



CHAPTER 528.1 RADIOLOGY SERVICES

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**DISCLAIMER:** This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.

## CHAPTER 528.1 RADIOLOGY SERVICES

### BACKGROUND

West Virginia Medicaid covers diagnostic and therapeutic radiology and nuclear medicine services. Prior authorization is required for specific services. If the radiology service is a covered service and requires prior approval, the prior authorization is required before the service is 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.

### POLICY

#### 528.1.1 COVERED SERVICES

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

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 some cases

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

- Diagnostic x-ray tests and therapeutic procedures
- Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), and Positron Emission Tomography (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: The [BMS Drug Code List](#) contains billing guidelines.
- One interpretation/report per radiology procedure

#### 528.1.2 PROVIDER PARTICIPATION AND ENROLLMENT

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.
- Be an enrolled West Virginia Medicaid provider who is Board certified in Radiology, 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.

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Refer to [Chapter 300, Provider Participation Requirements](#).

### 528.1.3 AUTHORIZATION

All requests for covered services requiring prior authorization must be submitted to the Utilization Management Contractor (UMC) for medical necessity determination. Nationally accredited, evidence-based, medically appropriate criteria, such as InterQual, or other medical appropriateness criteria approved by BMS, is utilized for reviewing medical necessity of services requested.

It is the responsibility of the enrolled treating, prescribing, ordering, or referring practitioner to submit a request to the UMC with relevant medical documentation that justifies the medical necessity of the proposed procedure/service. If the covered services are provided before the prior authorization is confirmed, the service will be denied and cannot be reimbursed by BMS. Request for or receipt of prior authorization does not guarantee approval or payment.

Radiology services require a written or electronic 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. Use of a non-specific diagnosis code does not satisfy this requirement. The radiology order and the results of the test must be kept on file with the member's medical record.

It is recommended that the [UMC's web portal](#) be utilized for submitting any request for services requiring prior authorization. Providers using the UMC password protected web portal to submit prior authorization requests may also use the password protected web portal to obtain the approval(s) and their assigned prior authorization number(s) or the denial(s) and the reason(s) for the denial(s) when the request and clinical documentation have been reviewed. Supporting clinical documentation must not be more than six months old when submitted for medical necessity determination. If the covered services are provided before the prior authorization is confirmed, the services will be denied and are not eligible for reimbursement by BMS. The request for prior authorization does not guarantee approval or payment.

When a request for service is denied based on medical necessity, the denial is communicated to the provider of service via the UMC's password protected web portal with the reason(s) of denial and their right for reconsideration of the denial. The member or their legal representative is notified of the denial with information related to their right of a fair hearing with a copy of the Request for Fair Hearing Form for submission to BMS. Non-covered services are not eligible for a DHHR Fair Hearing. See [42 § 431.220](#) When a hearing is required for more information.

Retrospective authorization is available by the UMC in the following circumstances:

- A procedure/service denied by the member's primary payer, providing all requirements for the primary payer have been followed, including appeal processes; or,
- Retroactive West Virginia Medicaid eligibility; or,
- A request for retrospective authorization is submitted the next business day following an emergent procedure/service occurring on a weekend, holiday, or time when the UMC is unavailable.

A request for consideration of retrospective authorization does not guarantee approval or payment

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Services by enrolled providers are subject to review by the BMS before, during, and after provision of services to Medicaid members. Medical documentation must substantiate provider services billed to West Virginia Medicaid are medically necessary and provided to an eligible West Virginia Medicaid member by an enrolled provider. Clinical documentation submitted for prior authorization must not be more than six months old. Documentation must be made available to BMS or its designee upon request.

Additional information is available in [Chapter 300, Provider Participation Requirements](#).

### 528.1.4 NON-COVERED SERVICES

Non-Covered services include, but are not limited to:

- Experimental and investigational 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 Mammography Quality Standards Act (MQSA) of 1992 ) 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 is 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;
- Services that are covered by Federal, State, or local grants; and,
- Services that are available free of charge to the general public.

Non-covered services are not eligible for a DHHR Fair Hearing. See [42 § 431.220 When a hearing is required](#) for more information.

### 528.1.5 BILLING AND REIMBURSEMENT

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

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- 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 ASC X12N 837P 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 ASC X12N 837I electronic format. Claims must be submitted to the BMS Fiscal Agent within 12 months of the date of service.

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.

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

## GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

**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 physician's 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.

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**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.

### REFERENCES

West Virginia Medicaid State Plan references radiology services at sections [3.1-A\(3\)](#) and [3.1-B\(3\)](#).

### CHANGE LOG

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