



## Payment Policy

### Subject: Imaging Services

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#### ***Policy***

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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.

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#### ***Definitions***

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**“Diagnostic imaging,”** means the use of high energy modalities and other technologies to allow the visualization and examination of body tissues. Diagnostic imaging includes, but is not limited to, x-rays, ultrasound, magnetic resonance imaging (“MRI”), positron emission tomography (“PET”), and computed tomography (“CT”). *(From NIM/NIH MedLine Plus)*

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#### ***Provider Reimbursement Guidelines***

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##### **Prior Authorization**

Diagnostic imaging services performed in the emergency room, observation, and inpatient settings do not require prior authorization.

CareSource requires providers to obtain authorization prior to requesting imaging services in an outpatient setting, including:

- CT/CTA
- MRI/MRA
- PET Scan
- Nuclear Cardiology

MRI/MRA, CT/CTA and PET procedures must be performed in a participating designated free-standing imaging center or a participating hospital.

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. NIA will either update the authorization record to include the extended examination or issue a new authorization number for the additional service.

##### **Global / Component Services**

CareSource covers global services for physicians in non-facility settings, and the professional component is covered for physicians in any setting. The technical component is only covered when the service is provided in an appropriate non-facility setting. The global service and its professional component service cannot both be covered for the same service since the professional component is

included in the global service.

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When a physician reports a global procedure, the physician is responsible for the overall performance and quality of the test. The physician must either personally perform the test or it must be performed under the physician's supervision and direction. The physician must personally interpret the results and complete the written report. 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.

Interpretation of radiology services are covered for any physician trained in the interpretation of the study. The provider who interprets the study must be the one who evaluates the study and prepares and signs the written report for the medical record.

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.

### **Multiple Services on Same day**

CareSource covers bilateral x-rays when medically necessary. 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. Providers should use a bilateral code when available. CareSource also covers multiple studies of both areas if reported with the appropriate modifier. 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.

### **Billing Information**

CareSource recognizes a professional component and a technical component for each radiological procedure. When both components are performed by one provider, they are recognized as the total (radiological) procedure.

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

When submitting a claim for radiology services, providers must use the appropriate modifiers. CareSource will directly reimburse a radiologist the professional component when the radiologist performs the initial interpretation of a radiological examination. 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. In this case, the radiologist's or cardiologist's interpretation is 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.

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. 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. A physician providing radiological services in an

inpatient hospital, an outpatient hospital, or an emergency room setting may bill CareSource only for the professional component.

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

- The physician personally performed the service or the service was performed by an employee of the physician/provider;
- The professional component was performed by another physician/provider; and
- The service was performed in a setting other than an inpatient hospital, an outpatient hospital or an emergency room.

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.

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

- The physician who performed the professional component has an employment or contractual arrangement for the provider to bill for the professional services; and
- The technical component was performed in a setting other than an inpatient hospital, an outpatient hospital, or an emergency room.

### **Diagnostic and Radiology Services**

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. According to the AMA Principles of CPT Coding, it is not appropriate to report the components of the professional and technical service separately.

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### ***Related Policies & References***

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OAC 5160-4-25, "Physician Services, Laboratory and Radiology services."

907 KAR 3:005. Physicians' Services, Section 5. Prior Authorization Requirements

CareSource Payment Policy: Emergency Department EKG and Imaging Interpretation

CareSource Payment Policy: Bilateral Procedures

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### ***State Exceptions***

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KY (product specific)

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### ***Document Revision History***

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**10/31/2013** – OAC Rule renumbered from "5101:3-4-25," per Legislative Service Commission Guidelines.