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Related Clinical Coverage Policies

Refer to http://www.ncdhhs.gov/dma/mp/ for the related coverage policies listed below:

1E-6, *Pregnancy Medical Home*
1E-4, *Fetal Surveillance*

1.0 Description of the Procedure, Product, or Service

NC Medicaid (Medicaid) requires prior approval (PA) for certain outpatient non-emergent imaging services. This imaging management program determines clinical appropriateness for the usage of imaging technology by providing guidelines for application and use based on expert information and evidence-based data.

MedSolutions, a National Committee for Quality Assurance (NCQA)–certified Company, based in Nashville, Tennessee, administers this program.

For implementation dates for prior approval, refer to **Attachment A, Table I**.

For a complete list of imaging procedures requiring prior approval, refer to **Attachment B, High Tech Imaging and Ultrasound Procedure Codes.**

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. **Medicaid**
None Apply.

b. **NCHC**
North Carolina Health Choice (NCHC) beneficiaries do not require prior approval for imaging services and are excluded from this policy.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Pregnancy Medical Home Providers

a. Providers enrolled in the Pregnancy Medical Home must register the obstetrical ultrasounds with MedSolutions within 5 business days of the date the procedure was performed.
b. No clinical information will be required.
c. The ultrasounds must be registered in order to receive reimbursement.
d. For beneficiaries with presumptive eligibility, as soon as the beneficiary receives a Medicaid card, the provider must submit the NC DMA Fax Request Form located on the MedSolutions website (located at https://www.medsolutionsonline.com). No clinical information is required.
e. The following information must be submitted, whether by phone, web, or fax:
    1. Demographics – beneficiary's name, date of birth and Medicaid ID number;
    2. Ordering physician's name and physical location;
    3. Performing provider (facility) name and physical location;
    4. CPT procedure code(s); and
    5. ICD-10-CM diagnosis code(s).

Note: Refer to clinical coverage policy 1E-6, *Pregnancy Medical Home* on DMA's website at http://www.ncdhhs.gov/dma/mp/, for information on obstetric ultrasounds in the pregnancy medical home project.

Refer to **Attachment B**, High Tech Imaging and Ultrasound Procedure Codes, for a list of imaging procedures that require prior approval.

Clinical guidelines used to establish prior approval are available by visiting the MedSolutions Web site at http://www.MedSolutionsOnline.com or by calling MedSolutions at (888) 693-3211.

Refer to **Section 5.0, Requirements for and Limitations on Coverage,** for prior approval criteria, exemptions, and procedures.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

For specific information on obstetrical ultrasounds, refer to **Attachment C.**

Note: Refer to clinical coverage policy 1E-6, *Pregnancy Medical Home* on DMA's website at http://www.ncdhhs.gov/dma/mp/, for information on obstetric ultrasounds in the pregnancy medical home project.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Prior Approval Imaging procedures listed in **Attachment B, High Tech Imaging and Ultrasound Procedure Codes** require prior approval, with the exceptions detailed below. Prior approval signifies medical necessity only; it does not address the beneficiary's eligibility or guarantee claim payment.

5.1.1 Exemptions

a. Imaging procedures performed in the following *situations* are exempt from the prior approval requirement:
   1. During an inpatient hospitalization.
   2. During an observation stay (this includes labor and delivery observation stay).
   3. During an emergency room visit.
   4. During an urgent care visit (only for urgent care, not primary care).
   5. As a referral from a hospital emergency department or an urgent care facility.

6. As an emergency procedure.

Note: Procedures that are exempt from the prior approval requirement must meet current North Carolina Medicaid policies that define medical necessity criteria and unit limitations for claims payment. Bypassing prior approval by having the procedures performed in the emergency room is not a guarantee of payment.

b. Outpatient imaging services other than those indicated in **Attachment B**, **High Tech Imaging and Ultrasound Procedure Codes** are exempt from the prior approval requirement.

c. Services provided to the following *beneficiaries* **do not** require prior approval (these beneficiaries will be identified as "non-delegated" and the option to create an authorization request will be unavailable):

1. Beneficiaries who are dually eligible (for Medicare and Medicaid)
2. Beneficiaries who are covered by one of the following third-party insurance:
   A. Major Medical Coverage.
   B. Indemnity Coverage.
   C. Basic Medicare Supplement.
3. Beneficiaries enrolled in the following Medicaid programs:
   A. Program of All-Inclusive Care for the Elderly (PACE).
   B. NCHC.
   C. Family Planning Waiver.
   D. Health Insurance Payment Plan (HIPP).
   E. Aid to the Aged.
   F. Special Assistance for the Blind.
   G. Special Assistance to the Aged.
4. Refugees.
5. Beneficiaries with emergency coverage for approved dates of service.

Note: Refer to clinical coverage policy 1E-6, *Pregnancy Medical Home* on DMA's Web site at http://www.ncdhhs.gov/dma/mp/, for information on obstetric ultrasounds in the pregnancy medical home project.

5.1.2 Responsibility

The ordering physician or non-physician practitioner is responsible for obtaining prior approval. A rendering facility may request prior approval if the facility has the clinical information necessary to support the requested imaging.

The providers rendering the imaging procedure shall verify that the ordering physician or non-physician practitioner has obtained prior approval before scheduling the procedure. Verification may be obtained by visiting the MedSolutions Web site at http://www.MedSolutionsOnline.com or by calling MedSolutions at 888-693-3211.

Reading radiologists who submit claims with the professional component (modifier 26) for imaging services indicated in **Attachment B** are subject to authorization requirements equal to the facility that rendered the imaging service and submitted claims with the technical component (modifier TC). Prior approval obtained for a service covers both the technical and professional components.

Failure to obtain and verify prior approval may result in nonpayment of the claim. Providers shall not bill beneficiaries in such a situation.

5.2 Prior Approval Procedures

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request;
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy; and
c. if the Medicaid beneficiary is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

5.2.1 Ordering Provider

For routine prior approval requests, the ordering physician or non-physician practitioner shall contact MedSolutions with the required medical information prior to the procedure's being scheduled and performed. The ordering provider and the requested rendering provider must be a North Carolina Medicaid enrolled provider with the Division. The individual ordering provider's NPI number should be used. Do not use the ordering group NPI or tax ID number. Only an individual provider can request the prior approval. To locate a rendering facility, search the MedSolutions database by name, group NPI or tax ID number.

To verify the individual provider's NPI, address or phone numbers that Medicaid has on file, go to http://www.ncdhhs.gov/dma/WebNPI/default.htm. If the address or other information needs to be updated or if the provider is not enrolled with Medicaid, go to the CSC NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html.

For trouble locating the beneficiary or the provider in the system, fill in one identifier and search for the provider or beneficiary. Do not fill in all the blanks. The MedSolutions Call Center is available from 8:00 a.m. to 9:00 p.m. (EST) at 1-888-693-3211. For continuing issues, contact the Provider Assistance Desk at 1-800-575-4517, option 2.

5.2.2 Submission of Prior Approval Requests

Prior approval requests for outpatient non-emergent diagnostic imaging procedures may be submitted through MedSolutions' secure Web site (http://www.MedSolutionsOnline.com) 24 hours a day, 7 days a week. Prior approval requests may also be made to MedSolutions by telephone (888-693-3211) or by fax (888-693-3210) during normal business hours (8:00 a.m. to 9:00 p.m. EST).

The following information is required when requesting prior approval:

a. The beneficiary's name, address, date of birth, and Medicaid ID number.
b. Enrolled ordering physician or non-physician practitioner name and contact information.
c. Enrolled facility at which the study is requested to be performed.
d. Beneficiary's history and diagnosis, including related surgeries.
e. Previously performed tests, lab work, and imaging related to this diagnosis, and their results.
f. Notes from the beneficiary's last visit related to the diagnosis.
g. Type and duration of medical and surgical treatment performed to date for the diagnosis.
h. Reason for the study (ICD-9-CM diagnosis code or diagnosis description).
i. CPT code(s) for requested procedures.
j. The provider's fax number.

5.2.3 Approval or Denial of the Request

Upon receipt of the request, MedSolutions shall approve or deny the request or request additional information within 5 business days for non-emergent request and 2 business days for urgent requests or as required by federal or state regulations. If additional information is requested, the provider will be notified and will have 10 business days to submit the information. If the additional information is not received as specified by the notice, the request will be denied.

a. If the request is approved, MedSolutions shall fax an authorization number to the ordering physician and requested facility. The prior approval number is an 8-digit alphanumeric number. Imaging providers shall document and archive prior approval numbers. The prior approval is valid for **30** calendar days from the date of issue. The authorization number is not required on the claim.
b. If the request is denied, MedSolutions shall notify the ordering physician, requested facility, and the beneficiary in writing in accordance with the Division's beneficiary notices procedure and shall provide a rationale for the determination within five business days of the request.
c. The prior approval requirement includes the specific facility performing the imaging study and the exact CPT code or codes for diagnostic imaging. Contact MedSolutions for changes to either (refer to **Subsections 5.3.3** and **5.3.4**).

5.3 Retroactive Beneficiary Eligibility or Changes to Approved Procedure

5.3.1 Retroactive Beneficiary Eligibility

MedSolutions will accept retroactive requests for beneficiaries who obtain Medicaid retroactively. MedSolutions will accepts these requests up to 12 months back or to the first day the MedSolutions program was required (November 1, 2009 for scans and January 1, 2010 for ultrasounds). Providers shall fill out the NC DMA Retro Request Fax Form (located at https://www.medsolutionsonline.com), include evidence of retroactive eligibility

and clinical information to support medical appropriateness, and fax the request to MedSolutions at (888) 693-3210.

This process will also include beneficiaries with presumptive eligibility. Once the beneficiary is issued a Medicaid number, the provider shall follow the same procedure as described above.

Examples of evidence of retroactive eligibility include:

a. If the beneficiary does not have Medicaid when seen by the provider and then later provides the Medicaid card, the issue date of the card should document retroactivity. Attach a copy of the Medicaid card to the Retro Request Fax Form.

b. Print a copy of the verification that the beneficiary does not have Medicaid at each visit. When Medicaid is approved, verification will be on the screen with the date of implementation. Attach copies of these verifications to the Retro Request Fax Form.

5.3.2 Misrepresentation of Medicaid

MedSolutions will accept retroactive requests for beneficiaries who misrepresented their Medicaid coverage on the date of service. This would include beneficiaries who failed to tell the provider of Medicaid coverage and beneficiaries who did not have their Medicaid information. Providers shall fill out the NC DMA Retro Request Fax Form (located at https://www.medsolutionsonline.com), include evidence of registration error and clinical information to support medical appropriateness, and fax the request to MedSolutions at (888) 693-3210.

5.3.3 CPT Code Mismatches

When a radiologist's opinion warrants an imaging procedure different from what has been authorized, the rendering facility shall contact MedSolutions for review and authorization prior to claim submission.

a. Higher Intensity Procedure or Additional Procedures Performed:

Requests for approval of higher intensity CPT codes (such as moving from a CT without contrast to a CT without and with contrast) or additional CPT codes will require clinical appropriateness review and approval. This can be accomplished by any one of the following methods.

1. Before the date of service, call (888-693-3211) or fax (888-693-3210) MedSolutions with the clinical information supporting the code change request;

2. After the date of service, fill out the NC DMA Retro Request Fax Form (located at https://www.medsolutionsonline.com), include a copy of the imaging study or studies report(s) and clinical information to support medical appropriateness, and fax the request to MedSolutions at (888) 693-3210. This must be submitted within 3 business days after the date of service.

b. Lower Intensity Procedure Performed:

Before November 30, 2010	If a beneficiary is authorized for a procedure of higher intensity, but the radiologist determines that a procedure of lower intensity in the same contrast family should be done, the facility or the ordering physician's office shall notify MedSolutions by any one of the following methods.	1. Call MedSolutions (888-693-3211) with the code change request; or 2. Send a secure e-mail containing the authorization number and CPT "down-code" change to AuthChange@MedSolutions.com prior to filing the claim; or 3. Fill out the NC DMA Retro Request Fax Form located at https://www.medsolutionsonline.com and fax the request to MedSolutions at (888) 693-3210. There is no time limit for notifying MedSolutions that a lower intensity procedure was performed, but until the code is changed in the Medicaid system, the claim will deny. Clinical appropriateness review is not required for down-coding requests.
On or after December 1, 2010	A provider can bill a "lesser intensity" procedure code from the same contrast family of the code that had been approved by MedSolutions. The system will match the claim detail to an approved authorization that contains a procedure code within the same contrast family of the procedure code billed. Claim details, when the billed procedure code is the same or of lesser intensity than the authorized procedure, will be reimbursed as billed. Claim details, when the billed procedure code is of greater intensity than the authorized procedure code, will be denied.	This applies to CT, MRI, and MRA scans only. A list of contrast family procedure reduction codes is located in Attachment D of this document.

5.3.4 Facility Location Mismatch

If there is a change in the facility performing the imaging study, the rendering facility shall notify MedSolutions by any one of the following methods.

a. Call MedSolutions (888-693-3211) with the facility change request; or

b. Send a secure e-mail containing the authorization number and "change of facility" to AuthChange@MedSolutions.com prior to filing the claim; or

c. Fill out the NC DMA Retro Request Fax Form, include a copy of the imaging study or studies report(s) to document location of services, and fax the request to MedSolutions at (888) 693-3210.

There is no time limit for notifying MedSolutions of a change in facility, but until the facility is changed in the Medicaid system, the claim will deny.

Note: The facility must be a Medicaid enrolled site and must have been approved by MedSolutions Accuracy Management as a participating provider (refer to **Subsection 6.1**).

5.4 Urgent Procedures

When imaging is required in less than 48 hours due to a medically urgent condition, the ordering physician shall call MedSolutions (888-693-3211) with the required medical information prior to scheduling and performing the procedure. MedSolutions shall expedite the review process. Please indicate clearly that the authorization is for medically urgent care. MedSolutions shall not accept an urgent request by their secure website or by fax.

5.5 Retrospective Requests

Requests made after service performance (retrospective requests) will be permitted only in cases where imaging is clinically urgent.

Retrospective requests for cases that are clinically urgent can be submitted up to and including two business days after the service was performed. The ordering physician shall call MedSolutions (888-693-3211) with the required medical information. Authorizations on retrospective requests are valid for the date of service only. Requests will be denied that are submitted beyond the established time limit, or if medical necessity and clinical urgency are not met.

5.6 Adverse Decisions

MedSolutions shall notify the ordering physician and requesting facility in writing of a denial and provide a rationale for the determination within five business days of the request. The provider may do a peer-to-peer and reconsideration request on the same denial, but both must be requested within five business days of the date of the denial.

5.6.1 Peer-to-Peer Consultation

MedSolutions offers the ordering physician or non-physician practitioner a consultation with a MedSolutions Medical Director on a peer-to-peer basis to discuss the clinical indications of the case and decide the appropriate imaging for the beneficiary.

Providers may initiate a peer-to-peer discussion with a MedSolutions physician about any prior approval decision by calling MedSolutions at 888-693-3211 during normal business hours, or as required by federal or state regulations. Requests for a peer-to-peer consultation without a formal appeal will be accepted for five business days following the date of MedSolutions' adverse decision. MedSolutions shall schedule the consultation within one business day and either uphold or overturn the initial adverse decision within two business days following the consultation. The provider will be notified in writing of the decision.

5.6.2 Reconsideration Request Based on Additional Information

The ordering physician or non-physician practitioner may elect to provide additional supporting clinical information in support of a reconsideration request of the original denial decision. The reconsideration request and the complete additional clinical information must be received within five business days following the date of MedSolutions' adverse decision. MedSolutions' medical director shall review the request and additional clinical information and either uphold or overturn the initial adverse decision within two business days of receipt. The provider will be notified in writing of the decision.

5.7 Beneficiary Appeals

MedSolutions shall notify the beneficiary or legal representative of the adverse decision in writing and provide appeal rights, in accordance with the Division's current beneficiary notices procedure.

5.8 Claims Submission

For information on claim submission, refer to **Attachment A.**

Providers shall submit the claim to the Medicaid designated vendor or agent for adjudication. The authorization number is not required on the claim.

Prior approval signifies medical necessity only; it does not address the beneficiary's eligibility or guarantee claim payment.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Accuracy Assessment and Management

Providers of high-technology in-office imaging and providers of ultrasound services shall complete an online accuracy assessment questionnaire and be granted privileged status to render services in the N.C. program for prior approval for imaging procedures. Hospitals are exempt from the accuracy assessment requirement.

Each location and expected procedure(s) of a rendering provider of services is subject to accuracy assessment prior to acceptance as an approved provider in the program. Providers will be privileged for one or more procedures and locations in accordance with the results of the online accuracy assessment questionnaire and within their submitted scope of practice.

Accuracy will be based on criteria adopted from the American College of Radiology (ACR), American Institute of Ultrasound in Medicine (AIUM), American College of

Obstetricians and Gynecologists (ACOG), Intersocietal Accreditation Commission (IAC), American College of Cardiology (ACC) and industry standards.

MedSolutions shall not approve authorization requests for services when:

a. the rendering provider has not completed the accuracy assessment
b. the rendering provider has completed the accuracy assessment but has not been approved
c. the rendering provider has completed and passed the accuracy assessment, but the service requested was not assessed or not approved
d. the rendering provider has completed and passed the accuracy assessment, but the servicing location requested was not assessed or not approved
e. the rendering provider has not been approved and the authorization request is made retrospectively

The assessment process is conducted through a questionnaire that requests information about imaging equipment, applicable personnel, and imaging policies and procedures. The questionnaire is available by visiting http://www.accuracymgmt.com website and applying. If a provider requests a paper questionnaire, send a request to accuracymgmt@medsolutions.com or fax a request to (615) 468-4450.

A new provider shall have 30 calendar days to complete the questionnaire after their provider enrollment process with Medicaid is completed. MedSolutions shall notify the provider in writing of the assessment results including procedure codes and recommendations for quality improvements and other relevant feedback within 30 calendar days of submission of a completed questionnaire.

For appealing an Accuracy Assessment decision, send the appeal in writing to accuracymgmt@medsolutions.com or fax the appeal to (615) 468-4450. All appeals must be sent in writing.

6.2 Incorrect Provider Information in the MedSolutions System

Medicaid supplies provider information to MedSolutions. If the information in the MedSolutions system is incorrect that means the information in the Medicaid system is incorrect.

To verify the individual provider's NPI, address or phone numbers that Medicaid has on file, go to **http://www.ncdhhs.gov/dma/WebNPI/default.htm**. If the address or other information needs to be updated, or if the provider is not enrolled with Medicaid, go to the CSC NC Tracks website at **http://www.nctracks.nc.gov/provider/cis.html** **Provider Qualifications**

7.0 Additional Requirements

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Records Retention

MedSolutions shall maintain all financial, clinical, medical, and other records related to utilization management program activities in accordance with 10A NCAC 22N Provider Enrollment and any subsequent amendments or editions and the terms and conditions of the NC DHHS Provider Administrative Participation Agreement.

8.0 Policy Implementation/Revision Information

Original Effective Date: Month Day, Year

Revision Information:

Date	Section Revised	Change
11/01/2009	Throughout	Initial promulgation of policy
10/01/2010	Subsection 3.2 and Attachment C	Added prior approval requirements for OB ultrasounds
11/01/2010	Subsection 5.3.3 and Attachment D	Added billing of lower intensity procedures
11/23/2010	Attachment B	Removal of 76519 from list of PA procedures effective 11/23/2010
12/31/2010	Attachment B	End-Dated code: 76880 for 2011 CPT Update
12/31/2010	Attachment B	Added codes: 74176, 74177, 74178, 76881, 76882 (Effective 1/1/2011) for 2011 CPT Update
1/31/2011	Subsections 3.2.1, 4.2 and 5.1.1	Added "**Note:** Refer to DMA's Clinical Coverage Policy 1E-6, *Pregnancy Medical Home* (on DMA's Web site at http://www.ncdhhs.gov/dma/mp/), for information on obstetric ultrasounds in the pregnancy medical home project."
03/01/2011	Subsection 3.2.3	Added information for registration for ultrasounds for Pregnancy Medical Home.
03/01/2011	Attachment A(F)	Added ICF, SNF
03/01/2011	Attachment A (J)	76880 end-dated 12/31/2010 and 76881 and 76882 added in its place 01/01/2011
03/01/2011	Attachment B	Removal of CPT codes 76510-76514, 76516, 76529, 76831 and 76873 from list of PA procedures effective 4/1/2012.
03/01/2011	Attachment D & E	Attachment lettering changed to accommodate the addition of a new Attachment C
3/1/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy
07/01/2013	Attachment A, Section K	Changed "HP Provider Services" to "CSC."
01/01/2015	All Sections and Attachments	Updated policy template language.
01/01/2015	Attachments A and B	CPT code 76645 end-dated 1/31/2014. CPT codes 76641 and 76642 replaced end-dated CPT code 76645, effective 1/1/2015. CPT codes 76641 and 76642 require prior approval from Med Solutions.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Refer to **Attachment B** for a complete list of covered procedures codes.

Institutional providers billing on a UB claim, shall bill the revenue code (RC) with the exact CPT code authorized.

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

If procedure is done as a referral from a hospital emergency department or urgent care facility or as an emergent procedure, enter appropriate CPT code with modifier U2.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Outpatient, Physician's office, ICF, SNF.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://www.ncdhhs.gov/dma/plan/sp.pdf.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

H. Reimbursement

Providers shall bill their usual and customary charges.
For a schedule of rates, see: http://www.ncdhhs.gov/dma/fee/

I. Dates of Implementation

Date	Procedures	Instructions for Providers
November 1, 2009	CT, CTA, MR, MRA, PET High Tech Imaging	Claims submitted to the Medicaid designated vendor or agent for imaging performed 11/01/2009 and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail.
January 1, 2010	Ultrasounds	Claims submitted to the Medicaid designated vendor or agent for ultrasound testing performed 01/01/2010 and after will require PA on file. Outpatient claims will require Revenue Codes and CPT codes on the UB-04 detail.

J. Billing for Independent Diagnostic Testing Facility Services (IDTF)

Independent diagnostic testing facility (IDTF) providers enrolled in North Carolina Medicaid are approved to bill certain ultrasound procedures. The following CPT codes included in this prior authorization policy that can be billed by an IDTF are:

76536	76813	76857	93922
76604	76814	76870	93923
76641	76815	76872	93924
76642	76816	76881	93925
76700	76817	76882	93926
76705	76818	93303	93930
76770	76819	93304	93931
76775	76820	93306	93965
76776	76821	93307	93970
76800	76825	93308	93971

76801	76826	93320	93975
76802	76827	93321	93976
76805	76828	93325	93978
76810	76830	93875	93979
76811	76831	93880	93990
76812	76856	93882	
IDTF providers must have prior authorization and must bill these codes with a modifier TC (technical component) or globally.			

K. Claims Submission

Claims submitted for unauthorized procedures, for beneficiaries who are ineligible at the time of service or from providers who are not enrolled in good standing at the time of service are subject to denial. Providers shall not bill beneficiaries in such a situation.

The MedSolutions authorization number is not required to be on the claim. The rendering facility's provider number and the CPT code(s) billed must match the prior authorization obtained. Institutional providers billing on a UB claim, shall bill the revenue code (RC) with the exact CPT code.

For claim denials with a valid authorization, contact CSC at (800) 688-6696.

The following items will be used to identify situations where PA is not required (this if for both the technical and professional components):

Type of Stay/Visit	Billing Instruction	
	Institutional Format	**Professional Format**
Inpatient stay	Enter bill type 11x in form locator 4	Enter modifier U2 in field 24D
Emergency department visit	Enter revenue code 450 in form locator 42	Enter modifier U2 in field 24D
Observation stay	Enter revenue code 762 in form locator 42	Enter modifier U2 in field 24D
Observation stay in labor & delivery	Enter modifier U2 in form locator 44	Enter modifier U2 in field 24D
Hospital emergency department or urgent care facility referral	Enter modifier U2 in form locator 44	Enter modifier U2 in field 24D

Attachment B: High Tech Imaging and Ultrasound Procedure Codes

The following procedure codes require prior approval for all ages and are subject to fee schedule reimbursement:

A. Positron Emission Tomography (PET) Scans

CPT Code(s)		
78608	78812	78815
78609	78813	78816
78811	78814	

B. Computed Tomography Angiography (CTA)

CPT Code(s)		
70496	72191	74174
70498	73206	74175
71275	73706	75635

C. Computed Tomography (CT) Scans

CPT Code(s)		
70450	72125	73202
70460	72126	73700
70470	72127	73701
70480	72128	73702
70481	72129	74150
70482	72130	74160
70486	72131	74170
70487	72132	74176
70488	72133	74177
70490	72192	74178
70491	72193	76380
70492	72194	76497
71250	73200	77078
71260	73201	77079
71270		

D. Magnetic Resonance Angiography (MRA)

CPT Code(s)		
70544	70548	72198
70545	70549	73225
70546	71555	73725
70547	72159	74185

E. Magnetic Resonance Imaging (MRI)

CPT Code(s)		
70336	72148	73718
70540	72149	73719
70542	72156	73720
70543	72157	73721
70551	72158	73722
70552	72195	73723
70553	72196	74181
71550	72197	74182
71551	73218	74183
71552	73219	76498
72141	73220	77058
72142	73221	77059
72146	73222	
72147	73223	

F. Ultrasound

For specific information on obstetrical ultrasounds refer to Attachment C. fetal surveillance procedures, refer **Subsection 3.2** and clinical coverage policy #1E-4, *Fetal Surveillance* on DMA's Web site at http://www.ncdhhs.gov/dma/mp/,.
The following CPT codes do not require prior approval effective 04/01/2012: 76510, 76511, 76512, 76513, 76514, 76516, 76529, 76831 and 76873.

CPT Code(s)		
76506	76818	93882
76536	76819	93886
76604	76820	93888
76641	76821	93890
76642	76825	93892
76700	76826	93893
76705	76827	93922
76770	76828	93923
76775	76830	93924
76776	76856	93925
76800	76857	93926
76801	76870	93930
76802	76872	93931
76805	76881	93965
76810	76882	93970
76811	76885	93971
76812	76886	93975
76813	76970	93976
76814	76999	93978
76815	93875	93979
76816	93880	93990
76817		

G. 3D Rendering

CPT Code(s)
76376
76377

H. Revenue Codes

Institutional providers billing on a UB claim, shall bill the revenue code (RC) with the exact CPT code.

Revenue Code(s)		
RC350	RC402	RC612
RC351	RC404	RC615
RC352	RC610	RC616
RC359	RC611	RC619

Attachment C: Obstetrical Ultrasounds

A. Obstetrical Ultrasound Requirements for North Carolina Medicaid Providers

The following prior approval requirements are effective with date of service October 1, 2010. All OB ultrasounds must be registered with or authorized by MedSolutions in order for claims to be processed. When registering or requesting prior authorization via the MedSolutions Web site, it is necessary to indicate the due date of the beneficiary.

a. CPT Procedure code 76813 (ultrasound pregnant uterus first trimester fetal nuchal translucency measurement single or first gestation) and 76814 (for each additional gestation):
   1. Allow one fetal nuchal translucency scan per pregnancy without requiring medical necessity indication if performed between 11 through 13 weeks gestation.
   2. This first trimester scan includes an assessment of fetal viability, crown rump measurement for dating, and measurement of nuchal fold thickness.
   3. Register the procedure with MedSolutions.

b. CPT Procedure code 76805 (ultrasound pregnant uterus fetal and maternal evaluation after first trimester single or first gestation) and 76810 (for each additional gestation):
   1. Allow one complete ultrasound per pregnancy without requiring medical necessity indication if performed after 16 weeks gestation.
   2. Register the procedure with MedSolutions.

c. CPT Procedure code 76811 (ultrasound pregnant uterus fetal and maternal evaluation plus detailed fetal anatomic examination single or first gestation) and 76812 (for each additional gestation):
   1. These procedure codes require medical necessity indication, such as a known or suspected fetal anatomic or genetic abnormality, and can only be performed by:
      (a.) Providers with sub-specialty in Maternal Fetal Medicine (Perinatology) or Radiology; or
      (b.) OB ultrasound providers who are in an American Institute of Ultrasound in Medicine (AIUM) accredited practice or an American College of Radiology (ACR) accredited practice.
   2. Allow one of these detailed anatomic scans per practice (same group practice, same tax identification number, etc.), per pregnancy for appropriate medical necessity indications.
   3. These examinations will be audited for report content and practice referral patterns.
   4. 76805 and 76811 should not be requested nor billed for the same date of service and should not be requested on the same authorization request.

d. All other OB ultrasound studies will be subject to medical necessity review.
   1. If there is an urgent medical need for an OB ultrasound in addition to or at dates/codes not identified above, the ultrasound can be obtained and the request for authorization can be made to MedSolutions within two business days after the date of service. These requests will be reviewed for both urgent and medical necessity indications.

      Example: A beneficiary presents early in pregnancy with bleeding or no fetal heart tones with Doppler at 12 weeks gestation. The provider can perform the ultrasound and bill for CPT procedure code 76801 (ultrasound pregnant uterus fetal and maternal evaluation first trimester single or first gestation) and 76802 (each additional gestation) and request prior authorization for medical necessity within two business days of the date of service.

The provider can still provide complete ultrasound and bill for CPT procedure code 76805 after 16 weeks gestation without requiring medical necessity.

B. Obstetrical Ultrasound Indications for Sequential Imaging

OB ultrasound indications for sequential imaging are based upon the MedSolutions Obstetrical Ultrasound Imaging Guidelines. Refer to the table on the following pages which will be used for evaluating requests for OB ultrasounds in certain patients with known or suspected high risk diagnoses with references to the appropriate guidelines. Some of these patients may require sequential imaging (batching).

a. Verbal approval for these batched authorizations cannot be requested online. Requests must be submitted by fax (1-888-693-3210) or by phone (1-888-693-3211) to the MedSolutions nurse. Batched authorizations would be approved at the suggested frequency for a 30-day period.
b. If ultrasounds or other OB studies that require preauthorization are requested over and above those approved in the batched authorization for the 30-day period, another authorization will need to be started and audits will be conducted to ensure proper coding, billing, and medical appropriateness of these additional studies. The CPT procedure codes referenced in the attached table not noted above include:
   76815 – Ultrasound pregnant uterus limited 1 or more fetuses
   76816 – Ultrasound pregnant uterus follow-up per fetus
   76817 – Ultrasound pregnant uterus transvaginal
   76818 – Fetal biophysical profile with non-stress testing
   76819 – Fetal biophysical profile without non-stress testing
   76820 – Doppler velocimetry fetal umbilical artery
   76821 – Doppler velocimetry fetal middle cerebral artery
c. The traditional, single use obstetrical ultrasound CPT codes (76801, 76802, 76805, 76810, 76811, 76812, 76813, & 76814) will not be included in the batching process.

Diagnosis (more than 1 diagnosis can apply)	When follow-up imaging can begin (76813 can be approved once per pregnancy at 11-13 weeks regardless of risk)	Follow-up imaging	Frequency until delivery	76818 OR 76819	Frequency until delivery	76820	Frequency until delivery	76821	Frequency until delivery	Guideline Reference
Abnormal First Trimester Screen	Following the 16-20 week fetal anatomic scan	76815 or 76816	1 every 2-4 weeks							2.4
Follow-up ultrasound for known fetal anomaly	Upon diagnosis	76815 or 76816	1 every 2-4 weeks							4.11
Abnormal Fetal Position or Presentation	Not before 35 weeks gestation unless delivery is imminent or version is being considered.	76815 or 76816	1 initially							4.2, 5.1
Premature Rupture of Membranes	Upon diagnosis	76815 or 76816 and/or 76817	Daily	X	1-2 weekly					3.10, 4.13, 5.3, 5.24
Confirmed polyhydramnios	Meets definition of polyhydramnios in OBUS GL 5.3	76815 or 76816	1 every 2-4 weeks	X	1 weekly					3.3, 4.5, 5.3
Confirmed oligohydramnios	Meets definition of oligohydramnios in OBUS GL 5.3	76815 or 76816	1 every 2-4 weeks	X	1 weekly	X	1 weekly			3.3, 4.5, 5.3
Follow-up of subchorionic hematoma or placental hematoma	Upon diagnosis	76815 or 76816 and/or 76817	>7 days from last US							2.5, 3.4, 4.1, 5.4
Known Abruptio Placentae	≥14 weeks-The number and frequency of follow-up ultrasounds will depend on the degree of abruption and the presence or absence of ongoing signs and symptoms.	76815 or 76816 and/or 76817	Send to MD review							3.4, 4.1, 5.4
Known Placenta Previa	28-32 weeks	76815 or 76816	1 initially (if Placenta Previa still present, may repeat at 35-37 weeks)							3.4, 4.1, 5.4

Diagnosis (more than 1 diagnosis can apply)	When follow-up imaging can begin (76813 can be approved once per pregnancy at 11-13 weeks regardless of risk)	Follow-up imaging	Frequency until delivery	76818 OR 76819	Frequency until delivery	76820	Frequency until delivery	76821	Frequency until delivery	Guideline Reference
Incompetent Cervix	16-18 weeks	76815 or 76816 and/or 76817	1 every 2-4 weeks (if funneling or shortening of the cervix is present, can do US weekly)							5.5
History of Preterm Delivery	16-18 weeks	76815 or 76816 and/or 76817	1 every 2-4 weeks							5.5
Maternal diet-controlled diabetes (patient has a diagnosis of any type of diabetes but requires **NO** medication for diabetes)	Fetal anatomic scan at 16-20 weeks gestation (76805 or 76811 if being performed by a MFM specialist, Perinatologist, or Radiologist). Follow-up imaging **BEGINS** at 35 weeks.	76815 or 76816	1 every 2-4 weeks	X	1-2 weekly					5.6

Diagnosis (more than 1 diagnosis can apply)	When follow-up imaging can begin (76813 can be approved once per pregnancy at 11-13 weeks regardless of risk)	Follow-up imaging	Frequency until delivery	76818 OR 76819	Frequency until delivery	76820	Frequency until delivery	76821	Frequency until delivery	Guideline Reference
Maternal non-diet-controlled diabetes (patient has any type of diabetes and requires medication for diabetes—includes Type 2 diabetes on diabetic medication, gestational diabetes on diabetic medication, insulin dependent diabetes [IDDM])	Fetal anatomic scan at 16-20 weeks gestation (76805 or 76811 if being performed by a MFM specialist, Perinatologist, or Radiologist), fetal echo (76825 or 76826) at 22-26 weeks. Follow-up imaging **BEGINS** at 28 weeks.	76815 or 76816	1 every 2-4 weeks	X	1-2 weekly starting at 32 weeks					5.6, 5.8
Known Single Umbilical Artery	Detailed anatomic ultrasound at 18 weeks (76811), fetal echo at 22-24 weeks (76825/76827). Follow-up imaging **BEGINS** at 28-32 weeks.	76816	1 every 2-4 weeks							4.11, 5.14
Chronic hypertension requiring **NO** medication	16-20 weeks	76815 or 76816	1 at 16-20 weeks and 1 at 30-34 weeks							5.15
Chronic hypertension requiring medication	16-20 weeks	76815 or 76816	1 every 2-4 weeks							5.15
Pregnancy-induced hypertension (PIH, preeclampsia, or toxemia)	Upon diagnosis	76815 or 76816	1 every 2-4 weeks	X	1 weekly	X	1 weekly if known diagnosis of IUGR			5.15

Diagnosis (more than 1 diagnosis can apply)	When follow-up imaging can begin (76813 can be approved once per pregnancy at 11-13 weeks regardless of risk)	Follow-up imaging	Frequency until delivery	76818 OR 76819	Frequency until delivery	76820	Frequency until delivery	76821	Frequency until delivery	Guideline Reference
Small for gestational age (<10%) or Small for dates (<10%)	Upon diagnosis	76815 or 76816	1 every 2-4 weeks							5.19
Suspected IUGR	≥14 weeks	76815 or 76816	2 initially (2 weeks apart)							3.7, 4.6, 5.19
Known IUGR	Meets definition of IUGR in OBUS GL 5.19	76815 or 76816	1 every 2-4 weeks	X	1 weekly	X	1 weekly			3.7, 4.6, 5.19
All twins except Monochorionic (Mo-Di and Mo-Mo)	See next column	Begin at 16 weeks. 76815 or 76816 and 76817	1 every 2-4 weeks	Begin at 24 weeks	1 weekly (if requested more than 1 weekly, send to MD review	X	1 weekly if known diagnosis of IUGR			3.6, 4.7, 5.21
Monochorionic twins(Mo-Di and Mo-Mo)	See next column	Begin at 16 weeks. 76815 or 76816 and 76817	1 every 2-4 weeks	Begin at 24 weeks	1 weekly (if requested more than 1 weekly, send to MD review	X	1 weekly if known diagnosis of IUGR	Begin at 28 weeks	1-2 weekly	3.6, 4.7, 5.21
Twin to Twin Transfusion syndrome	>18 weeks (to plan for imminent delivery)	76815 or 76816	Daily	X	Daily	X	Daily			3.6, 4.7, 5.21
Triplets or higher Multiple Pregnancy	See next column	Begin at 16 weeks. 76815 or 76816 and 76817	1 every 2-4 weeks	Begin at 24 weeks	1 weekly (if requested more than 1 weekly, send to MD review	X	1 weekly if known diagnosis of IUGR	Begin at 28 weeks	1-2 weekly	3.6, 4.7, 5.21

Diagnosis (more than 1 diagnosis can apply)	**When follow-up imaging can begin (76813 can be approved once per pregnancy at 11-13 weeks regardless of risk)**	**Follow-up imaging**	**Frequency until delivery**	**76818 OR 76819**	**Frequency until delivery**	**76820**	**Frequency until delivery**	**76821**	**Frequency until delivery**	**Guideline Reference**
Post Term Pregnancy	>40 weeks	76816	1 every 2 weeks	X	Twice a week					4.12, 5.23
Rh Isoimmunization and other causes of fetal anemia	See next column	Begin after performance of the fetal anatomic scan at 16-20 weeks. 76815 or 76816	1 every 2-4 weeks	Begin at 32 weeks (or sooner depending on fetal condition)	1 weekly			Begin at 20 weeks (or sooner depending on fetal condition)	1 weekly	5.25
Parvovirus B-19 (fifth disease)	See next column	Begin at time of known exposure. 76815 or 76816	1 every 2-4 weeks **for 8-10 weeks total**	Begin at time of known exposure	1 weekly **for 8-10 weeks total**			Begin at time of known exposure.	1 weekly **for 8-10 weeks total**	5.25
Risk of Stillbirth	Fetal anatomic scan at 16-20 weeks gestation (76805 or 76811 if being performed by a MFM specialist, Perinatologist, or Radiologist). Follow-up imaging **BEGINS** at 32 weeks.	76815 or 76816	1 every 2-4 weeks	X	1 weekly					5.26
History of Stillbirth	34 weeks gestation or one week before the previous pregnancy loss	76815 or 76816	1 weekly	X	1 weekly					3.12, 4.9, 5.26
Large Leiomyomata	Fetal anatomic scan at 16-20 weeks gestation (76805 or 76811 if being performed by a MFM specialist, Perinatologist, or Radiologist), transvaginal ultrasound (76817) at 22 weeks, and ultrasound (76815 or 76816) at 30-34 weeks to assess fetal growth.									5.30
Vasa Previa	28 weeks	76817 and/or 76815 or 76816	1 every 2-4 weeks							5.31

Attachment D: Procedure Reduction Criteria List

Contrast Family	Authorized CPT Codes (Contrast Status)	Lesser Intensity Procedure Allowed
CT HEAD	70450 (without)	70450 – must be exact match
	70460 (with)	70450 or 70460
	70470 (without followed by with)	70450 or 70460 or 70470
CT ORBIT	70480 (without)	70480 – must be exact match
	70481 (with)	70480 or 70481
	70482 (without followed by with)	70480 or 70481 or 70482
CT MAXILLO-FACIAL	70486 (without)	70486 – must be exact match
	70487 (with)	70486 or 70487
	70488 (without followed by with)	70486 or 70487 or 70488
CT SOFT TISSUE NECK	70490 (without)	70490 – must be exact match
	70491 (with)	70490 or 70491
	70492 (without followed by with)	70490 or 70491 or 70492
CT CHEST	71250 (without)	71250 – must be exact match
	71260 (with)	71250 or 71260
	71270 (without followed by with)	71250 or 71260 or 71270
CT CERVICAL SPINE	72125 (without)	72125 – must be exact match
	72126 (with)	72125 or 72126
	72127 (without followed by with)	72125 or 72126 or 72127
CT THORACIC SPINE	72128 (without)	72128 – must be exact match
	72129 (with)	72128 or 72129
	72130 (without followed by with)	72128 or 72129 or 72130
CT LUMBAR SPINE	72131 (without)	72131 – must be exact match
	72132 (with)	72131 or 72132
	72133 (without followed by with)	72131 or 72132 or 72133
CT ABDOMEN	74150 (without)	74150 – must be exact match
	74160 (with)	74150 or 74160
	74170 (without followed by with)	74150 or 74160 or 74170
CT PELVIS	72192 (without)	72192 – must be exact match
	72193 (with)	72192 or 72193
	72194 (without followed by with)	72192 or 72193 or 72194
CT ABDOMEN AND PELVIS	74176 (without)	74176 – must be exact match
	74177 (with)	74176 or 74177
	74178 (without followed by with)	74176 or 74177 or 74178
CT UPPER EXTREMITY	73200 (without)	73200 – must be exact match
	73201 (with)	73200 or 73201
	73202 (without followed by with)	73200 or 73201 or 73202
CT LOWER EXTREMITY	73700 (without)	73700 – must be exact match
	73701 (with)	73700 or 73701
	73702 (without followed by with)	73700 or 73701 or 73702
MRI BRAIN	70551 (without)	70551 – must be exact match

Contrast Family	Authorized CPT Codes (Contrast Status)	Lesser Intensity Procedure Allowed
(HEAD)	70552 (with)	70551 or 70552
	70553 (without followed by with)	70551 or 70552 or 70553
MRI FACE OR NECK	70540 (without)	70540 – must be exact match
	70542 (with)	70540 or 70542
	70543 (without followed by with)	70540 or 70542 or 70543
MRI CERVICAL SPINE	72141 (without)	72141– must be exact match
	72142 (with)	72141 or 72142
	72156 (without followed by with)	72141 or 72142 or 72156
MRI THORACIC SPINE	72146 (without)	72146-must be exact match
	72147 (with)	72146 or 72147
	72157 (without followed by with)	72146 or 72147 or 72157
MRI LUMBAR SPINE	72148 (without)	72148 – must be exact match
	72149 (with)	72148 or 72149
	72158 (without followed by with)	72148 or 72149 or 72158
MRI PELVIS	72195 (without)	72195 – must be exact match
	72196 (with)	72195 or 72196
	72197 (without followed by with)	72195or 72196 or 72197
MRI UPPER EXTREMITY	73218 (without)	73218 – must be exact match
	73219 (with)	73218 or 73219
	73220 (without followed by with)	73218 or 73219 or 73220
MRI UPPER EXTREMITY ANY JOINT	73221 (without)	73221 – must be exact match
	73222 (with)	73221 or 73222
	73223 (without followed by with)	73221 or 73222 or 73223
MRI LOWER EXTREMITY	73718 (without)	73718 – must be exact match
	73719 (with)	73718 or 73719
	73720 (without followed by with)	73718 or 73719 or 73720
MRI LOWER EXTREMITY ANY JOINT	73721 (without)	73721 – must be exact match
	73722 (with)	73721 or 73722
	73723 (without followed by with)	73721 or 73722 or 73723
MRI ABDOMEN	74181 (without)	74181 – must be exact match
	74182 (with)	74181 or 74182
	74183 (without followed by with)	74181 or 74182 or 74183
MRA HEAD	70544 (without)	70544 – must be exact match
	70545 (with)	70544 or 70545
	70546 (without followed by with)	70544 or 70545 or 70546
MRA NECK	70547 (without)	70547 – must be exact match
	70548 (with)	70547 or 70548
	70549 (without followed by with)	70547 or 70548 or 70549