ARC 1696C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Iowa Administrative Code.

This amendment addresses requirements for prior authorization (PA) of high-technology radiology procedures to ensure appropriate uses of these more expensive diagnostic imaging tests. A PA requirement for these procedures was implemented by the Iowa Medicaid Enterprise (IME) in 2010. At that time, it was determined that a specific rule was not necessary on the basis that existing PA rules provided authority for the additional requirement related to high-tech radiology procedures. However, it has now been determined that a specific rule is more appropriate. Complaints regarding the process or inappropriate decisions have largely diminished as providers have become more familiar with the process of seeking PA approvals for these high-technology radiology procedures.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 1620C** on September 3, 2014. The Department received no comments during the comment period. This amendment is identical to that published under Notice of Intended Action.

The Council on Human Services adopted this amendment on October 8, 2014.

This amendment does not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

This amendment is intended to implement Iowa Code section 249A.4.

This amendment will become effective January 1, 2015.

The following amendment is adopted.

Adopt the following **new** subrule 78.28(11):

78.28(11) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(11)*"b,"* the following radiology procedures require prior approval:

(1) Magnetic resonance imaging (MRIs);

(2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;

(3) Computed tomographic angiographs (CTAs);

(4) Positron emission tomography (PETs); and

(5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(11)*"a,"* prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member's receipt of such notice (see paragraph 78.28(11)*"e"*); or

(4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department's contractor for prior approval of high-technology radiology procedures.

e. Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member's retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.
2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/29/14.