Applicable To:

- ☑ Medicaid – MO, NE, NJ, NY, SC, FL
- ☑ Medicare

Claims and Payment Policy: Emergency Department Radiology Utilization

Policy Number: 106

Original Effective Date: 01/23/2019 (Medicare)
Revised Date(s): 04/15/2019

BACKGROUND

In recent years, CMS, national health plans and specialty societies have observed a significant increase in the utilization of advanced imaging procedures in the Emergency Department (ED) setting, without any corresponding improvement in patient outcomes. Inappropriate use of these services result in over-reimbursement. Additionally, it has resulted in patient overexposure to radiation, which has been shown to increase the risks of certain cancers and other conditions. In an effort to reduce unnecessary radiology use, the American College of Emergency Physicians (ACEP), The American College of Radiology (ACR) and other specialty societies have developed recommendations and guidelines for the correct use of these diagnostic procedures in the ED.

The need for any imaging procedure should be determined on the basis of medical necessity and the patient's individual medical needs. Use of these procedures should be supported by the clinical expertise of a physician, whenever possible.

POSITION STATEMENT

Health Plans has implemented a policy to address inappropriate use of advanced radiology procedures in the ED. This policy aims to ensure that provider facilities are utilizing high cost, or advanced, radiology procedures responsibly and only for diagnoses where the high acuity radiology procedures are deemed medically necessary. High cost procedures that are experiencing increased utilization rates include both magnetic resonance imaging (MRI) and computed tomography (CT) services, particularly in the ED setting.

Utilizing one of these advanced radiology services signifies that the service was required to accurately diagnose the patient, and implies that complex decision making was employed by the ordering physician based on significant burden of patient disease. WellCare supports the use of medically necessary imaging studies, in all places of service, including the Emergency Department.

Pre Pay Review
Should Health Plans encounter an ED facility claim for a CT or MRI, and all submitted diagnoses are non-emergent, Health Plans will remove the advanced imaging line and pay the adjusted amount of the claim. WellCare expects that hospitals submit claims that accurately reflect the performance of medically necessary services and resources utilized in theED. If the provider does not agree with Health Plan determination, the facility may dispute the denial by submitting medical records for review.

Post Pay Review
Health Plans may retrospectively audit providers regarding the use of advanced imaging codes. Should Health Plans review records for advanced imaging and medical necessity is not met for those services, Health Plans will issue a finding and recovery letter to the facility.

For Health Plans markets where medical necessity is not the standard for coverage of ER services, and instead the ER Prudent Lay Person standard applies, those markets are excluded from this payment policy.

CODING & BILLING

MRI/CT Scan CPT Codes: 70000-79999
Emergency Department CPT Codes: 99281 - 99285
Emergency Department HCPCS Codes: G0380-G0384

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

https://www.advisory.com/research/physician-executive-council/prescription-for-change/2015/02/head-ct-scan-overuse

https://www.hopkinsmedicine.org/news/media/releases/johns_hopkins_study_cost_of_treating_dizziness_in_the_emergency_room_soars

http://www.jabfm.org/content/25/1/33.full

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

. ~ Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ 'Ohana Health Plan, ~ Staywell of Florida ~ WellCare Prescription Insurance WellCare (Arkansas, Connecticut, Florida, Georgia, Illinois, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
01/23/2019	• Approved by RGC