May 23, 2022

Laurie E. Gianturco, MD, CPE, DABR
National Medical Director, Radiology
Value Creation Team
UnitedHealthcare Clinical Services

Dear Dr. Gianturco:

The American College of Radiology (ACR) representing more than 41,000 diagnostic and interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists and the Radiology Business Management Association (RBMA) representing more than 2,100 radiology practice executives are writing to ask for your assistance in allowing flexibilities in the prior authorization process as healthcare systems around the world manage a shortage of iodinated contrast media.

The Food and Drug Administration (FDA) continues to report shortages of GE Healthcare's iohexol and iodixanol intravenous contrast media products for computed tomography (CT) imaging as well as other imaging exams. In an April 19 letter to customers, GE Healthcare informed providers of a shortage of the contrast media after a COVID-19 lockdown temporarily shut down its production facility for iodinated contrast media in Shanghai, China. This shortage is expected to last at least through the end of June.

The ACR and RBMA seek your assistance in allowing flexibilities in the prior authorization to allow providers the option of changing patient orders for CT scans with contrast as needed without having to repeat the prior authorization process and potentially delaying patient care. We request that UnitedHealthcare make an immediate change to its prior authorization policy to allow for the prior authorization of "families" of CPT® codes. For many imaging services, "families" of CPT® codes exist to describe similar services which are unique with respect to the complexity of the examination or the use of intravenous contrast. For example, the CT head "family" of codes would consist of CT head without contrast (CPT® code 70450), CT head with contrast (CPT® code 70460), and CT head with and without contrast (CPT® code 70470). Allowing imaging providers the flexibility to change orders as needed without the burden of an additional prior authorization will permit streamlined and efficient patient care without unnecessary delays.

While there is an immediate need to revise UnitedHealthcare's prior authorization policy in the midst of the contrast media shortage, the ACR and RBMA believe that prior authorization of "families" of CPT® codes is a best practice that should be followed by all insurers and radiology benefit management companies. CPT® code specific prior-authorization allows the imaging

provider to only perform the exam exactly as ordered and prior-authorized, not to tailor the exam to the patient/clinical situation and best answer the diagnostic question.

Radiologists are physicians trained to interpret imaging studies and to determine the most accurate study to efficiently answer the clinical question at hand in order to best serve their patients. A CPT® specific prior authorization approach does not allow a radiologist, who may: a) have access to previous imaging studies, or b) have the opportunity to discuss issues personally with a patient and/or the patient's referring physician, or c) visualize an emergent condition during the pendency of a study, to timely and efficaciously make these determinations and use his/her clinical judgment. Thus, through the use of a CPT® specific prior authorization approach, the patient may not receive the most appropriate study based on their clinical condition or may experience unnecessary rescheduling and inconvenience. This commonly leads to repeat studies, delays while attempting to revise an order to permit a more appropriate study, and potentially unnecessary or repeated exposure to radiation and contrast.

Frequently, the findings at the time of the initial study will indicate the need for additional view(s), processing, or contrast (e.g., iodinated, Gadolinium) in order to ensure that the best possible imaging information is obtained for the radiologist to interpret the study and answer the clinical question at hand. In some cases, although the radiologist may indicate and prescribe the less expensive test, payment will still be denied due to code specific approval. The radiologist who is providing clinical supervision is the person most qualified in, and should not be prohibited from, making these determinations. This type of program also increases referring and rendering provider administrative costs, as well as mandating that they incur the burden and risk of the procedure not being paid if they determine additional studies within the approved modality are medically appropriate and/or necessary. Further, add-on codes which supplement an approved base examination (e.g., ejection fraction evaluation at the time of nuclear cardiac imaging, CPT® code 78480) should not require additional prior-authorization. These should be included in the family of codes that are initially prior-authorized.

The ACR and RBMA appreciate your consideration of this request in general but highlighted by this current iodinated contrast shortage. If you have questions and/or would like to discuss this request in more detail, please contact Katie Keysor, ACR Senior Director, Economic Policy at kkeysor@acr.org.

Sincerely,

William T. Thorwarth, Jr., MD, FACR
Chief Executive Officer
American College of Radiology

Robert T. Still, FRBMA
RBMA Executive Director