

## Provider Manual

### Chapter 19: Radiology Program

This chapter contains information about our diagnostic imaging management program for outpatient radiology services, including prior approval and radiology scheduling procedures, for all members.



#### Overview

The EmblemHealth Radiology Program, developed with eviCore, provides diagnostic imaging management for outpatient radiology services. Services targeted for utilization management depend on the EmblemHealth benefit plan. eviCore also conducts clinical standard and expedited appeals (excluding members with Medicare plans).

#### 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 the 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.

#### Film Review

Practitioners' 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 then assess these studies for technical quality and diagnostic interpretation.

#### Members Exempt from the EmblemHealth Radiology Program

As of January 1, 2018, ACPNY members are no longer exempt from the EmblemHealth Radiology Program. eviCore now provides utilization management (prior approval) for ACPNY radiology services. The referring provider will need to

contact eviCore to get the prior approval.

As of August 20, 2018, members assigned to a PCP affiliated with St. Barnabas Hospital are no longer exempt from the EmblemHealth Radiology Program. eviCore now provides utilization management (prior approval) for these members. The referring provider will need to contact eviCore to get the prior approval.

While most of our members' covered radiology services are managed by eviCore, the following exceptions apply:

- Members whose care is managed by Montefiore Medical Group (CMO) or HealthCare Partners (HCP) must contact the applicable organization for prior approval. Check the member's ID card or eligibility information on [emblemhealth.com](http://emblemhealth.com) to determine whether HIP, CMO, or HCP is the managing entity responsible for managing a member's care; if HIP is the managing entity, then eviCore is the organization to contact for prior approval.
- Effective January 1, 2018, this exemption no longer applies for:
  - Members who selected a PCP assigned to ACPNY. The prior approval request must be entered on [emblemhealth.com](http://emblemhealth.com).
- Effective August 20, 2018, this exemption no longer applies for:
  - Members who selected a physician affiliated with the St. Barnabas Hospital System. The prior approval request must be entered on [emblemhealth.com](http://emblemhealth.com).

## Prior Approval Procedures

### Services Requiring Prior Approval

Please refer to [Clinical Corner](#) for a list of services (and CPT-4 codes) that require prior approval.

Prior approval is required for services performed in the following places of service:

- Outpatient hospital facilities
- Freestanding radiology facilities
- Radiology office-based settings
- Non-radiology office-based settings

Neither prior approval nor referral is required for:

- Inpatient hospitalization
- Services rendered in hospital emergency departments
- Services provided when one of EmblemHealth's companies is the secondary insurer
- Pulmonary perfusion imaging

The following services do not require prior approval but may require a referral from the member's PCP:

- Basic X-rays

- Mammograms
- Bone density tests

### Who Requests Prior Approval

It is the responsibility of the referring practitioner (i.e., the practitioner developing the patient's treatment plan) to obtain the prior approval before services are rendered. If the referring and rendering practitioners are different, the rendering practitioner is encouraged to confirm that a prior approval is on file before services are rendered. The rendering practitioner is ultimately responsible for ensuring that all applicable radiology imaging procedures at the applicable service location have received all necessary prior approvals.

### How To Obtain Prior Approval

Before requesting prior approval from please have the patient's medical records on hand and complete the request form specific to the procedure being requested. These request forms are available at the links below and at [evicore.com](http://evicore.com). They list all clinical questions the practitioner must answer during the initial prior approval review.

For MRI, [General Use Clinical Certification Request Form](#)

For CT Scan, [CT/CTA Clinical Certification Request Form](#)

For PET Scan, [PET Scan Clinical Certification Request Form](#)

For MR/MRAs, [MR/MRA Clinical Certification Request Form](#)

Once the form is complete, submit prior approval requests in one of three ways:

**Online:** Visit [www.evicore.com](http://www.evicore.com). To submit online requests, the ordering physician must be a registered user. To register for a user ID and password, visit [www.evicore.com](http://www.evicore.com) and click the "Register" button.

**By phone:** Call **1-866-417-2345** for GHI HMO, HIP and EmblemHealth CompreHealth EPO (Retired August 1, 2018) and Vytra plan members. Call **1-800-835-7064** for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members. Representatives are available Monday through Friday, from 7 am to 7 pm, EST. The program is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving and Christmas Day.

**By fax:** Fax the completed request form to **1-800-540-2406**.

### Please have the following information available when you call:

- The completed form, as noted above
- The patient's full name, member ID number and insurance information
- The exam(s) requested for the patient
- The working diagnosis or rule-out
- The signs and symptoms that call for the exam, as well as their duration
- Any 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 exam

### Expedited Approval Requests

evicore.com cannot be used for expedited approval requests. These requests must be processed through the call center. Call **1-866-417-2345** for GHI HMO, HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO, and Vytra plan members. Call **1-800-835-7064** for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members. Utilization review staff is available 24 hours a day, 7 days a week. The program is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving and Christmas Day.

### Urgent Requests

If the treatment is medically urgent and must be performed outside business hours, the physician may deliver treatment and must submit the prior approval request (with supporting clinical documentation) within two (2) business days. Urgent requests are reviewed against medical necessity criteria, and an approval is issued as long as the request meets these medical necessity criteria. Urgent requests will be completed within 24 hours of receiving the request. evicore.com cannot be used for urgent approval requests. These requests must be processed through the call center. Call **1-866-417-2345** for GHI HMO, HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO and Vytra plan members. Call **1-800-835-7064** for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members. Utilization review staff is available 24 hours a day, 7 days a week. The program is closed New Year's Day, Memorial Day, Independence Day, Labor Day.

### Non-Urgent Requests

Non-urgent requests will be completed within three (3) business days of receiving all necessary information, or within the time frames otherwise required by the member's benefit plan (see Standard Pre-Service Review in the [Care Management](#) chapter). In most cases, the staff will review and determine prior approvals during the initial phone call, as long as all the required information is provided. The review and determination processes may, however, take longer if member or practitioner eligibility verification is required, or if the request requires additional clinical review (see Standard Pre-Service Review in the [Care Management](#) chapter).

A physician with office hours later than the call center's may initiate a case through [evicore.com](#) which will be processed on the next business day.

### Modifying a Prior Approval Request

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

### Verifying the Prior Approval Status

To verify the status of a prior approval request, either call the applicable number below or visit the Authorization Lookup section at [evicore.com](#).

Call **1-866-417-2345** for GHI HMO, HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO and Vytra plan members. Call **1-800-835-7064** for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members.

**Note:** While the program may approve or deny a prior approval request, this determination is based on medical necessity only. Always verify member eligibility, benefits and copayments with EmblemHealth directly at [www.emblemhealth.com](#).

### Determination Disagreement

If the referring physician disagrees with the determination, contact the Peer-to-Peer Consultation Line to discuss the case with a medical director. Call **1-866-417-2345** for GHI HMO, HIP, EmblemHealth CompreHealth EPO (Retired August 1, 2018), EmblemHealth Medicare HMO and Vytra plans. Call **1-800-835-7064** for EmblemHealth EPO/PPO and EmblemHealth Medicare PPO plan members.

**Claims will be denied and the member will not be liable for payment if:**

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

**Formal Dispute Resolution**

Please submit to EmblemHealth:

**Appeals for Medicare members.** Please follow EmblemHealth's standard processes for Medicare members, described in the [Dispute Resolution Medicare chapter](#).

**Complaints and grievances.** Please refer to the [Dispute Resolution chapters](#) for Commercial/CHP and Medicaid/HARP, as applicable.

Please submit to eviCore:

**Expedited and standard clinical appeals for Commercial/CHP 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. For a full description of member and practitioner rights regarding clinical and action appeals, see the [Dispute Resolution chapters](#) for Commercial/CHP and Medicaid/HARP, as applicable.

## GHI HMO, HIP and Vytra Radiology Scheduling Procedure

### Plan Participation

Members with HIP as their managing entity (see the member's ID card or eligibility information on [emblemhealth.com](http://emblemhealth.com)) follow the Radiology Scheduling Procedure.

### Scheduling Procedure

When a prior approval request is made, utilization review staff evaluates the requested procedure against the existing criteria and determines its medical necessity.

If the prior approval request is approved, a scheduling representative contacts the member to schedule the procedure at a participating location. Once the location is selected, the medical necessity determination is amended to include an authorization number.

Program staff attempts to contact the member for a 48-hour period. If at the end of that period the scheduling representative is unable to speak with the member, they select a participating imaging facility close to the member's home and send a letter to both the member and the referring practitioner with the contact information for the site selected.

Members may contact the scheduling department at **1-866-699-8131**, Monday through Friday, from 7 am to 7 pm, EST, to schedule a procedure or change the procedure site before the appointment date.

## Vytra Plans Radiology Program for Dates of Service Prior to January 1, 2016

### Overview

Vytra HMO contracted with various groups to provide radiology services for its members. All participating Vytra PCPs designated a radiology center that their Vytra patients used exclusively. The designated radiology center appeared on the ID card of each Vytra member on the PCP's panel.

### Designated Radiology Centers

For radiology services to be covered, Vytra plan members used the designated radiology center specified on their Vytra ID card. If no radiology center appeared on the ID card, the member was able to go to any Vytra network radiologist. Participating practitioners sent members directly, without a referral, to the designated radiologist by writing a prescription detailing the test required.

PCPs with more than one office location were able to select a different radiology center for each of their offices.

In the rare instance that the designated radiology center could not meet the member's needs, the practitioner contacted Vytra's Care Management department at **1-888-288-9872** for prior approval to send the member to another facility.

### Guarantee Waiver Agreement for Radiology Groups

Radiology centers treating a member outside their designation called Vytra's Provider Service Line at **1-888-288-9872** before rendering services. During this call, the center ensured prior approval was secured and use Vytra's Guarantee Waiver Agreement.

Each member seeking service outside their designated facility signed Vytra's Guarantee Waiver Agreement. This was the only waiver recognized by Vytra. At time of signing, members were advised that they would be responsible for payment of all services performed. Practitioners had the right to withhold service to any member who chose not to sign this waiver.

If the radiology facility rendered services without having a signed waiver, the member was reimbursed for any up-front payment and could not be balance billed. Vytra reserves the right to withhold future payment to the facility until the member was reimbursed.

### **Changing Designated Radiology Groups**

PCPs were able to change their designated radiologist under the following circumstances:

- PCP requested a change and Vytra's Provider Relations department deemed the change to be in the best interest of the PCP's patients (e.g., quality of care related, PCP location change)
- A corporate decision allowed all PCPs to change their designated radiologist
- Administrative purposes (e.g., correction of database)

### **Quality Issues**

All quality-related issues had to be reported to Vytra at **1-888-288-9877** promptly for immediate resolution.

### **Copies of X-Rays**

Copies of X-rays were not reimbursed unless the member received a second opinion for a cancer diagnosis and the practitioner received proper approval. Eligible copies were reimbursed at the then current fee schedule.

### **Radiation Therapy**

Radiation therapy required the hematologist/oncologist to obtain prior approval.

If appropriate, a Care Management representative authorized an initial series of three visits for radiation therapy. Upon completing the initial evaluation, the radiation oncologist contacted Vytra's Care Management department with the findings.

The radiologist then forwarded a copy of the proposed treatment plan to the referring hematologist/oncologist. Specialists were required to communicate with the member's PCP regarding all treatment and follow-up care provided.

### **DEXA Scans**

Vytra reimbursed only radiologists for dual energy X-ray absorptiometry (DEXA) scans. PCPs and specialists other than radiologists were not reimbursed for DEXA scans, regardless of any prior arrangements with or payments from Vytra.

If the member's designated radiologist did not perform DEXAs, the referring physician called Vytra's Care Management department to authorize services at another network radiologist.