INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Radiology Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: October 20, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of September 1, 2017 Published: December 12, 2017	Scheduled update: • Edited and reorganized text as needed for clarity • Added Portal billing options • Updated information in the *Low Osmolar Contrast Materials* section • Updated Fee Schedule references in the *PET Scans* section	FSSA and DXC

Table of Contents

Note:	*For policy information regarding coverage of radiology services, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

The Indiana Health Coverage Programs (IHCP) reimburses inpatient and outpatient facilities, freestanding clinics, surgical centers, and practitioners for radiological services provided to IHCP members, subject to the requirements and limitations laid out in this document. For provider type and specialties authorized to bill radiology services and related documentation requirements, see the *Provider Enrollment* module.

Note:	*For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the IHCP Quick Reference Guide available at indianamedicaid.com.*

Coverage and Limitations for Radiology Services

Radiological services must be ordered in writing by a physician or other practitioner authorized to do so under State law.

The IHCP requires prior authorization (PA) for any radiological services that exceed the use parameters set out in this document. Criteria for the use of radiological services include consideration of the following:

- Evidence exists that this radiologic procedure is necessary for the appropriate treatment of illness or injury.
- X-rays of the spinal column are limited to cases of acute, documented injury or a medical condition in which interpretation of x-rays would make a direct impact on the medical or surgical treatments.
- IHCP reimbursement is available for x-rays of the extremities and spine for the study of neuromusculoskeletal conditions.

The IHCP does not reimburse for radiology examinations of any body part taken as a routine study not necessary for the diagnosis or treatment of a medical condition. Situations generally not needing radiology services include, but are not limited to, the following:

- Fluoroscopy without films
- Pregnancy
- Premarital examinations
- Research studies
- Routine physical examinations or check-ups
- Screening, preoperative chest x-rays

Providers must document all services related to radiological examinations in the patient's record.

Billing for Radiology Services

Some radiological procedures encompass professional and technical components of the service. A physician typically performs the professional component of the procedure. Facilities must bill the IHCP directly for components provided by the facility. Professional and technical components are billed as follows:

- **Hospitals** billing under the provider type of "01" should bill only the technical component for radiology services provided in an outpatient hospital setting on the institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal [Portal] institutional claim, or 837I electronic transaction). No TC (technical component) modifier is necessary for provider type 01. Hospitals must bill radiology revenue codes in conjunction with the appropriate Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®[1]) procedure code. Revenue codes billed without the appropriate HCPCS or CPT procedure code are denied. Do not fragment radiology procedures and bill them separately.
- **Providers** must bill the professional component of a radiology service performed in an outpatient hospital setting with the appropriate HCPCS or CPT procedure code and 26 (professional component) modifier on the professional claim (*CMS-1500* claim form, Portal professional claim, or 837P transaction).
- **Freestanding radiology facilities** must bill the technical and/or professional components of a radiology service on the professional claim (*CMS-1500* claim form, Portal professional claim, or 837P transaction) with the appropriate HCPCS or CPT code. If the facility performed both components of the service, a modifier is not necessary. If the facility performed only one component, the applicable 26 or TC modifier is necessary.

See the *Claim Submission and Processing* module for instructions for completing the *CMS-1500* and *UB-04* claim forms. See the *Provider Healthcare Portal* module for instructions for completing claims online.

Practitioners billing for radiology services must adhere to the following guidelines:

- When two practitioners separately provide a portion of the radiology service, each practitioner may bill the IHCP directly for the component provided. The IHCP reimburses a physician or other practitioner for radiological services only when that physician or practitioner directly supervised the performance of those services.
- For radiology procedures, providers cannot fragment and bill separately. Such circumstances may include, but are not limited to, the following examples:
  - The IHCP does not reimburse for supervision and interpretation procedure codes when the same provider bills for the complete procedure code.
  - If two provider specialties are performing a radiology procedure, the radiologist bills for the supervision and interpretation procedure, and the second physician bills the appropriate injection, aspiration, or biopsy procedure.

Note:	*The attending physician's billed charges should not include costs for services such as x-rays and laboratory when provided to members in* ***hospice care****. The daily hospice care rates include these costs, and they are expressly the responsibility of the hospice provider. However, if an IHCP hospice member requires radiological services* ***not related to the terminal illness****, the hospice provider is not responsible for these radiological services. The IHCP allows for separate reimbursement of non-hospice-related radiological treatment in these circumstances. IHCP providers billing for the treatment of nonterminal conditions are reminded that they are responsible for obtaining Medicaid PA for any nonhospice services that require PA.*

[1] *CPT Copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Information for Specific Radiology Services

The following sections include billing and reimbursement information related to specific radiological procedures. For information on stereotactic radiosurgery (SRS), see the *Surgical Services* module.

Angiographic Procedures

The IHCP does not reimburse for angiographic procedures performed by the operating physician as an integral component of a surgical procedure. Such procedures include, but are not limited to, the following:

- Angiographic injection procedures during coronary artery bypass graft
- Peripheral, percutaneous transluminal angioplasty procedures

CT Scans

The IHCP may reimburse for diagnostic examination of the head (head scan) and of other parts of the body (body scans), performed by computerized tomography (CT) scanners, subject to the following restrictions:

- The scan should be reasonable and necessary for the individual patient.
- The use of a CT scan must be medically appropriate, considering the patient's symptoms and preliminary diagnosis.
- The equipment used to perform the CT scan must be certified by the Food and Drug Administration (FDA).
- The IHCP does not reimburse for whole abdomen or whole pelvis scans on greater than 20 cuts, except in staging cancer for treatment evaluation.

The IHCP does not require PA for CT scans.

Low Osmolar Contrast Materials

Separate reimbursement is not available for radiologic contrast material. For dates of service before July 1, 2017, the IHCP made an exception for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and intra-arterial injections, allowing LOCM procedure codes Q9965–Q9967 to be billed with revenue code 636 for IHCP reimbursement consideration. For dates of service on or after July 1, 2017, these codes are not separately reimbursed.

PET Scans

All claims for reimbursement of Positron Emission Tomography (PET) scans must include an appropriate International Classification of Diseases (ICD) diagnosis code.

If the member is an inpatient, the IHCP covers the PET scan in the diagnosis-related group (DRG) payment to the hospital.

If the member is an outpatient and the services are performed in the outpatient area of the hospital or a freestanding facility, the billing and reimbursement for the PET scan is as follows:

- Reimbursement for professional services, reported with the appropriate CPT or HCPCS code, modifier 26, and the appropriate diagnosis code, and billed on a professional claim (*CMS-1500* claim form electronic equivalent), is based on the Professional Fee Schedule at indianamedicaid.com.
- Reimbursement for the appropriate CPT or HCPCS code, when billed with the appropriate diagnosis code on an institutional claim (*UB-04* claim form or electronic equivalent), is based on the statewide maximum fee (see the Outpatient Fee Schedule at indianamedicaid.com).

The procedure codes for PET scans represent the global service. Providers performing only the technical or professional component of the test should appropriately use TC or 26 modifier.

Proton Treatment

The IHCP has determined that it is appropriate for providers to report only the technical component of proton treatment delivery, using the following CPT codes:

- 77520 – *Proton treatment delivery; simple, without compensation*
- 77522 – *Proton treatment delivery; simple, with compensation*
- 77523 – *Proton treatment delivery; intermediate*
- 77525 – *Proton treatment delivery; complex*

The IHCP does not reimburse proton treatment delivery services when billed using procedure codes 77520, 77522, 77523, or 77525 with modifier 26 – *Professional component.* Providers are required to bill these codes with modifier TC – *Technical component.* Providers are advised to report the professional services using an appropriate CPT procedure code.

Radionuclide Bone Scans

The IHCP reimburses for radionuclide bone scans when performed for the detection and evaluation of suspected or documented bone disease.

Upper Gastrointestinal Studies

The IHCP reimburses for upper gastrointestinal (GI) studies when performed for detection and evaluation of diseases of the esophagus, stomach, and duodenum.

The IHCP does not cover an upper GI study for the following:

- A patient with a history of duodenal or gastric ulcer disease, unless the patient was recently symptomatic
- In the preoperative cholecystectomy patient, unless symptoms indicate an upper GI abnormality in addition to cholelithiasis, or if the etiology of the abdominal pain is uncertain