CHAPTER– 512 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR LABORATORY AND RADIOLOGY SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 512.5	Specimen Collection	10/05/05	1/01/05
Section 512.14	Prior Authorization Requirements for Imaging Procedures	9/1/05	10/1/05

October 5, 2005

SECTION 512.5

Introduction: Removing procedure code G0001 and adding procedure code 36415.

Old Policy: G0001 Routine venipuncture for collection of specimen(s).

New Policy: Removing procedure code G0001 and adding procedure code 36415 – collection of venous blood by venipuncture.

Directions: Replace page.

September 1, 2005

Section 512.14

Introduction: Added Prior Authorization Requirements for Imaging Procedures.

Change: Added **Section 512.14 PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES**

Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Requests for prior authorization can be sent to: West Virginia Medical Institute, Radiology/Nuclear Medicine Review, 3001 Chesterfield Avenue SE, Charleston, West Virginia 25304. All phone requests can be routed to: (304) 346-9167, or toll free 1-800-982-6334. Fax transmissions can be sent to (304) 346-3669 or toll free 1-800-298-5144.

Renumbered all Sections.

Directions: Replace pages.

CHAPTER 512--COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR LABORATORY AND RADIOLOGY SERVICES

TABLE OF CONTENTS

TOPIC **PAGE NO.**

CHAPTER 512–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR LABORATORY AND RADIOLOGY SERVICES

INTRODUCTION

The West Virginia Medicaid Program covers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia. BMS in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the West Virginia Medicaid Program.

West Virginia Medicaid covers a comprehensive scope of clinical laboratory services and diagnostic/therapeutic radiology services to Medicaid members, subject to medical necessity and program criteria, and prior authorization requirements. Clinical laboratory and radiology services provided to Medicaid members must be based on an order from an attending physician or other qualified licensed practitioner who is treating the individual.

This chapter outlines West Virginia Medicaid's coverage policies for clinical laboratory services and radiology services.

Laboratory and radiological facilities must meet all of the provider enrollment requirements and must be fully operational before they may enroll as Medicaid providers.

IMPORTANT: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided.

512.1 REQUIREMENTS FOR CLINICAL LABORATORIES

A clinical laboratory is a facility that examines materials taken from the human body for the purpose of providing information to assist in the diagnosis, prevention or treatment of disease. A freestanding or independent facility is a clinical laboratory that is not controlled, managed, or supervised by a hospital or a hospital's organized medical staff or the treating health care practitioner.

A clinical laboratory facility must be certified by the Centers for Medicare & Medicaid Services (CMS) to perform the specialties or subspecialties of tests billed to Medicaid as of the date the tests are performed. Clinical laboratory services are paid only to laboratories certified under the Clinical Laboratory Improvement Amendments (CLIA) of 1988 or as amended. Physicians billing laboratory tests must have CLIA certification or registration certification. A copy of all

current certifications must be on file with the Medicaid Program. A certified laboratory that wishes to participate in the West Virginia Medicaid Program must complete the application/enrollment agreement and submit it to:

Unisys
Provider Relations
1600 Pennsylvania Avenue
Charleston, West Virginia 25302

Answers to questions about enrollment can be obtained by calling Unisys..

Subsequent Medicaid reimbursement depends on the laboratory's ongoing Clinical Laboratory Improvement Amendments (CLIA) certification.

512.2 OUT-OF-STATE CLINICAL LABORATORIES

A laboratory located outside West Virginia may be considered for participation in the West Virginia Medicaid Program only if licensed by the Federal Government under the Clinical Laboratory Improvement Amendments (CLIA) of 1988 and subsequent amendments.

Out-of-state clinical laboratories are not routinely enrolled in West Virginia Medicaid unless the lab is a large national laboratory that receives specimens from West Virginia providers.

512.3 RECORDS AND REPORTS

All requests for clinical laboratory services must identify the tests ordered and include the original signature of the treating physician or practitioner who has requested them. The order must be kept on file, along with the test results, and made available upon request to the Bureau for Medical Services for a period of no less than 5 years.

The laboratory must maintain records that indicate the daily accession of specimens. At a minimum, these records must contain the following information:

- Patient identification: Name, address, birthdate, Medicaid Identification Number
- Specimen identification if other than by patient name
- Name of physician/practitioner submitting specimen
- Date specimen collected
- Date specimen received
- Type of specimen
- Tests requested and performed
- Date test performed
- Test results or cross-reference to the results, and date test reported
- Specimens and test requests referred to other laboratories, and the name and location of the reference laboratory.

512.4 COVERED LABORATORY SERVICES

West Virginia Medicaid covers clinical laboratory services that are generally accepted standards of practice by leading authorities, such as the Centers for Disease Control and Prevention (CDC) or other national organizations, and which can be billed using Health Care Financing Administration Common Procedure Coding System (HCPCS) codes.

Health care practitioners must specify which particular tests or studies are medically necessary and ordered. West Virginia Medicaid covers only laboratory tests that are medically necessary, regardless of whether a particular test is part of a panel or profile of tests.

Laboratory services must be ordered by the member's treating physician/practitioner, within their scope practice under West Virginia Code. West Virginia Medicaid does not cover tests and procedures based solely on a member's request for such services.

512.5 SPECIMEN COLLECTION

West Virginia Medicaid pays for the collection of specimens either through routine venipuncture or catheterization (urine collection). Physicians/practitioners sending specimens to a reference lab may bill for collection of specimens through routine venipuncture using Procedure Code 36415. Separate payment will not be made for obtaining a blood sample through a finger, heel or ear stick.

Separate charges made by outpatient hospitals and laboratories for drawing or collecting specimens are allowable whether or not the specimens are referred to outside laboratories. Payment is made only to those extracting the specimen. Only one collection fee is allowed for each type of specimen (e.g., blood, urine) for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter. A specimen collection fee is allowed when drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

A specimen collection fee is NOT allowed for samples where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time). A separate payment is not made for the collection of a pap smear.

If it is medically necessary for a laboratory technician to draw a specimen by venipuncture or catheterization from either a nursing home or homebound patient, it will be covered. (Technician must personally draw the specimen, e.g., venipuncture or urine sample by catheterization.) Payment may be made to the laboratory even if the nursing facility has on-duty personnel qualified to perform the specimen collection. When the nursing home performs the specimen collection, no payment is made.

Procedure codes to be used:

36415 Collection of venous blood by venipuncture.

P9612 Catheterization for collection of specimen(s), single patient, all places of service.

If a specimen is collected in the physician's office but is directed to an independent laboratory for analysis, West Virginia Medicaid cannot make a payment to the physician's office for the laboratory procedure. The laboratory must enroll and request payment from West Virginia Medicaid. The physician must ensure that the member's Medicaid identification number accompanies the specimen to the laboratory and must provide a signed, written order for the test. Payment cannot be made unless the provider of service is enrolled with West Virginia Medicaid

512.6 AUTOMATED MULTICHANNEL TESTS

For billing purposes, a panel is a combination of tests. West Virginia Medicaid reviews on a pre and post-payment basis all paid claims for tests that are part of an automated profile and organ or disease-oriented panel, subject to Medicare's pricing guidelines. When all individual component tests that make up a particular panel are ordered and performed, West Virginia Medicaid pays for the panel, but not for the individual tests. Furthermore, when components of one panel are duplicated in another panel, only one panel code may be billed. Individual tests not included in the panel may be billed separately.

512.7 EXCLUSIONS

West Virginia Medicaid cannot reimburse an independent laboratory facility for a test ordered by a practitioner who has, or whose family has, an ownership or financial interest in the facility or who receives compensation for requesting laboratory services from that facility.

West Virginia Medicaid also does not make payment for the following tests, procedures or services:

- Blood tests required for marriage, employment, paternity determination, etc.
- Routine drug screening.
- Experimental/research/investigational examinations, testing, or screening.
- Services not ordered by the member's treating physician/practitioner.
- Services provided by facilities not properly licensed, certified, and enrolled in the West Virginia Medicaid Program
- Services that are provided to members who are not eligible to receive them on the date provided
- Reports to referring physicians or other licensed practitioners
- Reports requested by the Bureau for Medical Services or its authorized representative
- Mass screenings or examinations of members, e.g., nursing facilities, schools or other institutional settings.
- Lab tests performed for quality assurance

- Repeated tests due to provider error
- Reflex testing

512.8 BILLING AND REIMBURSEMENT

West Virginia Medicaid Program uses Medicare's Fee Schedule for Clinical Diagnostic Laboratory Services to determine the amount Medicaid pays for clinical laboratory services. The West Virginia Medicaid Program pays the lower of 80 percent of the Medicare fee or the amount the provider charges for the service.

The independent laboratory that provides covered services must perform both the technical and professional components of the service. The technical component is the test procedure. The professional component is the report that interprets the test results and identifies those that are outside the normal range.

Medicaid payment is made only for medically necessary tests ordered by the member's treating physician/practitioner within the scope of his/her license for the care and treatment indicated in the management of illness, injury, impairment, or maternity care, or for the purpose of determining the existence of an illness or disease process.

512.9 REQUIREMENTS FOR RADIOLOGY SERVICES

Radiological facilities may be located in a clinic, laboratory, or physician/practitioner's office.

Providers of radiological services who wish to participate in the West Virginia Medicaid Program must complete the enrollment agreement/application and submit it to Unisys at the following address:

Unisys
Provider Enrollment
1600 Pennsylvania Avenue
Charleston, West Virginia 25302

On the application, the applicant must indicate the location of the installation/equipment and provide its registration number.

The installation's equipment and personnel must meet applicable requirements, federal, state and local laws, as well as Medicaid rules and regulations. Subsequent reimbursement by Medicaid depends on satisfactory findings on equipment, personnel and performance in subsequent on-site inspections.

512.10 X-RAY SPECIALISTS

Radiological services must be performed by, or provided under the direct supervision of, a licensed practitioner who is qualified by advanced training and experience in the use of x-rays for diagnostic and therapeutic purposes.

The licensed practitioner must be (1) Board eligible or Board certified in radiology, or (2) Board eligible or Board certified in a medical specialty in which he/she is qualified by experience and training in the use of x-rays for diagnostic purposes.

512.11 MEDICAL SPECIALISTS

Medical specialists with advanced training and experience related to his/her specialty certification may furnish radiological services. These x-rays and procedures are those

customarily performed in the daily practice of the medical specialty. The facility's equipment must meet all applicable Federal, State, and local regulations.

512.12 COVERAGE OF DIAGNOSTIC RADIOLOGICAL SERVICES

The Centers for Medicare and Medicaid Services (CMS) has adopted the policy that all diagnostic tests, including diagnostic radiological procedures, diagnostic laboratory tests and other tests indicated as diagnostic in the CPT Book, must be ordered by the practitioner who treats the patient subject to any applicable prior authorization requirements. The practitioner who orders the test or radiological procedure must be the practitioner responsible for the treatment and management of the member's specific medical problems.

Diagnostic tests ordered by a physician who is not the patient's attending/treating physician, e.g., medical director of a nursing home for a nursing home patient, or a physician in a mobile center, will NOT be covered.

Payment for diagnostic tests will be considered when ordered by the following practitioners:

- "On Call" practitioner who has been given responsibility for a patient's care during a period when the patient's practitioner is unavailable.
- Specialist who is managing an aspect of the patient's care.
- Non-physician practitioners, i.e., audiologists, midwives, family nurse practitioners, podiatrists, etc., who are enrolled as West Virginia Medicaid providers may also order diagnostic tests if they are treating the patient and operating within the scope of their state license
- Mammography services are regulated by the Food and Drug Administration rather than CMS. A physician who is qualified to interpret a mammogram may order a diagnostic mammogram based upon the findings of the screening and does not have to be the treating practitioner.

An individual may have more than one treating physician/practitioner, for example, a primary care physician and a specialist, or perhaps more than one specialist, depending upon the patient's medical problems.

If the physician who is performing the test decides the patient needs additional testing procedures based upon the findings of the tests performed, the testing physician must receive authorization from the ordering physician (either by phone or fax) for the additional tests believed to be necessary. If an emergency situation occurs, the testing physician may order those tests necessary as a result of the emergency. The emergency must be documented.

512.13 NUCLEAR MEDICINE SERVICES

Nuclear medicine services are covered and payable to radiologists and nuclear medicine specialists. Nuclear medicine equipment must be registered with or licensed by the Nuclear Regulatory Commission (NRC).

512.14 PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES

Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic

Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Requests for prior authorization can be sent to: West Virginia Medical Institute, Radiology/Nuclear Medicine Review, 3001 Chesterfield Avenue SE, Charleston, West Virginia 25304. All phone requests can be routed to: (304) 346-9167, or toll free 1-800-982-6334. Fax transmissions can be sent to (304) 346-3669 or toll free 1-800-298-5144.

512.15 MULTIPLE NUCLEAR MEDICINE DIAGNOSTIC PROCEDURES

The American College of Nuclear Physicians and the Society of Nuclear Medicine recommended that patients with certain malignancies be allowed to have multiple diagnostic tests on the same date by using the multiple procedure modifier and payment policy with these selected diagnostic procedures. CMS has adopted their suggestion, which BMS also follows. Coverage is outlined below.

The regular multiple surgery rules apply to the following combination of codes when provided by the same provider (or group practice) on the same day:

78306 Bone and/or joint imaging; whole body, and

78320 Bone and/or joint imaging; tomographic; (SPECT)

78802 Radiopharmaceutical localization of tumor; whole body, and

78803 Radiopharmaceutical localization of tumor; tomographic; (SPECT)

78806 Radiopharmaceutical localization of abscess; whole body, and

78807 Radiopharmaceutical localization of abscess; tomographic; (SPECT)

Or, when any of the above six codes are billed with any other multiple surgery procedure.

512.16 DIAGNOSTIC ULTRASOUND SERVICES

West Virginia Medicaid covers diagnostic ultrasound services provided by radiologists and certain medical specialists qualified by advanced training and experience in the use of appropriate diagnostic ultrasound procedures. Additionally, the services must be of a type that the provider customarily performs in the daily practice of medicine in his or her medical specialty. The ultrasound procedure must be medically necessary and appropriate for the patient's diagnosis.

512.17 HOSPITAL OUTPATIENT RADIOLOGICAL SERVICES

West Virginia Medicaid covers hospital outpatient radiological services. The member may take the practitioner's order for x-rays, nuclear medicine, or ultrasound services to an outpatient

department of a hospital enrolled in the West Virginia Medicaid Program. The hospital bills the West Virginia Medicaid Program for the covered services provided. Prior authorization requirements may apply.

512.18 ORDERS FOR RADIOLOGICAL SERVICES

All orders for radiological services must identify the specific x-rays, nuclear medicine, or ultrasound procedures requested and have the original signature of the treating physician/practitioner requesting the service. The order, along with the results of the radiological services, must be kept on file at least five years with the billing facility and made available upon request to the Bureau for Medical

Services, Federal/State Auditors, or BMS contracted agencies.

512.19 INTERVENTIONAL RADIOLOGY

West Virginia Medicaid covers interventional radiology whereby billing the complete procedure code has been discontinued in favor of component billing. Providers should continue to bill “26” for professional component only, TC for technical component only and leave blank for total (both professional and technical).

512.20 X-RAYS TAKEN IN THE EMERGENCY ROOM

West Virginia Medicaid will cover only one interpretation of an x-ray procedure furnished to an emergency room patient. The professional component of service must include an interpretation and written report for inclusion in the patient’s medical record. Reviewing an x-ray without providing a written report does not meet the criterion for payment.

In the event multiple claims are submitted, West Virginia Medicaid will cover the interpretation and report that directly led to the diagnosis and treatment of the patient.

Payment for interpretation of x-rays for quality assurance/confirmation is NOT covered.

512.21 LOW OSMOLAR CONTRAST MEDIA

CPT Code 78990 should be billed for low osmolar contrast media. The manufacturer’s cost invoice must be attached to the claim submitted for payment.

512.22 RADIATION ONCOLOGY MANAGEMENT SERVICES

Physician must bill on a weekly basis for treatment management rather than daily treatment. See Physician Manual for further information for radiation treatment services.

512.23 MAMMOGRAPHY SCREENING

West Virginia Medicaid covers one screening mammography (CPT 76092) every 12 months for every female member regardless of her age.

Medicaid payments for the interpretation of mammography services are made to physicians who meet the qualifications of interpreting physicians under the Mammography Quality Standards Act of 1992. These physicians must possess a certificate issued by the FDA.

512.24 DIAGNOSTIC MAMMOGRAPHY

Congress has added diagnostic mammography as a part of the portable x-ray benefit. Therefore, providers may bill West Virginia Medicaid for diagnostic mammographies as a portable x-ray benefit if they have received proper certification from the Food and Drug

Administration. (West Virginia Medicaid does not cover screening mammographies as a portable x-ray covered benefit.)

Mammography services are regulated by the Food and Drug Administration rather than CMS. Therefore, a physician who meets the qualification requirements for an interpreting physician may order a diagnostic mammogram and ultrasound based upon the finding of the screening mammogram even though that particular physician does not treat the member.

512.25 PORTABLE X-RAYS

Diagnostic x-ray services provided by approved portable x-ray suppliers are covered when performed in the patient's home or other locations upon the order of the patient's treating physician/practitioner. These services must be provided under the general supervision of a physician.

The following services are the only x-rays covered by West Virginia Medicaid to portable x-ray suppliers:

- Skeletal films: upper extremity, lower extremity, spine/pelvis, head/neck
- Chest films not involving contract media
- Abdominal films not involving contrast media
- Diagnostic mammogram if FDA approved

Transportation charges (R0070 and R0075) and set-up charges (Q0092) for portable x-ray equipment may be billed by the portable x-ray supplier.

Electrocardiograms taken by an approved portable x-ray supplier is covered; however, transportation charges and set-up charges cannot be billed.

512.26 INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)

An independent diagnostic testing facility (IDTF) is a facility in which diagnostic tests are performed by licensed, certified non-physician personnel under the appropriate physician supervision. An IDTF is defined as a fixed location, a mobile entity, or an individual non-physician practitioner.

512.26.1 REQUIREMENTS FOR IDTF:

An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests and the qualifications of non-physician personnel who use the equipment.

The supervising physician must show evidence of proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF; however, there is no requirement that the IDTF supervising physician actually furnish the interpretation. (For example, a physician might order tests from the IDTF that he or she will interpret.) Proficiency may be documented by certification in specific medical specialties or subspecialties. The supervising physician must personally furnish this level of supervision whether the procedure is performed in the IDTF or in the case of mobile service, at a remote location. The IDTF must maintain documentation of sufficient physician resources during all hours of operations to assure that the required physician supervision is furnished.

Any non-physician personnel used by the IDTF to perform tests must demonstrate the basic qualifications to perform the test in question and have appropriate training and proficiency as evidenced by licensure or certification by the appropriate State Health Department. In the absence of a State Licensing Board, the technician must be certified by the appropriate national credentialing body. The IDTF must maintain documentation available for review that these requirements are met.

All procedures performed by the IDTF must be specifically ordered in writing by a physician who treats the member, that is, the physician who is furnishing a consultation or treating a member for a specific medical problem and who uses the results in the management of a member's specific medical problem. This requirement would be met when a member's primary care physician orders testing, the results of which may determine whether or not the physician refers the member to a specialist. The order must specify the diagnosis or other basis for the testing. The supervising physician for the IDTF may not order tests performed by the IDTF and the IDTF may not add any procedures based on internal protocols without written order from the treating physician.

An IDTF must comply with all applicable laws of any state in which it operates.

An IDTF that operates across State boundaries must maintain documentation that its supervising physicians and technicians are licensed and certified in each of the states in which it is furnishing services.

512.26.2 GENERAL INFORMATION – IDTF

There could be situations in which the IDTF supervising physician is, in fact, a member's treating physician. In these situations, the physician in question would have had a relationship with the member prior to the testing and would be treating the member for a specific medical problem.

Podiatrists and optometrists when operating within the scope of their state licensure may order tests from the IDTF.

Chiropractors may not order tests for members under any circumstances from the IDTF's.

Under West Virginia Medicaid, the IDTF would bill only for the technical component of the procedure. (Appropriate professional component charges will be billed by the interpreting physicians.) **Under no circumstances will reimbursement be made for more than one interpretation.**

The IDTF requirements apply to any procedures furnished by the IDTF regardless of the setting where they are performed.

Documentation of medical necessity must be available for review if requested.

512.26.3 MEDICAID COVERAGE OF IDTF's.

All entities wishing to be recognized as IDTF's with the Medicaid Program must send a copy of their Medicare approval with the completed enrollment agreement/application to the Provider Enrollment Unit at the address on page 5.

512.26.4 EXCEPTIONS TO IDTF CRITERIA

The following diagnostic tests are not required to be furnished in accordance with the IDTF criteria.

- Diagnostic mammogram, the coverage of which is required by law to be regulated by the Food and Drug Administration.
- Diagnostic tests personally furnished by an audiologist.
- Diagnostic psychological testing services personally furnished by a psychologist.
- Laboratory tests done in CLIA approved laboratories.

512.27 GENERATION AND INTERPRETATION OF AUTOMATED DATA

Payment for two procedure codes associated with the generation and interpretation of automated data 78890, for a service that requires up to 30 minutes, and 78891, for a service that exceeds 30 minutes, are now bundled into payment for the primary procedure, e.g., myocardial imaging. CMS felt that use of these two codes led to inappropriate and duplicate billing of services and that the amount of work for these services, 0.05 and 0.1 work RVU's, respectively, was within the range of work performed during the primary procedure. These RVU's were distributed across all other nuclear medicine procedure codes in the nuclear medicine section of the CPT Manual, 78000 through 78999.

512.28 EXCLUSIONS

West Virginia Medicaid does not cover diagnostic radiological tests ordered by a physician who is not the member's treating physician.

Comparison x-rays are not covered routinely. If performed, documentation must substantiate the necessity of the second x-ray and must be kept in the patient's record and made available upon request to the Bureau for Medical Services. West Virginia Medicaid neither covers nor pays separately for interpretations of x-rays that are performed for quality assurance or confirmation purposes.

West Virginia Medicaid also does not make payment for the following:

- Services not ordered by the member's treating physician/practitioner.
- Services provided by facilities not properly licensed, certified, and enrolled in the West Virginia Medicaid Program
- Services that are provided to members who are not eligible to receive them on the date provided
- Reports to referring physicians or other licensed practitioners
- Reports requested by the Bureau for Medical Services or its authorized representative
- Mass screenings or examinations of members, e.g. nursing facilities, schools, and other institutional settings, etc.

512.29 BILLING AND REIMBURSEMENT

For Medicaid payment, medically necessary tests or procedures must be performed by a participating certified facility and must be related to the diagnosis and treatment of disease, or

assessment of the member's medical condition. Medical records must substantiate that any service billed to Medicaid was actually provided to a member.

West Virginia Medicaid uses the Resource Based Relative Value Scale (RBRVS) fee schedule to pay for radiology services. The radiologist may bill for the professional and technical components of the procedure if he or she performs both parts of the procedure. A hospital or other facility may bill only the technical component unless the facility is allowed to bill for the radiologist's professional services; this must be over the radiologist's provider number. Medicaid payment is based on the lower of the amount the provider charges and the fee schedule amount. Chapter 600 explains the RBRVS fee schedule.

512.30 MANAGED CARE

If a Medicaid recipient is a member of an HMO, the HMO is responsible for reimbursement of services rendered in accordance with the HMO's requirements. If the Medicaid recipient is a member of the PAAS Program, the PAAS PCP must provide a referral for services prior to rendering the service if the treating/ordering provider is not the PCP. Medicaid will not reimburse for services provided when HMO or PAAS requirements are not met.