

**THIS PATIENT BELONGS TO:**

**JHMO Blue** (formerly HMO CNY or Healthguard Blue and HMO Blue of Utica Watertown)

**Blue Point / Blue Point 2**

**BC Child Health Plus**  **Family Health Plus**

**Blue Choice Options: Medicaid Managed Care**

**Contact: Provider Relations (315) 448-3735, (800) 920-8889**

Patient Name: \_\_\_\_\_ # Visit \_\_\_\_\_ out of \_\_\_\_\_

Effective Date of Referral: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Auth # \_\_\_\_\_

Referral Approved For: \_\_\_\_\_

**Referrals:** All initial approvals through PCP specialist may request further referrals directly

To verify the presence of an Authorization, call **448-3735**

**PCP to Specialist:** Requires phone authorization at **(800) 649-6646** (Medical Services)

**Specialist referrals for: All specialties require referral except:** OB/Gyn and Hematology/Oncology

**Specialist referrals for diagnostic testing/treatment:** Specialist may refer on for testing if it is within the scope of specialty. Referrals outside of their office: call **(800) 649-6646**

**Specialist to Specialist:** Specialist must contact PCP for further referrals

**Self Referrals:** Necessary GYN, optometry/ ophthalmology: 1 routine/24 months

**Emergency Services:** Patient/PCP must call **(800) 649-6646** in 48 hours-medically necessary

**LABS:** University Hospital, UPL, area hospitals, Roche, Smith Kline, Quest, LACNY, NTD, Centrex....

**RADIOLOGY:** University Hospital, area hospitals, Prospect Hill, Medical Imaging Center

**RADIOLOGY Referrals for:** See attached reference sheet: call **(888) 576-7783**

**PHARMACY:** Eckerds, Rx-Place, Wegmans, CVS, WalMart, Rite Aid, P&C....

**HOME CARE:** PCP Calls **(800) 649-6646**

**MENTAL HEALTH:** PCP Calls **(800) 649-6646**

**PRIOR APPROVALS:** These services require prior approval- including but not limited to:

**PHONE REFFERAL (800) 649-6646**

Abdominoplasty \* BCRA Testing \* Blepharoplasty \* Bone Density/Dexas \* Breast Implant/Insertion or Removal \* Breast Reduction for Gynomastia \* Cardiac Rehab \* Chronic Vagus Nerve Stimulation \* Chorionic Villi Sampling \* Cochlear Implants \* CT Scans \* D&C \* Dental Treatment due to Injury \* Dermabrasion \* DME \* EECF \* Gastric Bypass \* HOSPITAL ADMISSIONS \* Home Infusion \* Home Care \* Hysterectomy \* IVIG \* Keloid Scar Revision \* Laminectomy \* Laparoscopic Cholecystectomy \* Lesion removal \* LVAD \* Myringotomy \* MRI/MRA \* Neuropsychological testing \* NON-PAR PROVIDER \* Otoplasty \* Palatopharyngoplasty \* Pet Scan \* Rhinoplasty \* Schlerosing Injection \* Septoplasty \* Sleep Studies \* PT/OT/Speech \* Tonsillectomy \* Transplants \* Uterine Artery Embolization \* Viscosupplementation \* Vein Ligation\*



**April 1, 2004**

A nonprofit independent licensee of the BlueCross BlueShield Association

**#04-04**

**To: Participating Physicians, Chiropractors and Imaging Facilities**  
**From: Provider Relations**  
**Subject: Changes in Prior Authorization Requirements for Imaging Services**

Many Excellus BlueCross BlueShield health benefit plans require prior authorization for specific imaging services. **Effective May 1, 2004**, we are reducing the number of imaging services that require prior authorization in our Central New York, CNY Southern Tier and Utica Regions. ***It will no longer be necessary for you to request prior authorization for the following imaging services.***

- CAT scan of head, brain, orbit or soft tissue neck
- MRI of brain
- MRA of spinal canal and contents, chest, pelvis, lower extremity, upper extremity

*Please note that there are exceptions and/or additional requirements for some groups for whom we supply administrative services only.*

New tools for imaging services prior authorization

We are enclosing some new tools to make the process of requesting prior authorization for imaging services easier for you.

- **The enclosed tip sheet includes an updated list of the procedures (with CPT procedure code) that still require prior authorization, along with suggested types of information we will need for each category.**
- Also enclosed is a new sheet with member ID prefixes. The prefixes are for those products/groups that require prior authorization.
- You may use the enclosed fax form if you prefer to fax your request rather than telephone it in.
- To expedite your telephoned requests, we are introducing a toll-free telephone number that will take you directly to the radiology review unit.

**Please do not use the new telephone number or fax form until May 1, 2004.** In the meantime, continue to follow the current process.

If you have any questions about these changes, please contact your Provider Relations Representative.

# Obtaining Preauthorization for Radiology Imaging Studies

Fax a *Preauthorization for Imaging Studies* form to 1 (888) 465-1373, or call 1 (888) 576-7783.

Preauthorization is required for imaging studies listed in the table below *for specific health benefit plans. Please see separate member ID prefix listing to identify members who have these requirements.* Imaging studies conducted in emergency room or inpatient settings DO NOT require preauthorization. Urgent studies should be called in on the next business day.

- **For all imaging studies**, supply the following information:
  - Patient Name, ID# and date of birth
  - Provider ID#
  - Facility name where test is to be conducted
  - Diagnosis code
  - Test ordered
  - Reason for ordering test (physician's expected finding)
  - Worker's Compensation or No-Fault-related injury, date of injury
- **For CAT scans of the sinus**, also supply this clinical information:
  - Acute sinusitis vs. chronic sinusitis
  - Number of infections
  - Antibiotic treatment hx. (date of last treatment)
  - Patient symptoms and duration
  - Physical exam findings
- **For an MRI of the knee or lower extremity**, also supply this clinical information:
  - Note any trauma
  - Stable knee vs. unstable knee
  - Previous X-ray studies
  - Patient symptoms (pain, swelling, tenderness, locking, giving out)
  - Conservative therapy completed (physical therapy and medications)
  - Palpable mass (size)
- **For a CAT scan or MRI of the spine**, also supply this clinical information:
  - Note any trauma
  - Patient symptoms (duration, severity, worsening)
  - Neurologic findings on physical exam
  - Pain medications
  - Conservative treatment (physical therapy or chiropractic)
  - Other radiology studies conducted
- **For a PET scan**, also supply this clinical information:
  - Clinical notes
  - Diagnostic procedure results (SPECT, stress test, echocardiogram, lab, CT)
  - Biopsy or pathology report
  - Previous treatment
- **For Bone Density or DEXA Scans (SYU prefix only)**, also supply this clinical information:
  - Patient history
  - Physical exam findings
  - Letter of medical necessity

Imaging Studies Requiring Preauthorization			
<b>Computerized Axial Tomography (CAT)</b>			
Sinus (maxillofacial)	70486	70487	70488
Cervical spine	72125	72126	72127
Thoracic spine	72128	72129	72130
Lumbar spine	72131	72132	72133
Lower extremity	73700	73701	73702
<b>Magnetic Resonance Imaging (MRI)</b>			
Orbit / Face / Neck	70540	70542	70543
Cervical spine	72141	72142	72156
Thoracic spine	72146	72147	72157
Lumbar spine	72148	72149	72158
Lower extremity	73718	73719	73720
Lower extremity with joint	73721	73722	73723
TMJ	70336		
<b>Magnetic Resonance Angiography (MRA)</b>			
Head	70544	70545	70546
Abdomen	74185		
Neck	70547	70548	70549
<b>Positron Emission Tomography (PET)</b>			
Brain	78608		
Lung / Body	78810		
Cardiac RUB	78491		
Cardiac FDG	78459		
<b>Bone Density / DEXA Scan (Required for SYU prefix only)</b>			
Axial skeleton	76070	76075	
Appendicular skeleton (peripheral)	76076	76977	

Effective May 1, 2004

**IMPORTANT NOTE:** SYU requirements differ from other contracts. Not all imaging requirements for SYU are included on this form.



Central New York, CNY Southern Tier and Utica Regions

## PREFIX LIST FOR RADIOLOGY IMAGING STUDIES

The following HMO, Point of Service and PPO prefixes require prior authorization for specific imaging services. Call or fax Radiology Preauthorization:

Phone: 1 (888) 576-7783  
Fax: 1 (888) 465-1373

AFV	CCI	EVB	RYD	YOT	ZFD
AMK	CLR	IBF	SGL	YOY	ZFN
AMS	CMB	MAE	SYU*	YOZ	ZFS
ASD	CMX	ONC	WEA	ZFA	
AXT	DRP	PYS	WND	ZFB	
AZN	DSB	RMF	YOE	ZFC	

In addition to the above prefixes, **Medicaid managed care** (HMOBlue Option) and **Family Health Plus** members require prior authorization for specific imaging services. These members do not have identification numbers with BlueCross BlueShield prefixes. The identification number for these members is their Medicaid CIN.

*If you are not sure if one of our members requires prior authorization for radiology services, please call Provider Services:*

*Syracuse: 1 (800) 920-8889  
Utica: 1 (800) 311-3536*

\*Requirements differ slightly from other prefixes. Please call if you need clarification.



# Preauthorization for Imaging Studies

Fax this form to 1 (888) 465-1373

The imaging studies listed on this form require preauthorization.

Ordering physicians must follow these procedures to obtain preauthorization prior to scheduling a study.

- Complete this form and fax it to the number provided.
- If the requested procedure meets the criteria for medical necessity, the Plan will assign it a preauthorization number.
- Provide that number to the radiology facility when scheduling the study.

**Authorizations are valid for 60 days following the date of approval.**

Payment of claims is subject to eligibility on the date of service and to contractual limitations, provisions, and exclusions.

**Emergent and in-patient procedures do not require preauthorization.** Urgent after-hours procedures should be called in to 1 (888) 576-7783 the next business day.

**Questions? Call 1 (888) 576-7783.**

Date of Request:			
<b>Patient / Member Information</b>			
Last Name :		First Name:	
ID Number:	DOB: ___/___/___	Phone: _____	
<b>REQUIRED</b> <i>(Check One)</i>	<input type="checkbox"/> COB <input type="checkbox"/> No-Fault <input type="checkbox"/> WC <input type="checkbox"/> N/A	Date of Injury:	___/___/___
<b>Ordering Physician Information</b>			
Name of Ordering Physician:		Prov. ID#:	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist		Phone:	
Office Contact:		Fax:	
<b>Procedure Information</b>			
Name of Radiology Facility:			
Diagnosis:		ICD9 Code:	
<b>Clinical Review</b>			
CT	<input type="checkbox"/> Sinus	Clinical Indications for Requested Study:	
	<input type="checkbox"/> Cervical Spine		
	<input type="checkbox"/> Thoracic Spine	Patient Symptoms and Duration:	
	<input type="checkbox"/> Lumbar Spine		
	<input type="checkbox"/> Lower Extremity		
MRI	<input type="checkbox"/> Orbit / Face / Neck	Results of Previous Imaging Studies for Present Condition:	
	<input type="checkbox"/> Cervical Spine		
	<input type="checkbox"/> Thoracic Spine	What conservative therapy was attempted prior to requesting study?	
	<input type="checkbox"/> Lumbar Spine		
	<input type="checkbox"/> Lower Extremity		
	<input type="checkbox"/> Lower Extremity Joint		
	<input type="checkbox"/> TMJ		
PET	<input type="checkbox"/> Brain	Other pertinent information:	
	<input type="checkbox"/> Lung / Body		
	<input type="checkbox"/> Cardiac		
MRA	<input type="checkbox"/> Head		
	<input type="checkbox"/> Abdomen		
	<input type="checkbox"/> Neck		
BONE DENSITY / DEXA SCAN	Applies to SYU only		