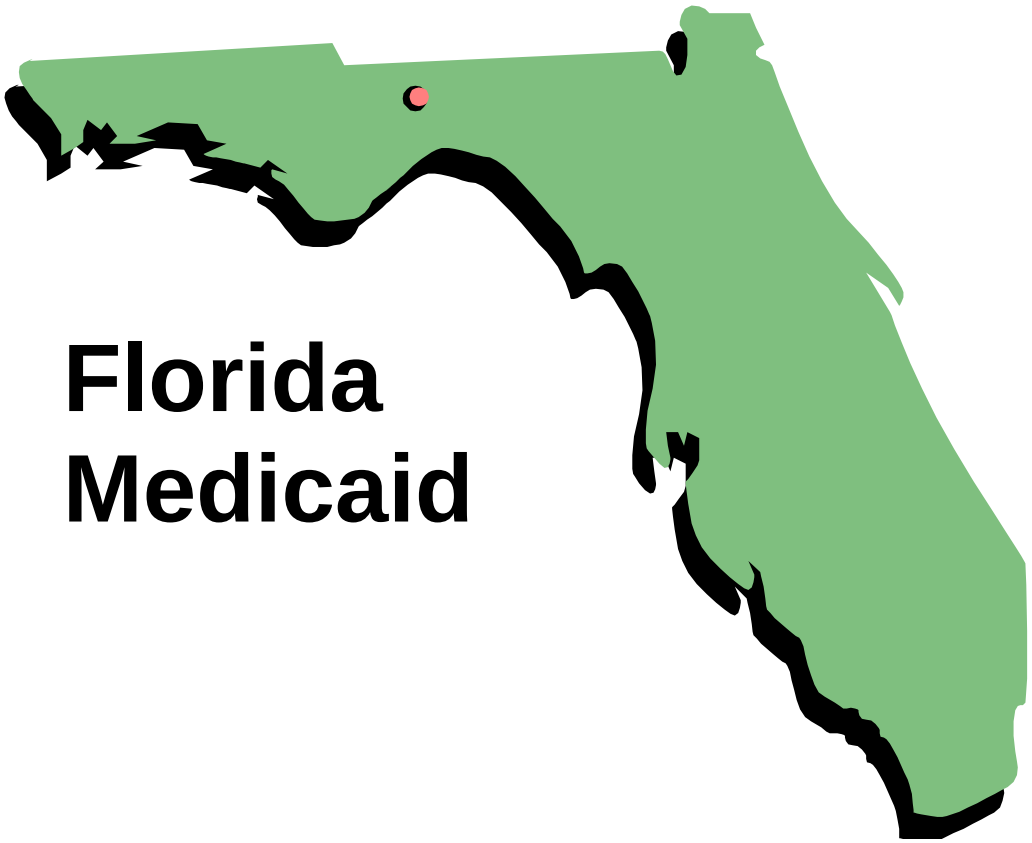

# Florida Medicaid

## Radiology and Nuclear Medicine Services Coverage Policy

**Agency for Health Care Administration**

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# 1.0 Introduction

## 1.1 Description

Florida Medicaid radiology and nuclear medicine services provide diagnostic radiology, diagnostic ultrasound, radiation therapy, and nuclear medicine services.

### 1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render radiology and nuclear medicine services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

### 1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of radiology and nuclear medicine services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

## 1.2 Legal Authority

Radiology and nuclear medicine services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440 , 441, and 410.32
- Section 409.905, Florida Statutes (F.S.)
- Rule 59G-4.240, F.A.C.

## 1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

### 1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

### 1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

### 1.3.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

### 1.3.4 High-Risk Pregnancy

A pregnancy in which the woman whose medical history and diagnosis indicates, without consideration of a previous cesarean section, that a normal uncomplicated pregnancy and delivery are unlikely to occur.

#### 1.3.5 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

#### 1.3.6 Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

#### 1.3.7 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

## 2.0 Eligible Recipient

### 2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

### 2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary radiology and nuclear medicine services. Some services may be subject to additional coverage criteria as specified in section 4.0.

### 2.3 Coinsurance, Copayment, or Deductible
Recipients are responsible for the following copayment, unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For information on copayment requirements and exemptions, please refer to Florida Medicaid's copayment and coinsurance policy:

- $1.00 per portable X-ray service, per day
- $2.00 per practitioner office visit, per day
- $3.00 per federally qualified health center visit, per day
- $3.00 per rural health clinic visit, per day

## 3.0 Eligible Provider

### 3.1 General Criteria
Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

### 3.2 Who Can Provide
To be reimbursed for services rendered to eligible recipients, providers must meet one of the following:

- Practitioners licensed within their scope of practice to perform this service
- Portable X-Ray providers certified by Medicare in accordance with 42 CFR 410.32(c)
- County health departments administered by the Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Rural health clinics certified by Medicare

Providers performing complex, detailed ultrasounds must be enrolled or registered with Florida Medicaid as one of the following specialty types:

- Radiology
- Maternal/fetal

## 4.0 Coverage Information

### 4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

### 4.2 Specific Criteria

Florida Medicaid reimburses for the following services in accordance with the American Medical Association Current Procedural Terminology and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

- Bone and joint studies
- Diagnostic radiology (imaging)
- Mammography (breast)
- Nuclear Medicine
- Portable X-Ray
- Radiation oncology
- Radiopharmaceuticals

#### 4.2.1 Fetal Biophysical Profile

Up to two biophysical profiles per pregnancy.

#### 4.2.2 Fetal Echocardiography

- One per pregnancy.
- Up to two follow-up, or repeat, services for recipients with a high-risk pregnancy.

#### 4.2.3 Fetal Velocimetry

Up to two of each of the following for recipients with a high-risk pregnancy:

- Umbilical artery doppler velocimetry
- Middle cerebral artery doppler velocimetry

#### 4.2.4 Mammography Screening

One per year, per recipient.

#### 4.2.5 Nuchal Translucency Measurement

One ultrasound for nuchal translucency measurement per pregnancy for recipients with a high-risk pregnancy.

#### 4.2.6 Ultrasounds

- Up to three obstetrical ultrasounds per pregnancy.
- Up to three transvaginal obstetrical ultrasounds for recipients with a high-risk pregnancy.

### 4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule

may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

## 5.0 Exclusion

### 5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

### 5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy

## 6.0 Documentation

### 6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

### 6.2 Specific Criteria

There is no coverage-specific documentation requirement for this service.

## 7.0 Authorization

### 7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

### 7.2 Specific Criteria

Providers must obtain authorization for radiology and nuclear medicine services from the quality improvement organization when indicated on the applicable Florida Medicaid fee schedule(s) and for the following:

- Transvaginal obstetrical ultrasounds and obstetrical ultrasounds for high-risk pregnancies beyond the coverage specified in section 4.2.6
- Proton beam therapy

## 8.0 Reimbursement

### 8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

### 8.2 Claim Type

Professional (837P/CMS-1500)

### 8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

### 8.3.1 Modifier

Providers must include the following modifiers, as appropriate, on the claim form:

- 26 Professional component performed by a different provider than the technical component
- TC Technical component performed by a different provider than the professional component
- TH Multiple gestations

Providers may not include both the TC and 26 modifiers for a single procedure on the claim form.

## 8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

## 8.5 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.