Answers to member questions: Radiology and Cardiology Prior Authorization programs.

You may have questions about the prior authorization process for radiology and cardiology services. Below are answers to frequently asked questions.

**What are the Radiology and Cardiology Prior Authorization programs?**

The Radiology and Cardiology programs help improve health care quality and cost outcomes for imaging and cardiac procedures with evidence-based medicine. The process is designed to ensure that you receive access to the right imaging and cardiac study for the right reason.

**How does the prior authorization process work?**

If prior authorization is required, a clinical coverage review will be conducted prior to the service being performed to determine whether the service is medically necessary based on evidence-based clinical guidelines. Prior authorization is a process that must be completed before the service is performed.

**Prior Authorization Process**

1. **Member visits a physician for care and physician recommends a test, procedure or service that requires prior authorization.**
2. **Physician or facility contacts UnitedHealthcare to inform us of the proposed service.**
3. **UnitedHealthcare reviews the request to verify the service is a covered benefit and is medically necessary. A determination is rendered.**
4. **Physician and member review determination letter and plan a course of care.**
5. **Claim is submitted for service rendered.**

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What procedures are included in the Radiology and Cardiology Prior Authorization programs?

Radiology services subject to prior authorization include: Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Nuclear Medicine and Nuclear Cardiology procedures.

Cardiology services subject to prior authorization include: Outpatient diagnostic catheterizations, echocardiograms, stress echocardiograms and inpatient and outpatient electrophysiology implant procedures.

How can you determine if prior authorization is required for a Radiology or Cardiology procedure?

You can call the toll-free member number on your health plan ID card to confirm prior authorization requirements.

How can you confirm if you are responsible for obtaining a radiology or cardiology prior authorization?

Your benefit coverage documents will summarize the radiology and cardiology prior authorization requirements. Generally, your network provider—a physician, facility or other health care professional who contracts to participate in the UnitedHealthcare network—will facilitate this process for you. When seeking services from a non-network provider, you will be responsible for obtaining prior authorization.

How will you be notified of the outcome of your radiology or cardiology prior authorization request?

You will receive a determination letter by mail and a copy will be sent to your provider.

How long is a radiology or cardiology prior authorization number valid?

A prior authorization number is valid for 45 calendar days. An authorization is specific to the procedure requested and can only be used once within the 45-day period.

Are you responsible for the cost of the service when the service is determined to be not medically necessary?

If it is determined that the service is not medically necessary, the claim for the service will be denied. You can be billed by a network provider for claims that are denied for services that did not meet medical necessity, if the provider obtained adequate written consent from you before performing the service.

How do you appeal a request that did not meet medical necessity?

If the request does not meet medical necessity, the determination letter will include an explanation for the decision, the criteria used and available appeal rights.