22

22 Independent Radiology

Global: Replaced HP with HPE

The policy provisions for radiology providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 34.

22.1 Enrollment

HPE enrolls Independent Radiology providers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an independent radiology provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for radiology-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Independent Radiology providers are assigned a provider type of 29 (Independent Radiology). Valid specialties for Independent Radiology providers include the following:

- 292 Mammography
- 327 Nuclear Medicine
- 570 Physiological Lab (Independent Diagnostic Testing Facility)
- 291 Portable X Ray Equipment
- 290 Radiology
- 021 Cardiac Electrophysiology
- 996 Nuclear Medicine in an Independent Radiology
- 341 Radiologist
- 995 Radiology Clinic (CRS)
- 312 Cardiologist
- 326 Neurologist

Enrollment Policy for Independent Radiology Providers

To participate in Medicaid, Independent Radiology providers must meet the following requirements:

- Possess certification as a Medicare provider
- Possess a Physician's Supervisory Certification and utilize certified technicians for ultrasounds, Doppler services, and non-invasive peripheral vascular studies if a physiological labs
- Exist independently of any hospital, clinic, or physician's office
- Possess licensure in the state where located, when it is required by that state
- For mammography services, possess a certification issued by the FDA.

22.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care

Radiology services are professional and technical radiological services, ordered and provided under the direction of a physician or other licensed practitioner of the healing arts. Within the scope of his practice as defined by state law and are provided in an office or similar facility other than an outpatient department of a hospital or clinic and meets the requirements for participation in Medicare. Radiology services are restricted to those that are described by procedures in the CPT manual. Providers will be paid only for covered services, which they actually perform.

An Independent Radiology provider may perform diagnostic mammography, a radiological procedure furnished to a man or woman with signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease. A diagnostic mammogram includes a physician’s interpretation of the results of the procedure. Services are unlimited, but should be billed with procedure codes 77055 and 77056.

An Independent Radiology provider may perform screening mammography, a radiological procedure furnished to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer. A screening mammogram includes a physician’s interpretation of the results of the procedure. Services are limited to one screening mammogram every 12 months for women ages 50 through 64. This screening should be billed under procedure codes 77052 and 77057.

Beginning on January 1, 2015, the complete examination is reported with code 76641 Ultrasound, breast, unilateral, real time with image documentation. Code 76641 represents a complete ultrasound examination of the breast. Code 76641 consists of an ultrasound examination of all four quadrants of the breast and the retroareolar region. It also includes ultrasound examination of the axilla, if performed. The limited code, 76642, is for a focused exam of the breast that is limited to one or more of the elements included in 76641. (e.g., a focused examination limited to one or more elements of 76641, but not all four). You may report either 76641 or 76442 once, per breast, per session. Both codes are unilateral: If medical necessity requires bilateral imaging, you may append modifier 50 Bilateral procedure.

Code	Description
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
76642	Ultrasound, breast unilateral, real time with image documentation, including axilla when performed; limited

Additionally, three new codes have been created for digital breast tomosynthesis (DBT) to address both screening and diagnostic studies. The screening DBT code +77063 is an add-on code that will be reported together with the screening mammogram code 77057.

Code	Description
77061	Digital breast tomosynthesis; unilateral
77062	Digital breast tomosynthesis; bilateral
+77063	Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)

As with all ultrasound examinations, there must be a thorough evaluation of the anatomic area, image documentation, and a final written report to ensure that it is separately reportable. Whenever a screening examination is performed, the screening diagnosis code is the first-listed, regardless of the findings or any procedure that may be performed as a result of the findings. An ultrasound screening examination of the breast should be reported with:

- ICD-9 code V76.19 (Special screening for malignant neoplasm, other screening breast examination)
- ICD-10 code Z12.39 (Encounter for other screening for malignant neoplasm of breast)

An Independent Radiology provider may bill for obstetrical ultrasounds. Medicaid covers two obstetrical ultrasounds per year for recipients under fee-for-service. Ultrasound payment is limited to one per day. Medicaid may approve additional ultrasounds if a patient's documented medical condition meets the established criteria. Requests for additional obstetrical ultrasounds must include the required patient information as well as the following:

- Date of requested ultrasound
- Date of request
- A list of all dates of prior ultrasounds for the current pregnancy
- A diagnosis code for each ultrasound that has been done, starting with number one
- Recipient date of birth and Medicaid number
- HPE-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

For patients covered under the Maternity Care Program, refer to chapter 24.

Nerve Conduction Studies and Electromyography

Nerve Conduction Studies (NCS) measure action potentials recorded over the nerve or from an innervated muscle. Nerve Conduction Velocity (NCV), one aspect of NCS, is measured between two sites of stimulation or between a stimulus and a recording site. It is axiomatic that neurodiagnostic studies are an extension of the history and physical examination of the patient and must be performed as part of a face-to-face encounter. Obtaining and interpreting nerve conduction velocities requires extensive interaction between the performing physician and patient and is most effective when both obtaining raw data and interpretation are performed together on a real-time basis.

Results of NCV reflect on the integrity and function of: 1) the myelin sheath (Schwann cell-derived insulation covering an axon); and, 2) the axon (an extension of the neuronal cell body) of a nerve. Axonal damage or dysfunction generally results in loss of nerve or muscle potential amplitude, whereas demyelination leads to prolongation of conduction time.

The following are examples of appropriate clinical settings where nerve conduction studies are helpful in diagnosing:

- Focal neuropathies or compressive lesions such as carpal tunnel syndrome, ulnar neuropathies or root lesions for localization.
- Traumatic nerve lesions for diagnosis and prognosis.
- Diagnosis or confirmation of suspected generalized neuropathies, such as diabetic, uremic, metabolic, inflammatory or immune.
- Repetitive nerve stimulation in diagnosis of neuromuscular junction disorders such as myasthenia gravis and myasthenic syndromes.

F-wave studies are often performed in conjunction with motor NCS; H-reflex studies involve both sensory and motor nerves and their connections with the spinal cord. The device used must be capable of recording amplitude, duration, response configuration (motor NCV) and latency and sensory nerve action potential amplitudes (sensory NCV).

Electromyography (EMG) is the study of intrinsic electrical properties of skeletal muscle utilizing insertion of a (frequently disposable) needle electrode into muscles of interest. EMG testing relies on both auditory and visual feedback from the electromyographer. EMG results reflect not only the integrity of the functioning connection between a nerve and its innervated muscle, but on the integrity of the muscle itself. The device used must be capable of recording motor unit recruitment, amplitude, configuration, spontaneous and insertional activity. Use for intraoperative monitoring of central nervous system tissue during the resection of benign and malignant neoplasia and during corrective surgery for scoliosis may also be needed.

The axon innervating a muscle is primarily responsible for the muscles' volitional contraction, survival and trophic functions. Prime examples of diseases characterized by abnormal EMG are disc disease with abnormal nerve compression, amyotrophic lateral sclerosis and neuropathies. Axonal and muscle involvement are most sensitively detected by EMGs, and myelin and axonal involvement are best detected by NCV.

Use of EMG with Botulinum Toxin Injection

EMG may be used to optimize the anatomic location of botulinum toxin injection. It is expected there will be one study performed per anatomic location of injection, if needed. It is expected that the accompanying study to the injection be billed as a limited study (95874) unless supportive documentation is noted to show why more extensive studies are indicated.

Limitations

- Sensory nerve function testing performed with various sensory discrimination and pressure-sensitive devices, including but not limited to current perception testing (e.g., Neurometer®), is not covered. Do not report such testing as nerve conduction testing using any CPT code included in this Policy.
- Nerve conduction studies and EMG will not be covered if provided in the beneficiary's home.

Providers shall consider a service to be reasonable and necessary if the provider determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, which meet the requirements of the clinical trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
    - Furnished in a setting appropriate to the patient's medical needs and condition.
    - Ordered and furnished by qualified personnel.
    - The EMG must always be ordered, performed and interpreted by a physician trained in electrodiagnostic medicine.
    - The NCS may be performed by a physician or a trained allied health professional working under the direct supervision of a physician trained in electrodiagnostic medicine. The American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) states, "NCSs should be either (a) performed directly by physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed". One that meets, but does not exceed, the patient's medical need.
    - At least as beneficial as an existing and available medically appropriate alternative.

Documentation Requirements

Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and made available to Medicaid upon request.

It is expected that the (Nerve Conduction Velocity) NCV and EMG reports will contain data from the study as well as the interpretation and diagnosis.

- In the event of a review for medical necessity, the patient's medical record must support the need for the studies performed. The number of limbs or areas tested should be the minimum needed to evaluate the patient's condition. Repeat testing should be infrequent; limitation of testing services will be determined on the basis of individual medical necessity.
- Documentation addressing the need to evaluate the patient for peripheral neuropathy must be maintained by the practitioner and available upon request.
- Documentation addressing the indications and circumstances requiring individual nerve conduction studies (without accompanying EMG) must be maintained by the practitioner, and made available upon request.
- Credentials of providers billing for needle electromyography must be made available on request. According to the AANEM American Association of Neuromuscular & Electrodiagnostic Medicine, the EMG must be performed and interpreted by a physician who received training during residency and/or in special EDX fellowships after residency. Knowledge of EDX medicine is necessary to pass the board exams given by the American Board of Physical Medicine and Rehabilitation and the American Board of Psychiatry and Neurology.
- The NCS may be performed by a physician or by a trained allied health professional under direct supervision of a physician trained in electrodiagnostic medicine; although always interpreted by a credentialed physician.
- The record must reflect the need for EMG to localize the optimal injection site for the botulinum toxin.

Medicaid would not expect to see multiple uses of EMG in the same patient at the same location for the purpose of optimizing botulinum toxin injections.

Medicaid does not expect to see nerve conduction testing accomplished with discriminatory devices that use fixed anatomic templates and computer-generated reports used as an adjunct to physical examination routinely on all patients.

NOTE:
Medicaid requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record.

22.3 Prior Authorization and Referral Radiology Services

For all MRI's, MRA's, CT scans, CTA's, and PET scans performed on or after March 2, 2009, providers will be required to request prior authorization from eviCore (Formerly MedSolution). Scans performed as an inpatient hospital service, as an emergency room service, or for Medicaid recipients who are also covered by Medicare are exempt from the PA requirement.

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Added: MedSolution

The PA requirements will apply to Medicaid recipients for the State of Alabama:

- Those certified as children through the Sixth Omnibus Budget Reconciliation Act (SOBRA) Program.
- Those certified through the Parent and Other Caretaker Relatives formerly called Medicaid for Low Income Families Program (MLIF)
- Refugees
- Those certified for Supplemental Security Income (SSI)

Services provided to recipients certified as follows do not require prior authorization:

- Dual Eligibility (Medicare/Medicaid)
- Plan First
- SOBRA Adults
- Individuals granted emergency Medicaid due to their illegal alien status

Prior authorization (PA) requests for outpatient diagnostic imaging procedures may be made to eviCore (formerly MedSolutions) by:

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Added: MedSolution

- Phone at (888) 693-3211
- Fax at (888) 693-3210
- Website at www.MedSolutionsOnline.com

(Normal business hours for phone or fax are 7:00 a.m. to 8:00 p.m. C.T.)

Only the referring/ordering provider or performing provider (facility) may request prior authorization from eviCore (formerly MedSolutions). Request by third party companies are not allowed. Providers must obtain the PA before performing the service. The requesting and performing providers will receive notification of the status for the requested PA. In some instances there may be a need for additional information. The provider will have fifteen (15) calendar days of the original request for prior authorization to provide this information. The reception of no information will cause the PA request to deny.

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Added: MedSolution

In the event of an urgent situation (when the prior authorization cannot be obtained before the test is performed), a PA may be requested within 14 days from the date of service. In this circumstance, meeting the "urgent" criteria is required for consideration. PA request with approval receives a valid authorization number. The authorization number will be valid for sixty days from the approval date, not the date of the request.

Added: PA request with…of the request.

Form 471 (Prior Authorization (PA) Change Request) is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers. This form may be found in Appendix E. **This form is not to be used for reconsiderations of denied PAs or for procedure code changes**. If changing a procedure code, void the approved PA and submit a new PA request.

NOTE:

It is the responsibility of all providers to verify the PA has been approved before performing the service.

In the event of recipient retro eligibility, submit a PA request, the recipient's procedure summary, and an error free red drop ink claim to:

Alabama Medicaid
Attn: Medical Services Division
501 Dexter Avenue
Montgomery, Alabama 36103

Prior Authorization is required for the following radiology codes:

PET SCANS
78459 Myocardial -metabolic
78491 Myocardial-single-rest/stress
78492 Myocardial, perfusion-multi
78608 Brain-metabolic
78609 Brain, perfusion
78811 Limited area
78812 Skull base to mid-thigh
78813 Whole body
78814 w/CT; limited area
78815 w/CT skull base to mid-thigh
78816 w/CT full body
CTA
70496 Head
70498 Neck
71275 Chest (non-coronary)
73206 Upper extremity
73706 Lower extremity
75635 CT Angio Abdominal Arteries
CT
70450 Head/brain w/o contrast
70460 Head/brain w/ contrast
70470 Head/brain w/o & w/contrast
70480 Orbit w/o contrast
70481 Orbit w/ contrast
70482 Orbit w/o & w/contrast
70486 Maxllfcl w/o contrast
70487 Maxllfcl w/ contrast
70488 Maxllfcl w/o & w/contrast
70490 Soft tissue neck w/o contrast

70491 Soft tissue neck w/o, w/contrast
70492 Soft tissue neck w/o & w/contrast
71250 Thorax w/o contrast
71260 Thorax w/contrast
71270 Thorax w/o & w/contrast
72125 C-spine w/o contrast
72126 C-spine w/contrast
72127 C-spine w/o & w/contrast
72128 T-spine w/o contrast
72129 T- spine w/contrast
72130 T-spine w/ & w/o contrast
72131 L-spine w/o contrast
72132 L-spine w/contrast
72133 L-spine w/o & w/ contrast
72192 Pelvis w/o contrast
72191 CT Angiograph Pelv W/O&W/Dye
72193 Pelvis w/contrast
72194 Pelvis w/o & w/ contrast
73200 UE- w/o contrast
73201 UE- w/contrast
73202 UE w/o & with contrast
73700 LE w/o contrast
73701 LE w/ contrast
73702 LE w/o & w/contrast
74150 Abdomen w/o contrast
74160 Abdomen w/contrast
74170 Abdome w/o & w/contrast
74174 CT Angio Abd & Pelv W/O&W/Dye
74176 Abdomen & Pelvis w/o contrast
74177 Abdomen & Pelvis with contrast
74178 Abdomen & Pelvis; w/o & w/contrast
75571 Heart w/o contrast. Added: Code 75571-is age restricted 0-18 years; on their 19th birthday they become ineligible.
75572 Heart with contrast. Added: Code 75572 is age restricted 0-18 years; on their 19th birthday they become ineligible
75573 Heart with contrast, in the setting of CHD. Added: Code 75573 is age restricted 0-18 years; on their 19th birthday they become ineligible
75574 Heart CT Angiography. Added: Code 75574 is age restricted 0-18 years; on their 19th birthday they become ineligible
76380 Limited or localized f/u study
76497 Unlisted Computed Tomography procedure
77078 CT Bone Density Axial

MRA
77080 DXA BONE DENSITY AXIAL
77081 DXA BONE DENSITY/PERIPHERAL
77085 DXA BONE DENSITY STUDY
77086 FRACTURE ASSESSMENT VIA DXA
70544 Head w/o contrast
70545 Head w/contrast
70546 Head w/ & w/o contrast
70547 Neck w/o contrast
70548 Neck w/contrast
70549 Neck w/o & w/contrast
71555 Chest w/ or w/o contrast
72198 Pelvis w/ or w/o contrast
73225 UE w/ or w/o contrast
73725 LE w/ or w/o contrast
74174 CTA, Abdomen and pelvis with contrast
74185 Abdomen w/ or w/o contrast
MRI
70336 TMJ
70540 Face, orbit, &/or neck w/o contrast
70542 Face orbit &/or neck w & w/o cont.
70543 Face, orbit, &/or neck w & w/o cont.
70551 Brain w/o contrast
70552 Brain w/ contrast
70553 Brain w/& w/o contrast
71550 Chest w/o contrast
71551 Chest w/ contrast
71552 Chest w & w/o contrast
72141 C-spine w/o contrast
72142 C-spine w/contrast
72146 T-spine w/o contrast
72147 T-spine w/contrast
72148 L-spine w/o contrast
72149 L spine w/contrast
72156 c-spine w/ & w/o contrast
72157 T-spine w/ & w/o contrast
72158 L-spine w/ & w/o contrast
72195 Pelvis w/o contrast
72196 Pelvis w/ contrast
72197 Pelvis w/&w/o contrast

73218 UE w/o contrast
73219 UE w/contrast
73220 UE w/& w/o contrast
73221 UE joint w/o contrast
73222 UE joint w/contrast
73223 UE joint w/& w/o contrast
73718 LE w/o contrast
73719 LE w/ contrast
73720 LE w/ & w/o contrast
73721 LE joint w/o contrast
73722 LE joint w/ contrast
73723 LE joint w & w/o contrast
74181 Abdomen w/o contrast
74182 Abdomen w/contrast
74183 Abdomen w & w/o contrast
75557 Cardiac w/o contrast
75559 Cardiac w/o contrast, w/stress imag
75561 Cardiac w & w/o contrast
75563 Cardiac w & w/o contrast, w stress imag
76498 Unlisted magnetic resonance procedure
77058 Breast w/ & or w/o contrast, unilat
77059 Breast w/& or w/o contrast, bilat
77084 Bone marrow blood supply

22.4 Prior Authorization and Referral Requirements Cardiology Services

For all Nuclear Cardiology, Diagnostic Heart Catherization, Stress Test (ECHO), Transesophageal Echo, and Transthoracic Echo procedures performed on or after October 1, 2014, providers will be required to request prior authorization from eviCore (formerly MedSolutions). Scans performed as an inpatient hospital service or as an emergency room service are exempt from the PA requirement.

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Added: MedSolution

PA requirements will apply to Medicaid recipients for the State of Alabama:

- Those certified as children through the SOBRA (Sixth Omnibus Budget Reconciliation Act) Program.
- Those certified through the Parent and Other Caretaker Relatives formerly called MLIF (Medicaid for Low Income Families Program)
- Refugees
- Those certified for SSI (Supplemental Security Income

Services provided to recipients certified as follows do not require prior authorization:

- Dual Eligibility (Medicare/Medicaid)

- Plan First
- SOBRA Adults
- Individuals granted emergency Medicaid due to their illegal alien status

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Added: may be requested

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Added: NOTE

Prior authorization requests for outpatient diagnostic imaging procedures may be made to eviCore (formerly MedSolutions) by:

- phone at (855) 774-1318 Monday – Friday during normal business hours 7:00 a.m. to 6:00 p.m. CST.
- website at www.carecorenational.com.

Requests by third party companies are not allowed. Only the referring/ ordering provider and performing provider (facility) may request prior authorization from eviCore (formerly MedSolutions). Prior authorization must be obtained prior to the test being performed. In the event of an urgent situation (when the prior authorization cannot be obtained before the test is performed), a PA may be requested. The case must then meet the "urgent" criteria/ guidelines as provided on eviCore (formerly MedSolutions) National's website before the prior authorization will be approved. In the event additional information is requested the provider must submit the additional information within 15 calendar days of the receipt of the original request for prior authorization. If the information is not submitted within the time period, the request will be denied. PA request with approval receives a valid authorization number. The authorization number will be valid for sixty days from the approval date, not the date of the request.

NOTE:

It is the responsibility of all providers to verify the PA has been approved before performing the service. In the event of recipient retro eligibility, submit a PA request, the recipient's procedure summary, and red drop ink claim form to:
Alabama Medicaid
Attn: Medical Services Division
501 Dexter Avenue
Montgomery, Alabama 36103-5624

Prior Authorization is required for the following cardiology codes:

HEART CATHERIZATION
93451 RIGHT HEART CATHETERIZATION INCLUDING MEASUREMENT(S) OF OXYGEN SATURATION AND CARDIAC OUTPUT, WHEN PERFORMED.
93452 LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED
93453 COMBINED RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED
93454 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION;
93455 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) INCLUDING INTRAPROCEDURAL

INJECTION(S) FOR BYPASS GRAFTANGIOGRAPHY
93456 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT HEART CATHETERIZATION
93457 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) INCLUDING INTRAPROCEDURAL INJECTION(S) FOR BYPASS GRAFT ANGIOGRAPHY AND RIGHT HEART CATHETERIZATION
93458 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S)
93459 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED, CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) WITH BYPASS GRAFT ANGIOGRAPHY
93460 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED
93461 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED, CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) WITH BYPASS GRAFT ANGIOGRAPHY
93532 INSERTION OF CATHETER INTO RIGHT AND LEFT HEART CHAMBERS FOR EVALUATION OF CONGENITAL ABNORMALITIES
93533 INSERTION OF CATHETER INTO RIGHT AND LEFT HEART CHAMBERS FOR EVALUATION OF CONGENITAL ABNORMALITIES
NUCLEAR CARDIOLOGY
78472 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM; PLANAR, SINGLE STUDY AT REST OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT ADDITIONAL QUANTITATIVE PROCESSING
78473 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM; MULTIPLE STUDIES, WALL MOTION STUDY PLUS EJECTION FRACTION, AT REST AND STRESS (EXERCISE AND/OR PHARMACOLOGIC), WITH OR WITHOUT ADDITIONAL QUANTIFICATION
78481 CARDIAC BLOOD POOL IMAGING (PLANAR), FIRST PASS TECHNIQUE;

SINGLE STUDY, AT REST OR WITH STRESS (EXERCISE AND/OR PHARMACOLOGIC), WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT QUANTIFICATION
78483 CARDIAC BLOOD POOL IMAGING (PLANAR), FIRST PASS TECHNIQUE; MULTIPLE STUDIES, AT REST AND WITH STRESS (EXERCISE AND/OR PHARMACOLOGIC), WALL MOTION STUDY PLUS EJECTION RACTION, WITH OR WITHOUT QUANTIFICATION
78494 CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM, SPECT, AT REST, WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT QUANTITATIVE PROCESSING
78468 MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; WITH EJECTION FRACTION BY FIRST PASS TECHNIQUE
78469 MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; TOMOGRAPHIC SPECT WITH OR WITHOUT QUANTIFICATION
78451 MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)
78452 MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION
78453 MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)
78454 MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION
78466 NUCLEAR MEDICINE STUDY OF HEART MUSCLE FOLLOWING HEART ATTACK
78499 NUCLEAR MEDICINE STUDY OF CARDIOVASCULAR SYSTEMS
STRESS ECHO
93350 ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, DURING REST AND CARDIOVASCULAR STRESS TEST USING TREADMILL, BICYCLE EXERCISE AND/OR PHARMACOLOGICALLY INDUCED STRESS, WITH INTERPRETATION AND REPORT;
93351 ULTRASOUND EXAMINATION AND CONTINUOUS MONITORING OF THE HEART PERFORMED DURING REST, EXERCISE, AND/OR DRUG-INDUCED STRESS WITH INTERPRETATION AND REPORT 93352 INJECTION OF X-RAY CONTRAST MATERIAL FOR ULTRASOUND EXAMINATION OF THE HEART
TRANSESOPHAGEAL ECHO
93312 ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL-TIME WITH IMAGE

DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT
93313 ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL-TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); PLACEMENT OF TRANSESOPHAGEAL PROBE ONLY
93314 ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL-TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); IMAGE ACQUISITION, INTERPRETATION AND REPORT ONLY
93315 TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT
93316 TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; PLACEMENT OF TRANSESOPHAGEAL PROBE ONLY
93317 TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; IMAGE ACQUISITION, INTERPRETATION AND REPORT ONLY
93318 ECHOCARDIOGRAPHY, TRANSESOPHAGEAL (TEE) FOR MONITORING PURPOSES, INCLUDING PROBE PLACEMENT, REAL TIME 2-DIMENSIONAL IMAGE ACQUISITION AND INTERPRETATION LEADING TO ONGOING (CONTINUOUS) ASSESSMENT OF (DYNAMICALLY CHANGING) CARDIAC PUMPING FUNCTION AND TO THERAPEUTIC MEASURES ON AN IMMEDIATE TIME BASIS
TRANSTHORACIC ECHO
93303 TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; COMPLETE
93304 TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; FOLLOW-UP OR LIMITED STUDY
93306 ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITH SPECTRAL DOPPLER ECHOCARDIOGRAPHY, AND WITH COLOR FLOW DOPPLER ECHOCARDIOGRAPHY
93307 ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITHOUT SPECTRAL OR COLOR DOPPLER ECHOCARDIOGRAPHY
93308 ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, FOLLOW-UP OR LIMITED STUDY NJECTION, PERFLUTREN LIPID MICROSPHERES, PERML
93451 RIGHT HEART CATHETERIZATION INCLUDING MEASUREMENT(S) OF OXYGEN SATURATION AND CARDIAC OUTPUT, WHEN PERFORMED.
93452 LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED
93453 COMBINED RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED
93454 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION;

93455 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) INCLUDING INTRAPROCEDURAL INJECTION(S) FOR BYPASS GRAFTANGIOGRAPHY
93456 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT HEART CATHETERIZATION
93457 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL, VENOUS GRAFTS) INCLUDING INTRAPROCEDURAL INJECTION(S) FOR BYPASS GRAFT ANGIOGRAPHY AND RIGHT HEART CATHETERIZATION
93458 CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S)

22.5 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Independent Radiology providers.

22.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Radiology providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a paper claim, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form 340. All paper claims must be a one page red drop ink form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

22.6.1 Time Limit for Filing Claims

Medicaid requires all claims for Independent Radiology providers to be filed within one year of the date of service. Refer to Chapter 5, Filing Claims, for more information regarding timely filing limits and exceptions.

22.6.2 Diagnosis Codes

For dates of service 01/01/99 and after valid diagnosis codes are required. The International Classification of Diseases - 10th Revision - Clinical Modification (ICD-10-CM) manual lists Medicaid required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

For dates of service prior to 01/01/99, Independent Radiology providers are not required to provide valid diagnosis codes. Providers must bill diagnosis code V729 for ICD-9 or Z01.89 for ICD-10 on hard copy and electronically submitted claims.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

22.6.3 Procedure Codes and Modifiers

Radiology providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, P. O. Box 930876 Atlanta, GA 31193-0873 or 1-800-621-8335.

Radiology Facilities are limited to billing CPT radiology procedure codes. The range of codes is 70010 through 79999. Physiological labs are restricted to the codes listed in their contract with Medicaid.

The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Professional and Technical Components

Some procedure codes in the 70000 and 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers.

- **Professional component**, the provider does not own the equipment. The provider operates the equipment and/or reviews the results, and provides a written report of the findings. The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations:

Deleted: ~~- 21 (inpatient)… - 65 (end stage renal disease facility)~~

- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code.

22.6.4 Place of Service Codes

Radiology service claims may be filed using, but not limited to, the following place of service:

POS Code	*Description*
11	Clinic

22.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, submit a hard copy error free red drop ink form.

Refer to Chapter 5, for more information on required attachments.

22.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Medicaid Forms	Appendix E