



PAYMENT POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
10/31/2013	03/09/2017	03/09/2016
Policy Name		Policy Number
Advanced Diagnostic Imaging Services		PY-0041
Policy Type		
<input type="checkbox"/> Medical	<input type="checkbox"/> Administrative	<input checked="" type="checkbox"/> Payment

Payment Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Payment Policies.

In addition to this Policy, payment of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

A. SUBJECT

Advanced diagnostic imaging Services

B. BACKGROUND

CareSource will cover medically necessary imaging services including diagnostic radiology, mammography, bone densitometry, nuclear medicine, magnetic resonance imaging/magnetic resonance angiography (MRI/MRA), computerized tomography/ computerized tomographic angiography (CT/CTA), positron emission tomography (PET scan) and ultrasound procedures.

C. DEFINITIONS

- **Advanced diagnostic Imaging (ADI)** refers to the applications of high energy modalities and other technologies to allow the visualization and examination of body tissues including but not limited to computed tomography ("CT"), magnetic resonance imaging ("MRI"), magnetic resonance angiography (MRA), and positron emission tomography ("PET").
- **Technical Component** represents the non-physician work (including facility, equipment, personnel and administrative costs) related to the procedure.
- **Professional Component** refers to the physician work related to performing and interpreting the results of a procedure.



D. POLICY

I. Prior Authorization

- A. Diagnostic imaging services performed in the emergency room, observation, and inpatient settings do not require prior authorization.
- B. CareSource requires providers to obtain authorization prior to requesting ADI services in an outpatient setting, including:
 - 1. CT/CTA
 - 2. MRI/MRA
 - 3. PET Scan
 - 4. Nuclear Cardiology
- C. MRI/MRA, CT/CTA and PET procedures must be performed in a participating designated free-standing imaging center or a participating hospital.
- D. If the rendering provider identifies a need to extend the examination to a contiguous body area or identifies a need to perform a different examination than what was originally authorized, the radiologist or facility should notify NIA of the extended study or additional service within the same day.
 - 1. NIA will either update the authorization record to include the extended examination or issue a new authorization number for the additional service.

II. Global Payment and Component Services

- A. CareSource covers the "professional component" for physicians in any setting.
 - 1. The "technical component" is covered only when that service is provided in an appropriate non-facility setting.
- B. The global service (which is inclusive of the professional component) is covered by CareSource in non-facility settings.
 - 1. When a physician reports a global procedure, the physician is responsible for the overall performance and quality of the test.
 - 2. The physician must either personally perform the test or it must be performed under the physician's supervision and direction.
 - 3. The physician must personally interpret the results and complete the written report.
 - 4. While some radiology procedures and diagnostic tests may not require the presence of the supervising physician on the premises, other procedures dictate that the physician be present and and/or directly involved in the performance of the procedure.
- C. Interpretation of radiology services are covered for any physician trained in the interpretation of the study.
 - 1. The provider who interprets the study must be the one who prepares and signs the written report for the medical record.
- D. Review of results and explanation to the beneficiary are part of the attending physician's E/M service and are not considered as interpretation of the study.
- E. Incidental and ancillary services (e.g. contrast, drugs, related supplies etc) utilized in advanced diagnostic imaging studies will be reimbursed within the global payment and will not be reimbursed separately.
 - 1. This includes (but is not limited to) submissions involving "A" codes, "J" codes, "Q" codes).

III. Multiple Services on Same day

- A. CareSource covers bilateral x-rays when medically necessary.
 - 1. Bilateral services are studies done on the same body area, once on the right side and once on the left side. Comparison films obtained for routine purposes are not



covered.

2. Providers should use a bilateral code when available.

B. CareSource also covers multiple studies of both areas if reported with the appropriate modifier.

1. Examples would include bilateral wrist studies done before and after fracture care on both wrists the same day for the same patient or doing films to assess a patient's response to medical care, such as multiple chest films to monitor the cardiopulmonary status of a critically ill patient.

IV. Billing Information

A. CareSource recognizes a professional component and a technical component for each radiological procedure.

1. When both components are performed by one provider, they are recognized as the total (radiological) procedure.

B. X-rays and documentation of all results of radiological procedures must be maintained on file for a period of six years.

1. In addition, x-rays must be of sufficient quality to ensure ease of diagnosis and must be marked with the patient's name and dated for ready identification.

C. When submitting a claim for radiology services, providers must use the appropriate modifiers.

1. CareSource will directly reimburse a radiologist the professional component when the radiologist performs the initial interpretation of a radiological examination.

2. CareSource will directly reimburse a radiologist or cardiologist for the professional component when the radiologist or cardiologist interprets a radiological procedure that has already been interpreted by another physician.

3. In this case, the radiologist's or cardiologist's interpretation is deemed a specialist's evaluation (of the interpretation of the treating physician) whose findings could affect the course of treatment initiated or cause a new course of treatment to begin.

D. Reimbursement is not allowed for an interpretation of a radiologic procedure performed by the attending, treating, or emergency room physician after a radiologist's or cardiologist's interpretation.

1. Such a service would be considered a part of the physician's overall workup or treatment of the patient and reimbursed as part of the visit.

2. Physician providing radiological services in an inpatient hospital, an outpatient hospital, or an emergency room setting may bill CareSource only for the professional component.

E. CareSource will reimburse a physician/provider for only the technical component if:

1. The physician personally performed the service or the service was performed by an employee of the physician/provider

2. The professional component was performed by another physician/provider

3. The service was performed in a setting other than an inpatient hospital, an outpatient hospital or an emergency room.

F. CareSource will reimburse a physician for the total procedure when the radiologist or treating physician performs the professional and technical components of a radiological procedure in a setting other than an inpatient hospital, an outpatient hospital, or an emergency room.

G. CareSource will reimburse any other non-hospital provider for the total procedure when:

1. The physician who performed the professional component has an employment or contractual arrangement for the provider to bill for the professional services

2. The technical component was performed in a setting other than an inpatient



hospital, an outpatient hospital, or an emergency room.

V. Diagnostic and Radiology Services

- A. In accordance with AMA Principles of CPT Coding CareSource will not compensate a diagnostic test or radiology service billed with modifier 26 (professional component) and modifier TC (technical component) if the technical and professional components of the service are performed by the same provider billed on the same or different claim on the same date of service.

CONDITIONS OF COVERAGE

HCPCS

CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

- CareSource Payment Policy: Emergency Department EKG and Imaging Interpretation
 - CareSource Payment Policy: Bilateral Procedures
- OHIO: <https://www.caresource.com/providers/ohio/ohio-providers/payment-policies/>
KENTUCKY: <https://www.caresource.com/providers/kentucky/medicaid/payment-policies/>

F. REVIEW/REVISION HISTORY

Date Issued: 10/31/2013
Date Reviewed: 10/31/2013, 03/09/2016
Date Revised: 03/09/2016 - CareSource requires providers to obtain authorization prior to requesting ADI services in an office or outpatient setting.

G. REFERENCES

1. OAC 5160-4-25, "Physician Services, Laboratory and Radiology services."
2. 907 KAR 3:005. Physicians' Services, Section 5. Prior Authorization Requirements

The Payment Policy Statement detailed above has received due consideration as defined in the Payment Policy Statement Policy and is approved.