviCore's clinical worksheets and guidelines?

You can obtain a worksheet of required information for EviCore's Radiation Therapy Program by using the applicable clinical worksheets.

- The physician worksheet is best completed by the physician during the initial consultation with the patient.
- Inaccurate information causes authorized services to differ from those that are actually delivered and can lead to adverse determinations.

Worksheets and guidelines are available online 24/7 and can be found by visiting one of the following links:

- **Clinical worksheets**: Clinical Worksheets & Online Forms | EviCore by Evernorth
- **Clinical Guidelines:** Clinical Guidelines | EviCore by Evernorth

What happens if the provider's office does not know the treatment regimen that needs to be ordered?

The caller must be able to provide either the drug name or the HCPCS code in order to submit a request. EviCore will assist the physician's office in identifying the appropriate code based on presented clinical information and the current HCPCS code(s)provided.

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What happens when the on-line system does not provide immediate authorization?

EviCore will review and issue an authorization if the requested treatment meets the established evidence-based criteria. All other requests will be sent to the EviCore Medical Director for review and determination. All decisions should be made within 2 business days for non- urgent requests once complete clinical information is received. All determination decisions will be sent in writing to the members. Referring providers and the rendering provider and facility can access all correspondence on the EviCore portal.

How can providers indicate that the procedure is clinically urgent?

Urgent requests are defined as a condition that is a risk to the patient's health, ability to regain maximum function and/or the patient is experiencing severe pain that requires a medically urgent procedure. Urgent requests may be initiated on our web portal at www.EviCore.com, or by contacting our contact center at 855- 727-7444.

Note that for in-scope services rendered in settings other than ER, observation, or urgent care, a physician or other health care professional may request prior authorization on an urgent or expedited basis in cases where there is a medical need to provide the service sooner than the conventional prior authorization process would accommodate

Once prior authorization has been requested, how long will it take for EviCore to make the determination?

Decisions for non-urgent prior authorization requests are typically made within two 2-3 business days of receipt of all necessary clinical information but would not take longer than 14 calendar days.
When services are required due to a medically urgent condition, EviCore healthcare will usually give a decision within 24 hours of receiving all necessary demographic and clinical information but would not take longer than 72 hours. Please indicate that the authorization is for medically urgent care.

When will I receive the authorization number once the prior authorization request has been approved?

Once the prior authorization request has been approved, the authorization information will be provided to clinician's office via fax. It's possible to receive a 'real time' authorization immediately after web submission, and clinician offices may also visit Provider's Hub | EviCore by Evernorth to view the authorization determination. The members will receive a letter of approval by mail.

Note: The authorization number will begin with the letter 'A' followed by an eight-digit number.

How long is the authorization valid?

Authorizations for the Radiation Oncology Program are effective for 45 days. Requests for clinical trials should be directed to Network Health at the number on the back of the member/participant ID card

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If my authorization request is denied, what are my options?
For commercial cases, you can request a reconsideration of the denial within 3 business days from the date of the determination. If an appeal has already been filed, the reconsideration option is not allowed. Medicare cases that are denied will not have a reconsideration option. Please appeal to Network Health.

Who should request prior authorization in cases where a Primary Care Physician refers a patient to a specialist, who determines that the patient needs cancer treatment, including a treatment that requires prior authorization?
The physician who orders the drug should request prior authorization. In this case, it would be the specialist.

If a denial occurs because of a coding mistake, can I resubmit the claim?
Yes, if the mistake is administrative (related to coding) then a claim can be resubmitted as long as prior authorization remains in effect and the procedure on the claim is medically necessary.

What happens if a service is rendered despite an authorization denial?
The Network Health Radiation Therapy Program is a prior authorization program that includes a medical necessity determination for the requested treatment regimen. Coverage for treatments that are not medically necessary will be denied as not covered under the member's benefit plan because services that are not medically necessary are not covered under Network Health Wisconsin plans. Failure to comply with any prior authorization protocol may result in administrative claim denial.

Does EviCore review cases retrospectively if no authorization was obtained?
Retro requests must be submitted within 15 business days following the treatment start date. Requests submitted after 15 business days will be administratively denied. Retro cases are reviewed for clinical urgency and medical necessity.

What if an authorization is issued and revisions need to be made?
The requesting provider or member should contact EviCore at 855-727-7444 with any change to the authorization. It is very important to update EviCore with any changes to the authorization in order for claims to be correctly processed for the facility that receives the member.

How can the provider confirm that the existing prior authorization number is valid?
Providers can confirm that the prior authorization is valid by logging into our web portal, which provides 24/7 access to view prior authorization numbers. To access the portal, please visit www.EviCore.com. To request a fax letter with the prior authorization number, please call EviCore at 855-727-7444 to speak with a customer service specialist.

Who will handle a request for an appeal?
Please refer to the denial letter for details regarding post decision options.

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Where do I submit my claims?

All claims will continue to be filed directly to Network Health Wisconsin.

How do I submit a program related question, or report an issue?

For assistance with membership, claims, provider network issues, etc., submit the issue to our dedicated teams via EviCore Communication Relationship Management (ECRM):

- Access: ECRM Services
- ECRM educational resources: ECRM Resources | EviCore by Evernorth
- For trouble using ECRM, reach out to our technical support team via: ECRMSupport@EviCore.com

If a member goes to a new provider for services, will a new prior authorization request be required?

Yes. When a member changes to a treating provider who is not within the same practice, a new authorization request is required. If the member has discontinued care with the original provider, please include the discharge date with the original provider when submitting your request. EviCore will not provide authorization for overlapping services or duplicate care as it is not medically necessary.
Note: A new authorization is not required if member sees a different provider within the same practice.

Where can I find additional educational materials?

For more information and reference documents, please visit our resource page at Network Health WI Provider Resources | EviCore by Evernorth.