TO: Physicians, Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), Chiropractors, Certified Nurse-Midwives (CNM), Independent Radiology Centers and Outpatient Hospitals

RE: Important Changes to the Radiology Benefit Management Program

Effective January 1, 2017 the HUSKY Health radiology benefit management program will be transitioned to eviCore healthcare (eviCore). eviCore will review prior authorization (PA) requests and render medical necessity determinations for non-emergent outpatient advanced imaging services scheduled for dates of service January 1, 2017 and forward. The existing radiology benefit management program that is currently administered by Care to Care will end as of December 31, 2016.

eviCore is prepared to accept PA requests beginning December 19, 2016 for dates of service January 1, 2017 and forward.

December 19, 2016 – December 31, 2016
- Providers should submit requests for studies with dates of service prior to January 1, 2017 to Care to Care.
- Providers should submit requests for studies with dates of service January 1, 2017 and forward to eviCore.
- Providers should submit requests for modifications to existing authorizations and requests for retrospective reviews to Care to Care.

January 1, 2017 and Forward
Beginning January 1, 2017, providers should no longer submit new PA requests, modifications to existing authorizations or requests for retrospective reviews to Care to Care.

Providers should submit all requests to eviCore.

Services Requiring Prior Authorization (PA)

Advanced Imaging Services
Non-emergent advanced imaging services will continue to require PA when performed in an outpatient setting for HUSKY A, B, C, D and limited eligibility members who are 19 years of age and over at the time of service. Members under the age of 19 do not require prior authorization for advanced imaging services.

Advanced imaging services performed as part of an emergency department (ED) visit, observation stay or inpatient hospital stay does not require PA. PA is also not required for the professional component of advanced imaging services (i.e. advanced imaging services billed with modifier 26).

Authorization for Members with Other Insurance (OI) or Medicare
As outlined in the Department of Social Services (DSS) Provider Bulletin PB 2014-24 “Authorization for Clients with Other Insurance (OI) or Medicare”, if a client has OI, providers are required to obtain authorization prior to the service being rendered. However, if a client has Medicare as their primary insurance, prior authorization is not required with the exception of members with Medicare Part A only. Members with Medicare Part A only will continue to require prior authorization for advanced imaging services.

Advanced Imaging Services
Effective for dates of service January 1, 2017 and forward, the following services will require prior authorization. Please consult the applicable fee schedule for your provider type to verify the codes payable and that require prior authorization.
Computed Tomography (CT) and Computed Tomographic Angiography (CTA)

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Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA)

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Positron Emission Tomography (PET)

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**IMPORTANT- OUTPATIENT HOSPITAL**

Effective January 1, 2017, when the following services are to be performed **in an outpatient hospital setting**, the **ordering provider must request authorization using the corresponding Healthcare Common Procedure Coding System (HCPCS) “C” code instead of the Current Procedural Terminology (CPT) code.** Hospitals should confirm that a valid, approved authorization is on file for the appropriate “C” code prior to performing the service.

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<td>MRA with contrast, pelvis</td>
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<td>C8919</td>
<td>MRA with contrast, pelvis</td>
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<td>73725</td>
<td>C8920</td>
<td>MRA with contrast followed by with contrast,</td>
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Process for Obtaining Prior Authorization (PA) for Advanced Imaging Services

For dates of service January 1, 2017 and forward, PA for advanced imaging services may be obtained by:

- Submitting an online authorization request by going to www.huskyhealth.com, clicking “For Providers” then clicking on the eviCore radiology button. Provider offices/facilities will be required to set up a user account during initial log in. For initial registration, providers should navigate directly to the provider log-in page of the eviCore Web site at: https://www.evicore.com/pages/provide rlogin.aspx. When registering, providers should confirm that MedSolutions is set as the default portal. Providers may begin registering for the portal at any time but will not be able to submit authorization requests until 12/19/2016.

- Calling the HUSKY Health Provider Line at 1-800-440-5071 and following the prompts to radiology authorizations.

- Faxing the authorization request to eviCore at 1-888-693-3210. To access authorization forms for advanced imaging services, go to www.huskyhealth.com, click “For Providers”, “Provider Bulletins and Forms”, “Advanced Imaging PA Request Forms”. Once on the eviCore Web site, click on “Resources”, “Providers”, “Online Forms and Resources”. From the Health Plan drop-down menu, select “HUSKY Health”, select “Radiology” from the “Select Solution” drop-down menu and click on “Show Results”.

Alternatively, providers may navigate directly to www.eviCore.com and click on “Resources”, “Providers”, “Online Forms and Resources”. From the Health Plan drop-down menu, select “HUSKY Health”, select “Radiology” from the “Select Solution” drop-down menu and click on “Show Results”.

Note: When submitting clinical information, providers must include a copy of the physician order along with documentation supporting the medical necessity of the requested study. For requests submitted via phone or web portal, it is the providers’ responsibility to ensure that a valid order is on file in the member’s medical record.

Authorization Fax Forms

Effective for dates of service January 1, 2017 and forward, providers will be required to use eviCore’s prior authorization fax forms. eviCore uses a suite of fax forms which are specific to modality, body region and/or condition. Providers should select the appropriate form corresponding to the specific study being ordered.

Authorization Modification Requests

Effective for dates of service January 1, 2017 and forward, the use of code groupings as outlined in DSS Provider Bulletin PB 2013-48 “Prior Authorization Process for Radiology Services” will no longer be allowed. Provider Bulletin 2013-48 is superseded by this current bulletin. Providers must follow the process to request
modifications to existing authorizations based on the instructions provided below.

**Prior to Date of Service**
Effective for dates of service January 1, 2017 and forward:
- Providers may request a site change or down-code from a study with contrast to a study without contrast, prior to the date of service, **without additional medical necessity review**.
- Providers may request a change in CPT code based on a change in modality (e.g. CT to MRI), change in body region (e.g. abdomen to abdomen and pelvis, non-joint to joint) or up-code from a study without contrast to a study with contrast, prior to date of service. **These requests will be subject to a medical necessity review for the newly requested service.**

**After Date of Service**
Effective for dates of service January 1, 2017 and forward, ordering or rendering providers must request authorization modifications within 180 days after the service has been performed.

The following modification requests **will not** require an additional medical necessity review:
- Site changes
- Down-coding from a study with contrast to a study without contrast

The following modification requests **will** require an additional medical necessity review:
- Up-coding from a study without contrast to a study with contrast
- Change in modality
- Change in body region

**Retrospective Authorization Requests**

**Retrospective Urgent Requests**
Effective for dates of service January 1, 2017 and forward, providers will be given up to three business days after services are rendered to request authorization for urgent studies performed outside of normal business hours. eviCore will review the request to determine if the service performed was truly of an urgent nature. If the service is determined to be of an urgent nature and is received within 3 business days from the date of service, the request will be reviewed for medical necessity. If it is determined that the service was not of an urgent nature, it will be treated as a retrospective standard request and will be handled as outlined below.

If the request is not received within 3 business days after services are rendered, a denial will be issued for failure to obtain authorization prior to the services being rendered. Providers will need to submit an administrative appeal request to Community Health Network of Connecticut, Inc. (CHNCT). The request will be reviewed to determine if the provider has demonstrated good cause for the delay in obtaining authorization. Additionally, the request is reviewed to determine the medical necessity of the requested service.

As a reminder, prior authorization is not needed for studies performed as part of an emergency department visit, observation stay or inpatient admission. **Urgent requests should be submitted by phone** by calling the HUSKY Health Provider Line at 1-800-440-5071 and following the prompts to radiology authorizations.

**Retrospective Standard Requests**
Effective for dates of service January 1, 2017 and forward, when non-urgent studies are performed without prior authorization, a denial will be issued for failure to obtain authorization prior to the services being rendered. Providers will need to submit an administrative appeal request to CHNCT. The request will be reviewed to determine if the provider has demonstrated good cause for the delay in obtaining authorization. Additionally, the
request is reviewed to determine the medical necessity of the requested study. 
As a reminder, both ordering and rendering providers are responsible for confirming that a 
valid authorization is in place for the correct study and for the correct service location prior 
to performing the study. Providers are also responsible for confirming members’ Medicaid 
status including Medicaid members with OI. CMAP providers may not hold a member 
financially responsible for denied services or services performed without authorization.

**Retrospective Requests Based on Retro-eligibility**
Authorization requests received retrospectively 
for members granted retro-eligibility will be 
accepted and processed. Providers have up to 
one year after services are rendered to submit a 
request.

**Authorization Time-frames**
Effective for dates of service January 1, 2017 
and forward, the start date of a radiology 
authorization will be the date the authorization 
is received at eviCore. Authorizations are valid 
for 30 days from the date of receipt. Only one 
thirty day extension is allowed. Providers 
will need to request extensions from eviCore.

**Provider Training**
Webinars will be offered and hosted by 
representatives from CHNCT and eviCore. 
The webinars will include the following:
- eviCore Program overview
- PA submission (web, phone and fax) 
  process
- Fax forms
- Web Portal
- Information required for review
- Clinical review process
- Authorization modification requests
- Urgent requests
- Retrospective authorization requests

**Webinar Dates:**
All webinars will be held from 12:00 p.m. to 1:30 p.m. on the following dates:
- December 8, 2016
- December 15, 2016
- December 20, 2016
- December 22, 2016

Invitations will be emailed in November and 
will provide all necessary information to 
register and connect to the webinar.

Providers may also refer to the HUSKY Health 
Web site at: [www.huskyhealth.com](http://www.huskyhealth.com). From the 
home page, click on “For Providers”, “Provider 
News, Trainings & Events”, “Provider 
Webinars”.

For questions regarding the prior authorization 
process, please contact CHNCT at 1-800-440-
5071, Monday through Friday, between the 
hours of 8:00 a.m. to 6:00 p.m.