Policy and Procedure

Title: High-Tech Radiologic Studies	Division: Medical Management Department: Utilization Management
Approval Date: 10/26/2018	LOB: Medicaid, Medicare, FIDA, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP
Effective Date: 11/16/2018	Policy Number: UM-MP242
Review Date:	Cross Reference Number:
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POLICY DESCRIPTION:
Update to authorization requirements for high tech diagnostic imaging.

1. RESPONSIBLE PARTIES:
Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

2. DEFINITIONS:
High-tech imaging is defined as MRI, MRA, PET and CT.

3. POLICY:
Effective November 16, 2018 MetroPlus Health Plan is changing the authorization requirements for high-tech radiology services.

1. All out-of-network requests for high-tech radiology will require prior authorization and will be reviewed and managed directly by MetroPlus.
2. For in-network requests, certain imaging services will still require prior-approval and will be reviewed and managed directly by MetroPlus.

Effective November 16, 2018, the following high tech radiology services will require notification and authorization for in-network providers:

- All PET Scans will continue to require authorizations. See CPT Code listing below.

CPT® Code	CPT® Code Description
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh
78813	Positron emission tomography (PET) imaging; whole body
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)

78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body

- All spinal MRIs administered after an initial spinal MRI in the prior 12-month period will require authorization. The initial spinal MRI (if one has not been administered to the member in the prior 12-months) will not require authorization. See CPT Code listing below.

CPT® Code	CPT® Code Description
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)

4. LIMITATIONS/ EXCLUSIONS:

Multiple high-tech imaging services performed on the same day and on the same organ system will require authorization. High-tech imaging is defined as MRI, MRA, PET and CT.

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5. APPLICABLE PROCEDURE CODES:

The table below contains the CPT codes that apply to our radiology notification and prior authorization programs

CPT	Description	Auth Requirement
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation	Prior Auth Required
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	Prior Auth Required
78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress	Prior Auth Required
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	Prior Auth Required
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	Prior Auth Required
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Prior Auth Required
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Prior Auth Required
78813	Positron emission tomography (PET) imaging; whole body	Prior Auth Required
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Prior Auth Required
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Prior Auth Required
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Prior Auth Required
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	Auth Required after 1st study, within rolling 12-month

72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	Auth Required after 1st study, within rolling 12-month
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	Auth Required after 1st study, within rolling 12-month
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)	Auth Required after 1st study, within rolling 12-month
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	Auth Required after 1st study, within rolling 12-month
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)	Auth Required after 1st study, within rolling 12-month
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	Auth Required after 1st study, within rolling 12-month
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	Auth Required after 1st study, within rolling 12-month
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	Auth Required after 1st study, within rolling 12-month
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)	Auth Required after 1st study, within rolling 12-month

6. APPLICABLE DIAGNOSIS CODES:

NA

7. REFERENCES:

NA

REVISION LOG:

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REVISIONS	DATE
Creation date	10/26/2018

Approved: Date:	Approved: Date:
Bruce Sosler, MD Clinical Medical Director	Talya Schwartz, MD Chief Medical Officer

Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.