Diagnostic Radiology Services

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16.1 Enrollment
To enroll and be reimbursed for services in the CSHCN Services Program, diagnostic radiology services providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state and federal laws and requirements. Out-of-state radiology providers must meet all of the above conditions and be located in the United States within 50 miles of the Texas state border.

Physicians, physician groups, advanced practice registered nurses (APRNs), hospitals, radiological laboratories, and portable X-ray providers (limited to magnetic resonance angiography [MRA] or magnetic resonance imaging [MRI] procedures only) are eligible to enroll in Texas Medicaid and to receive reimbursement for CSHCN Services Program diagnostic radiology services.

Important: CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 25 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(6) for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 25 TAC §38.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, “Provider Enrollment,” on page 2-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

16.2 Benefits, Limitations, and Authorization Requirements

16.2.1 Diagnostic Radiology Services Provided by Hospitals
When submitting claims for services provided in an inpatient or outpatient hospital setting, radiologists may be reimbursed only for the interpretation. All medically necessary diagnostic radiology services provided to hospital inpatients must be ordered by the client’s attending or consulting physician. Additionally, the medical necessity must be documented in the client’s medical record.

16.2.2 Diagnostic Radiology Services Provided by Physicians, Advanced Practice Registered Nurses (APRNs), Physician Groups, and Clinics
In compliance with Health and Human Services (HHS) regulations, physicians, APRNs, physician groups, and clinics may not submit claims for diagnostic radiology services provided outside of their offices. These services must be submitted directly by the facility or provider that performs the service. This regulation does not affect services performed by the physician or others under his or her personal supervision in the physician’s office.

For services provided by physicians in their offices or clinics, providers may submit total or technical components, as applicable, for procedures that were performed using equipment owned by that physician and located in that physician’s office. The technical component is denied when submitted by a physician in the inpatient or outpatient hospital setting. If the physician is a member of a clinic that owns and operates radiology facilities, the physician may submit these services. However, if the physician practices independently and shares space in a medical complex where radiology facilities are located, the physician may not submit these services even if he or she owns or shares ownership of the facility unless he or she personally supervises and is responsible for the daily operation of the facilities.
If a physician owns equipment and performs studies in his or her office, but has a radiologist come to the office to perform the interpretations, the physician may submit all services connected with the study and may reimburse the radiologist for an interpretation or the physician may submit the technical component and allow the interpreting physician to submit the interpretation separately. A separate charge for radiology interpretation submitted by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician’s overall work-up and treatment of the client. Providers who perform the technical service and interpretation must submit the total component. Providers who perform only the technical service must submit the technical component. Providers who perform only the interpretation must submit the interpretation component. Claims filed in excess of the amount allowed for the total component for the same procedure submitted with the same date of service, for the same client, any provider, are denied.

Claims are considered for reimbursement based on the order in which they are received. For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure submitted with the same dates of service for the same client by any provider, the claim for the total component is denied. The same is true if a total component has already been paid and claims are received for the individual components.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be reimbursed if a radiologist is not submitting the interpretation component of radiology procedures.

If duplicate submissions are found between a radiologist and other specialties, the radiologist’s claim is considered for reimbursement and the other providers’ claims are denied.

16.2.3 Cardiac Blood Pool Imaging
Procedure codes 78472, 78473, 78481, 78483, 78494, and 78496 for cardiac blood pool imaging services are benefits of the CSHCN Services Program.

16.2.4 Computed Tomography (CT) Scan
Scout views and reconstruction are considered part of any CT scan procedure and are not considered for reimbursement in addition to any other CT scan. Procedure code 76380 is denied when submitted with the same date of service as any other CT scan.
Freestanding facilities may submit only the technical component of CT scans. The radiologist or neurologist who then reads the scan may submit only interpretation. In addition, the radiologist or neurologist may submit the interpretation for clients in an inpatient or outpatient setting.

16.2.5 Contrast Material
Radiological procedures that specify with contrast include payment for high osmolar, low osmolar, and paramagnetic contrast material. No additional payment is made for contrast material.
16.2.6 Magnetic Resonance Angiography (MRA)

MRA procedures of the head and neck, chest, abdomen, pelvis, and the lower extremities are benefits for CSHCN Services Program clients. The use of MRA in some areas of the body (spinal canal and upper extremities) is considered investigational and is not a benefit of the CSHCN Services Program. The CSHCN Services Program may reimburse either an MRA or a conventional angiography but not both in the same day without documentation of medical necessity for both tests.

<table>
<thead>
<tr>
<th>Region</th>
<th>Procedure Code(s)</th>
<th>Benefits and Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head or Neck</td>
<td>70544, 70545, 70546, 70547, 70548, and 70549</td>
<td>An MRA of the head or neck is a benefit when indicated and used to visualize or rule out cerebrovascular disease, subarachnoid and intracerebral hemorrhage, and occlusion or stenosis of intracranial vessels.</td>
</tr>
<tr>
<td>Chest</td>
<td>71555</td>
<td>An MRA of the chest is a benefit when performed to evaluate coronary artery disease or anomalous arteriopulmonary systems and to identify thoracic aneurysms or pulmonary embolism in cases when contrast material is contraindicated. MRAs are also benefits for evaluating the coronary vessels in coronary artery disease, vasculitis, or vessel patency postoperatively. An MRA of the chest is a benefit when used to diagnose a pulmonary embolism only when the client has a documented allergy to iodinated contrast material.</td>
</tr>
<tr>
<td>Abdomen</td>
<td>74185</td>
<td>An MRA of the abdomen is a benefit when used to assess the main renal arteries for the evaluation of renal artery stenosis, abdominal aortic aneurysm or dissection, and associated occlusive disease.</td>
</tr>
<tr>
<td>Pelvis</td>
<td>72198</td>
<td>An MRA of the pelvis is a benefit when performed to evaluate pelvic arteries for stenosis and for the detection, grading, and differentiation of renovascular disease.</td>
</tr>
<tr>
<td>Lower Extremities</td>
<td>73725</td>
<td>An MRA of the lower extremities is a benefit when indicated for the evaluation of peripheral vascular disease related to the lower extremities, such as hemangioma, atherosclerosis, arterial embolism and thrombosis, and arterial anomalies. If an MRA and a conventional angiography are performed on the same day, the documentation of medical necessity must indicate that a conventional angiography did not identify a viable run off vessel for bypass, or that MRA results were inconclusive, or other medical necessity documentation.</td>
</tr>
</tbody>
</table>

16.2.7 Magnetic Resonance Imaging (MRI)

MRI is a benefit of the CSHCN Services Program. The CSHCN Services Program considers functional MRI (fMRI) medically necessary when it is being used as a part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, and which might potentially be put at risk during the proposed surgery.

Indications for intracranial neurosurgical procedures using intraoperative MRI (iMRI) include, but are not limited to, the following:

- Oncologic neurosurgical procedures
- Epilepsy
- Chiari surgery
- Deep-brain stimulators
The following procedure codes may be used to bill MRI procedures:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>70336</th>
<th>70540</th>
<th>70542</th>
<th>70543</th>
<th>70551</th>
</tr>
</thead>
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<tr>
<td>70552</td>
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<td>70557</td>
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<tr>
<td>70558</td>
<td>70559</td>
<td>71550</td>
<td>71551</td>
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<td></td>
</tr>
<tr>
<td>72141</td>
<td>72142</td>
<td>72146</td>
<td>72147</td>
<td>72148</td>
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</tr>
<tr>
<td>72149</td>
<td>72156</td>
<td>72157</td>
<td>72158</td>
<td>72195</td>
<td></td>
</tr>
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<td>72196</td>
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<td>73219</td>
<td>73220</td>
<td></td>
</tr>
<tr>
<td>73221</td>
<td>73222</td>
<td>73223</td>
<td>73718</td>
<td>73719</td>
<td></td>
</tr>
<tr>
<td>73720</td>
<td>73721</td>
<td>73722</td>
<td>73723</td>
<td>74181</td>
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<td>74182</td>
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<td>75557</td>
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<tr>
<td>76376</td>
<td>76377</td>
<td>77058</td>
<td>77059</td>
<td>77084</td>
<td></td>
</tr>
</tbody>
</table>

16.2.7.1 MRI Authorization Requirements

Authorization is not required for up to four MRI procedures per year.

Prior authorization will be considered for any additional MRI procedures with documentation of a severe or life-threatening medical condition that:
- Requires close monitoring with MRI to determine appropriate treatment.
- Could progress to death or severe disability without such monitoring or treatment.

Refer to: Section 4.3, “Prior Authorizations,” on page 4-5 for detailed information about prior authorization requirements.

16.2.7.2 MRI Benefits and Limitations

A free-standing MRI facility may bill the technical portion only. The radiologist or neurologist who then reads the MRI may bill the interpretation only. In addition, when the client is in the inpatient or outpatient setting, the radiologist or neurologist may bill the interpretation.

MRI procedures that specify with contrast include payment for paramagnetic contrast; therefore, low osmolar contrast material is not reimbursed separately.

Procedure codes 75559, 75560, 75563, or 75564 must be billed in conjunction with stress testing procedure codes 93015, 93016, 93017, or 93018.

The following procedure codes in Column A will be denied when billed with the same date of service by the same provider as the procedure codes in Column B:

<table>
<thead>
<tr>
<th>Column A (Denied)</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>01922, 76350, and 77021</td>
<td>70557</td>
</tr>
<tr>
<td>01922, 36000, 36005, 36406, 36410, 70557, 76000, 76350, 76942, 77002, 77021, 96360, 96365, 96372, 96374, and 96375</td>
<td>70558</td>
</tr>
<tr>
<td>01922, 36000, 36005, 36406, 36410, 70557, 70558, 76000, 76350, 76942, 77002, 77021, 96360, 96365, 96372, 96374, and 96375</td>
<td>70559</td>
</tr>
<tr>
<td>01922 and 76350</td>
<td>71550 or 74181</td>
</tr>
<tr>
<td>01922, 36000, 36005, 36011, 36406, 36410, 71550, 71551, 76000, 76350, 76942, 77002, 96360, 96365, 96372, 96374, and 96375</td>
<td>71552</td>
</tr>
</tbody>
</table>
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Both professional and radiological services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

16.2.8 Mammography Certification

DSHS issues mammography certification to providers who render mammography services. Providers can submit this certification to the TMHP Provider Enrollment Department in lieu of certification issued by the Food and Drug Administration (FDA) because the FDA recognizes the DSHS certification. TMHP will continue to accept mammography certification issued by the FDA.

Providers are reminded to check the expiration date of their certification and submit an updated mammography certification prior to its expiration date. Mail or fax certifications to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
Fax: 1-512-514-4214

16.2.9 Positron Emission Tomography (PET)

The CSHCN Services Program may cover PET as part of the diagnostic workup for those clients with uncontrolled complex partial seizures to locate and document a seizure focus in preparation for possible anterior temporal lobectomy surgery. PET scans may also be benefits when used to evaluate the extent of melanoma formation. PET services do not require authorization, but all procedures are diagnosis-restricted.

Procedure codes 78608, 78811, 78812, and 78813 may be submitted to obtain reimbursement for PET procedures to identify a seizure focus.

Procedure code 78608 is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>34540</td>
<td>Partial epilepsy with impairment of consciousness, without mention of intractable epilepsy</td>
</tr>
<tr>
<td>34541</td>
<td>Partial epilepsy with intractable epilepsy</td>
</tr>
<tr>
<td>78039</td>
<td>Other convulsions</td>
</tr>
</tbody>
</table>

Procedure codes 78811, 78812, and 78813 must be submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1720</td>
<td>Malignant melanoma of skin of lip</td>
</tr>
<tr>
<td>1721</td>
<td>Malignant melanoma of skin of eyelid, including canthus</td>
</tr>
<tr>
<td>1722</td>
<td>Malignant melanoma of skin of ear and external auditory canal</td>
</tr>
<tr>
<td>1723</td>
<td>Malignant melanoma of skin of other and unspecified parts of face</td>
</tr>
<tr>
<td>1724</td>
<td>Malignant melanoma of skin of scalp and neck</td>
</tr>
<tr>
<td>1725</td>
<td>Malignant melanoma of skin of trunk, except scrotum</td>
</tr>
<tr>
<td>1726</td>
<td>Malignant melanoma of skin of upper limb, including shoulder</td>
</tr>
<tr>
<td>1727</td>
<td>Malignant melanoma of skin of lower limb, including hip</td>
</tr>
<tr>
<td>1728</td>
<td>Malignant melanoma of other specified sites of skin</td>
</tr>
<tr>
<td>1729</td>
<td>Melanoma of skin, site unspecified</td>
</tr>
</tbody>
</table>
16.2.10 X-rays and Ultrasounds

Prior authorization is not required for X-rays and ultrasounds.

The CSHCN Services Program reimburses X-rays and ultrasounds when they are billed directly by the facility/provider that performs the service. Physicians, group practices, and clinics may not bill diagnostic radiology services provided outside their offices.

Abdominal flat plates (AFP) or kidneys, ureters, and bladder (KUB) procedures (procedure codes 74000, 74010, and 74020) are frequently taken as preliminary X-rays before other, more complicated procedures. If a physician submits an AFP or KUB separately and a more complicated procedure submitted with the same date of service, the charges are combined and the more complex procedures are considered for reimbursement. If, however, the claim specifically states that the AFP or KUB was done first and the results required further radiographic procedures, each procedure is considered for reimbursement separately.

Oral preparations for X-rays are included in the charge for the X-ray procedure. Separate charges for oral preparations are denied as part of another procedure submitted with the same date of service.

Separate charges for injectable radioactive materials used in the performance of specialized X-ray procedures are considered for payment.

Claims submitted for reimbursement of X-ray services must indicate the number of views and type. When unusual or extenuating circumstances occur, the claim may also include a brief medical report.

16.2.11 Noncovered Services

Intraoperative ultrasonic guidance is considered a part of a surgical procedure and is not a benefit of the CSHCN Services Program. Portable X-ray services are not benefits of the CSHCN Services Program.

16.3 Claims Information

Claims for diagnostic radiology services must include the referring provider. Radiologists are required to identify the referring provider by full name and address or CSHCN Services Program provider identifier in Block 17 of the CMS-1500 paper claim form. Baseline screening and comparison studies are not benefits.

Diagnostic radiology services must be submitted to TMHP in an approved electronic format on the CMS-1500 paper claim form or the UB-04 CMS-1450 paper claim form. Providers may purchase CMS-1500 paper claim forms and UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply the forms.
When completing a CMS-1500 paper claim form or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Chapter 37, “TMHP Electronic Data Interchange (EDI),” on page 37-1 for information about electronic claims submissions.


Chapter 5, “CMS-1500 Paper Claim Form Instructions,” on page 5-22 and “Instructions for Completing the UB-04 CMS-1450 Paper Claim Form,” on page 5-27 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

If the client is admitted as an inpatient within 24 hours of treatment in the emergency room or clinic, the emergency room or clinic charges must be billed on the UB-04 CMS-1450 paper claim form as an ancillary charge. Hospitals are not required to submit itemized charge tickets with their UB-04 CMS-1450 paper claim forms for inpatient stays, but a description including the location and the number of views must be provided or the applicable HCPCS code may be provided.

Professional services provided by a physician must be billed separately by the physician. The NPI of the ordering physician must be in Block 78-79. The itemized charges must be retained by the facility for at least 5 years from the date of service.

16.4 Reimbursement

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. APRNs may be reimbursed the lower of the billed amount or 85 percent of the Texas Medicaid amount allowed to physicians for the same service.

When submitting claims for services provided in an inpatient or outpatient hospital setting, radiologists may be reimbursed only for the interpretation. Hospital inpatient and outpatient services—including radiology therapy services—may be reimbursed at 80 percent of the rate authorized by Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which is equivalent to the hospital’s Medicaid interim rate. Reimbursement of the separate technical and interpretation components cannot exceed reimbursement for the total component.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

16.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.