| Priority Health | BILLING POLICY<br>No. 039 |
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| HIGH TECH RADIOLOGY SERVICES | |
| **Date of origin: Oct. 7, 2024** | **Review dates: 2/2025, 8/2025, 3/2026, 04/2026** |

# 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.

Modifier PI- Positron emission tomography (PET) or PET/computed tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing
Modifier PS- Positron emission tomography (PET) or PET/computed tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the PET study is needed to inform subsequent antitumor strategy

## 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 reports. 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).
- PI & PS modifiers are required

## Radiopharmaceuticals and Contrast Materials

## Definition

Radiopharmaceuticals are drugs that contain radioactive isotopes, used for medical diagnosis and therapy. They emit radiation, which allows for the detection or treatment of specific tissues or organs in the body.

Contrast materials are substances used to enhance the visibility of certain organs, blood vessels, or tissues during medical imaging procedures like X-rays, CT scans, ultrasounds, or MRIs. It works by altering how these structures absorb or reflect energy waves, making them stand out against surrounding tissues.

## Reimbursement Guidelines

The services associated with the HCPCS codes listed below are deemed part of the overall reimbursement for the corresponding radiology or cardiology imaging procedure and therefore are not eligible for separate payment:
• Contrast agents used during an MRI procedure
• Radiopharmaceuticals administered in connection with a PET scan

The list(s) of procedure and/or diagnosis codes below are offered solely for reference and may not encompass all relevant codes. The presence of a specific code in this policy does not indicate whether the associated service is covered or not covered. Coverage for health services depends on the member's individual benefit plan and applicable laws that may mandate certain services. Including a code does not entitle reimbursement or ensure payment of claims. Additional Policies and Guidelines may also be relevant.

Priority Health follows CMS reimbursement guidance for HCPCS Codes A9500-A9699 and Q9951 - Q9968

Payment indicator N – no separate payment

Payment indicator K2 - Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.

The following codes are not reimbursed separately for commercial claims:

CPT codes 76014, 76015, 76016, 76017

## Billing Details

Pay attention to description of code language such as “per study dose, up to 30 millicuries”, which should be billed as 1 unit when up to 30mCi is administered. Codes with description of “per mCi” should be billed based on units given such as 5mCi = 5 units.

Per NCCI Manual, Chapter 9 - The injection of a radiopharmaceutical is an integral component of a nuclear medicine procedure. CPT codes for vascular access (e.g., CPT code 36000) and injection of the radiopharmaceutical (e.g., CPT codes 96360-96379) are not separately reportable.

Chapter 9 of the NCCI Manual also states HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic, per millicurie) describes a radiopharmaceutical used for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 shall not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study.

The NCCI program sometimes combines radiopharmaceutical codes with nuclear medicine procedure codes. If a patient has two different nuclear medicine procedures on the same day, and the material used for one can’t be used with the other, you might need to separately report the radiopharmaceutical using modifier 59, XE, or XS.

## Revenue Codes:

- 0255 – Pharmacy Drugs Incident to Radiology
- 0343 – Nuclear medicine – Diagnostic Radiopharmaceuticals
- 0636 -Pharmacy Extension of 025X – Drugs Requiring Detailed Coding

## Resources

MDHHS Medicaid Provider Manual/CHAMPS- Align- ☐ CMS- https://www.cms.gov/files/document/mm13485-appropriate-use-criteria-advanced-diagnostic-imaging-cy-2024-update.pdf

MDHHS Medicaid Provider Manual/CHAMPS- https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

https://static.cigna.com/assets/chcp/pdf/coveragePolicies/medical/mm_0550_coveragepositioncriteria_soc_htr.pdf

## DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. 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 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 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.

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## CHANGE / REVIEW HISTORY

| Date | Revisions made |
|---|---|
| Feb. 13, 2025 | Added "Disclaimer" section |
| Aug. 12, 2025 | Added coding and billing information on radiopharmaceuticals and contrast materials |
| March 18, 2026 | Modifiers PI and PS added |
| April 27, 2026 | Added a list of CPT codes that are not reimbursed separately for commercial claims |