



HEALTHPLUS OF
MICHIGAN
IMAGING MANAGEMENT
PROGRAM
PROVIDER EDUCATION



Reasons:

- To improve patient safety and quality of care through appropriate radiological testing
- To manage HealthPlus of Michigan's radiology costs and utilization compared to benchmarks

Implementation Date:

- High Tech Authorizations – December 1, 2005
- In-Office Privileging – January 1, 2006

Vendor:

- CareCore National, serving 30 million covered lives
- Only Licensed Healthcare professionals perform certification
- NCQA certified, URAC accredited

Imaging Management Program Specifics :

- Prior Authorization required for **Outpatient** High Tech Radiology Imaging Services but **DOES NOT APPLY** to Inpatient, ER, or Urgent Care services
- In-Office Privileging required to perform low tech radiology in the physician's office (Completed office assessment form required)

High Tech Testing includes:

- CT/CTA
- MRI/MRA
- PET
- Nuclear Medicine
- Cardio Nuclear

Lines of Business Requiring Prior Authorization:

- HPI/PPO
- Commercial / Mi Child
- Medicare Advantage
- Medicaid Partners
- TPA (self-funded)
- County Health Plans (excludes Nuclear Medicine and Nuclear Cardiology modalities)
- CHP-A Prior auth required **EXCEPT** for nuclear and cardio nuclear which are a covered benefit, but without a prior auth requirement
- CHP-B Contact the HealthPlus website at www.healthplus.org or Customer Services (1-800-332-9161) for verification of most current county specific benefit packages
- Where HealthPlus is secondary to other commercial carriers (same as in-patient authorization process)

Note: Excluded from prior auth program – Medicare Supplemental packages beginning with W, S, or 1Y

Prior Authorization Process:

- Prior authorization is obtained by the ordering physician (PCP or specialist)
- Ordering physician provides clinical information (patient signs and symptoms, previous diagnostic imaging with results, prior management including any medications, dose and duration) to CareCore and requests prior authorization via:
 - Web: www.carecorenational.com
 - Fax: 1-866-466-6964
 - Phone: 1-800-792-8744
- CareCore clinical staff review information and issue authorization if appropriate
- Upon decision made by CareCore:
 - Immediate outbound call and notification fax to ordering physician
 - Mailed notification letter to member

- Follow up notification fax sent at close of business day to ordering physician
- Physician office schedules test including prior auth approval number, if normal practice

Note: The ordering physician may obtain authorization after the service if provided on an STAT basis outside of CareCore business hours (7PM – 7AM). The ordering physician must contact CareCore within two business days of the service to request an authorization.

Program Tips:

- A physician-to-physician conversation is available upon request at 1-800-792-8744 ext 11858
- Physician offices may check status on prior auth requests at www.carecorenational.com under Auth Lookup. Provider ID, Patient ID and birth date are required.
- One authorization number is assigned *per* CPT code.
- Prior authorization requests will result in determination within two business days or sooner with complete medical documentation
 - **Note to ordering physicians: Complete clinical information is key to quick turnaround. Use Prior Auth request form for gathering medical info.**
- If the case is **MEDICALLY URGENT**, meaning a delay in imaging may result in an unforeseen illness, injury or condition with clinical circumstances, the office can notify CareCore and will have an answer within 3 hours.
- Physicians may appeal denials to CareCore on behalf of member. All first level appeals are processed through CareCore, **EXCEPT** for Advantage member appeals. Advantage appeals are processed through HPM. (Contact HPM Customer Services for direction at 1-800-332-9161)
- Authorization will be code specific w/a pre-determined substitution code list to allow for slight modification of certain tests upon patient presentation (e.g. **CT** with Contrast). Contrast added to CT Scans does not need to be sent to CareCore for up grading. HealthPlus will reimburse the facility for the test performed and billed.
- If Contrast is added to an **MRI**, the rendering site must contact CareCore within 2 business days to upgrade the authorization and clinical indications for adding contrast must be provided. If CareCore is not contacted or upgraded CPT code is not approved, HealthPlus will reimburse the facility for the without contrast test.
 - **Note to ordering physicians: If the test is approved without contrast and you requested with contrast, schedule the member for the test and allow the radiologist to determine if contrast is necessary. The rendering imaging facility will contact CareCore with the medical necessity clinical info to support the addition (upgrading) of the contrast.**

Hospital/Freestanding Site Process:

- Prior authorization number must be obtained **prior to services being rendered**, in order to assure payment
- Patient registration may verify prior authorization by one of these options:
 - Physician offices and rendering site may check status on prior auth requests at www.carecorenational.com under Auth Lookup. Provider ID, Patient ID and birth date are required.
 - Contact CareCore Customer Service at 1-800-792-8744
 - Request approved authorization number from the ordering physician prior to services
 - Request approval letter from the member

Program Tips for Rendering Facilities:

- If exam is not approved or prior authorization has not been obtained, contact CareCore Customer Service 1-800-420-3471 or go to www.carecorenational.com to determine if authorization is in process. If not in process, contact the ordering physician.
- One authorization number is assigned *per* CPT code
- The approved authorization number is a 10 digit number beginning with an "A" (i.e.)

A001234567-70450. Remember, the last five digits after the Authorization Number is the CPT code that has been approved for testing

- Authorization will be code specific w/a pre-determined substitution code list to allow for slight modification of certain tests upon patient presentation (e.g. CT with Contrast allow for payment or of contiguous body part code substitutions) **Example:** If an MRI of a lower extremity was authorized, but the rendering radiologist determined that an MRI of ankle would be a more appropriate test for the member, it is acceptable for the rendering radiologist to perform an MRI of the ankle (contiguous body part), instead of performing the MRI of the lower extremity that was authorized
- Contrast added to **CT** does not need to be sent in to CareCore. HealthPlus will reimburse the facility for the test performed and billed
- If Contrast is added to an **MRI**, the rendering site must contact CareCore within 2 business days to upgrade the authorization and clinical indications for adding contrast must be provided. Test "Upgrade" form may be found at www.carecorenational.com www.healthplus.org. If CareCore is not contacted or upgraded CPT code is not approved, HealthPlus will reimburse the facility for the without contrast test.