

7.6 General Requirements for Prior Authorization and Program Exception Requests for Advanced Radiologic Imaging Services

7.6.1 Services That Require Prior Authorization or a Program Exception

The following advanced radiologic imaging services require prior authorization or a program exception, as described below:

- Computerized Tomography (CT) Scans
- Magnetic Resonance Angiogram (MRA) Scans
- Magnetic Resonance Imaging (MRI) Scans
- Magnetic Resonance Spectroscopy (MRS) Scans
- Nuclear Medicine Cardiology Scans
- Positron Emission Tomography (PET) Scans
- Single Photon Emission Computed Tomography (SPECT) Scans

7.6.1.1 Prior Authorization

A. Prior authorization is required for the following advanced radiologic imaging services:

- A non-emergency service listed on the MA Program Fee Schedule that is provided in an outpatient setting.
- A non-emergency service listed on the MA Program Fee Schedule that is provided in an outpatient setting to a Medical Assistance (MA) beneficiary who is in an inpatient facility.

B. Prior authorization is not required for the following advanced radiologic imaging services:

- A non-emergency service listed on the MA Program Fee Schedule that is provided in an inpatient setting.
- A service listed on the MA Program Fee Schedule that is provided on an emergency basis.

7.6.1.2 Program Exception (1150 Waiver)

A program exception requested through the administrative waiver process authorized by 55 Pa. Code § 1150.63 is required for the following advanced radiologic imaging services:

- A non-emergency service not listed on the MA Program Fee Schedule that is provided in an outpatient setting.
- The professional component of a non-emergency service not listed on the MA Program Fee Schedule that is provided in an inpatient setting.

7.6.1.3 Retrospective Review

A. Emergency Services Not on the MA Program Fee Schedule

A program exception is required for the following advanced radiologic imaging services provided on an emergency basis:

- A service not listed on the MA Program Fee Schedule that is provided in an outpatient setting.
- The professional component of a service not listed on the MA Program Fee Schedule that is provided in an inpatient setting.
- The request must be submitted within thirty days of the date of service, following the procedure in 7.6.2. If it is determined that the service was not provided to diagnose or treat an emergency medical condition, as set forth in Department regulations and program bulletins, the program exception request will be denied

B. Retroactive MA Eligibility

A prescriber may request authorization for claims for advanced radiologic imaging services provided to individuals who are determined to be eligible for MA retroactively (“late pickups”). The request must be submitted within thirty days of the date the prescriber or rendering provider receives notice of the eligibility determination. If it is determined that the service was not medically necessary, the authorization request will be denied.

C. Individuals with Third Party Resources

For those individuals with Third Party Resources, including Medicare and private insurance, the Department will not require PA or PE approval of advanced radiologic imaging services prior to the service being performed. In these instances, the rendering provider will submit its claim for cost sharing to the MA Program in the usual manner as set forth in the CMS 1500 Billing Guide for PROMISE. If the Third Party Resource denies payment for the advanced radiologic imaging service or pays less than the MA Program fee, the prescriber may request retrospective approval from the Department within 30 days of the date of the Third Party Resource Explanation of Benefits.

D. Documentation Supporting the Need for a Service That Requires Prior Authorization or a Program Exception

The clinical information provided during the course of the prior authorization or program exception review must be verifiable within the patient’s medical record. Upon retrospective review, the Department may seek restitution for the payment of the service and any applicable restitution penalties from the prescriber if the medical record does not support the medical necessity for the service. See 55 Pa. Code § 1101.83(b).

7.6.2 Procedure for Requesting Prior Authorization or a Program Exception for Advanced Radiologic Imaging Services

7.6.2.1 Initiating the Prior Authorization or Program Exception Request

A. Who May Initiate the Request

The prescribing practitioner must request prior authorization or a program exception.

B. How to Initiate the Request

The Department accepts prior authorization and program exception requests for advanced radiologic imaging services performed in an outpatient setting by telephone. Prescribers are to call 1-800-537-8862, (select Option # 1, then select Option # 3, then select Option # 3 again) between 7:30 a.m. and 4:00 p.m. (Eastern Standard Time), Monday through Friday.

7.6.2.2 Information and Supporting Documentation that Must Be Available for the Prior Authorization or Program Exception Review

The information required at the time prior authorization or a program exception is requested includes the following:

- Prescribing practitioner's name, address, and office phone number
- Rendering provider's or facility's Medical Assistance Identification (MAID) number and/or National Provider Identifier (NPI) number/taxonomy/zip code

NOTE: For a program exception request for an advanced radiologic imaging service not listed on the MA Program Fee Schedule, when the rendering provider and the reading physician are different providers, the MAID or NPI number is required for both providers.

- Beneficiary's name and Medical Assistance identification number
- Procedure code of the requested service
- Diagnosis and diagnosis code
- Clinical information to support the medical necessity of the requested service, including:
 - o Symptoms and their duration
 - o Physical examination findings
 - o Actions previously taken to determine the beneficiary's diagnosis (e.g., X-rays, CT scans, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation)
 - o Treatments that the beneficiary received (e.g., physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications)
 - o Reason the service is being requested (e.g., further evaluation, rule out a disorder)

The following documentation from the medical record may also be requested:

- Clinical notes
- Specialist reports or evaluations
- Reports from previously completed diagnostic procedures (e.g., X-ray, CT, MRI, ultrasound reports)

7.6.2.3 Documentation for Medical Necessity

In evaluating a prior authorization or program exception request for an advanced radiologic imaging service performed in an outpatient setting, the determination of whether the requested service is medically necessary will take into account the elements specified in the most current version of the InterQual Clinical Content – Imaging guidelines.

7.6.2.4 Clinical Review Process

Requests for advanced radiologic imaging services will be reviewed by applying the clinical guidelines identified in 7.6.2.3 above, to assess the medical necessity of the requested service. If the reviewer determines that the requested service meets the clinical guidelines, the reviewer will approve the request. If the reviewer determines that the guidelines are not met, or is unable to determine whether the guidelines are met, the request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization or a program exception may be approved when, in the professional judgment of the physician reviewer, the advanced radiologic imaging service is medically necessary to meet the needs of the beneficiary.

7.6.2.5 Timeframe of Review and Notification of Decision

The Department will make a decision on the prior authorization or program exception request within two business days of receiving all information reasonably needed to make a decision regarding the medical necessity of the service. A decision may be made during the call, if sufficient information is provided at that time. If additional information is requested and not received by the 15th day of the date of initial request, the request will be denied for lack of insufficient information.

The Department will issue a written notice of the decision to the beneficiary, the prescribing provider and the rendering provider (if applicable). If a prior authorization or program exception request is denied or approved other than as requested, the beneficiary has the right to appeal the decision within thirty days from the date on the notice by submitting an appeal in writing to the address listed on the notice.

NOTE: An approved prior authorization or program exception request means only that the service has been determined to be medically necessary. It does not address the beneficiary's eligibility for the service on the date of service. It is the responsibility of the rendering provider to verify the beneficiary's eligibility

through the Eligibility Verification System (EVS) on the date the service is provided.

7.6.2.6 Prior Authorization or Program Exception Number

If the prior authorization or program exception request is approved, the Department will issue a prior authorization or program exception number, which is valid for sixty days from the date the request. If the service appointment is rescheduled to a date beyond the sixty-day period, the prescribing practitioner must call 1-800-537-8862 (select Option #1, then select Option # 3, then select Option # 3 again) between 7:30 a.m. and 4:00 p.m. (Eastern Standard Time), Monday through Friday to request the authorization period be adjusted.

7.6.3 Procedures to Submit Claims

7.6.3.1 Submission of Claims

Follow the instructions for submitting a claim for an approved advanced radiologic imaging service found in the provider-specific billing guides on the Department's website at the following address:

<http://www.dpw.state.pa.us/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm>.

Providers who are unable to access the billing guides online may obtain a hard copy by calling the Provider Service Center at 1-800-537-8862, Option # 1.

7.6.3.2 Submission of Physician Claims

- A. A physician claim submitted for the professional component of an advanced radiologic imaging service listed on the MA Program Fee Schedule that is provided in an outpatient or emergency room setting need not include the prior authorization number.
- B. A physician claim submitted for the professional component of an advanced radiologic imaging service not listed on the MA Program Fee Schedule that is provided in an outpatient, emergency room or inpatient setting must include the program exception number.
- C. When the rendering provider and reading provider are permitted to submit separate claims for a service provided in an outpatient setting approved through the program exception process, the MAID or NPI number of both providers must be included on both claims.

7.6.3.3 Claims for Emergency Room Services

When an advanced radiologic imaging service is provided in the emergency room and the beneficiary is admitted directly to the inpatient setting from the emergency room, the service must be included on the inpatient invoice rather than being billed as an outpatient claim.