EmblemHealth

Radiology Related Programs

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Chapter Summary

eviCore administers several radiology-related programs for us, including:

- Outpatient Diagnostic Imaging Privileging – for *non-radiologists.*
- Radiology Program – diagnostic imaging management for outpatient radiology services.
- Cardiology Imaging Program – diagnostic cardiology imaging management for outpatient cardiology imaging services.
- Radiation Therapy Program – for select outpatient radiation therapy services including Cancer Clinical Pathways. See also: Oncology Drug Management Program.

Services targeted for utilization management vary by benefit plan. eviCore also conducts standard and expedited clinical appeals (excluding members with Medicare plans).

Note: While eviCore may approve or deny a preauthorization request, their determination is based on medical necessity only. Always verify member eligibility, benefits, and copayments with EmblemHealth by signing in to emblemhealth.com/providers and using the Eligibility drop-down under the Member Management tab.

Authorizations do not guarantee claim payment. Services must be covered by the member's benefit plan and the member must be eligible at the time of service.

For other programs managed by eviCore, see the Durable Medical Equipment chapter.

Program Exclusions

eviCore's programs described in this chapter cover most, but not all, of our members. For all radiology-related programs, members assigned to HealthCare Partners (HCP) as their Managing Entity are managed by that organization, not eviCore. Further, HCP determines which services their contracted providers may perform in their offices and the criteria required to do so. For instructions on obtaining preauthorization for these exempt members, see the Utilization and Care Management chapter. Additional program-specific excluded members and services are:

Additional Radiation Therapy Program Exclusions

- GHI CBP Program for City of New York Employees and Retirees.

Additional Self-Referral Payment Policy Exclusions

- Services rendered in Putnam, Ulster and Onondaga counties for HIP, EmblemHealth Insurance Company (formerly HIPIC) members, and Bridge Members.

Outpatient Diagnostic Imaging Privileging For Non-Radiologist

Non-radiologists may be paid for in-office imaging (subject to the member's plan) if they meet the specialty, certification, and accreditation requirements. Our protocols are based on a careful review of the literature and standards of the National Board of Echocardiography (NBE), Intersocietal Accreditation Commission (IAC), American College of Radiology (ACR), and American Board of Radiology (ABR).

Minimum practitioner accreditation and certification requirement: Board certification (by an American Board of Medical Specialties recognized board) in the adult or pediatric provider specialties listed. For specialties, applicable procedures, and accreditation requirements, see the EmblemHealth Outpatient Diagnostic Imaging Self-Referral Payment Policy .

Payment policy: Claims are denied when outpatient imaging procedures are performed outside the practitioner's specialty, or when the practitioner fails to maintain the minimum certification requirements or does not obtain preauthorization when required. Practitioners may not seek payment from members for denied claims.

Accreditation Status and Submission

Participating practitioners are reviewed for active accreditation. For echocardiography services, the review appears in the national databases of IAC Echocardiography. For nuclear medicine/nuclear cardiology services, the review appears in the national database of ACR and IAC Nuclear/PET. For PET services, the review appears in the national database of IAC Nuclear/PET and ACR PET.

All other specialties must email their certification(s) directly to provideraccreditations@evicore.com. For more information about accreditation status or certificate submissions, email provideraccreditations@evicore.com or call 800-918-8924, ext. 27901.

For information on accreditation requirements and instructions for applying for accreditation, refer to the websites of the accrediting organizations listed at the end of the payment policies.

Radiology Site and Equipment Inspection for Both Radiologists and Non-Radiologists

Assessment and Certification

All radiologists and non-radiologists participating in our radiology programs undergo a comprehensive site visit, as well as

evaluation of equipment, technical staff credentials, continuing education, equipment maintenance records, and operating policies. They may also be required to complete appropriate assessment and certification forms. This process is based on nationally recognized requirements of the American Institute of Ultrasound in Medicine, the American College of Radiology, and The Joint Commission. Refer to the Credentialing chapter for credentialing and certification requirements.

Non-radiologists who meet certain criteria may perform designated radiology procedures. See the Outpatient Diagnostic Imaging Privileging for Non-Radiologists section of this chapter.

Film Review

Practitioner film images must comply with the high standards of the American College of Radiology. At least once every two years, practitioners may be required to provide EmblemHealth and/or eviCore with requested materials for an independent review and professional interpretation of films. For this review, we randomly select a sampling of patient studies. At least two board-certified radiologists assess these studies for technical quality and diagnostic interpretation.

Preauthorization Procedures

Services Requiring Preauthorization

Preauthorizations are specific to the CPT-4 procedure code and site location. Refer to Clinical Corner for services (and CPT-4 codes) requiring preauthorization. Each requires a separate preauthorization. They are valid for 45 days from the approval date.

Claims are denied, and the member is not held liable for payment if:

- A preauthorization is required but not obtained for the CPT-4 code performed.
- Procedures are performed at a service location other than the address on the preauthorization issued.

Who Requests Preauthorization

The practitioner developing the patient's treatment plan is responsible for obtaining the preauthorization. If the referring and servicing practitioners are different, the servicing practitioner is encouraged to confirm that a preauthorization is on file before rendering services.

PCPs referring patients to a cardiologist for testing are responsible for initiating the preauthorization. If the cardiologist is already treating the patient, the cardiologist should initiate the request. The servicing practitioner is ultimately responsible for ensuring all applicable cardiology imaging procedures at the applicable service location are authorized.

How to Request Preauthorization

Clinical worksheets are available to assist in collecting all the required information for preauthorization. The worksheets include clinical questions the practitioner must answer during the initial preauthorization review.

You may submit preauthorization requests in one of three ways:

1. Online for all programs: evicore.com
2. By faxing the completed worksheet specific to the procedure being requested:
    - For radiology: 800-540-2406
    - For cardiology imaging: 888-622-7369
3. By phone (Representatives are available Monday through Friday, from 7 a.m. to 7 p.m. ET.)

- HIP, EmblemHealth Insurance Company (formerly HIPIC), and Bridge members: 866-417-2345
- EmblemHealth Plan, Inc. (formerly GHI) members: 800-835-7064

eviCore is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving Day, and Christmas Day. Multiple requests may be handled on one call.

Please have the following information available when you call:

- Information requested on the applicable worksheet.
- Patient's full name, member ID number, and insurance information.
- Ordering practitioner information.
- Rendering site information.
- Exam(s) requested.
- Working diagnosis or rule-out.
- Signs and symptoms, as well as their duration.
- Previous imaging studies performed, corresponding results, or pertinent lab results.
- History of prior treatment methods, drugs, surgery or other therapies, as well as duration of prior treatment.
- Any other information indicating the need for the procedure.
- Cancer type being treated with radiation therapy.
- Treatment plan specifics.

Expedited Approval Requests

evicore.com cannot be used for expedited approval requests. They must be processed through the call center. See the How to Request Preauthorization subsection of this chapter.

Urgent Requests

If the treatment is medically urgent and must be performed outside eviCore's business hours, the physician may deliver treatment. The preauthorization request (with supporting clinical documentation) must be submitted within two (2) business days of treatment. Urgent requests are reviewed against medical necessity criteria; approval is issued if they are met. eviCore completes urgent requests within 24 hours of the request's receipt.

evicore.com cannot be used for urgent approval requests. They must be processed through the call center. See the How to Request Preauthorization subsection of this chapter.

Non-Urgent Requests

Non-urgent requests are completed within three business days of eviCore's receipt of all necessary information, or within the time frames otherwise required by the member's benefit plan (see Standard Pre-Service Reviewin the Utilization and Care Management chapter).

A physician with office hours later than eviCore's call center may initiate a case through evicore.com and the request will be processed on the next business day.

Modifying a Preauthorization Request

If it becomes necessary to change or update the procedure after preauthorization is obtained, eviCore must be contacted no later than 48 hours after the modified procedure is performed. If the preauthorization for the modified procedure is not updated, and the claim does not match the authorized procedures, the claim is denied, with no member liability.

Verifying the Preauthorization Status

To verify the status of a preauthorization request, either call the applicable number as described in the How to Request Preauthorization subsection of this chapter or visit the Authorization Lookup section on evicore.com.

Determination Disagreement Procedure

Determination Disagreement

If a physician disagrees with a determination, contact eviCore's Peer-to-Peer Consultation Line as described in the How to Request Preauthorization subsection of this chapter to discuss the case with a medical director.

Formal Dispute Resolution

Submit to EmblemHealth:

- Appeals for Medicare members. Follow EmblemHealth's standard process for Medicare members, described in the Dispute Resolution Medicare Plans chapter.
- Complaints and grievances. Refer to the Dispute Resolution chapters for Commercial/CHPlus and Medicaid/HARP, as applicable.

Submit to eviCore:

- Expedited and standard clinical appeals for Commercial/CHPlus members and expedited and standard action appeals for Medicaid/HARP members. Appeals may be filed by the member, the member's delegate (including the practitioner acting as the member's delegate), or by practitioners on their own behalf. See the determination notification for appeal options. For a full description of member and practitioner rights regarding clinical and action appeals, see the Dispute Resolution chapters for Commercial/CHPlus and Medicaid/HARP, as applicable.

Radiation Therapy Treatment

See also: Oncology Drug Management Program.

Cancer Clinical Pathways

Listed below are types of cancer for which eviCore has a specific clinical pathway. For cancers less commonly treated with radiation therapy, the preauthorization follows an "Other Cancer Types" clinical pathway.

- Adrenal Cancer
- Anal Cancer
- Bile duct Cancer
- Bladder Cancer
- Bone Metastases
- Brain Metastases
- Breast Cancer
- Cervical Cancer
- Primary CNS Lymphoma
- Primary CNS Neoplasms
- Endometrial Cancer
- Esophageal Cancer
  Gastric Cancer

- Gallbladder Cancer
- Hodgkins Lymphoma
- Head and Neck Carcinoma
- Hepatobiliary Cancer
- Kidney Cancer
- Liver Cancer
- Metastases (Non-Bone/Brain)
- Multiple Myeloma
- Non-Hodgkins Lymphoma
- Non-Cancer Radiation Therapy
- Non-Small Cell Lung Cancer
- Oligometastases
- Pancreatic Cancer
- Prostate Adenocarcinoma
- Rectal Adenocarcinoma
- Soft Tissue Sarcoma
- Small Cell Lung Cancer
- Skin Cancer
- Testicular Cancer
- Urethral and Ureter Cancer
- Vulva Cancer

Each radiation treatment plan requires preauthorization. Preauthorizations are specific to the cancer type being treated. Preauthorizations have an expiration date based on the cancer diagnosis, treatment modality, and the number of phases and fractions being requested. Preauthorization must be obtained for radiation therapy treatment used to treat both malignant and benign cancers.

Preauthorization for Authorized Treatment

One preauthorization case number is assigned per treatment plan. The preauthorization will include all pertinent radiation therapy services for a member's entire episode of care within the scope of procedure codes managed under the program.

The preauthorization letter will communicate approved and/or denied services, which include treatment technique and number of fractions (ex: 10 fractions of 3D conformal treatment) as well as the preauthorization case number, appeal rights (if applicable), and claim instructions. If you have any questions about what is authorized, call eviCore as described in the How to Request Preauthorization subsection of this chapter.

Preauthorization Duration

The duration, or validity period, of a preauthorization is communicated once the treatment plan is approved. If additional time is needed, the referring or serving physician must contact eviCore to request an extension prior to billing for the corresponding services. The physician may call eviCore's Clinical Review Department as described in the How to Request Preauthorization subsection of this chapter.

Preauthorization for Additional Treatment

A preauthorization is only valid for the requested and approved treatment plan (an "episode of care"). If the member is provided with an additional episode of care, the referring and servicing physicians must contact eviCore to obtain a new preauthorization.

Modifying a Treatment

During a course of treatment, if the servicing physician opts to modify an approved treatment plan, the referring or servicing physician should call eviCore to discuss the new treatment plan. A new Medical Necessity Determination is needed for any new or modified treatment plans. It is strongly recommended to call eviCore as soon as it is known there is a change in treatment plan and prior to billing for the corresponding services. The referring or servicing physician must submit the supporting clinical

history to determine medical necessity. The referring or servicing physician is notified as to whether the proposed changes to the treatment plan are deemed medically necessary. If the preauthorization for the treatment plan is not updated and the claim does not match the authorized procedures, the claim is denied, with no liability to the member.

Last reviewed: 11/19/2020