Prior Authorization of Advanced Imaging and Cardiology Services for Highmark

Provider Orientation
Company Overview
Comprehensive Solutions

End-to-End Solution on a single integrated platform

- Radiology
- Cardiology
- Musculoskeletal
- Sleep Management
- Medical Oncology
- Specialty Drug
- Radiation Therapy
- Lab Management
- Post-Acute Care
Our Clinical Approach
Clinical Platform

Multi-Specialty Expertise

- **Family Medicine**
- **Internal Medicine**
- **Pediatrics**
- **Sports Medicine**
- **OB/GYN**
- **Cardiology**
- **Nuclear Medicine**
- **Anesthesiology**
- **Radiation Oncology**
- **Sleep Medicine**

**Oncology/Hematology**
- **Surgery**
  - General
  - Orthopedic
  - Thoracic
  - Cardiac
  - Neurological
  - Otolaryngology
  - Spine

**Radiology**
- Nuclear Medicine
- Musculoskeletal
- Neuroradiology

- **260 board-certified medical directors**
- **Diverse representation of medical specialties**
- **450 nurses with diverse specialties and experience**
- **Dedicated nursing and physician teams by specialty for Cardiology, Oncology, OB-GYN, Spine/Orthopedics, Neurology, and Medical/Surgical**
Evidence-Based Guidelines

The foundation of our solutions:

- Dedicated pediatric guidelines
- Contributions from a panel of community physicians
- Experts associated with academic institutions
- Current clinical literature

Aligned with National Societies

- American College of Cardiology
- American Heart Association
- American Society of Nuclear Cardiology
- Heart Rhythm Society
- American College of Radiology
- American Academy of Neurology
- American College of Chest Physicians
- American College of Rheumatology
- American Academy of Sleep Medicine
- American Urological Association
- National Comprehensive Cancer Network
- American College of Therapeutic Radiology and Oncology
- American Society for Radiation Oncology
- American Society of Clinical Oncology
- American Academy of Pediatrics
- American Society of Colon and Rectal Surgeons
- American Academy of Orthopedic Surgeons
- American College of Obstetricians and Gynecologists
- North American Spine Society
- American Association of Neurological Surgeons
- The Society of Maternal-Fetal Medicine
Advanced Imaging and Cardiology Services Prior Authorization Program for Highmark
Program Overview

eviCore will begin accepting requests on Dec. 17, 2018 for dates of service Jan. 1, 2019 and beyond

Prior authorization applies to services that are:

• Outpatient
• Elective / Non-emergent
• Diagnostic

Prior authorization does not apply to services that are performed in:

• Emergency room
• Inpatient
• Observation

It is the responsibility of the ordering provider to request prior authorization approval for services.

It is the responsibility of the rendering provider to verify that the necessary authorization has been obtained before providing the service.
**Applicable Membership**

**Authorization by eviCore is required** for Highmark members in Pennsylvania, Delaware and West Virginia enrolled in the following programs:

- Commercial Fully Insured
- Commercial Self Insured
- Medicare Advantage (PA and WV)
- Affordable Care Act
- Administrative Services Only (select groups)
- Children’s Health Insurance Program (CHIP) (PA only)
- Out of Area select ASO groups

Members who **do not require prior authorization are**:

- All other Out Of Area (OOA)

Benefits can vary by member contract, so please be sure to check the member’s benefits before delivering care to confirm if an authorization is required. NaviNet® is available to help you check member benefits and to verify if an authorization is required.
Advanced Imaging & Cardiology Services
Covered Services:

Advanced Imaging
- CT, CTA
- MRI, MRA
- PET, PET/CT
- Nuclear Medicine*

Cardiology Services
- Stress Testing
  - Myocardial Perfusion Imaging (SPECT & PET)
  - Stress Echocardiography
- Cardiac CT & MRI
- Echocardiography; Transthoracic, Transesophageal*
- Diagnostic Heart Catheterization*

*Additional Advanced Imaging & Cardiology Services modalities in eviCore's program scope.

To find a list of CPT (Current Procedural Terminology) codes that require prior authorization through eviCore, please visit:

https://www.evicore.com/healthplan/highmark
Prior Authorization Requests

How to request prior authorization:

**WEB**

NaviNet®

Available 24/7 and the quickest way to create prior authorizations and check existing case status

Or by phone*: 888-564-5492
7:00 a.m. to 7:00 p.m. EST
Monday - Friday

Fax* option: 800.540.2406 Fax forms available at [www.evicore.com](http://www.evicore.com)
Clinical Review Process

Methods of Intake

Predictive Intelligence/Clinical Decision Support

Real-Time Decision with Web

START

Nurse Review

MD Review

Clinical Consultations

Appropriate Decision

Easy for providers and staff
If clinical information* is needed, please be able to supply:

- Prior tests, lab work, and/or imaging studies performed related to this diagnosis
- The notes from the patient’s last visit related to the diagnosis
- Type and duration of treatment performed to date for the diagnosis

*Clinical information may be uploaded electronically via the Provider Portal
Prior Authorization Outcomes

Approved Requests:

- All requests are processed within 2 business days after receipt of all necessary clinical information.
- Authorizations are typically good for 60 days from the date of determination.
- Highmark will honor existing prior authorizations for continuity of care on claims for advanced imaging & cardiology services which overlap during the transition to the new program.

Delivery:

- Faxed to ordering provider
- Mailed to the member
- Information can be printed on demand from the Highmark provider web portal

Denied Requests:

- Communication of denial determination
- Communication of the rationale for the denial
- How to request a Peer Review for commercial members

Delivery:

- Faxed to the ordering provider and
- Mailed to the member
- Information can be printed on demand from the Highmark provider web portal
Prior Authorization Outcomes- Commercial

Reconsiderations

• Additional clinical information can be provided without the need for a physician to participate
• Must be requested on or before the anticipated date of service
• Commercial members only

Clinical Consultations:

• If a request is denied and requires further clinical discussion for approval, we welcome requests for clinical determination discussions from referring physicians. In certain instances, additional information provided during the consultation is sufficient to satisfy the medical necessity criteria for approval.
• Clinical Consultations can be scheduled at a time convenient to your physician
• Commercial members only
Prior Authorization Outcomes – Medicare / Medicare Advantage

Pre-Decision Consultations

- If your case requires further clinical discussion for approval, we welcome requests for clinical determination discussions from referring physicians prior to a decision being rendered.

- In certain instances, additional information provided during the pre-decision consultation is sufficient to satisfy the medical necessity criteria for approval.
Medical Necessity Appeals:

- eviCore will process first level provider appeals for Commercial members.
- Requests for appeals must be submitted to eviCore within:
  - West Virginia & Delaware: 365 calendar days of the initial determination.
  - Pennsylvania: 180 calendar days of the initial determination.
- Requests will be considered an appeal if:
  - A clinical consultation or reconsideration was completed.
  - An appeal is formerly requested
  - Prior to 180 calendar days
  - Appeals after 180 calendar days will not be processed and will be directed to Highmark.
- The procedure request and all clinical information provided will be reviewed by a physician other than the one who made the initial determination.
- A written notice of the appeal decision will be mailed to the member and faxed to the provider.
- Highmark will process first level provider appeals for all other members.
- Appeals for services that were denied before the new advanced imaging and cardiology services program goes into effect must be submitted to NIA.
Special Circumstances

**Outpatient Urgent Studies:**

- Urgent requests may be submitted on the portal or by phone 7:00 AM - 7:00 PM (EST): (888) 564-5492
- In order to submit an urgent request online, providers must upload all supporting clinical documentation during case initiation.
- If submitted by phone, request an expedited outpatient prior authorization review and provide clinical information.
- Urgent outpatient cases will be reviewed within 24 hours not to exceed 72 hours of the request.

**Retrospective Studies:**

- Retro requests must be submitted within 730 business days following the date of service. Requests submitted after 730 business days will be administratively denied.
- Retro requests can be submitted via phone or fax.
- Retro requests are reviewed for medical necessity. Turnaround time on retro requests is 30 calendar days.
- Retro requests for dates of service prior to 1/1/19 must be submitted to NIA.

Urgent care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. (National Committee for Quality Assurance [NCQA] HUM8)
NaviNet Services
Please make sure you are utilizing NaviNet to see if a member requires authorization for outpatient Advanced Imaging and Cardiology Services.
When searching for benefits in NaviNet, you can enter a Member ID or First Name, Last Name and Date of Birth.
A category for Advanced Imaging and Cardiology Services is located on the Eligibility and Benefits screen in NaviNet to indicate if authorization is required. Advanced Imaging Ind. NO indicates no outpatient authorization is required.
Select Authorization Submission from the Plan Central page to start the request
Select the Referred from Billing Provider associated with the NaviNet office account.
Select the Referred from Service Provider and the Proposed Date of Service. Enter the Member information and select the Category & Service.

Will be disabled on 1/1/19. For eviCore requests, ANY IMAGING CATEGORY can be selected for ANY advanced imaging and cardiology procedure.
Single-Sign On for Highmark Providers / NaviNet

Service Details:
Requested Service: CT Scan - Heart - Congenital Studies Non-coronary Arteries
Proposed Date of Service: 08/22/2018

Referred To Provider:
Remember to verify the provider network that is considered at the in-network level for a member's benefit plan.

Please enter a provider ID, search for a provider, or select a preferred provider from the dropdown.

Billing Provider: Preferred Providers
Description:
Service Provider: Description:

Optional Search
Add Preferred Provider:

Submit  Save  View Referral/Auth  Review Notes

Select the Referred to Provider
Select up to 2 diagnosis codes, enter the remaining required fields and then Submit.
Enter the **ordering practitioner name**, who to contact from the ordering practice and appropriate information for the **point of contact individual**.
Select the CPT and Diagnosis codes. Both fields in the CPT code and diagnosis code section are searchable by drop down lists - once you select one and click outside the box the other populates.
Verify Service Selection

Click **continue** to confirm your selection.
To request additional procedures for the same member, site, and date of service, select “Yes” & Submit. Enter the Procedure Code being requested. Additional codes to be added do not have a search capability. Additional codes need to be manually entered.
If the additional code cannot be added to the request you will see this message. The additional procedure code would require a separate authorization request/submission.
After entering all requested procedures, click "No" to proceed to the Clinical Certification.
Verify all information entered and make any needed changes prior to moving into the clinical collection phase of the prior authorization process.

You will not have the opportunity to make changes after that point.
Urgency Indicator

If the case is standard select Yes.

If your request is urgent select No, Select an Urgency Indicator and Upload your patient’s relevant medical records that support your request.

In order to submit an urgent request online, providers are required upload all supporting clinical documentation, including medical records, during case initiation.

Important - If you choose to fax clinical information, you must initiate the request via phone and provide the clinical information over the phone or via fax (800) 540-2406.

You can upload up to FIVE documents in .doc, .docx, or .pdf format. Your case will only be considered Urgent if there is a successful upload.

Note: Offices that are part of health systems may need to check with your internal IT resources to enable permission for upload capability.
Clinical Certification

Questions will populate based upon the information provided, such as procedure code and diagnosis code.

Fewer codes require submission of clinical information
Do not utilize the “Finish Later” feature when initiating requests on NaviNet. This feature is not enabled. You may lose the clinical information which was previously provided during clinical certification.
Acknowledge the Clinical Certification statements, and hit “Submit Case.”
Once the clinical pathway questions are completed and if the answers have met the clinical criteria, an approval will be issued.

The Authorization Number will begin with an “A” followed by 9 digits.

Print the screen and store in the patient’s file.

Fewer codes require submission of clinical information.
If you don’t receive an immediate approval then you’ll be directed to this screen where there is the opportunity to provide **additional clinical information**. You will have the option to either upload documentation, enter information into the text field, or contact us via phone. At this point, you know that your case is pended for medical review.
If additional information is required, you will have the option to either upload documentation, enter information into the text field, or contact us via phone or fax.
Once the clinical pathway questions are complete and additional clinical information is provided, the request is sent to Medical Review. A **Case Number** will be issued.

The Case Number will be a 10 digit number beginning with a “1”.

Print the screen and store in the patient’s file.
Auth Inquiry and Reports lets you check the real-time status and details of your authorization if you are the referred to or the referred from provider. You can search by Member ID, member name or by Date of Service.
This is Auth Inquiry when searching by Member ID. eviCore provides an authorization starting with the letter A followed by 9 digits. NaviNet Authorization Inquiry displays EXT followed by 9 digits (for NaviNet submissions) or C followed by 9 digits (for phone/fax submissions).
This screen shows the Auth Inquiry search by Member name. Enter the members first name, last name and Date of birth. Select the member.
After selecting the member, you will be taken to this screen where you will select the Billing Provider / Facility Name and search for the authorization by Date of Service.
### Referral/Authorization Inquiry

**Billing Provider / Facility Name:** [Dropdown]

**Date Of Service From:** 11/14/2018

**Date Of Service To:** 11/21/2018

**Type:** [Dropdown]

**Type Of Service:** [Dropdown]

**Authorization Number:** [Dropdown]

**Referral/Authorization Status:** [Dropdown]

### Records 1-22 of 22, page: 1

<table>
<thead>
<tr>
<th>Type / Place Of Service</th>
<th>Status</th>
<th>Referral/Authorization Number</th>
<th>Date of Service</th>
<th>Patient Name</th>
<th>Patient Date of Birth</th>
<th>Referred from Billing Provider / Facility</th>
<th>Referred to Billing Provider / Facility</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization / Outpatient Medical</td>
<td>Approved</td>
<td>EXT-</td>
<td>11/20/2018</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

---

This screen shows the Auth Inquiry Search by Date of Service
Although you cannot initiate requests directly on eviCore.com, the Authorization Lookup function is enabled on the CareCore National Portal. You may search by Member Information or Auth/Case Number. For new users, to search authorization status, you can create a new login by going to www.evicore.com, click ‘Providers’ at the top of the webpage and when prompted to enter a User ID and Password, under the Login button click ‘Register’ and complete the user registration form.
Provider Resources
To access Advanced Imaging & Cardiology Services Program educational materials on Highmark’s Provider Resource center go to www.highmark.com. Click Providers and the applicable “Plan Name” under For Providers.
You can also get to the Provider Resource Center in NaviNet by selecting Resource Center on Highmark’s Plan Central Page.
Then click + next to Care Management Programs and then select Advanced Imaging and Cardiology Services Program. Provider Educational Materials/Communications are posted on this site.
Clinical Guidelines, FAQ’s, Online Forms, and other important resources can be accessed at [www.evicore.com](http://www.evicore.com). Click Solutions from the menu bar, and select the specific program needed. This information is also accessible on the eviCore/Highmark Provider Resource Page - [https://www.evicore.com/healthplan/highmark](https://www.evicore.com/healthplan/highmark)
Clinical Worksheets and Fax Forms can be accessed at [www.evicore.com](http://www.evicore.com). Click **Resources & Providers** from the menu bar. Click **Online Forms & Resources** & Select Solution **Cardiology or Radiology** from the dropdown menu.
The eviCore blog series focuses on making processes more efficient and easier to understand by providing helpful tips on how to navigate prior authorizations, avoid peer-to-peer phone calls, and utilize our clinical guidelines.

You can access the blog publications from the Insights tab or via the direct link at https://www.evicore.com/insights.
Provider Resources: Prior Authorization Call Center

7:00 AM - 7:00 PM (EST): (888) 564-5492*

- Obtain prior authorization or check the status of an existing case
- Discuss questions regarding authorizations and case decisions
- Change facility or CPT Code(s) on an existing case
- To request a Clinical Consultation
- Status check

eviCore fax* number: (800) 540-2406

*NaviNet remains the preferred initiation method
Provider Resources: Web-Based Services

www.evicore.com

To speak with a Web Specialist*, call (800) 646-0418 (Option #2) or email portal.support@evicore.com.

- Pause/Start feature to complete initiated cases
- Upload electronic PDF/word clinical documents

*For issues with NaviNet, click on Help at the top of Highmark Plan Central to access NaviNet Support
Provider Resources: Client Provider Operations

8:00 AM – 8:00 PM (EST): (800) 575-4517

clientservices@evicore.com

- Issues experienced during case creation
- Reports of eviCore system issues
Provider Resources: Implementation Document

Highmark Implementation site - includes all implementation documents:

https://www.evicore.com/healthplan/highmark

• Provider Orientation Presentation
• CPT code list of the procedures that require prior authorization
• Quick Reference Guide
• eviCore clinical guidelines
• FAQ documents and announcement letters

Materials are also available on the Highmark Provider Resource Center Site under Care Management Programs

You can obtain a copy of this presentation on the implementation site listed above. If you are unable to locate a copy of the presentation, please contact the Client Provider Operations team at ClientServices@evicore.com.
Diagnostic Imaging Services Privileging Program for Highmark
Privileging Program Overview

Highmark, with the assistance of eviCore healthcare, has implemented a new imaging privileging process, effective Jan. 1, 2019.

• All network providers are required to comply with the terms and conditions of their contracts and meet the applicable requirements for performing imaging services.

• Highmark has established privileging requirements for providers who bill for imaging services in an outpatient setting.

• If you perform diagnostic imaging services and would like to become a privileged provider, you must complete a Highmark Privileging Application.
New Privileging Program Implementation

Does every provider who bills for imaging services in an outpatient setting have to submit a new application to eviCore effective January 1, 2019?

• No. Highmark has a current privileging program and will be honoring those decisions and no new application will be required. Providers will only need to contact eviCore if they wish to add a new modality.

When will a new application be required?

• Highmark’s network is on a 3 year reassessment cycle and will continue that process. Providers will receive a mailed letter, faxes, and a call when it is time for their reassessment. Providers will only need to contact eviCore if they wish to add a new modality.
Highmark did not change the imaging criteria for providers and there are no new requirements to perform imaging. The new eviCore program will honor the existing Highmark program criteria.

Highmark will extend privileges by 3 months for those providers whose privileges would expire in the first 3 months; Jan. 1, 2019 through March 31, 2019.

The new program will notify providers 3 months before their privileges expires. Previously, providers were notified 6 months in advance. Providers will now have 3 months to comply with their reassessment and not 6 months.

Highmark will not accept any privileging applications under the current program from Dec. 14, 2018 – Dec. 31, 2018.
Providers must obtain a secure logon ID from eviCore and then complete the online Highmark Imaging Assessment available at www.accuracymgmt.com.

- To obtain a logon ID to access and complete the application, the provider must request a login ID at www.accuracymgmt.com.

eviCore will request the following information in order to assign a logon ID:

- Provider name
- Address of diagnostic imaging location
- Tax identification number
- Specialty

Once the provider receives their logon ID from eviCore, they should go to www.accuracymgmt.com

- Enter the assigned login ID into the box on the webpage and click on start
- Each time the user clicks next within the application, the previous information entered is stored so providers do not have to complete the application all at once
New Privileging Processes

Highmark providers are grandfathered into the existing privileging program and eviCore will mail, fax, and call when it is time for your reassessment. There is no need to contact eviCore until you reach the end of your current 3 year reassessment cycle.

All provider questions should be directed to eviCore’s Facility Assessment Department by email accuracymgmt@evicore.com or by phone 800-457-2759.

Privileging education materials are also available on the Highmark Provider Resource Center Site under Care Management Programs.
Thank You!