Cardiac Imaging Frequently Asked Questions

Cardiac Studies for CareSource Exchange

Why do some cardiac-related studies require prior authorization?
Prior authorization is required to minimize radiation exposure and promote the most appropriate test for the continuum of care.

When did the program begin?
The CareSource cardiac prior authorization program began Jan. 1, 2015.

How does the program work?
The cardiac imaging management program assesses imaging technologies used to diagnose and monitor members with cardiac-related conditions in non-emergent cases. The program takes a comprehensive approach to determine if a recommended test is the proper next step in diagnosing cardiac-related conditions or if another test is more appropriate.

What cardiac-related imaging procedures are included in the CareSource cardiac program?

Prior authorization through National Imaging Associates, Inc. (NIA) is required for the following cardiac modalities:

- CCTA
- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Stress Echocardiography
- Echocardiography

What additional services are provided?

- Evidence-based algorithms to support the best diagnostic options for each member
- Consultations with board-certified internists with specialized cardiac training and board-certified cardiologists related to elective cardiac diagnostic imaging when peer-to-peer review is required

What do ordering providers need to do?

Ordering providers need to get prior authorization for non-emergent, outpatient:

- Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiography (MRA)

- Computed Tomography (CT)/Computed Tomography Angiography (CTA)
- Positron Emission Tomography (PET)
- CCTA
- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Stress Echocardiography
- Echocardiography (transthoracic and transesophageal echocardiography)

How does this program impact claims?

Specific CPT codes related to the included procedures require prior authorization. Please refer to the CareSource Utilization Review Matrix, available on www.RadMD.com to determine if a specific procedure code requires prior authorization. Please be aware that although add-on codes are sometimes included in a procedure code group that does not mean that an add-on code is automatically payable. See the foot note on the Utilization Review Matrix that states: "Payment for add-on codes may depend upon the appropriateness of the application of such codes related to the approved primary code." For example, if a Doppler add-on code is billed along with an approved Stress Echocardiography code, the claim should include a diagnosis code for one of the medical conditions that supports the need for the Doppler add-on. See the presentation "Cardiac Claim Edit – Explanation for Providers" for approvable medical conditions.

Who administers clinical oversight of the cardiac program?

Board-certified cardiologists developed evidence-based clinical guidelines and algorithms that determine the best available diagnostic pathway. These physicians consult with referring physicians to apply these guidelines and algorithms to a member's specific symptoms and medical history. By determining the most appropriate clinical imaging protocol for each member, we can reduce duplicative testing, minimize member radiation exposure, shorten diagnosis time, and improve the overall health care experience.

Is there anything else I should be doing?

If you haven't done so already, please take a few minutes to register on www.RadMD.com. This portal gives you the most expedient way to process your imaging requests.

What happens if I need to have an inpatient or emergent cardiac procedure performed?

CareSource continues to manage inpatient and emergency cardiac procedures as is done today.

KEY PROVISIONS

- Emergency room and inpatient imaging procedures do not require prior authorization.

Multi-EXC-P-2444462