Prior Authorization for Radiology Services

Effective for dates of service on or after May 1, 2006, both traditional Medicaid and PCCM require prior authorization or retrospective authorization for:

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Computed Tomography Imaging (CT)
- Computed Tomography Angiography (CTA)

Authorization is not required for emergency department or inpatient hospital MRI, MRA, CT, or CTA.

Prior authorization is required for all outpatient non-emergent CT, CTA, MRI, and MRA studies (i.e. those that are preplanned or scheduled) before services are rendered. Retrospective authorization is required for outpatient emergent studies when the physician determines that a medical emergency that imminently threatens life or limb exists, and the medical emergency requires advanced diagnostic imaging (CT, CTA, MRI, or MRA). Providers must submit a retrospective authorization request no later than two business days after the study is completed.

The addition of post 3-D reconstruction (76376 and 76377) CT and MR studies must be prior authorized. No additional payment will be made without prior authorization.

Intraoperative MRI of the brain, codes 70557 through 70559, is not a benefit of the Texas Medicaid Program.

Refer to the end of this document for a list of procedure codes that require prior or retrospective authorization.

Providers and facilities are required to use the lowest possible radiation dose consistent with acceptable image quality for CT examinations of children. It is recommended that providers and facilities utilize national standards, such as those by the American College of Radiology, *Practice Guidelines for Performing and Interpreting Diagnostic CT examinations*, for CT imaging.

Nationally accepted guidelines and radiology protocols based on medical literature are utilized in the authorization processes for both emergent and nonemergent studies. These include: American College of Radiology (specifically, the Appropriateness Criteria), American Academy of Neurology, American Academy of Orthopedic Surgeons, American College of Cardiology, the American Heart Association, and the National Comprehensive Cancer Care Network.
Prior authorization of nonemergent and emergent retrospective authorization of CT, CTA, MRI, and MRA studies are considered on an individual basis adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the study.

Providers may request prior or retrospective authorization by:

- Telephone: 1-800-572-2116
- Fax: 1-800-572-2119, or
- Mail:

  Texas Medicaid & Healthcare Partnership
  730 Cool Springs Blvd, Suite 800
  Franklin, TN 37067

Please be prepared to provide the following patient information for all requests:

- Diagnosis
- Treatment history
- Treatment plan
- Medications
- Previous imaging results

Providers may be requested to provide additional documentation.

Requests that are faxed or mailed must be accompanied by a Radiology Prior Authorization Form (see page 39 of this bulletin). Complete the demographics box at the top of the form and include the information as outlined above.

The Radiology Prior Authorization Form must be completed, signed, and dated by the ordering physician before requesting authorization for CT, CTA, MRI, or MRA studies, regardless of the method of request for authorization. The physician’s signature must be current, unaltered, original, and handwritten. A computerized or stamped signature will not be accepted. The physician who ordered the test(s) must keep the completed form with original signature in the client’s medical record. In addition, medical record documentation must support the medical necessity of the study.

Authorization requirements for both nonemergent and emergent studies must be met in order to be considered for reimbursement. In the absence of authorization, both the technical and professional interpretation components will be denied.

Reimbursement for outpatient emergent and nonemergent CT, CTA, MRI, and MRA studies requires that the authorization number is added to the claim.
Claims for emergency CT, CTA, MRI, and MRA studies provided in the emergency department must be submitted with modifier U6 and must have the appropriate corresponding emergency services revenue code (450 through 459) to be considered for payment.

If two CTs, CTAs, MRAs, or MRIs are performed in the emergency room or an outpatient setting on the same day without an authorization on file, the second procedure will deny. Providers may submit additional medical necessity documentation for payment reconsideration.

<table>
<thead>
<tr>
<th>Procedure Codes That Require Authorization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>350</td>
</tr>
<tr>
<td>70470</td>
</tr>
<tr>
<td>70496</td>
</tr>
<tr>
<td>70549</td>
</tr>
<tr>
<td>71552</td>
</tr>
<tr>
<td>72133</td>
</tr>
<tr>
<td>72159</td>
</tr>
<tr>
<td>73201</td>
</tr>
<tr>
<td>73700</td>
</tr>
<tr>
<td>73725</td>
</tr>
<tr>
<td>75553</td>
</tr>
<tr>
<td>76380</td>
</tr>
</tbody>
</table>

The Radiology Prior Authorization Form is located on the TMHP website.

For more information, visit the TMHP website at www.tmhp.com, or call the TMHP Contact Center at 1-800-925-9126.