INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Radiology Services

LIBRARY REFERENCE NUMBER: PROMOD00044
PUBLISHED: APRIL 30, 2024
POLICIES AND PROCEDURES AS OF MARCH 1, 2024
VERSION: 7.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: Oct. 20, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of Sept. 1, 2017 Published: Dec. 12, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of June 1, 2018 Published: Jan. 3, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of Feb. 7, 2020 Published: May 21, 2020	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of Dec. 1, 2020 Published: Feb. 9, 2021	Scheduled update	FSSA and Gainwell
6.0	Policies and procedures as of March 1, 2022 Published: April 13, 2022	Scheduled update	FSSA and Gainwell
7.0	Policies and procedures as of March 1, 2024 Published: April 30, 2024	Scheduled update: • Edited and reorganized text as needed for clarity • Added the *CT Colonography Screening* section • Added the *Interventional Radiology* section • Added MRA reference in the *Magnetic Resonance Exams* section • Added the *Nuclear Medicine* section	FSSA and Gainwell

Table of Contents

> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system.*
>
> *For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise member services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to the information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

Introduction

Indiana Administrative Code 405 IAC 5-27 lists requirements for radiology services covered by the Indiana Health Coverage Programs (IHCP), including:

- Computerized tomography
- Interventional radiology
- Magnetic resonance exams
- Nuclear medicine
- Positron emission tomography
- Sonography
- Upper gastrointestinal studies

The IHCP reimburses inpatient and outpatient facilities, freestanding clinics, ambulatory surgical centers (ASCs), and practitioners for radiological services provided to IHCP members, subject to the requirements and limits presented in this document. For IHCP enrollment requirements for these provider types and specialties, see the *Provider Enrollment* module.

Coverage and Limits for Radiology Services

Radiology services must be ordered in writing by a physician or other practitioner authorized to do so under state of Indiana law. The IHCP requires prior authorization (PA) for any radiology services that exceed the parameters set out in this document.

Criteria for the use of radiology services include consideration of the following:

- Evidence exists that the radiological procedure is necessary for the appropriate treatment of the 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 treatment.
- IHCP reimbursement is available for X-rays of the extremities and spine for the study of neuromusculoskeletal conditions.

- Radiological procedures must be limited to the minimum number of views or films to appropriately diagnose or assess a patient's condition. Procedures must also be limited to the most appropriate body part or area to provide or rule out a diagnosis for the suspected condition.
- The IHCP does not reimburse for radiological examinations of any body part taken as a routine study not necessary for the diagnosis or treatment of a medical condition.

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

Billing and Reimbursement for Radiology Services

Some radiological procedures encompass professional and technical components. A physician typically performs the professional component of the procedure. Facilities must bill the IHCP directly for components provided by the facility.

For applicable radiology services, professional and technical components are billed as follows:

- **For radiology services provided in a facility setting (such as a hospital or ASC):**
  - **Facilities** (usually provider types 01 or 02) bill the *technical component* of the radiology service on the institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal [IHCP Portal] institutional claim or 837I electronic transaction) as follows:
    - If the service is performed on an **outpatient** basis, the facility must bill the appropriate Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®[1]) procedure code in conjunction with the radiology revenue code. Revenue codes billed without the appropriate HCPCS or CPT procedure code are denied. Modifier TC – *Technical component* is not necessary for facility claims. Reimbursement is based on the Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.
    - If the service is performed on an **inpatient** basis, the hospital bills only the appropriate revenue code. Reimbursement for the technical component of the radiology service is included in the inpatient diagnosis-related group (DRG) payment to the hospital.
  - **Practitioners** bill the *professional* component of a radiology service performed in a facility setting on the professional claim (*CMS-1500* claim form, IHCP Portal professional claim or 837P transaction), using the appropriate CPT procedure code and modifier 26 – *Professional component*. Reimbursement is based on the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.
- **For radiology services provided by a freestanding or mobile radiology clinic (provider type 29):**
  - Providers must bill the technical and/or professional components of a radiology service on the professional claim (*CMS-1500* claim form or electronic equivalent), using the appropriate HCPCS or CPT code, as follows:
    - If the clinic performed both components of the service, no modifier is necessary.
    - If the clinic performed only one component, the applicable 26 or TC modifier is necessary.
  - Reimbursement is based on the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

See the *Claim Submission and Processing* module for general instructions for completing professional and institutional claims.

[1] *CPT Copyright 2024 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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

> *Note: For members in **hospice care**, the attending physician should not bill the IHCP for radiology services related to the terminal illness. 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 radiology services **not related to the terminal illness**, the hospice provider is not responsible for these radiology 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.*

Radiological Contrast Materials

In an outpatient facility setting, separate reimbursement is not available for radiological contrast material, including for low osmolar contrast material (LOCM) used in intrathecal, intravenous and intra-arterial injections. The cost of these materials is considered bundled into the rate for the other outpatient services; therefore, they cannot be billed with revenue code 636 – *Drugs requiring detailed coding* for separate reimbursement.

When the service is delivered in a freestanding or mobile X-ray clinic, a National Drug Code (NDC) must be included with the following LOCM procedure codes on the professional claim:

- Q9965 – *Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml*
- Q9966 – *Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml*
- Q9967 – *Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml*

Information for Specific Radiology Services

The following sections include billing and reimbursement information related to specific radiological procedures.

Computerized Tomography

The IHCP may reimburse for diagnostic examination of the head (head scan) and 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 found to be medically necessary, 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 more than 20 cuts, except in staging cancer for treatment evaluation.

The IHCP does not require PA for CT scans.

CT Colonography Screening

Effective Aug. 30, 2022, the IHCP covers CPT code 74263 – *Computed tomographic (CT) colonography, screening, including image postprocessing for colorectal cancer screenings*.

Coverage for CT colonography screening is available for individuals ages 45 through 75 and is limited to once every three years. Additionally, one of the following medical necessity criteria must be met:

- Standard colonoscopy failed or is incomplete, as indicated by one or more of the following:
  - Altered anatomy or scarring from previous surgery
  - Extrinsic compression
  - Obstructing mass
  - Redundant colon
  - Spasm
  - Stricture
- Standard colonoscopy is contraindicated, as indicated by one or more of the following:
  - Adhesions or strictures likely (for example, patient who has undergone peritoneal dialysis)
  - Anticoagulation therapy with increased patient risk if discontinued
  - Complication from previous colonoscopy
  - Contraindication to conscious sedation
  - Diverticular disease and high risk for perforation
  - Patient refusal
- Positive fecal blood or immunochemical test, when colonoscopy has failed, is incomplete or is contraindicated.
- Symptoms suggestive of colorectal cancer, when colonoscopy has failed, is incomplete or is contraindicated.

The main risks of CT colonography are colonic perforation and radiation exposure. The patient must be aware that any CT colonography abnormality that is detected will require follow-up with colonoscopy or other invasive technique.

Interventional Radiology

IHCP reimbursement may be available, with prior authorization, for interventional radiology procedures determined medically necessary

For information about radiology treatment for cancer, see the *Oncology Services* module.

For radioimmunotherapy drugs, see the *Injections, Vaccines and Other Physician-Administered Drugs* module.

For information on stereotactic radiosurgery (SRS), see the *Surgical Services* module.

Magnetic Resonance Exams

The IHCP reimburses for medically necessary magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) exams.

MRI for Essential Tremors

The IHCP covers MRIs for essential tremors, when prior authorized and billed using CPT code 0398T – *Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.*

PA requires the following criteria be met for coverage of procedure code 0398T for treatment of essential tremors (ET):

- Medication refractory ET, defined as refractory to at least two trials of medical therapy, including at least one first-line agent
- Moderate to severe postural or intention tremor of the dominant hand, defined by a score of greater than or equal to 2 on the Clinical Rating Scale for Tremor (CRST)
- Disabling ET, defined by a score of greater than or equal to 2 on any of the eight items in the disability subsection of the CRST
- Not a surgical candidate for deep brain stimulation (DBS) (for example, advanced age, anticoagulant therapy or surgical comorbidities)

CPT code 0398T will not be covered for the following indications or conditions:

- Treatment of head or voice tremor
- Bilateral thalamotomy
- A neurodegenerative condition
- Unstable cardiac disease
- Coagulopathy
- Risk factors for deep-vein thrombosis
- Severe depression – Defined by a score greater than or equal to 20 on the Patient Health Questionnaire (PHQ-9)
- Cognitive impairment – Defined by a score of less than 24 on the Mini-Mental State Examination
- Previous brain procedure (transcranial magnetic stimulation, DBS, stereotactic lesioning or electroconvulsive therapy)
- A skull density ratio (the ratio of cortical to cancellous bone) less than 0.45
- MRI contraindicated

Nuclear Medicine

IHCP reimbursement is available for radionuclide bone scans when performed for the detection and evaluation of suspected or documented bone disease.

Positron Emission Tomography

Prior authorization is required for all positron emission tomography (PET) scans, including any combined radiological exam, such as a computerized tomography (PET-CT) exam or magnetic resonance (PET-MR) exam. IHCP reimbursement may be available for PET scans performed for medically necessary conditions as determined by the Family and Social Services Administration (FSSA).

Providers performing only the technical or professional component of the PET scan should bill using the appropriate procedure code and modifier combination, as described in the *Billing and Reimbursement for Radiology Services* section.

Sonography

The IHCP reimburses for the following sonography procedures:

- Sonography exams performed during pregnancy when warranted by one or more of the following conditions:
  - Early diagnosis of ectopic or molar pregnancy
  - Placental localization associated with abnormal bleeding
  - Fetal postmaturity syndrome
  - Suspected multiple births
  - Suspected congenital anomaly
  - Polyhydramnios or oligohydramnios
  - Fetal age determination if necessitated by one of the following:
    - Discrepancy in size versus fetal age
    - Lack of fetal growth or suspected fetal death
  - Guide for amniocentesis
  - Suspected uterine and pelvic abnormality
  - Determination of fetal position
  - Evaluation of cervix for risk of preterm loss or birth
- Venous Doppler exams for blood flow
- Diagnostic exams of soft tissues or organs
- Echocardiograms
- Other sonography exams as determined by the FSSA

For additional information regarding pregnancy-related sonography, see the *Obstetrical and Gynecological Services* module.

Liver Elastography

The IHCP covers ultrasound transient elastography to assess liver fibrosis. The service is billed using procedure code 91200 – *Liver elastography, mechanically induced shear wave (e.g., vibration), without imaging, with interpretation and report*.

Prior authorization is required. Members may be found eligible for ultrasound transient elastography to assess liver fibrosis when the following criteria are met:

- Diagnosis is either of the following:
  - Chronic liver disease as evidenced by sustained elevation of liver function tests (LFTs) of greater than six months
  - Hepatitis C virus (HCV), as evidenced by either quantitative (such as HCV RNA viral load) and/or qualitative (such as HCV antibody positive serum serology) testing
- Liver biopsy has not been performed within previous six months
- Ultrasound transient elastography has not been performed more frequently than once every six months

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
- A preoperative cholecystectomy patient, unless symptoms indicate an upper GI abnormality in addition to cholelithiasis, or if the etiology of the abdominal pain is uncertain