



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

# Radiology Services

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## Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: October 20, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of September 1, 2017 Published: December 12, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of June 1, 2018 Published: January 3, 2019	Scheduled update: <ul style="list-style-type: none"> <li>• Reorganized and edited text as needed for clarity</li> <li>• Incorporated relevant information from the <i>Medical Policy Manual</i></li> <li>• Updated links to new IHCP website</li> <li>• Replaced the introductory note box with the new standard verbiage</li> <li>• Removed examples of situations not typically requiring radiology from the <a href="#">Coverage and Limitations for Radiology Services</a> section</li> <li>• Updated the <a href="#">Billing and Reimbursement for Radiology Services</a> section, including:               <ul style="list-style-type: none"> <li>– Clarified and expanded billing and reimbursement information for professional and technical components</li> <li>– Incorporated information from the former <i>Angiographic Procedures</i> section</li> <li>– Clarified the note regarding hospice members</li> </ul> </li> <li>• Added the <a href="#">Liver Elastography</a> section</li> <li>• Updated the <a href="#">PET Scans</a> section, including:               <ul style="list-style-type: none"> <li>– Added a reference to the new <i>Radiology Services Codes</i></li> <li>– Updated the billing instructions and provided a reference to section with full instructions</li> </ul> </li> </ul>	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"><li>• Updated billing instructions in the <a href="#">Proton Treatment</a> section</li><li>• Removed the <i>Radionuclide Bone Scans</i> section</li></ul>	

# Table of Contents

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Introduction.....	1
Coverage and Limitations for Radiology Services.....	1
Billing and Reimbursement for Radiology Services.....	2
Information for Specific Radiology Services.....	3
CT Scans.....	3
Liver Elastography.....	4
Low Osmolar Contrast Materials.....	4
PET Scans.....	4
Proton Treatment.....	4
Upper Gastrointestinal Studies.....	5



# Radiology Services

*Note: For updates to coding, coverage, and benefit information, see [IHCP Banner Pages and Bulletins](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

*The information in this module applies to services provided under the fee-for-service delivery system. Within the managed care delivery system, individual managed care entities (MCEs) establish their own coverage criteria, prior authorization requirements, billing procedures, and reimbursement methodologies. For services covered under the managed care delivery system, providers must contact the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise member's MCE or refer to the MCE provider manual for specific policies and procedures. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

## Introduction

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

## Coverage and Limitations for Radiology Services

Radiological services must be ordered in writing by a physician or other practitioner authorized to do so under State law.

The IHCP requires prior authorization (PA) for any radiological services that exceed the parameters set out in this document. Criteria for the use of radiological services include consideration of the following:

- Evidence exists that the radiologic 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 treatments.
- IHCP reimbursement is available for x-rays of the extremities and spine for the study of neuromusculoskeletal conditions.

The IHCP does not reimburse for radiology 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 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:**

**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 [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<sup>®1</sup>) 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](http://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.

**Physicians** bill the professional component of a radiology service performed in a facility setting on the professional claim (*CMS-1500* claim form, 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](http://in.gov/medicaid/providers).

- **For radiology services provided by freestanding or mobile radiology clinics:**

Providers must bill the technical and/or professional components of a radiology service on the professional claim (*CMS-1500* claim form, Portal professional claim, or 837P transaction), 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](http://in.gov/medicaid/providers).

See the [Claim Submission and Processing](#) module for instructions for completing the *CMS-1500* and *UB-04* claim forms. See the [Provider Healthcare Portal](#) module for instructions for completing claims online.

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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 radiological services only when that physician or practitioner performed or directly supervised the performance of those services.
- Providers cannot fragment radiology 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 radiology 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 radiological 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 radiological services **not related to the terminal illness**, the hospice provider is not responsible for these radiological 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.*

## Information for Specific Radiology Services

The following sections include billing and reimbursement information related to specific radiological procedures. For information on stereotactic radiosurgery (SRS), see the [Surgical Services](#) module.

### **CT Scans**

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 medically appropriate, 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.

## ***Liver Elastography***

Effective November 25, 2017, 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 6 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 6 months
- Ultrasound transient elastography has not been performed more frequently than once every 6 months

## ***Low Osmolar Contrast Materials***

Separate reimbursement is not available for radiologic contrast material. For dates of service before July 1, 2017, the IHCP made an exception for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and intra-arterial injections, allowing LOCM procedure codes Q9965–Q9967 to be billed with revenue code 636 for IHCP reimbursement consideration. For dates of service on or after July 1, 2017, these codes are not separately reimbursed.

## ***PET Scans***

All claims for reimbursement of Positron Emission Tomography (PET) scans must include an appropriate International Classification of Diseases (ICD) diagnosis code. See *Radiology Services Codes*, accessible from the [Code Sets](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers) for diagnosis codes that support medical necessity for PET scan procedure codes.

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.

## ***Proton Treatment***

The IHCP has determined that the following procedure codes are appropriate to report *only* the technical component of proton treatment delivery:

- 77520 – *Proton treatment delivery; simple, without compensation*
- 77522 – *Proton treatment delivery; simple, with compensation*
- 77523 – *Proton treatment delivery; intermediate*
- 77525 – *Proton treatment delivery; complex*

The IHCP does not reimburse proton treatment delivery services when billed using procedure codes 77520, 77522, 77523, or 77525 with modifier 26 – *Professional component*. Providers are advised to report any professional services using an appropriate CPT procedure code.

## ***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