

Radiology: Diagnostic

This section describes policies and guidelines for billing diagnostic radiology (diagnostic imaging) procedures. For additional help, refer to the *Radiology Billing Example* section of this manual.

National Correct Coding Initiative Impact

A number of diagnostic radiology procedures are subject to National Correct Coding Initiative (NCCI) edits. To process correctly, claims submitted for multiple diagnostic radiology procedures on the same day may require addition of an NCCI-associated modifier. Information about NCCI-associated modifiers is included in the *Correct Coding Initiative: National* section of this manual.

Computed Tomography Scan Guidelines

Providers may be reimbursed for Computed Tomography (CT) scan procedures when performed on patients where other noninvasive and less costly diagnostic measures have been attempted or are not appropriate.

Multiple (Different) Anatomic Sites/ Same Session

Reimbursement for CT scans of multiple (different) anatomic sites performed at the same session/time on the same date are as follows:

- Reimbursement for the professional component (modifier 26) is 100 percent for the CT scan with the highest reimbursement price and 75 percent for all other CT scans.
- Reimbursement for the technical component (modifier TC) is 100 percent for the CT scan with the highest reimbursement price and 50 percent for all other CT scans, reflecting the reduction in time for the technical component.
- Providers must document the times of the CT scans performed, the CPT-4 codes and a notation that the scans were performed in the “same session.” For example, “0800 – CPT-4 code 74150, 0815 – CPT-4 code 70450, same session.” In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided.

Repeat CT/Same Date	Reimbursement for a subsequent CT session for the <u>same</u> anatomical area(s) as previously studied, same date of service, same provider is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For second and subsequent sessions performed on same day, enter the CPT-4 code(s) and time of both the initial and repeat CT scans stating “repeat CT scan, different session” in the <i>Remarks</i> field (Box 80)/ <i>Reserved for Local Use</i> field (Box 19) of the claim. If space is not available, the documentation must be attached to the claim. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT-4 codes and evidence or statement that this is a “repeat CT/same date” scan will result in the claim being reimbursed according to the “same session” policy.
Different Anatomic Site/ Different Time/Same Date	Reimbursement for a subsequent session for a CT scan of (a) <u>different</u> anatomic site(s) than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) component. For second or subsequent sessions performed on the same day, enter the CPT-4 code(s) and time of the earlier session(s) and the subsequent CT scan(s) stating “different sessions” in the <i>Remarks</i> field (Box 80)/ <i>Reserved for Local Use</i> field (Box 19) of the claim. If space is not available, attach this documentation to the claim. If more than one CT scan is performed in the second or subsequent session(s), cutbacks to reimbursement will be applied as stated previously. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT-4 codes and evidence or statement that this is a “different anatomic site/different time/same date” scan will result in the claim being reimbursed according to the “same session” policy.
Bilateral Services	Providers must document bilateral services when claiming more than one unit for codes 73200 – 73202 and 73700 – 73702.
CT Abdomen and Pelvis Methodologies	When submitting claims for CT abdomen and pelvis codes 74176 – 74178, do not submit codes 72192 – 72194 or 74150 – 74170. Combined reimbursement for more than one methodology (with contrast material; without contrast material; with/without contrast material) per recipient and same anatomical area, for the same session and date of service will not exceed the maximum amount of the highest-priced methodology (with/without contrast material).

Anesthesia	Anesthesia billed with modifier P1 (anesthesia services, normal, uncomplicated) in conjunction with a CT scan procedure code is a benefit. These services should be billed using the appropriate five-digit CPT-4 anesthesia code. However, justification of the need for anesthesia with this procedure must be entered in the <i>Remarks</i> field (Box 80)/ <i>Additional Claim Information</i> field (Box 19) of the claim.
Mobile and Non-Mobile CT Scans	Medi-Cal reimburses providers for mobile CT scan services at the same reimbursement rate as for non-mobile CT scans. No additional reimbursement is made for mileage or out-of-office calls.
Lung Cancer Screening	<p>The National Lung Screening Trial (NLST) recommends a low-dose CT for lung cancer screening under HCPCS code S8032 (low-dose computed tomography for lung cancer screening) for recipients who meet the following criteria:</p> <ul style="list-style-type: none">• Age 55 – 77 years• Asymptomatic (no signs or symptoms of lung cancer)• Tobacco-smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)• Current smoker or one who quit smoking within the last 15 years, and• Receives a written order for low-dose computed tomography (LDCT) lung cancer screening that meets the following criteria:<ul style="list-style-type: none">– For the initial LDCT lung cancer screening service: a recipient must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit, furnished by a physician (as defined in Section 1861(r)(1) of the Social Security Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Social Security Act). A lung cancer screening counseling and shared decision making visit includes the following elements (and is appropriately documented in the recipient’s medical records):<ul style="list-style-type: none">❖ Determination of recipient eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting❖ Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure

- ❖ Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment

- ❖ Counseling on the importance of cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions and
- ❖ If appropriate, furnishing a written order for lung cancer screening with LDCT
- For subsequent LDCT lung cancer screenings: the recipient must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician (as defined in Section 1861(r)(1) of the Social Security Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in Section 1861(aa)(5) of the Social Security Act). If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the criteria described above for a counseling and shared decision making visit.
- Written orders for both initial and subsequent LDCT lung cancer screenings must contain the following information, which must also be appropriately documented in the recipient’s medical records:
 - ❖ Recipient date of birth
 - ❖ Actual pack-year (number) smoking history
 - ❖ Current smoking status and, for former smokers, the number of years since quitting smoking
 - ❖ Statement that the recipient is asymptomatic (no signs or symptoms of lung cancer), and
 - ❖ National Provider Identifier (NPI) of the ordering practitioner

Claims for this code will be reimbursed “By Report.”

**Computed Tomography
Angiography**

Computed tomography angiography (CTA) is a computed tomography technique that provides high-resolution vascular images and detailed images of the adjacent bone and soft tissue. It is non-invasive, with injection of the contrast medium through a peripheral vein. Providers may be reimbursed for the following CPT-4 codes:

<u>CPT-4 Code</u>	<u>Description</u>
70496	CTA, head, with contrast material(s), including non-contrast images, if performed and image postprocessing
70498	CTA, neck, with contrast material(s), including non-contrast images, if performed and image postprocessing
71275	CTA, chest, [noncoronary] with contrast material[s], including non-contrast images, if performed, and image postprocessing
72191	CTA, pelvis, with contrast material(s), including non-contrast images, if performed and image postprocessing
73206	CTA, upper extremity, with contrast material(s), including non-contrast images, if performed and image postprocessing
73706	CTA, lower extremity, with contrast material(s), including non-contrast images, if performed and image postprocessing
74174	CTA, abdomen and pelvis, with contrast material(s), including non-contrast images, if performed, and image postprocessing
74175	CTA, abdomen, with contrast material(s), including non-contrast images, if performed and image postprocessing
75635	CTA, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

**Multiple (Different) Anatomic
Sites/Same Session**

Reimbursement for CTA scans of multiple (different) anatomic sites performed at the same session/time on the same date are as follows:

- Reimbursement for the professional component (modifier 26) is 100 percent for the CTA scan with the highest reimbursement price and 75 percent for all other CTA scans.
- Reimbursement for the technical component (modifier TC) is 100 percent for the CTA scan with the highest reimbursement price and 50 percent for all other CTA scans reflecting the reduction in time for the technical component.

- Providers must document the times of the CTAs performed, the CPT-4 codes and a notation that the CTAs were performed in the “same session.” For example “0800 – CPT-4 code 74174, 0815 – CPT-4 code 70496, same session.” In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided.

Repeat CTA/Same Date

Reimbursement for a subsequent CTA session for the same anatomical area(s) as previously studied, same date of service, same provider is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For second and subsequent sessions performed on same day, enter the CPT-4 code(s) and time of both the initial and repeat CTA scans stating “repeat CTA scan, different session” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, the documentation must be attached to the claim. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT-4 codes and evidence or statement that this is a “repeat CTA/same date” scan will result in the claim being reimbursed according to the “same session” policy.

**Different Anatomic Site/
Different Time/Same Date**

Reimbursement for a subsequent session for a CTA scan of (a) different anatomic site(s) than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) component. For second or subsequent sessions performed on the same day, enter the CPT-4 code(s) and time of the earlier session(s) and the subsequent CTAs stating different sessions in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim. If more than one CTA scan is performed in the second or subsequent session(s), cutbacks to reimbursement will be applied as stated previously. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT-4 codes and evidence or statement that this is a “different anatomic site/different time/same date” scan will result in the claim being reimbursed according to the “same session” policy.

Bilateral Services

Providers must document bilateral services when claiming more than one unit for codes 73206 and 73706.

Do Not Report Codes

Computed Tomographic Angiography codes may not be reimbursed on the same date of service as the following CT codes:

<u>CTA Code</u>	<u>Do Not Report With CT Code:</u>
70496 *	70450, 70460 or 70470 (head) *
70498	70490, 70491 or 70492 (neck)
71275	71250, 71260 or 71270 (chest)
72191	72192, 72193 or 72194 (pelvis)
73206	73200, 73201 or 73202 (upper extremity)
73706	73700, 73701 or 73702 (lower extremity)
74174	72191 – 72194, 73706, 74175 – 74178 or 75635 (abdomen and pelvis) 72192 is allowable with code 72194 with documentation of medical necessity
74175	74150, 74160, 74170, 74176, 74177 or 74178 (abdomen/abdomen and pelvis)
75635	74150, 74160, 74170, 74176, 74177, 74178 or CTA code 74175 (aorta)

* May be reimbursed on the same date for services that are provided during different sessions (different times) with documentation of medical necessity. Radiology reports are required and must be submitted with the claim to substantiate medical necessity.

Magnetic Resonance Imaging (MRI)

Magnetic resonance imaging (MRI) is a method of visualizing and imaging internal structures of the body. It is an important tool in the diagnosis and evaluation of diseases. MRI is based upon the magnetization properties of atomic nuclei and was developed in 1946. Over the years refinements in image acquisition and processing allowed sharper visualization of anatomic detail and broader clinical applications of MRI.

Authorization

An approved *Treatment Authorization Request (TAR)* is required for reimbursement.

General Guidelines

Providers may be reimbursed for the following CPT-4 codes:

<u>CPT-4 Code</u>	<u>Description</u>
70540, 70542, 70543	Orbit, face and/or neck
70551 – 70553	Brain including brainstem
70557 – 70559*	Brain, intraoperative
71550 – 71552	Chest
72141, 72142, 72156	Cervical spine
72146, 72147, 72157	Thoracic spine
72148, 72149, 72158	Lumbar spine
72195 – 72197	Pelvis
73218 – 73220	Upper extremity, other than joint
73221 – 73223	Upper extremity, joint
73718 – 73720	Lower extremity, other than joint
73721 – 73723	Lower extremity, joint
74181 – 74183	Abdomen
77058	Breast, unilateral
77059	Breast, bilateral

* These CPT-4 codes for MRI services will not be subject to the reimbursement reduction of services provided during the same session. (See below for reimbursement policies). These codes may be reimbursed when billed in any combination for services on the same day or when billed for one of these services more than once on the same day. CPT-4 codes 70557 – 70559 are split billable, so one professional component and one technical component may be reimbursable to allow full reimbursement of the code.

Multiple (different) Anatomic Sites/Same Session

Reimbursement for MRIs of multiple (different) anatomic sites performed at the same session/time on the same date are as follows:

- Reimbursement for the professional component (modifier 26) is 100 percent for the MRI with the highest reimbursement price and 75 percent for all other MRIs.
- Reimbursement for the technical component (modifier TC) is 100 percent for the MRI with the highest reimbursement price and 50 percent for all other MRIs reflecting the reduction in time for the technical component.

- Providers must document the times of the MRIs performed, the CPT-4 codes and a notation that they were performed in the “same session.” For example “0800 – CPT-4 code 71550, 0815 – CPT-4 code 74183, same session.” In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided.

Repeat MRI/Same Date

Reimbursement for a subsequent MRI session for the same anatomical area(s) as previously studied, same date of service, same provider is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For second and subsequent sessions performed on same day, enter the CPT-4 code(s) and time of both the initial and repeat MRI scans stating “repeat MRI scan, different session” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, the documentation must be attached to the claim.

In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT-4 codes and evidence or statement that this is a “repeat MRI/same date” scan will result in the claim being reimbursed according to the “same session” policy.

Different Anatomic Site/ Different Time/Same Date

Reimbursement for a subsequent session for an MRI of (a) different anatomic site(s) than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) component. For second or subsequent sessions performed on the same day, enter the CPT-4 code(s) and time of the earlier session(s) and the subsequent MRIs stating “different sessions” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim.

If more than one MRI scan is performed in the second or subsequent session(s), cutbacks to reimbursement will be applied as stated previously. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT-4 codes and evidence or statement that this is a “different anatomic site/different time/same date” scan will result in the claim being reimbursed according to the “same session” policy.

Bilateral Services

Providers must document bilateral services when billing more than one unit for CPT codes 73218 – 73223 and 73718 – 73723.

MRI Methodologies

One MRI per anatomical area is reimbursable for one session for the same recipient and date of service. Combined reimbursement for more than one methodology (with contrast material; without contrast material; without/with contrast material) per recipient and same anatomical area, for the same session and date of service will not exceed the maximum amount of the highest-priced methodology (without/with contrast material).

For example, 72148 (MRI lumbar spine without contrast) + 72149 (MRI lumbar spine with contrast) = 72158 (MRI lumbar spine without contrast, followed by with contrast).

Repeat MRI

Reimbursement for a subsequent MRI session for the same anatomical area as previously studied, same date of service, will be 100 percent for both the technical (modifier TC) and professional (modifier 26) components. For subsequent sessions performed on the same day, enter the times of the initial and the subsequent MRI sessions and the corresponding CPT-4 code(s) and state “different sessions same anatomic site” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim.

Different Anatomic Site Same Date

Reimbursement for a subsequent session for an MRI of a different anatomic site than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For subsequent sessions performed on the same day, enter the CPT-4 code(s) and times of the initial and the subsequent MRI scans and state “different sessions” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim. Failure to provide the documentation of the times and codes and “different sessions” will result in denial of the claim.

Modifiers

The only modifiers to be used for MRI CPT-4 codes are modifier TC (technical component) and 26 (professional component). Use one of the following scenarios when submitting a TAR:

- One TAR and one provider for both the professional (26) and technical (TC) components of service in which the TAR must be submitted with two lines of service. The first line must have the CPT-4 code and one of the two modifiers (26 or TC). The second line must have the same CPT-4 code and the corresponding modifier (26 and TC).

- One TAR and two different providers for the professional (26) and technical (TC) components of service with one of the providers submitting the TAR on behalf of both providers of the two components of service (26 and TC) and both providers should use the same TAR for claim submission. The TAR must be submitted with two lines of service. The first line must have the CPT-4 code and one of the two modifiers (26 or TC). The second line must have the same CPT-4 code and corresponding modifier (26 or TC). This is the preferred method for two different providers.
- Two TARs and two different providers for the professional (26) and technical (TC) components of service with each provider submitting their own TAR with one line of service and the appropriate modifier designating the service (26 or TC) they will provide or have provided.

Claim Completion

Providers use one of the following methods when submitting a claim for MRI services:

- The facility and physician each bill for their service components, respectively, with modifiers 26 or TC. Each facility/provider submits their own claim with one line of service and the appropriate modifier. When billing only for the professional component, use modifier 26. When billing for only the technical component, use modifier TC.
- Physician Billing – The physician bills for both the professional and technical components and later reimburses the facility for the technical component, according to their mutual agreements. The physician submits a *CSM-1500* claim form, completing two separate claim lines. The first line contains the split-billable procedure code and one of the two modifiers (26 or TC). The second line contains the same procedure code and the other of the two modifiers (26 or TC).
- Facility Billing – The facility bills for both the technical and professional components and reimburses the physician for the professional component, according to their mutual agreements. The facility submits a *UB-04* claim form and completes two separate claim lines. The first line contains the split-billable procedure code and one of the two modifiers (26 or TC). The second line contains the same procedure code and the other of the two modifiers (26 or TC).

**Magnetic Resonance
Angiography**

Magnetic Resonance Angiography (MRA) is a non-invasive diagnostic test that is an application of magnetic resonance imaging. By analyzing the amount of energy released from tissues exposed to a strong magnetic field, MRA provides images of normal and diseased blood vessels, as well as visualization and quantification of blood flow through these vessels

Authorization

A *Treatment Authorization Request* (TAR) is required for reimbursement.

General Guidelines

Providers may be reimbursed for the following CPT-4 codes:

<u>CPT-4 Code</u>	<u>Description</u>
70544 – 70546	Head
70547 – 70549	Neck
71555	Chest
72159	Spinal canal
72198	Pelvis
73225	Upper extremity
73725	Lower extremity
74185	Abdomen

Multiple (Different) Anatomic Sites/Same Session

Reimbursement for MRAs of multiple (different) anatomic sites performed at the same session/time on the same date is as follows:

- Reimbursement for the professional component (modifier 26) is 100 percent for the MRA with the highest reimbursement price and 75 percent for all other MRAs.
- Reimbursement for the technical component (modifier TC) is 100 percent for the MRA with the highest reimbursement price and 50 percent for all other MRAs reflecting the reduction in time for the technical component.
- Providers must document the times of the MRAs performed, the CPT codes and a notation that they were performed in the “same session.” For example, “0800 – CPT-4 code 71555, 0815 – CPT-4 code 74185, same session.” In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided.

Repeat MRA/Same Date

Reimbursement for a subsequent MRA session for the same anatomical area(s) as previously studied, same date of service, same provider is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For second and subsequent sessions performed on same day, enter the CPT-4 code(s) and time of both the initial and repeat MRA scans stating “repeat MRA scan, different session” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, the documentation must be attached to the claim.

In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT-4 codes and evidence or statement that this is a “repeat MRA/same date” scan will result in the claim being reimbursed according to the “same session” policy.

Different Anatomic Site/
Different Time/Same Date

Reimbursement for a subsequent session for an MRA scan of (a) different anatomic site(s) than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) component. For second or subsequent sessions performed on the same day, enter the CPT-4 code(s) and time of the earlier session(s) and the subsequent MRAs stating “different sessions” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim.

If more than one MRA scan is performed in the second or subsequent session(s), cutbacks to reimbursement will be applied as stated previously. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT-4 codes and evidence or statement that this is a “different anatomic site/different time/sane date” scan will result in the claim being reimbursed according to the “same session” policy.

Bilateral Services

Providers will need to document bilateral services when billing for more than one unit for CPT-4 codes 73225 and 73725.

MRA Methodologies

One MRA per anatomical area is reimbursable for one session for the same recipient and date of service. Combined reimbursement for more than one methodology (with contrast material; without contrast material; without/with contrast material) per recipient and same anatomical area, for the same session and date of service will not exceed the maximum amount of the highest-priced methodology (without/with contrast material). For example, 70544 (MRA head without contrast) + 70545 (MRA head with contrast) = 70546 (MRA head without contrast, followed by with contrast).

Modifiers

The only modifiers to be used for MRA CPT-4 codes are modifier TC (technical component) and 26 (professional component). Use one of the following scenarios when submitting a TAR:

- One TAR and one provider for both the professional (26) and technical (TC) components of service in which the TAR must be submitted with two lines of service. The first line must have the CPT-4 code and one of the two modifiers (26 or TC). The second line must have the same CPT-4 code and the corresponding modifier (26 and TC)
- One TAR and two different providers for the professional (26) and technical (TC) components of service with one of the providers submitting the TAR on behalf of both providers of the two components of service (26 and TC) and both providers should use the same TAR for claim submission. The TAR must be submitted with two lines of service. The first line must have the CPT-4 code and one of the two modifiers (26 or TC). The second line must have the same CPT-4 code and corresponding modifier (26 or TC). This is the preferred method for two different providers.
- Two TARs and two different providers for the professional (26) and technical (TC) components of service with each provider submitting their own TAR with one line of service and the appropriate modifier designating the service (26 or TC) they will provide or have provided.

Organized Outpatient Clinics

to diagnostic magnetic resonance imaging (MRI), diagnostic magnetic resonance angiography (MRA), and other diagnostic (but not therapeutic) radiological services.

Organized outpatient clinics exempt from licensure pursuant to *Health and Safety Code*, Section 1206, may provide services limited to diagnostic magnetic resonance imaging (MRI), diagnostic magnetic resonance angiography (MRA), and other diagnostic (but not therapeutic) radiological services. Please refer to “Magnetic Resonance Angiography (MRA)” and “Magnetic Resonance Imaging (MRI)” on a previous page in this section, and refer to *Radiology: Nuclear Medicine* in the appropriate Part 2 manual for Positron Emission Tomography (PET) scan services.

**Magnetic Resonance
Cholangiopancreatography
(MRCP)**

Magnetic Resonance Cholangiopancreatography (MRCP) is a Medi-Cal benefit when billed with HCPCS Level II code S8037. MRCP procedures may, in certain situations, provide information similar to endoscopic retrograde cholangiopancreatography (ERCP), but offer some advantages:

- Iodine-based contrast is not used, avoiding allergic and osmolar risks
- Avoids ERCP with its potential attendant medical complications
- Avoids risk of sedation and/or anesthesia
- May be less costly

Authorization is required for MRCP. In addition to a TAR, providers must submit documentation of at least one of the following medical indications:

- The recipient has undergone an unsuccessful ERCP procedure and requires further evaluation.
- The recipient has altered biliary tract anatomy from prior disease or surgery that contraindicates ERCP.
- The recipient requires evaluation of a suspected congenital defect of the pancreaticobiliary tract.
- The recipient has a pancreaticobiliary medical problem suspected to present a low probability for therapeutic intervention with ERCP, but requires diagnostic work-up to direct medical management.
- The recipient has a proximal pancreaticobiliary anatomic defect that cannot be reached by ERCP, due to obstruction.
- The recipient is a young child or compromised adult where ERCP may be unsafe or cannot be performed.
- The recipient is allergic to or has a contraindication to receive iodine-based contrast media for an ERCP.

Providers may bill code S8037 with no modifier (professional and technical component combined) or with modifiers 26 (professional component) and/or TC (technical component).

**Endoscopic Retrograde
Cholangiopancreatography**

For more information on Endoscopic Retrograde Cholangiopancreatography (ERCP), refer to the *Surgery: Digestive System* section of this manual.

Contrast Media

The Radiology section of the CPT-4 code book provides two different codes for billing each radiologic procedure involving injection of contrast media defined as follows:

Complete Procedure

- The complete procedure is performed in full by a single physician and includes all usual pre-injection and post-injection services (for example, necessary local anesthesia, placement of needle or catheter and injection of contrast media).

Supervision and Interpretation Only Procedure

- A supervision and interpretation only procedure is performed by more than one physician (for example, a radiologist-clinician team) and the injection procedure is billed separately using the appropriate code from the Surgery section of the CPT-4 book.

Medi-Cal-Only Billing

However, when billing Medi-Cal for such procedures:

- Use only the CPT-4 procedure codes for “Supervision and Interpretation Only” procedures, even if the procedure is performed by one physician. Claims received for “Complete Procedures” will be denied.
- Continue using split-billing modifiers on claims to denote billings for professional component only (26) and technical component only (TC). When billing for both the professional and technical components, a modifier is neither required nor allowed and the CPT-4 code must be billed without a modifier for proper reimbursement. For Medi-Cal billing purposes, the term “Supervision and Interpretation Only,” as used in the CPT-4 book, does not exclude the technical component of radiological billings.
- To bill for the separate injection procedure, use the appropriate code from the Surgery section of the CPT-4 book.

Medicare/Medi-Cal Crossover Billing

Note: These special instructions do not apply to Medicare/Medi-Cal crossover billings. These claims should be submitted according to current Medicare instructions which permit billings for either “Complete Procedures” or “Supervision and interpretation Only” procedures. Crossover claims for “Complete Procedures” will be accepted by Medi-Cal.

Paramagnetic Contrast Material

Paramagnetic contrast material HCPCS codes A9575 – A9579, A9581, A9583, A9585, Q9953 and Q9954 are separately reimbursable for MRI or MRA procedures. These codes are not split-billable and must not be billed with any modifier.

An invoice is required when billing for codes A9575 – A9579.

HCPCS code A9581 (injection, gadoxetate disodium, 1 ml), one unit = 1 ml; may be billed for a maximum dosage of 14 ml (quantity of 14). Claims billed for greater quantities require documentation that the recipient's weight exceeds 140 kg.

HCPCS code A9583 (injection, gadofosveset trisodium, 1 ml), one unit = 1 ml; may be billed for a maximum dosage of 18 ml (quantity of 18) for recipients age 18 and older. Claims billed for greater quantities require documentation that the recipient's weight exceeds 150kg. This code is not split-billable.

HCPCS code A9585 (injection, gadobutrol, 0.1 ml), one unit = 0.1 ml; may be billed for a maximum dosage of 18 ml (quantity of 180) for recipients age 2 and older. Claims billed for greater quantities require documentation that the recipient's weight exceeds 180 kg. This code is reimbursable "By Report."

Low Osmolar Radiographic Contrast Media Guidelines

The following guidelines are for appropriate use and reimbursement of non-ionic radiographic contrast media services:

- Provision of low osmolar contrast media (HCPCS codes Q9951 and Q9965 – Q9967) is not split-billable and must not be billed with any modifier. The provider who supplies the contrast media should bill for this service. An invoice is required when billing for code Q9951.
- Low osmolar contrast media may be used instead of metrizamide for myelography.

High Osmolar Radiographic Contrast Media

High osmolar contrast material (HCPCS codes Q9958 – Q9964) is not split-billable and must not be billed with any modifier. Only one code in the range is reimbursable, per date of service, any provider, unless medical justification is attached.

**Diagnostic
Radiopharmaceutical Agents**

Reimbursement for the following HCPCS codes is limited to one unit (one study dose): A4642, A9500 – A9504, A9507, A9510, A9520, A9521, A9526, A9536 – A9542, A9546, A9550 – A9554, A9557, A9559 – A9562, A9566, A9567, A9569 – A9572, A9575, A9580, A9582, A9584 and A9599. These codes are not split-billable and must not be billed with any modifier.

When billing for diagnostic radiopharmaceutical agents, services that include the acquisition of both the rest and stress data sets/images are considered one study and the billed amount includes the total dose administered to the recipient for their acquisition. For example if a provider administers the radiopharmaceutical agent for the rest data set/image and then administers the same agent for the stress component, the total dose administered should be billed as one unit.

HCPCS code A9520 (technetium tc-99m, tilmanocept, diagnostic, up to 0.5 millicuries) requires an invoice for reimbursement.

HCPCS code A9552 (fluorodeoxyglucose F-18 FDG, diagnostic, per study dose) will be reimbursed only if a positron emission tomography (PET) scan code is billed on the same date of service.

HCPCS codes C2698 (brachytherapy source, stranded, not otherwise specified, per source) and C2699 (brachytherapy source, nonstranded, not otherwise specified, per source) are non-specific. Providers must attach an invoice for reimbursement.

Chest X-Rays

Medi-Cal policy restricts the use of routine chest X-ray examinations to individuals or selected populations whose history, physical examination or need for diagnosis specifically indicates the necessity for a chest X-ray. An example of a selected population would be newly arrived immigrants from Central America or Southeast Asia.

The yield of unsuspected disease (for example, lung cancer, heart disease and tuberculosis) found by routine chest X-ray examinations of unselected populations, pregnant recipients or recipients admitted to inpatient hospitals has been shown to be of insufficient clinical value to justify the monetary cost, added radiation exposure, and inconvenience to the patient.

**Restrictions on Routine
Chest X-Rays**

Therefore, chest X-rays should not be performed routinely:

- As part of prenatal testing,
- On members of unselected populations, or
- On recipients on admission to hospitals or Long Term Care facilities.

**Restrictions on
Recipients with Tuberculosis**

Repeat chest X-rays should not be performed routinely on recipients with tuberculosis:

- Who are reactors, or
- Who are involved in therapy, or
- Who have completed therapy and are asymptomatic.

There is no legal requirement for acute hospital inpatients to have chest X-rays. However, state licensing requirements mandate evidence of tuberculosis screening on patients in Long Term Care facilities. Annual chest X-rays are recommended only when clinically indicated, as noted on a previous page.

Radiologic Examination

Most conditions do not require more than one radiologic examination per day. Occasionally it is medically necessary to repeat chest X-rays for medical conditions such as, but not limited to, the evaluation of pleural effusions, thoracic trauma, post thoracentesis, post pneumothorax evacuation and post central venous catheter placement.

Under these circumstances, the following applies:

- CPT-4 code 71010 is reimbursable more than once on the same day, for the same recipient and same provider.
- CPT-4 code 71020 is reimbursable more than once on the same day, for the same recipient and same provider.
- The combination of CPT-4 codes 71010 and 71020 is reimbursable on the same day, same recipient and same provider.

When billing for CPT-4 code 71010 or code 71020 with a quantity greater than one, providers should include supporting information or an explanation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. Failure to supply supporting information may result in claim denial or a reduction in payment. Additionally, quantities greater than one must be billed on a single claim line.

Portable Imaging Services

Non-emergency services performed by portable imaging providers require authorization in all Places of Service except Nursing Facility (NF) Level B, NF Level A and subacute care facilities. Regardless of location, if an emergency service is rendered, the claim must be accompanied by a copy of a written order by the attending physician, podiatrist or dentist.

Important: For information about portable imaging billing for recipients in a free-standing pediatric subacute facility, refer to “Free-standing Pediatric Subacute Per Diem Rate” in the *Subacute Care Programs: Pediatric* section of the appropriate Part 2 manual.

Emergency Certification

When attaching an emergency certification to the claim, enter an “81” in the *Condition Codes* field (Boxes 18 – 28) on the *UB-04 Claim* form or an “X” in the *EMG* field (Box 24C) on the *CMS-1500*. A statement documenting the emergency nature of the service must also be entered either in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of a claim or submitted as an attachment.

Reimbursement

Reimbursement for portable imaging transportation includes transportation of the imaging equipment and personnel to the patient’s home or a skilled nursing facility. The following codes are used:

<u>HCPCS Code</u>	<u>Patient Per Trip</u>
R0070	One
R0075	More than one

HCPCS code R0075 must be billed with national modifiers UN (two patients), UP (three patients), UQ (four patients), UR (five patients), or US (six or more patients). Portable imaging service providers may only bill R0070 and R0075 for the same beneficiary a second time on the same date of service if justification is documented in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) section of the claim, or on an attachment. Failure to justify the second visit on the same patient for the same date of service will result in denial of the claim.

Portable Imaging Set-Up

Providers should use HCPCS code Q0092 (set-up portable X-ray equipment) when billing for portable imaging set-up.

Fluoroscopy and Esophagus Studies

When fluoroscopy (CPT-4 procedure code 76000) or esophagus study (CPT-4 code 74220) is performed at the same time as an upper G.I. study (CPT-4 codes 74240, 74241 and 74245) and billed separately, a copy of the X-ray report and a statement of the need for fluoroscopy or esophagus study must accompany the claim. Only the upper G.I. study is paid if these reports are not attached to the claim.

Fluoroscopy:
"By Report" Billing

When billing for fluoroscopy services (CPT-4 code 76001, physician time of more than one hour), providers must include the clock time as part of the "By Report" information in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim (for example, "13:15 to 14:45, totaling 1.5 hours").

Mammography With Xeroradiography

Providers must use CPT-4 codes 77055 for unilateral diagnostic mammography and 77056 for bilateral diagnostic mammography whether or not xeroradiography was used in the examination.

Multiple Views

Providers must use CPT-4 code 77057 for bilateral screening mammography (two view film study of each breast).

Mammographies with multiple views are reimbursable when billed with CPT-4 code 77055 or 77056 and medical justification is documented.

Claims for mammography with multiple views may include one of the appropriate following modifier(s), or no modifier when billing for both the technical and professional components:

<u>HCPCS Modifier</u>	<u>Description</u>
99	Multiple modifiers
22	Unusual services (indicate the number of views in the <i>Remarks</i> field [Box 80]/ <i>Additional Claim Information</i> field [Box 19] of the claim or on an attachment)
TC	Technical only
26	Professional only

Note: When billing split-billable codes, a claim without a modifier indicates both professional and technical components were provided.

Note: Modifier 99 must not be billed in conjunction with modifier 26 and modifier TC. The claim will be denied.

Screening Mammography

Screening mammography must be billed with one of the following codes:

<u>HCPCS Code</u>	<u>Description</u>
G0202	Screening mammography, producing direct digital image, bilateral, all views
<u>CPT-4 Code</u>	<u>Description</u>
77052	Computer aided detection with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography
77057	Screening mammography, bilateral (two view film study of each breast)

Screening mammograms are restricted to females. There are no diagnostic restrictions for screening mammograms. The following age and frequency restrictions apply:

- Younger than 35 years of age do not receive this benefit
- Ages 35 through 39 receive screening to establish a baseline; only one screening is reimbursable for women within this age range
- 40 years of age or older are restricted to one screening per year

Digital screening mammography (code G0202) and film screening mammography (code 77057) will not be reimbursed in the same year by the same provider.

Diagnostic Mammography

Diagnostic mammography must be billed with one of the following codes:

<u>HCPCS Code</u>	<u>Description</u>
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	unilateral, all views

<u>CPT-4 Code</u>	<u>Description</u>
77051	Computer aided detection with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography
77055	Mammography; unilateral
77056	bilateral

Diagnostic mammography is reimbursable if one of the following applies:

- The recipient has distinct signs and symptoms for which a mammogram is indicated or
- The recipient has a history of breast cancer or
- The recipient is asymptomatic, but on the basis of the recipient's history and other significant factors in the physician's judgment, a diagnostic mammogram is indicated and appropriate

ICD-9-CM Code Requirements

Claims billing for diagnostic mammograms must include one of the following ICD-9-CM diagnosis codes. Claims without a diagnosis code will be denied.

174.0 – 174.9	610.0 – 611.99
175.0 – 175.9	793.80 – 793.89
198.81	V10.3 – V10.39
198.89	V16.3 – V16.39
233.0 – 233.09	V76.10 – V76.19
238.3 – 238.39	
239.3 – 239.39	

Modifiers

For information about modifiers required on claims for multiple views, see "Mammography With Xeroradiography" in this section.

**Dual Energy X-Ray
Absorptiometry (DXA)**

The following codes are benefits for recipients with osteoporosis.

Bone Density Studies

<u>CPT-4 Code</u>	<u>Description</u>
77080	Dual Energy X-ray Absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

DXA tests are the only bone mineral density measurement studies reimbursable by Medi-Cal and are limited to one test (code 77080 or 77081) per recipient, per year, any provider. Authorization is not required.

Note: CPT-4 codes 78350 (bone density [bone mineral content] study, one or more sites; single photon absorptiometry) and 78351 (...dual photon absorptiometry, one or more sites) are not reimbursable and claims for these procedures will be denied

DXA Restrictions

DXA studies are not reimbursable when ordered solely for bone density screening. The test should be used only for recipients with at least one of the following medical conditions:

1. Significant risk of developing osteoporosis, including:
 - Primary osteoporosis: Postmenopausal (Type I) vertebral crush fracture syndrome, senile (Type II) fracture of the proximal femur, idiopathic (juvenile and adult)
 - Endocrine osteoporosis: Hyperparathyroidism, Cushing's syndrome or glucocorticoid administration, hyperthyroidism, hypogonadism
 - Nutritional osteoporosis: Vitamin C deficiency; malabsorption: calcium deficiency, protein-calorie malnutrition
 - Hematopoietic osteoporosis: Multiple myeloma, systemic mastocytosis
 - Immobilization
 - Genetic disorders: Osteogenesis Imperfecta, homocystinuria, Ehlers-Danlos syndrome, Marfan's syndrome, Menke's syndrome
 - Miscellaneous: Rheumatoid arthritis, alcoholism, liver disease, diabetes mellitus, prolonged heparin therapy, chronic obstructive pulmonary disease
2. A fracture clinically suspected to be a result of undiagnosed osteoporosis
3. Established osteoporosis that may require pharmacologic treatment of osteoporosis
4. Receiving a medication approved by the FDA for the treatment of osteoporosis

Bone mineral density studies are recommended to confirm the presence of osteoporosis before beginning treatment with pharmacologic regimens. A bone mineral density study may help manage patients who fail to respond or continue to deteriorate on pharmacologic treatment or who need adjustment of medication dosage.

**Angiographic Procedures
by Serialography**

The CPT-4 book contains basic CPT-4 procedure codes for angiographic procedures performed by serialography (CPT-4 codes 75605, 75625 and 75630). These codes are defined as being applicable to the initial projection of each serialographic procedure. Providers are advised to use CPT-4 code 75774 to bill Medi-Cal for each additional serialographic projection or run performed at the time of the initial examination. Do not report code 75774 in conjunction with CPT-4 codes 36221 – 36228.

**Angiography for Arteriovenous
Shunt Imaging**

CPT-4 code 75791 (angiography, arteriovenous shunt [eg, dialysis patient fistula/graft], complete evaluation of dialysis access, including fluoroscopy, image documentation and report [includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava], radiological supervision and interpretation) is split-billed, and must be billed with either modifier 26 or TC. This code is not reimbursable when billed with CPT-4 codes 36147 and 36148.

**Catheter Placement for
Renal Angiography**

CPT-4 codes 36251 – 36254 are billed for catheter placement for renal angiography. CPT-4 code 36253 is not reimbursable in conjunction with 36251 when performed for the same kidney. Providers must document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) or on a claim attachment when performed on a different kidney.

**Placement of Proximal
Extension Prosthesis**

Claims for CPT-4 code 75958 (placement of proximal extension prosthesis, radiological supervision and interpretation) require medical justification when billed for more than three procedures on the same date of service.

**Placement of Distal
Extension Prosthesis**

Reimbursement for CPT-4 code 75959 (placement of distal extension prosthesis, radiological supervision and interpretation) is limited to once per date of service, regardless of the number of modules deployed.