Priority Health	BILLING POLICY No. 039
HIGH TECH RADIOLOGY SERVICES	
Date of origin: Oct. 7, 2024	**Review dates: 2/2025**

APPLIES TO

- All plans except Medigap (Medicare supplement insurance) and in other situational exceptions below
- Medicare plans follow Medicare coverage rules

DEFINITION

High tech radiology services are imaging services which include, but aren't limited to MRIs, MRAs, CT scans, PET scans and nuclear cardiology.

POLICY SPECIFIC INFORMATION

Place of service

This policy doesn't apply to studies performed during an emergency room visit or during an inpatient or observation unit stay.

Modifiers

High tech radiology services may be billed with a 26 modifier (Professional Component) and/or Technical Component (TC) modifier. Some services may also be billed globally, not requiring either modifier because both components are defined within the service.

Documentation requirements

Diagnostic radiology services provided to commercial or Medicare plan members who aren't hospital inpatients or outpatients must be ordered by the treating physician/practitioner. A "treating physician" is a physician, as defined in §1861(r) of the Social Security Act, who furnishes a consultation or treats a plan member for a specific medical problem, and who uses the results of a diagnostic test in the management of the member's specific medical problem" " A "treating practitioner" is similarly defined as a nurse practitioner, clinical nurse specialist, or physician assistant, as defined in §1861(s)(2)(K) of the Act, who furnishes, pursuant to State law, a consultation or treats a beneficiary for a specific medical problem, and who uses the result of a diagnostic test in the management of the beneficiary's specific medical problem." (Exception: an interpreting physician may order a diagnostic mammogram based on the results of a screening mammogram.)

- Ordering physicians are required to provide diagnostic information to the radiology facility at the time services are ordered. Radiology services not ordered by the physician who is treating the plan member are not covered.
- The order may be:
    - A written document, signed by the treating physician/practitioner, which is hand-delivered, mailed or faxed to the radiology facility;
    - A telephone call from the treating physician/practitioner or their office to the radiology facility; or
    - An e-mail from the treating physician/practitioner or their office to the testing facility.
- If the order is communicated via telephone, both the treating physician and the testing facility must document the telephone call in their respective copies of the member's medical records. While a physician order isn't required to be signed, the physician must clearly document, in the medical record, their intent that the test be performed.

For commercial or Medicare plan members who are hospital inpatients or outpatients, “radiology services must be provided only on the order of practitioners with clinical privileges or, consistent with state law, of other practitioners authorized by the medical staff and the governing body to order the services (§ 482.26 Condition of participation: Radiologic services (b)(4)).” There must be an order for all radiology services in the member’s medical records, and the order must be dated, timed and authenticated by an authorized practitioner prior to the time the diagnostic radiology service is performed.

The patient's medical record must reflect the medical necessity for the care provided. These medical records may include but aren’t limited to: records from the professional provider's office, hospital, nursing home, home health agencies, therapies and test reports.

Priority Health may conduct reviews and audits of services to our members, regardless of the participation status of the provider. All documentation is to be available to the Priority Health upon request. Failure to produce the requested information may result in a denial for the service.

Definitions

- **Global Services**: A global service includes both a technical element and professional element within the description of the service.
- **Technical Component**: A technical component represents the equipment, facility costs and staffing required to perform a service. These services may be represented with the TC modifier or may be defined by code definition as technical services.
- **Professional Component**: The professional component (PC) represents the physician or health care provider portion of the service(s). This may include supervision, interpretation and documentation of report. The interpretive report is the written narrative that details the services, treatment, and associated diagnosis. These services are identified by the use of modifier 26 or when the definition of the code specifically details professional services only.

Billing and coding guidelines

Technical services only should be billed on a UB-04 form.

- Both revenue and CPT/HCPCS codes with appropriate modifier(s) should be submitted.
- List the ordering physician with NPI number in Box 78 on the UB-04 form.
- Claims must be submitted with the appropriate diagnosis code(s).
- Identify multiple units of radiological services in UB-04 Form Locator 46.

Professional services should be submitted on a CMS-1500 form.

- Claims should be billed with appropriate CPT/HCPCS codes and modifier(s).
- List the referring physician in Box 17 with NPI number in Box 17b of the CMS-1500 form.
- Claims must be submitted with the appropriate diagnosis code(s).

Either a UB-04 or a CMS-1500 form can be used for global radiology services.

- Claims should be billed with appropriate CPT/HCPCS codes.
- List the referring physician in Box 17 with NPI number in Box 17b of the CMS-1500 form.
- Claims must be submitted with the appropriate diagnosis code(s).
- List the ordering physician with NPI number in Box 78 on the UB-04 form.
- Identify multiple units of radiological services in UB-04 Form Locator 46.

When both a CPT code and a HCPCS code exist that describe the same service or procedure, bill with the CPT unless otherwise directed.

Modifiers

- Use modifier 26 to indicate that only the interpretation and report were performed.

- Use modifier TC to indicate only technical services were provided.
- 26 or TC modifiers are not appropriate if the procedure code represents an inherently professional/technical service (identified by status indicators).

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 13, 2025	Added "Disclaimer" section