Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2016-70**
www.ctdssmap.com **October 2016**

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

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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)

70450	70460	70470	70480	70481	70482
70486	70487	70488	70490	70491	70492
70496	70498	71250	71260	71270	71275
72125	72126	72127	72128	72129	72130
72131	72132	72133	72191	72192	72193
72194	73200	73201	73202	73206	73700
73701	73702	73706	74150	74160	74170
74174	74175	74176	74177	74178	74261
74262	74263	75571	75572	75573	75574
75635	76380	77078			

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

70336	70540	70542	70543	70544	70545
70546	70547	70548	70549	70551	70552
70553	70554	70555	71550	71551	71552
71555	72141	72142	72146	72147	72148
72149	72156	72157	72158	72159	72195
72196	72197	72198	73218	73219	73220
73221	73222	73223	73225	73718	73719
73720	73721	73722	73723	73725	74181
74182	74183	74185	74712	75557	75559
75561	75563	75565	76390	77058	77059
77084					

Positron Emission Tomography (PET)

78608	78609	78811	78812	78813	78814
78815	78816				

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.

CPT	HCPCS	Description
74185	**C8900**	MRA with contrast, abdomen
	C8901	MRA without contrast, abdomen
	C8902	MRA without contrast followed by with contrast, abdomen
77058	**C8903**	MRI with contrast, breast; unilateral
	C8904	MRI without contrast, breast; unilateral
	C8905	MRI without contrast followed by with contrast, breast; unilateral
77059	**C8906**	MRI with contrast, breast; bilateral
	C8907	MRI without contrast, breast; bilateral
	C8908	MRI without contrast followed by with contrast, breast; bilateral
71555	**C8909**	MRA with contrast, chest (excluding myocardium)
	C8910	MRA without contrast, chest (excluding myocardium)
	C8911	MRA without contrast followed by with contrast, chest (excluding myocardium)
73725	**C8912**	MRA with contrast, lower extremity
	C8913	MRA without contrast, lower extremity
	C8914	MRA without contrast followed by with contrast, lower extremity
72198	**C8918**	MRA with contrast, pelvis
	C8919	MRA without contrast, pelvis
	C8920	MRA without contrast followed by with contrast,

		pelvis
72159	**C8931**	MRA with contrast, spinal canal/contents
	C8932	MRA without contrast, spinal canal/contents
	C8933	MRA without contrast followed by with contrast, spinal canal/contents
73225	**C8934**	MRA with contrast, upper extremity
	C8935	MRA without contrast, upper extremity
	C8936	MRA without contrast followed by with contrast, upper extremity

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/providerlogin.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. 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.