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Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov for the related coverage policies listed below:

1E-6, *Pregnancy Medical Home*

1E-4, *Fetal Surveillance*

1K-2, Bone Mass Measurement

1.0 Description of the Procedure, Product, or Service

Vaya requires prior approval (PA) for certain outpatient non-emergent imaging services. Medical imaging is the process of using technology to view the human body in the interest of diagnosing, monitoring, and treating medical problems.

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

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible member shall be enrolled in:
   1. Vaya Total Care – a NC Medicaid Behavioral Health/Intellectual and/or Developmental Disabilities Tailored Plan
b. Provider(s) shall verify each Medicaid member's eligibility each time a service is rendered.
c. The Medicaid member may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Member 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 member 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 their 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 member'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 member'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 member'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 member 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: https://medicaid.ncdhhs.gov

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 Member under 21 Years of Age.

3.1 General Criteria Covered

Medicaid 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 member'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 member, the member's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply

3.2.2 Medicaid Additional Criteria Covered

Pregnancy Medical Home Providers

Note: Refer to clinical coverage policy 1E-6, Pregnancy Medical Home at https://medicaid.ncdhhs.gov, 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

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

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 Members under 21 Years of Age.

4.1 General Criteria Not Covered

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

a. the member does not meet the eligibility requirements listed in Section 2.0;
b. the member 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

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Note: Refer to clinical coverage policy 1E-6, Pregnancy Medical Home at https://medicaid.ncdhhs.gov, for information on obstetric ultrasounds in the pregnancy medical home project.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Member 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 member'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 exempt from the prior approval requirement must comply with

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 members do not require prior approval (these members will be identified as "non-delegated" and the option to create an authorization request will be unavailable):

1. Members who are dually eligible (for Medicare and Medicaid).
2. Members enrolled in the following Medicaid programs:
   A. Aid to the Aged
   B. Special Assistance for the Blind
   C. Special Assistance to the Aged
3. Members with emergency coverage for approved dates of service.
4. Medicaid for Pregnant Women

Note: Refer to clinical coverage policy 1E-6, *Pregnancy Medical Home* at https://medicaid.ncdhhs.gov, 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.

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 can result in nonpayment of the claim. Providers shall not bill for services not authorized.

5.2 Prior Approval Procedures

The provider(s) shall submit to the eviCore portal or fax line the following for service authorization review:

a. the service authorization request (SAR)

b. all health records and any other records that support the member has met the specific criteria in Subsection 3.2 of this policy

c. for members 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 submits materials for service authorization review prior to provision of the service.

5.2.2 Submission of Prior Approval Requests

The following information is required when requesting prior approval:

a. The member'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. Member'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 member'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-10-CM diagnosis code or diagnosis description)
i. CPT code(s) for requested procedures
j. The provider's fax number

6.0 Additional Requirements

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

6.1 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 NC Medicaid's clinical (medical) coverage policies, with the exception of this policy, 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)

Attachment A: Claims-Related Information

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

A. Claim Type

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

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, 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, Independent Diagnostic Testing Facility (IDTF).

G Co-payments

For Medicaid refer to Medicaid State Plan: https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: Rate and Checkwrite Schedules | Vaya Health

I Claims Submission

Claims submitted for unauthorized procedures, for members 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 members in such a situation.

The eviCore 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 a Vaya claims representative at 828-225-2785, extension 2455 or our Provider Support Line at 1-866-990-9712.

The following items will be used to identify situations where PA is not required (this is 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	
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	77046
72142	73221	77047
72146	73222	77048
72147	73223	77049

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 at

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	93970
76810	76882	93971
76811	76885	93975
76812	76886	93976
76813	76970	93978
76814	76978	93979
76815	+76979	93990
76816	76999	
76817	93325	
	93880	

G. 3D Rendering

CPT Code(s)
76376
76377

The following CPT codes do not require prior approval effective 04/01/2012: 76510, 76511, 76512, 76513, 76514, 76516, 76529, 76831 and 76873.

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 performed by non-PMH providers must be registered with or authorized by eviCore in order for claims to be processed. When registering or requesting prior authorization via the eviCore Web site, it is necessary to indicate the due date of the beneficiary. For detailed information regarding eviCore's clinical criteria, please refer to the Clinical Guidelines and Quick Reference Guides located at www.evicore.com under the "Clinical Guidelines and Forms" section. These guidelines are routinely updated and housed on the eviCore website for your convenience.

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

Contrast Family	Authorized CPT Codes (Contrast Status)	Lesser Intensity Procedure Allowed
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 (HEAD)	70551 (without)	70551 – must be exact match
	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

Contrast Family	Authorized CPT Codes (Contrast Status)	Lesser Intensity Procedure Allowed
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