

****PAYOR ALERT****
**BCBS AND AETNA PRIOR OUTPATIENT DIAGNOSTIC AUTHORIZATION
REQUIRED**

EFFECTIVE 2.1.07 BCBS WILL REQUIRE PRIOR APPROVAL/AUTHORIZATION FROM THE ATTENDING PHYSICIAN FOR SPECIFIC OUTPATIENT DIAGNOSTICS. CVMC WILL REQUIRE THE AUTHORIZATION FROM ORDERING PHYSICIAION PRIOR TO SERVICES RENDERED. AETNA'S SIMILAR PROGRAM IS EFFECTIVE 3.1.07.

CVMC AND FRMC HAVE PARTNERED AND CREATED STANDARDIZED AUTHORIZATION FORMS FOR PROVIDER USE. FORMS ARE ENCLOSED AND SHOULD BE SUBMITTED WITH EACH SCHEDULED NON-EMERGENT DIAGNOSTIC. PLEASE CONTACT OUR REGISTRATION DEPARTMENT FOR ADDITIONAL INFORMATION. WE APPRECIATE YOUR SUPPORT AND UNDERSTANDING OF THIS NEW PAYOR DICTATED REQUIREMENT.

HISTORICAL REFERENCE:

Though the outpatient precert prior authorization is not a new concept or program in managed care and some current Payors such as Cigna currently have such plans in place, the significant difference with the new BCBS plan is that the **ORDERING MD** is the **only one** who can obtain the authorization. This authorization is required **prior** to services being rendered and downstream providers **may NOT obtain the authorization.** Ordering MDs are those who see the patient and prescribe the outpatient diagnostic. Hospitals, free standing centers etc. are considered downstream Providers and therefore, our **Hospital and CVIC will NOT receive payment if the authorization is not obtained but the ORDERING MD prior to services rendered.**

Furthermore, BCBS will not allow downstream Providers/Facilities to appeal if services are provided without the prior authorization--regardless of medical necessity--and unfortunately, contractually CVMC may not balance bill the patient for such services.

CHANGES:

1--BCBS "AIM" Outpatient Diagnostic Prior Authorization Approval Plan":

Effective 2/15/07 BCBS will utilize a third party vendor, AIM, for the prior approval review and authorization of **CT/CTA, MRI/MRA/Nuclear cardiology studies and PET** outpatient diagnostics. If the prior authorization has not been obtained by the Ordering MD, PRIOR to services rendered, the downstream provider (s) will not be paid and patient cannot be balanced billed.

This does not impact Inpatient or Emergent services.

2--Aetna Health Plans (utilizes the SouthCare network in our market) **Outpatient Diagnostic Prior Authorization Approval Plan**":

Effective 3/1/07, will utilize **MedSolutions** (just like Cigna) for all diagnostic reviews. Prior approval will be required for **MRI/MRA, Nuclear Cardiology, CT Scan and Pet Scans** before services are rendered. If the prior authorization has not been obtained PRIOR to services rendered, the downstream provider (s) will not be paid and patient cannot be balanced billed.

****The significant difference between the Aetna plan and the BCBS plan is that Aetna will allow (for now) any downstream provider to obtain the authorization if the ORDERING does not. They prefer the "ordering" to obtain, but Aetna, unlike BCBS, will accept it from the downstream provider.**

This does not impact Inpatient or Emergent services.

3---**United Health Plan (UHC) Outpatient Diagnostic Prior Notification Plan**":

Their plan effective date has been pended and UHC retracted their original correspondence. We do know that the program will be very similar to Aetna's in that the downstream provider will be able to obtain the authorization in the event the ORDERING does not.

Once we have the specific Plan and effective date, we will disseminate the information.
his does not impact Inpatient or Emergent services.

DIAGNOSTIC SERVICES ORDER FORM

CENTRAL SCHEDULING: (828)326-3858 FAX: (828)326-3844

PLEASE INDICATE THE LOCATION THAT YOU HAVE SCHEDULED THE EXAM AT:

CATAWBA VALLEY MEDICAL CENTER - MAIN CAMPUS (828) 326-2170 _____

CATAWBA VALLEY IMAGING CENTER – TATE BLVD. (828) 485-2766 _____

PATIENT NAME: _____ **DOB:** _____ **SSN#** _____

INSURANCE CO. _____ **AUTHORIZATION #** _____

Note: If you are ordering a PET scan, MRI, CT, or Nuclear Medicine study, we will be unable to schedule the requested exam without insurance name and accurate authorization #

EXAM DATE _____ EXAM TIME ____ am ____ pm	EXAM 1: _____ SIGNS & SYMPTOMS:(1) _____ (2) _____ (3) _____	LABS Yes _____ No _____
EXAM DATE _____ EXAM TIME ____ am ____ pm	EXAM 2: _____ SIGNS & SYMPTOMS:(1) _____ (2) _____ (3) _____	
EXAM DATE _____ EXAM TIME ____ am ____ pm	EXAM 3: _____ SIGNS & SYMPTOMS:(1) _____ (2) _____ (3) _____	

****NO EXAM WILL BE PERFORMED WITHOUT THIS REQUISITION****

The undersigned physician certifies that either: (1) The tests ordered are medically necessary and specific tests ordered on this requisition for the diagnosis and treatment of the patient; the physician is treating the patient in connection with the diagnosis or complaints listed on this requisition; the information on this requisition accurately reflects the medical reasons for requesting the specific tests ordered on this requisition; and the medical necessity of each of the individual tests ordered on this requisition is appropriately documented in the patient's medical record; or (2) The tests ordered are for the purpose of screening that the physician believes is appropriate for the patient, even though the payor may not allow reimbursement for the tests; and the fact that payment is likely to be denied by Medicare or other payors has been explained to the patient, who has agreed to pay for the tests personally by signing the attached Advance Beneficiary Notice (ABN).

Physician's Signature: _____
(Physician Signature) (Printed Physician's Name)

Addressograph

Catawba Valley Imaging Center

Diagnostic Service Form



JUST FAX IT 828-326-3844

GENERAL INFORMATION

Today's Date: _____ / _____ / _____

Scheduler's Name: _____

Transfer from another facility? **Yes** or **No** (circle one) Facility: _____

PATIENT INFORMATION

Patient's Name: _____

Home#: _____

Work#: _____

Cell#: _____

Date of Birth: _____ / _____ / _____ Gender: **Male** or **Female** (circle one)

Social Security Number: _____ - _____ - _____

PROCEDURE INFORMATION

Patient Type: **Inpatient** or **Outpatient** (circle one)

Date: _____ / _____ / _____ Time: _____ Location: _____

Diagnosis/Reason for Exam: _____ ICD-9 Code: _____

Test/Procedure: _____ CPT4 Code: _____

Ordering Physician: _____ Office #: _____

 Contact Name: _____ Extension: _____

Primary Care Physician: _____ Office #: _____

Surgeon/Specialist: _____ Office #: _____

INSURANCE INFORMATION

Insurance Plan: **Blue Cross** **Medicare (HMO/PPO)** **Medicaid** **Self-pay** (circle one)

Other: _____ (HMO/PPO) Policy Number: _____

Address: _____ Group Number: _____

Address: _____ Insurance Phone Number: _____

City/State/Zip: _____ Authorization #: _____