Overview

Oxford is expanding its prior authorization to include stress echocardiogram and echocardiogram procedures for Oxford commercial members. Please reference the policy and CPT codes which will require prior authorization through CareCore National at OxfordHealthPlans.com > Medical and Administrative Policies > Cardiology Procedures Requiring Precertification.

* The exceptions to this policy are explained in questions 37 through 44.

Q1. When does the prior authorization requirement become effective?

The prior authorization requirement becomes effective for procedures performed on or after April 1, 2014.

Q2. Is Oxford using a vendor to administer the prior authorization requirements?

Yes. CareCore National's cardiology division will administer the prior authorization requirements on behalf of Oxford. We have taken special steps to ensure that the clinical criteria adhere to current best practices and have sought guidance from our external cardiac Scientific Advisory Board, which is comprised of leading clinical and academic board-certified cardiologists. For your reference, the clinical criteria can be found in the 2013 Provider Reference Manual available on OxfordHealthPlans.com > Providers > Tools and Resources > Practical Resources > Provider Reference Manual (PRM).

Q3. How do I submit a request for prior authorization for cardiac procedures?

Commercial cardiology prior authorization can be obtained or verified by:

- Online at CareCoreNational.com
- By calling 877-773-2884 (7 a.m. to 7 p.m. Monday - Friday)

Q4. What happens after I submit a request for prior authorization?

CareCore National, on behalf of Oxford, will conduct a clinical coverage review to determine whether the procedure is a covered benefit and is medically necessary. If the procedure is medically necessary and is a covered benefit, a prior authorization number will be issued.

If it is determined that the procedure is not a covered benefit and/or is not medically necessary, the procedure will not be authorized. If you perform the procedure, we will deny any claim for the procedure and all services associated with it. Standard appeal rights will apply.

The member cannot be billed for services determined to be medically unnecessary, unless the member, with knowledge of our determination, agrees in writing to be responsible for the cost of the services.

Q5. What are CareCore National's qualifications for administering the program?

CareCore National was founded in 1994 by physicians to provide comprehensive, evidenced-based programs to improve the use of diagnostic imaging. CareCore National's clinical expertise covers nine specialty areas including cardiology. Board-certified physicians provide health plans like ours with evidence-based medical necessity criteria for determining the appropriate utilization of cardiology services.
Q6. What information is required to obtain an echocardiogram or stress echocardiogram prior authorization?

Member information required:
- Oxford ID number.
- Member’s name.
- Member’s date of birth.
- Member’s address and telephone number.

Ordering provider information required:
- Tax identification number (TIN).
- 10-digit telephone number.
- 10-digit fax number.
- Specialty.
- Address.
- Contact person at your office and the facility where the procedure is to be performed.

Rendering provider information required (if different than ordering provider):
- Name and address. (To help ensure proper payment, the rendering provider must be the provider noted in the authorization.)

Clinical information required:
- Procedure(s) requested with the Current Procedural Terminology (CPT) code(s).
- Proposed date for performing the procedure.
- Diagnosis or “rule out” with the ICD-9-CM (or its successor) code(s).
- Member’s clinical condition, which may include any symptoms, treatments, dates (and results) of prior imaging studies performed.
- Information the provider believes will help in evaluating the request, including but not limited to prior diagnostic tests and consultation reports.
- If the rendering provider is different from the ordering provider, the authorization number should be obtained and communicated by the ordering provider to the rendering provider.

Receipt of an authorization number does not guarantee or authorize payment, but is confirmation that prior authorization was obtained. Medical necessity determinations and payment authorization are separate processes. Payment for covered services is contingent upon many factors, including the member’s eligibility on the date of the service, any claim processing requirements and the terms of your participation agreement with Oxford.

Q7. How do I know if prior authorization is required for an Oxford member?

In most cases, if an Oxford member is enrolled in a commercial benefit plan, prior authorization is required. If you need assistance determining prior authorization requirements, please call the number on the back of the member’s ID card. You can also verify prior authorization requirements at OxfordHealthPlans.com and by calling Oxford at 800-666-1353.

Q8. Who is responsible for obtaining prior authorization?

The ordering provider’s office requesting the procedure or their designees is responsible for obtaining prior authorization. A designee may be a member of the physician’s office staff or the facility if that person has the relevant clinical information. The rendering provider is responsible for ensuring the prior authorization is in place before administering services.

Q9. Do facilities or members have obligations for verifying/obtaining prior authorization?

Yes. Facilities are responsible for verifying that a prior authorization is in place before scheduling the procedure to ensure they receive payment for the rendered services. Members are responsible for obtaining prior authorization for out-of-network services and services will be subject to their applicable out-of-network benefits.
Q10. What if a stress echocardiogram or echocardiogram is needed on an emergent or urgent basis?

Please do not delay patient care to obtain prior authorization for either stress echocardiogram or echocardiogram when, in their opinion, the procedures are required on an emergent basis or urgent basis.

**Emergency procedures:** You are not required to seek prior authorization for emergent procedures performed in an emergency room or urgent care center (billed with place of service 23 or 20). When a procedure was performed in an outpatient hospital (billed with place of service 22) or in the ambulatory surgical center (billed with place of service 24), and, in your opinion the procedure was required on an emergent basis, you must contact CareCore within two business days after performing the procedure to obtain a prior authorization number.

**Urgent Requests**

The ordering provider may request a prior authorization number on an "urgent" basis if the provider determines it to be medically required. Make urgent requests by calling 877-773-2884 and state that the case is clinically urgent and explain the clinical urgency. CareCore National will follow state and Federal regulated turnaround time for urgent case requests. You should not delay patient care to obtain prior authorization for either stress echocardiogram or echocardiogram when the procedures are required on an urgent basis.

If the procedure is rendered on an urgent basis, a prior authorization number must be requested retrospectively within two business days. The retrospective process is outlined in question 12. The retrospective process is reserved for urgent, emergent or after-hours procedures only.

Q11. In what places of service is prior authorization required?

Prior authorization is required for stress echocardiogram and echocardiogram procedures performed in any outpatient setting other than emergency rooms (place of service 23) and urgent care centers (place of service 20).

Q12. What is the retrospective authorization process?

If you determine that a stress echocardiogram or echocardiogram is required on an urgent basis, prior to the **state and Federal regulated turnaround time for urgent case requests**, as referenced in Q10, you should perform the service and then seek authorization retrospectively.

If the services are required in an urgent, emergent or after-hours situation, you should perform the service as determined and seek authorization retrospectively.

Ordering physicians should follow the same processes outlined for a standard prior authorization request. Documentation must include an explanation as to why the procedure was required on an urgent, emergent or after-hours basis. Retrospective authorization will be available for two business days after the procedure is performed, only if the situation was urgent, emergent or after-hours. If the member’s benefit plan requires health services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary. Urgent services rendered without a required prior authorization number will be subject to retrospective review for medical necessity and payment may be withheld if the services are determined not to have been medically necessary. Please note, the member cannot be balance billed for any denied charges under these circumstances.

If a claim is submitted prior to the completion of the retrospective authorization process, it will be denied for lack of authorization. **Claim denials may be appealed using the standard appeals process. Retrospective authorization is not available for elective procedures. The retrospective process is only available for urgent, emergent or after-hours cases.**
Q13. Does the prior authorization requirement apply when the member does not provide the physician or facility with sufficient health coverage information to know that a prior authorization was/is required?

If the provider is given inaccurate or insufficient health coverage information for a member, and as a result did not know that prior authorization was required, the provider will not be held responsible for failure to obtain prior authorization. Under these circumstances, the provider must submit sufficient documentation to demonstrate that a denied claim should be overturned. The standard claims appeal process will apply.

Sufficient documentation to overturn the denied claim may include the following: member presented the wrong insurance card, did not present any insurance card (presented as self-pay) or was admitted through the emergency room and was unable to provide an insurance card or the hospital admission sheet does not show Oxford as the primary plan.


The following stress echocardiogram and echocardiogram CPT codes will require prior authorization when performed in any outpatient setting other than emergency rooms (place of service 23) and urgent care centers (place of service 20):

**Echocardiogram**
- CPT codes: 93303, 93304, 93306, 93307, 93308

**Stress Echocardiogram**
- CPT codes: 93350, 93351

Q15. Do I need a prior authorization number for each procedure I order?

Yes. A prior authorization number is required for each CPT code. Each prior authorization number is CPT code-specific. Physicians are not required to include the prior authorization numbers on the claim form because Oxford automatically matches claims and the associated authorizations.

Q16. Are facility claims subject to claim denial for cardiac prior authorization requirements?

Yes. Facility claims submitted on a UB94 or CMS 1500 form or their electronic equivalent will be administratively denied in whole or in part if the facility failed to ensure that prior authorization has been obtained before a procedure was performed. Claims will also be denied for services determined to be medically unnecessary. The member cannot be billed for services determined to be medically unnecessary unless the member, with knowledge of our determination, agrees in writing to be responsible for the cost of the services.

Q17. After I submit a request for prior authorization, may I submit additional clinical information to support the request?

Yes. You may submit additional clinical information by calling CareCore National at 877-773-2884 or faxing the additional information to 866-889-8061.

Q18. What should I do if I’m having trouble submitting a prior authorization on CareCoreNational.com?

If you are having difficulties utilizing the CareCore National website to obtain prior authorization, please contact CareCore National at 877-773-2884 to request a prior authorization.

Q19. When will I receive notice that a prior authorization has been granted or denied? And if granted, when will I receive a prior authorization number?

Generally, we will respond to standard prior authorization requests within two business days of receipt of all required information. If granted, the prior authorization number will be provided with the response.

Q20. How can I confirm that a prior authorization request has been submitted for a cardiac procedure?

For echocardiogram and stress echocardiogram, confirmation that a prior authorization is on file can be found by visiting CareCoreNational.com or by calling 877-773-2884.
Q21. What should I do if I determine there is no prior authorization on file for a member who is scheduled to have a procedure?

If there is no prior authorization on file, submit a prior authorization request as follows:

- Online at CareCoreNational.com
- Call 877-773-2884

Q22. What is the difference between a case number and a prior authorization number?

A case number is a 10-digit number assigned to each cardiology prior authorization case. They are used for reference purposes only during the submission and review processes and are not valid for claims payment.

A prior authorization number is issued after a determination has been made. The number begins with the letter "A" followed by an eight-digit number along with the CPT code separated by a hyphen (for example, A09123456-93458).

Q23. Am I required to participate in a physician-to-physician dialogue for cardiac procedures including echocardiogram and stress echocardiogram?

No. If the cardiac procedure requested is not consistent with evidence-based clinical guidelines and we conclude it is not medically necessary, we will issue an adverse determination. You may request a physician-to-physician discussion to review the prior authorization request, provide additional clinical information or discuss alternative approaches.

Q24. Will a prior authorization approval number be issued for the requested procedure if the physician-to-physician discussion does not result in an approval?

No. After the discussion, if you and the reviewing physician do not agree about the medical necessity of the procedure, the adverse determination will stand and will result in claim denial for you and the facility if the procedure is performed. The adverse determination will still have an assigned record and number denying the request. This allows for differentiating between a clinical denial (lack of medical necessity) and administrative denial (lack of authorization).

The member cannot be billed for services we determine to be medically unnecessary unless the member, with knowledge of our determination, agrees in writing to be responsible for the cost of the services. You always maintain the responsibility to decide whether to perform the procedure.

Q25. Can I request a physician-to-physician dialogue at any time prior to performing a procedure that is found to be not medically necessary?

Yes. When a cardiac procedure is found to be not medically necessary, you can request a physician-to-physician discussion at any time prior to performing the procedure.

Q26. How long do I have to submit all information required to make a medical necessity determination for an Oxford member?

Once a request for prior authorization is initiated, all information required to render a decision regarding the medical necessity of the procedure must be received within 45 calendar days (subject to state regulatory standards and requirements). If the information received is not sufficient to render a decision, CareCore will request additional information and you will have up to an additional 45 calendar days to respond. If the additional required information is not received within 45 calendar days, the prior authorization will be denied. Generally, a decision will be rendered within two business days after receipt of all clinical information.

Q27. How long is a prior authorization number valid?

Prior authorization numbers are valid for 45 calendar days. When a prior authorization is entered for a cardiac procedure, UnitedHealthcare will use the day the cardiology prior authorization was issued as the starting date. If the examination or procedure is not completed within 45 calendar days, the provider must begin the cardiology prior authorization process again.
Q28. What if I need to reschedule a procedure?

If the original prior authorization date of service has changed, please contact CareCore to have the authorization updated.

Q29. If my claim is denied for failure to obtain prior authorization, can I bill the member if I perform the procedure?

No. Members cannot be billed when a provider fails to obtain prior authorization. The member cannot be billed for services determined to be medically unnecessary unless the member, with knowledge of our determination, agrees in writing to be responsible for the cost of the services.

Q30. Does receipt of a prior authorization number guarantee that Oxford will pay the claim?

No. Receipt of a prior authorization number does not guarantee or authorize payment. Payment for covered services is contingent upon many factors, including the member's eligibility on the date of service, any claim processing requirements and the terms of your participation agreement.

Q31. Must the prior authorization number be provided on the claim form to ensure payment?

No. There is no need to put the prior authorization number on the claim form.

Q32. Will any professional component(s) be affected by this requirement?

Echocardiograms and stress echocardiograms when billed with the modifier 26 will not be subject to the administrative denial for lack of prior authorization.

Q33. How will I be notified if a claim for a cardiac procedure has been denied for failure to obtain prior authorization?

A rendering physician remittance advice that includes remark code D2 will be sent to the rendering physician or facility stating an administrative reimbursement denial for lack of prior authorization.

Q34. If Oxford is the secondary plan, is prior authorization required on cardiac procedures?

Yes. Prior authorization is required to ensure coordination of benefits when Oxford is secondary to any other plan.

Q35. Where can I reference the prior authorization requirement and relevant evidence-based clinical guidelines?

The cardiology prior authorization requirements are within the Oxford policies located at OxfordHealthPlans.com > Medical and Administrative Policies. All evidence-based clinical guidelines can be found at CareCoreNational.com.

Q36. What benefit plans are subject to a medical necessity review?

- New Jersey small group and individual plans.
- New Jersey municipality plans.
- New Jersey school board plans.

Q37. Why is a medical necessity review required for the plans mentioned in Q36?

Certificates of coverage for New Jersey small group, individual and municipality and school board plans do not require a prior authorization, however they do allow for a medical necessity review.

Q38. How does the medical necessity process work?

Upon claim submission for a member of New Jersey small group, individual, municipality and school board plans, you will receive notice from Oxford Health Plan requesting clinical notes and/or medical records for a medical necessity review before claim payment. You may begin to submit this information with your claims or wait until Oxford or CareCore National requests additional information. For efficient handling of claims and appropriate reimbursements, please display the patient's Oxford identification number prominently on all documentation. Cases not meeting medical necessity criteria will be denied. Do not submit test findings to Oxford or CareCore National.
Q39. May I have a medical necessity review completed before providing the services?
Yes, you can obtain a medical necessity review online at CareCoreNational.com or by calling 877-773-2884 (7 a.m. to 7 p.m. Monday - Friday).

Q40. If I choose not to have a medical necessity review completed before providing the services, where do I submit my clinical notes?
Please mail them to:
Oxford Health Plans
Attn: Claims Department
P.O. Box 29130
Hot Springs, AR 71903

Q41. What information is required for a medical necessity review?
Please provide a cover letter requesting review for medical necessity including the member’s name, identification number, claim number, date of birth, date of service and CPT code(s).

Supporting clinical information must contain the ordering/referring provider’s name and signature, address, phone and fax numbers, specialty, tax identification number and:
• Reason for the procedure performed.
• Member’s signs and symptoms.
• Treatment, including type and duration.
• Previous notes for the specific medical issue.
• Any other pertinent clinical information to determine medical necessity.

Q42. Whose responsibility is it to submit the required clinical documentation?
It is the ordering provider’s responsibility to provide medical documentation to demonstrate clinical necessity for the requested outpatient cardiology procedure.

Q43. Who can I contact if I have questions?
If you have any questions, please call Oxford Health Plan at 800-666-1353 or CareCore National Customer Service at 877-773-2884.