CHAPTER– 528 COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR RADIOLOGY SERVICES

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INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally define parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

Radiological covered services available to Medicaid members may be provided in a hospital, Independent Diagnostic Testing Facility (IDTF), office, or clinic setting in accordance with State regulations. The Health Care Authority (HCA) must provide Certificate of Need (CON) approval in many cases (e.g., Cardiac CT). Specific covered diagnostic radiology services may be provided by enrolled Portable X-ray Providers when it is medically necessary.

Certain radiological services may require prior authorization. A request from the referring provider must be submitted to BMS' Utilization Management Contractor (UMC) with the appropriate medical documentation prior to services being rendered. Prior authorization is required regardless of the place of service unless the service is medically necessary during a documented emergent visit at an emergency room.

528.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services shall apply pursuant to the Provider Manual, *Chapter 200, Definitions*. In addition, the following definitions apply and/or relate to radiology services.

Computed Tomography (CT) - A diagnostic technology that combines x-ray equipment with a computer and cathode ray tube display to produce images of cross sections of the human body.

Contrast Material - A substance that is opaque to x-rays; when administered it allows the radiologist to examine an organ or tissue.

General Supervision – When the radiological procedure is furnished under the physicians overall direction, but the physician's presence is not required.

Independent Diagnostic Testing Facility (IDTF) - A facility in which diagnostic tests are performed by licensed and certified non-physician personnel under the appropriate physician supervision.

Magnetic Resonance Angiography (MRA) - An application of magnetic resonance imaging (MRI) that provides visualization of blood flow, as well as images of normal and diseased blood vessels.

Magnetic Resonance Imaging (MRI) – The performance of medical imaging using radio waves, magnetic fields and a computer to produce images of the body tissues.

Mammogram - A radiographic image of the breast.

Mammography - A radiograph of the breast, which may utilize specialized diagnostic procedures including computer analyzed digitalization or digital mammography.

Nuclear Medicine - A diagnostic and treatment imaging process that uses special cameras and radioactive materials to form images of the body.

Portable X-ray Provider – A provider of radiological procedures that utilizes hand-carried or mobile radiological systems or components in the member's residence.

Positron Emission Tomography (PET) Scan - A diagnostic technology that involves the acquisition of physiologic images based on the detection of positrons. Positrons are tiny particles emitted from a radioactive substance administered to the patient. The subsequent views of the human body developed by this technique are used to evaluate the patient for the presence of a variety of diseases.

Radiopharmaceutical - A radioactive compound used in radiotherapy or diagnosis.

Ultrasonography - A diagnostic technology that produces a visual image from the application of high frequency sound waves.

Utilization Management Contractor (UMC) - The UMC is authorized to grant prior authorization for radiology services provided to West Virginia Medicaid members. The UMC utilizes nationally recognized medical appropriateness criteria established and approved by BMS for medical necessity reviews.

528.2 PROVIDER PARTICIPATION

To participate in the West Virginia Medicaid Program and receive reimbursement from BMS, providers must:

- Meet and maintain all applicable licensing as required by the state in which the practice is located: [Note: When the license and/or certification(s) are not current, the provider shall not participate in Medicaid until such time the BMS' Provider Enrollment Unit receives the copy of current license(s) and/or certification(s). When current license and/or certification(s) are not on file, reimbursement cannot be provided.
- Have a valid signed provider enrollment application/agreement on file.
- Meet and maintain all BMS provider enrollment requirements.

Refer to *Chapter 300, Provider Participation Requirements*, for additional information related to West Virginia Medicaid provider enrollment.

In addition to the above, to be eligible for payment for radiology, or diagnostic services, the provider must:

- Indicate the location of the installation/equipment and provide its registration number on the enrollment application. The equipment installation and personnel must comply with any applicable federal, state, and local laws as well as federal and state Medicaid rules and regulations.
- Provide a copy of Board Certification in Radiology to provider enrollment, or be Board eligible or Board certified in a medical specialty in which they are qualified by experience and training in the use of x-rays for diagnostic purposes. Radiological services must be performed by, or provided under the supervision of, a licensed provider who is qualified by advanced training and experience in the use of x-rays for diagnostic and therapeutic purposes.

528.3 PORTABLE X-RAY PROVIDER

Specific diagnostic radiology services provided by portable x-ray providers are considered for payment when it is deemed medically necessary by the member's provider for the service to be rendered in a Nursing Facility or the member's home. These services shall only be performed where there is true medical necessity and when the member cannot access or otherwise be examined on fixed conventional radiology equipment.

Portable x-rays are not to be performed for "routine" purposes or for reasons of convenience. Portable x-ray services provided in the member's home are subject to prior authorization.

Covered radiology services limited to portable x-ray providers are defined as:

- Skeletal films involving the extremities, pelvis, vertebral column, or skull
- Chest and abdominal films that do not involve the use of contrast media
- Diagnostic mammograms if the approved portable x-ray provider, as defined in 42 CFR part 486, subpart C, meets the certification requirements of section 354 of the Public Health Services Act, as implemented by 21 CFR part 900, subpart B. FDA certification under the Mammography Quality Standards Act (MQSA) is required.

Transportation of portable x-ray equipment is reimbursable only when the equipment used is transported to the location where the x-ray services are provided. West Virginia Medicaid will not reimburse for transportation of portable x-ray equipment when the x-ray equipment is stored at the facility for use as needed.

Reimbursement for transportation of equipment and personnel to provide radiological services, (R0070), is limited to one unit of service, per location, per day when one West Virginia Medicaid member is seen.

If more than one Medicaid member is x-rayed at the same place of service, R0075 (transportation of portable x-ray equipment and personnel, more than one member seen), is to be reported with the appropriate modifier. The appropriate modifiers are:

- R0070 One member served
- R0075 - UN Two members served
- R0075 - UP Three members served
- R0075 - UQ Four members served
- R0075 - UR Five members served
- R0075 - US Six members or more served (paper claim must be submitted indicating the number of members served).

Setup of portable x-ray equipment at the site of service, and transportation and/or set up charges for portable EKG services are not reimbursable.

528.3.1 ENROLLMENT (PORTABLE X-RAY PROVIDER)

The portable x-ray provider must meet the Centers for Medicare and Medicaid Services' (CMS) enrollment requirements (see 42 CFR §486.100-110) as a portable x-ray provider in order to be reimbursed for services provided to West Virginia Medicaid members. Portable x-ray services must be provided under the general supervision of one or more licensed physicians qualified by advanced training and experienced in the use of diagnostic x-rays. The supervising physician is responsible for the ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of non-physician personnel that use the equipment. Any non-physician personnel utilized by the portable x-ray provider to perform tests must demonstrate the basic qualifications and possess appropriate training and proficiency as evidenced by licensure or certification.

All entities wishing to enroll as a portable x-ray provider with the West Virginia Medicaid Program must provide Provider Enrollment with the following:

- A copy of the Medicare approval that certifies them by CMS as a Portable X-ray Provider
- Completed West Virginia Medicaid enrollment application
- Registration/certification of radiological equipment
- List of procedure codes provider is approved by CMS to provide

- Name and copy of current license of each supervising radiologist, including any medical specialty certifications
- Mammography Certification issued by Mammography Quality Standards Act of 1992 (MQSA). (Only if mammograms are performed)
- Certificate of Need

Refer to *Chapter 300, Provider Participation Requirements*, for additional information related to West Virginia Medicaid Provider Enrollment.

528.4 INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)

Certain diagnostic services provided by an IDTF are considered for payment if medically necessary. An IDTF may be a fixed location, a mobile facility, or an individual non-physician provider, but must be independent of a hospital. An IDTF must have one or more supervising physicians with experience in each type of diagnostic procedure performed by the IDTF. The supervising physician is responsible for the 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 that use the equipment. Any non-physician personnel utilized by the IDTF to perform tests must demonstrate the basic qualifications and possess appropriate training and proficiency as evidenced by licensure or certification.

Any procedures performed by an IDTF must be ordered by the provider who is treating the member, that is, the provider who is furnishing the consultation or treating a member for a specific medical problem and uses the results in the management of the member's medical problem. The supervising physician for the IDTF shall not order tests performed by the IDTF and the IDTF shall not add any procedures based on internal protocols without an order from the treating provider. An exception to this rule is if the supervising physician is the members treating provider. In this situation, the supervising physician would have been treating the member for a specific medical diagnosis prior to the testing.

An IDTF must comply with all applicable laws of any state in which it operates. Exceptions for diagnostic x-rays and other diagnostic tests that are not required to be furnished in accordance with IDTF criteria can be referenced in 42 CFR 410.33.

528.4.1 ENROLLMENT (IDTF)

An IDTF must meet CMS's enrollment requirements (see 42 CFR §410.32 and 410.33) as an IDTF in order to be reimbursed for services provided to West Virginia Medicaid members. All entities wishing to enroll as an IDTF with the West Virginia Medicaid Program shall provide Provider Enrollment with the following:

- A copy of the Medicare approval that certifies them by the Centers for Medicare and Medicaid Services (CMS) as an IDTF Medicare provider
- Completed West Virginia Medicaid enrollment application
- Registration/certification/location of radiological equipment
- List of procedure codes provider is approved by CMS to provide

- Name and copy of current license of each supervising radiologist, including any medical specialty certifications
- Mammography Certification issued by Mammography Quality Standards Act of 1992 (MQSA). (Only if mammograms are performed)
- Certificate of Need

Refer to *Chapter 300, Provider Participation Requirements*, for additional information related to West Virginia Medicaid Provider Enrollment.

528.5 COVERED SERVICES

Radiology services provided by Medicaid enrolled providers are considered for reimbursement by West Virginia Medicaid when the services are determined medically necessary to meet the healthcare needs of the member. If the radiology service is a covered service and requires prior approval, the prior authorization is required prior to the service being rendered regardless of the place of service unless medically necessary during an emergent visit at an emergency room. A referring/treating provider must order all covered services. The treating provider is the provider responsible for the management of the member's specific medical problems.

Services must be performed under the supervision of a licensed physician or other authorized, licensed provider within the scope of his or her licensure and must be medically necessary. Generally accepted professional standards of care must be followed by all personnel.

Radiology services eligible for coverage include, but are not limited to:

- Diagnostic x-ray tests and therapeutic procedures
- CT, MRI, MRA and PET Scans
- Radiation oncology/Interventional Radiology
- Bone Density Tests
- Nuclear medicine services [Note: Nuclear medicine equipment must be registered with or licensed by the Nuclear Regulatory Commission (NRC)]
- Ultrasound services provided by radiologists and certain medical specialists qualified by advanced training and experience in the use of diagnostic ultrasound procedures
- Radiopharmaceutical and contrast materials: A list with billing guidelines can be found on the WVDHHR webpage:

http://www.wvdhhr.org/bms/sPharmacy/PractitionerOutpatient/NDC_DrugCodeList.pdf

- One interpretation/report per radiology procedure

528.5.1 MAMMOGRAPHY

Diagnostic and screening mammography services are a covered service if medically necessary. A screening mammography is limited to one per year. All facilities providing these services are required to have FDA certification under the Mammography Quality Standards Act (MQSA) of 1992. MQSA requires that all mammography facilities in the United States meet certain

stringent quality standards, be accredited by an FDA-approved accreditation body, and be inspected annually.

Physicians providing an interpretation/report for mammographies performed in MQSA approved facilities may order a diagnostic mammogram based on the findings of a screening mammogram even though the physician does not treat the member, in accordance with 42 CFR 410.32.

528.6 NON-COVERED SERVICES

Non-covered radiology services include, but are not limited to:

- Experimental, investigational, clinical trials or services for research purposes
- Radiology services for which a required prior authorization has been denied or not obtained
- Radiology services rendered by providers and facilities not properly licensed, certified, or enrolled with West Virginia Medicaid
- Mass screenings or examination of members at nursing facilities, schools, or other institutional or public settings
- Non-compliant MQSA mammograms
- Diagnostic services ordered by a provider who is not the member's attending/treating provider. (Exception: FDA regulated mammograms)
- Interpretation of x-rays for quality assurance/confirmation
- Radiology services provided to persons who are not Medicaid eligible on the date of service
- Reports requested by BMS or its designee
- Review of x-ray without providing a written report
- Set up of portable x-ray/EKG equipment are considered included in the procedure itself
- A second interpretation/report of a radiology procedure. Payment for initial report is considered payment in full and includes any additional reports that may be submitted.

528.7 PRIOR AUTHORIZATION REQUIREMENTS FOR IMAGING PROCEDURES

For radiology services requiring prior authorization for medical necessity by the Utilization Management Contractor (UMC), the referring/treating provider must submit the appropriate CPT code with clinical documentation and any other pertinent information to be used for clinical justification of services by the UMC. The information must be provided to the UMC, and the prior authorization granted, prior to services being rendered. Prior authorization requests for radiological services must be submitted within the timeframe required by the UMC.

The UMC reviews all requests for services requiring prior authorization. When the medical documentation does not meet medical necessity criteria or additional information is not received a denial letter is sent to the member or their legal representative, the requesting provider and facility. This denial letter notes the reason for the denial and includes information regarding the member's right to a fair hearing and a Request for Hearing Form for completion. In addition, the

letter sent to the provider contains information regarding their right to a reconsideration of the denial. To obtain a copy of the prior authorization form and a list of radiological procedures requiring prior authorization refer to www.wvdhhr.org.

If services are provided before the prior authorization is confirmed, the provider and/or facility shall not be reimbursed. Prior authorization does not guarantee payment. Prior authorization is required regardless of the place of service unless the service is medically necessary during a documented emergent visit at an emergency room.

Nationally recognized medical appropriateness criteria, or other criterion that has been approved by BMS may be utilized for medical necessity reviews of radiology services requiring prior authorization.

Retrospective authorization is available (1) for West Virginia Medicaid covered services denied by the member's primary payer (2) retroactive Medicaid eligibility; and, (3) the next business day following a medically necessary emergency procedure occurring on weekends, holidays, or at times when the UMC is unavailable. A request for consideration of retrospective authorization does not guarantee approval or payment.

528.8 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in *Common Chapter 300 Provider Participation Requirements, Section 320.5 Document and Retain Records*, providers and facilities submitting claims for Medicaid reimbursement must maintain complete, individual, accurate and legible records. Records must include documentation of services provided to Medicaid members and billed to West Virginia Medicaid.

Radiological services require a written order which includes the original signature of the member's treating provider, date test was ordered, member's diagnosis, and the specific test or procedure requested. These records must be made available upon request to the Bureau for Medical Services, Federal/State Auditors and Investigators, or BMS contracted agencies.

528.9 BILLING

West Virginia Medicaid utilizes Current Procedure Terminology (CPT) and/or Healthcare Procedure Coding System (HCPCS) codes for billing of services provided to Medicaid members. These codes are recommended by CMS and can be found in procedure code books published by the American Medical Association. Some services are not assigned a CPT or HCPCS code; therefore, an unlisted code may be available for the service provided. The appropriate unlisted code with the documentation describing the service performed must be submitted on a paper claim for payment consideration. Use of an unlisted code when a national CPT code is available is not reimbursable. In addition, coding modifiers may be required to accurately and completely report any service provided to the member.

Specific procedure/service codes are bundled into other codes to reflect the complexity of the service provided and West Virginia Medicaid requires the use of the correct code for service

provided. West Virginia Medicaid utilizes clinical auditing bundling software for prepayment review of claims, which prevents overpayments from occurring when services are unbundled.

West Virginia Medicaid requires providers and facilities to be enrolled with West Virginia Medicaid to be eligible for reimbursement of services rendered. Providing services prior to enrollment, with the exception of emergency room services provided by an Out of Network hospital is not reimbursable.

Radiology services generally include a technical and professional component that together equals the total procedure. The professional component is the interpretation of the x-ray and the written report. The technical component includes the use of equipment, personnel and materials. The date of service the technical component is performed is the appropriate date of service for both the professional and technical components. The professional or technical components are billed with the appropriate modifier in addition to the CPT/HCPCS code for payment consideration:

- Facilities, including IDTF's and Portable X-ray Providers, bill the technical component only of the procedure code.
- Practitioners bill the professional component of the procedure for their services when only an interpretation/report is done.
- Practitioners who own radiology equipment and interpret the x-ray may bill for the total procedure.
- Practitioners who own radiology equipment but choose to send to another practitioner for interpretation would bill the technical component only and the practitioner who reads the x-ray would bill for the interpretation/report.

The professional, technical, or total components of radiology services provided by providers are billed on the CMS 1500 paper claim or ASCX12N837P electronic format with the appropriate modifier when applicable. The technical component of radiology services provided by IDTFs is billed this way as well. Hospitals bill the technical component of radiology services with the appropriate modifier on a UB04 or ASCX12N837I electronic format. Claims must be submitted to the BMS Fiscal Agent within 12 months of the date of service. Please refer to *Chapter 800, General Administration*, for more information on timely filing.

Medicaid is the payer of last resort. Third-Party Liability (TPL) is a method of ensuring that Medicaid is the last payer to reimburse for covered Medicaid services. Please see *Chapter 600, Reimbursement Methodologies*, for further information regarding TPL.

528.9.1 REIMBURSEMENT METHODOLOGY

Physicians, Outpatient Hospitals Facilities/Services, IDTFs, Portable X-ray Providers, Rural Health Clinics and Federally Qualified Health Center's are reimbursed for radiology services based on the Resource-Based Relative Value Scale (RBRVS) or the lesser of the established fees or the providers usual customary charge to the public. Refer to *Chapter 600, Reimbursement Methodologies*, for further information on RBRVS. Radiology services for Critical Access Hospital's are reimbursed at a percent of billed charges.

528.10 MANAGED CARE

Unless otherwise noted in this manual or appendices, these services are the responsibility of the Managed Care Organization (MCO). If the Medicaid member is enrolled in a West Virginia MCO, MCO requirements must be met for reimbursement. If a Medicaid member is enrolled in the PAAS Program, the member's PAAS Primary Care Provider (PCP) must provide a referral for all benefits/services ordered prior to rendering the service. Medicaid shall not reimburse for services provided when MCO or PAAS requirements are not met.

528.11 MOUNTAIN HEALTH CHOICES

Mountain Health Choices (MHC) is the name of West Virginia Medicaid's Program where members have a choice of benefit packages. This program promotes member choice, member responsibility and health improvement. This program was developed as a result of the Deficit Reduction Act 2005 and allows for the tailoring of benefit packages to meet the needs of certain populations. This program is a part of the redesign of Medicaid to promote wellness and to prevent and/or manage the progression of chronic diseases by encouraging healthier lifestyles for Medicaid members.

The services outlined in this manual are covered for children and adults in both the Basic and Enhanced Benefit packages. Diagnostic radiology services are covered for all benefit plans. Prior authorization is required for certain services.