

Chapter 11

Laboratory/Pathology, Radiology, and Diagnostic Services

Laboratory/pathology, radiological, and diagnostic services enable physicians and other licensed practitioners to identify the existence, nature, or extent of illness, injury, or health deviation in a patient.

Definitions

Contrast Material: The phrase “with contrast” represents contrast material administered intravascularly or intra-articularly injections for image enhancement.

Laboratory: A facility that performs laboratory testing on specimens derived from humans for the purpose of providing information on diagnosis, prevention care, health assessment, or treatment of diseases or impairments.

Panel Codes: Groups of laboratory tests (components) that are frequently performed together. Tests included in each panel are listed by name with the Current Procedural Terminology (CPT) code identified in parentheses. In order to report a panel code, all listed tests must be performed.

Pathology: A service requiring additional medical interpretive decision, consisting of a written report performed by a pathologist, at the request of a physician.

Professional Component: The professional component of a radiology procedure includes the professional services of the physician and the following:

1. Examination of patient when indicated
2. Performance or supervision of the procedure
3. Interpretation
4. Written report of the examination

The professional component is applicable in an encounter when the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities.

Provider-Performed Microscopy Procedures (PPMP): Allows physician office laboratories to perform a limited number of microscopy procedures. Certified PPMP-approved procedures are subject to change at any time.

Radiology: Radioactive substance’s radiant energy for the diagnostic and treatment of disease by means of both ionizing and non-ionizing radiation.

Technical Component: Includes the personnel and materials, including contrast media and drugs, film or xerography, space, equipment, or other facilities.

Waived Complexity: The Centers for Medicare & Medicaid Services (CMS) has identified a number of simple laboratory procedures that can be performed in the physician offices after obtaining a Certificate of Waiver. Waived tests are subject to change at any time, so review all Medicare mailing for changes to waived tests.

Laboratory/Pathology Services

Covered Services

IMCare covers all laboratory tests paid under the Clinical Laboratory Improvement Amendment ([CLIA Certificate Fee Schedule](#)) from CMS.

To be eligible for IMCare payment as a laboratory/pathology service, the service must be all of the following:

1. Ordered and provided by or under the direction of a member's treating physician (Medical Doctor [MD], Doctor of Optometry [OD], Doctor of Podiatric Medicine [DPM], or Doctor of Dental Surgery [DDS]) or practitioner (nurse practitioner, clinical nurse specialist, physician assistant, or certified professional midwife) who gives a consultation or treats a member for a specific medical problem within his/her scope of practice as defined by State law
2. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) products/services and laboratory and X-ray services payable under Medicare Part B ordered or referred by an optometrist
3. Provided in a hospital or independent laboratory
4. Directly related to the diagnosis and treatment of a member's health status
5. Authorized under the laboratory's CLIA certification

IMCare follows Medicare guidelines. All hospitals and physician owned and freestanding laboratories require CLIA certification. Claims will be denied for lab services provided by laboratories without CLIA certification or if the CLIA certification number is not on file with IMCare.

Eligible Providers

To be eligible as a provider of laboratory services, a vendor must be certified under CMS' [CLIA](#) program.

Providers of lab services must have their CLIA certificate number current and up-to-date with their most recent level of certification on file with IMCare. If you did not indicate your certificate number on your IMCare enrollment application, or your office has obtained a certificate since your original enrollment, please provide IMCare with the following information:

1. Provider name
2. IMCare provider number
3. CLIA certificate number
4. CLIA certificate expiration date

Send or fax this information to:

IMCare
1219 Southeast 2nd Avenue
Grand Rapids, MN 55744

Fax: **1-218-327-5545**

Clinical Laboratory Improvement Amendment (CLIA)

Congress passed CLIA in 1988, establishing a minimum quality of standards for all laboratory testing to ensure high quality of testing regardless of the laboratory location.

IMCare follows Medicare guidelines. All hospitals and physician owned and freestanding laboratories require

CLIA certification. IMCare will not cover lab services provided by laboratories without CLIA certification.

CMS CLIA Requirements

CMS requires all providers performing laboratory testing to register with the CLIA program. Direct inquiries about CLIA certification to CMS.

Use the [CMS website](#) as a means to obtain current information about CLIA certification as CMS updates its site on a regular basis. CLIA waiver tests, PPMPs, and tests required under CLIA edit are subject to change at any time. Refer to the CMS web page [How to Apply for a CLIA Certificate](#), which also includes the CMS [Clinical Laboratory Improvement Amendments \(CLIA\) Application for Certification](#) and instructions.

Provider-Performed Microscopy Procedures (PPMP)

PPMP laboratories must meet only the following requirements under CLIA:

1. Enroll in the CLIA program
2. Pay applicable certificate fees biennially
3. Certain quality and administrative requirements

Laboratories with a PPMP certification and those granted CLIA waiver status may perform PPMP tests. Certified PPMP-approved procedures are subject to change at any time.

CLIA Waiver Tests

Waived laboratories must meet only the following requirements under CLIA:

1. Enroll in the CLIA program
2. Pay applicable certificate fees biennially
3. Follow manufacturer's test instructions

Laboratories with waiver certification (certification type 2) are approved to bill only for waiver tests.

To bill CLIA waiver tests, the procedure code must have the modifier QW. Do not use the CLIA number on the claim form.

All types of certification are effective for two years and include a Certificate of Provider-Performed Microscopy Procedures (PPMP). PPMP certificates are issued to a laboratory in which a physician, midlevel practitioner, or dentist performs [specific microscopy procedures](#). It allows a laboratory to conduct tests categorized as moderately complex. This certificate also permits the laboratory to perform waived tests.

Certificate of Waiver

1. Issued to laboratories that perform only tests the Food and Drug Administration (FDA) or the Centers for Disease Control and Prevention (CDC) have determined are [waived tests](#).
2. Allows the laboratory to conduct tests so simple that there is little risk of error.
3. Laboratories must follow the manufacturer's instruction for test performance.

Certification of Registration

1. Issued to allow laboratories to conduct tests until they are surveyed and determined to be compliant with the CLIA regulations.
2. Allows the laboratory to conduct tests categorized as moderately and/or highly complex tests.
3. Only laboratories applying for a Certificate of Compliance or a Certificate of Accreditation will receive a Certificate of Registration.

Certification of Compliance

1. Issued after an on-site survey finds that the laboratory is in compliance with all applicable CLIA requirements.
2. Allows the laboratory to conduct tests categorized as moderately and/or highly complex tests.

Outpatient Hospital Laboratory Tests

Effective for dates of service (DOS) on or after January 1, 2014, IMCare follows Medicare hospital outpatient clinical laboratory test payment and billing policy, except where services under arrangement and referred lab services are concerned. Most clinical diagnostic laboratory tests (excluding molecular pathology tests) performed in an outpatient hospital setting are packaged under the Outpatient Prospective Payment System (OPPS), instead of the Clinical Laboratory Fee Schedule (CLFS).

Refer to [Medicare Learning Network \(MLN\) Matters #SE 1412](#) for additional information.

Technical Component of Surgical Pathology

The technical component of surgical pathology and supplies is not subject to CLIA requirements. When providing only these services, do not apply for CLIA certification. Billing for the technical component of a lab test includes the following:

1. The slide preparation for interpretation by the physician
2. Other usual pre-slide preparation

Automated Multichannel Laboratory Organ or Disease Oriented Panels

The organ and disease panel codes represent chemistry tests that are frequently performed in combination on automated multichannel equipment. When combinations of these tests are provided for a member on the same date, claims submitted to IMCare are subject to a payment cap specified by CMS for the Medicare program.

The organ and disease panel codes are defined in the physician's CPT manual. If other tests are performed in addition to those indicated for a particular panel, report the tests on individual lines on the claim along with CPT panel codes 80048 – 80090 (codes are subject to change yearly per CPT and American Medical Association [AMA]).

All multichannel laboratory tests performed on the same member on the same date must be submitted on one claim. Billing the complete automated chemistry panel is advisable, if all tests are done.

Do not separately report individual laboratory tests that are components of a multichannel test analysis.

If subsequent tests are provided for the same member on the same date, submit a replacement claim on a separate claim, and include the additional tests on one claim.

IMCare will process Medicare crossover claims as submitted per Medicare's billing instructions in the [Medicare Claims Processing Manual](#).

Handling/Specimen Collection

IMCare does not reimburse for collection of blood by access port in conjunction with another service. These services are incidental and included in the primary service.

IMCare will cover the collection and handling (if applicable) for each type of specimen listed below, per

member, per day:

1. Routine venipuncture for collection of specimens; use 36415
2. Collection of Pap smears; use HCPCS code Q0091
3. Catheterization for collection of a specimen, single patient, homebound/nursing facilities (NFs); use CPT P9612
4. Catheterization for collection of a specimen, multiple patients; use CPT P9615

Minnesota Department of Health (MDH) Newborn Screening Program

IMCare will cover the cost of the [MDH newborn screening for metabolic disorder card](#) when the screening **cannot** be completed at the inpatient hospital or birthing center setting. Please use Healthcare Common Procedure Coding System (HCPCS) code S3620. If MDH requests a repeat newborn screening card, bill using code S3620 and modifier 76 or 77.

IMCare includes the payment for the newborn screening card in the Diagnosis Related Group (DRG) or facility service when provided in the inpatient hospital or birthing center. Do not bill separately.

Laboratory Services

IMCare requires all physician office laboratories to be CLIA-certified in order to receive payment. CLIA regulations include the conditions that all laboratories must meet to be certified to perform testing on human specimens under CLIA. Claims will be denied for physician office laboratories that do not meet CLIA requirements, either because the laboratory's CLIA certificate has expired, the billed test is not covered by the laboratory's CLIA certificate, or the services rendered are outside the effective dates of the CLIA certificate.

Payment for a laboratory service performed in a CLIA-certified physician's laboratory will not exceed the amount paid for similar services performed in an independent laboratory. Physicians may also send laboratory specimens to independent or outpatient hospital laboratories.

Reference (Outside) Lab

Effective for dates of service on and after January 1, 2015, in conjunction with [Section 1902\(a\)\(32\) of the Social Security Act](#), IMCare must only reimburse a provider who personally performed a service. Providers will no longer be reimbursed for lab tests they did not complete. IMCare will no longer pay a provider for laboratory services that the provider sent to a reference or outside laboratory.

Tests submitted with modifier 90 will be denied. Do not include lab services you did not complete on your claim. When a specimen is sent to another provider, the ordering provider must also send all necessary information required for the laboratory to bill for the service.

The following exceptions apply:

- Outpatient hospitals, provider-based clinics, and independent laboratories
- For dates of services prior to July 1, 2015, continue to bill IMCare, using modifier 90, for laboratory services sent to a reference or outside laboratory.

Inpatient hospitals and nursing facilities

This policy does not apply to services included in a hospital diagnosis-related group (DRG) payment or nursing facility per-diem payment. Payments for services included in these types of all-inclusive payments are paid to the facility. The reference or outside laboratory may not bill separately in these situations.

Minnesota Family Planning Program (MFPP) lab tests and services

Refer to the Lab Services section when billing lab tests.

MFPP-certified physicians treating members that have presumptive eligibility (PE) for MFPP may bill for lab tests or services when the following are true:

1. The tests or services are performed at your facility
2. The tests or services are performed on the same day as other family planning services
3. The primary diagnosis is in the Z30 – Z30.9 range

If you send lab tests to a reference or independent lab provider, refer to the Reference and Outside Lab Services policy in the Lab Services section. Give the lab provider the following information so the lab can bill for the service:

1. A copy of the member's MFPP Short-Term Approval Notice (gives the lab provider at least two of three recipient identifiers [first and last name, date of birth, SSN] so the lab can verify eligibility on EVS or MN-ITS)
2. Primary diagnosis code in the Z30 – Z30.9 range
3. Secondary diagnosis codes as appropriate
4. The primary ordering provider's NPI

If an MFPP member does not have an MHCP ID number, do the following:

1. Perform the lab tests
2. Wait 3 business days
3. Use the information from the MFPP provider to obtain the member's IMCare ID number
4. Bill IMCare for the lab tests performed using the primary diagnosis code in the Z30 – Z30.9 range from the referring/ordering provider

All IMCare-enrolled labs are required to perform lab tests ordered for members during the PE period and after a member's MFPP ID number is determined and available on EVS or MN-ITS (usually 3 business days after the physician determines PE).

Pathology Services Claiming

IMCare will pay the global rate for the following procedure codes when they are billed in the 837I claim format:

88104 – 88125	88300 – 88319
88160 – 88162	88323
88172	88331 – 88362
88173	88365 – 88368
88177	88380 – 88388
88182	

Use the TC modifier to receive the technical component rate.

IMCare will pay the technical component rate for these codes when billed in the 837I format without the TC modifier.

Independent Pathologist Services

Independent pathologists do not need CLIA certification; the laboratory requires CLIA certification.

Pathology and Laboratory (CPT codes 80049 – 89399): If a pathologist must review a test result and render an opinion, the modifier 26 should be attached to indicate that only a professional component was provided. On a global code, if the CPT code is defined as a professional service, do not use modifier 26.

1. Independent pathologists who bill for the professional component of laboratory services must indicate the hospital's or independent laboratory's NPI as the rendering provider.
2. Use modifier 26 and modifier 90 in the modifier field.
3. If modifier 90 is used, the system will look at the rendering provider field for CLIA certification.
4. Do not use CLIA numbers on claims to IMCare.

Modifiers

Modifier 59: Used for distinct procedural services such as multiple services submitted by a laboratory for the same member on the same day. These situations usually involve microbiology where samples or cultures are taken from a patient from different anatomical sites or different wounds, use the same CPT code, and are tested on the same day.

Modifier 90 (reference [outside] laboratory): Identifies laboratory procedures performed by a CLIA-certified lab other than the treating or reporting physician.

Modifier 91: Used to indicate a repeat clinical diagnostic laboratory test (CPT code) on the same date of services, at different intervals to obtain subsequent, additional test results. Bill laboratory services in units that are run on the same day and **not** repeated. The 91 modifier may only be used for laboratory tests paid under the clinical laboratory fee schedule. For example: repeating an arterial blood sample or potassium at different intervals on the same day.

The 91 modifier can be used to bill repeat laboratory services, except for the following CPT codes: Q0111 (non-inclusive list).

The 91 modifier may **not** be used when:

1. There are standard CPT/HCPCS codes available that describe a series of results (e.g., glucose tolerance tests, evocation/suppression tests, etc.);
2. Tests are run to confirm initial results due to testing problems with the specimen or equipment; and/or
3. A normal, one-time, reportable result is required.

When billing pathology codes, modifiers 76, 77, and 91 are allowed. Modifiers 22 and 52 cannot be used when billing pathology codes.

Billing in Units

Bill laboratory tests that are not repeats in units. Do not use the repeat modifier. For example, bill blood, urine, and other cultures in “units of.” Multiple organism identifications (IDs) should also be billed in “units of.”

Pap Smear Billing

IMCare covers one professional and one technical component for Pap smear testing, per specimen per day. For Pap smear collection, use Q0091.

Cytogenetic Testing

IMCare covers cytogenetic testing performed on any IMCare member. Documentation in the medical record must reflect the medical necessity for the testing. All claims submitted for payment of cytogenetic testing must contain the specific diagnosis related to the tests being performed. Use the most specific *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* code available. (Some cytogenetic tests require authorization (e.g, chromosome analysis). Bill cytogenetic testing in units.

IMCare does not cover cytogenetic testing for the following:

1. Legal, paternity, or informational purposes, unless it is medically necessary for the member to receive cytogenetic testing
2. Family members who are not IMCare members
3. Fetus testing

Genetic Testing

All genetic testing requires Service Authorization (*Itasca Medical Care Authorization Request Form*) before it is performed for in-network and out-of-network providers. Documentation in the medical record must reflect the medical necessity for the testing.

IMCare requires a written physician order for the following genetic analysis procedure codes: 81225, 81226, 81227, 81240, 81241, 81291, and 81355. The molecular pathology/gene analysis tests must be ordered by a physician or qualified practitioner when it is medically necessary for the diagnosis or treatment of the member. Tests not ordered by the physician who is treating the member are not considered reasonable and necessary.

Genetic testing is considered medically necessary when **all** of the following conditions are met and documented in the medical record:

1. The member displays clinical features or is at direct risk of inheriting the genetic condition in question (pre-symptomatic).
2. The result of the test will have a clinically significant effect on the treatment being delivered for a disease or syndrome.
3. The testing method is considered scientifically valid for the identification of a specific genetically linked inheritable disease.
4. Appropriate genetic counseling occurs before and after testing. Counseling documentation supports the intent to change therapy based on the results of the testing.

Genetic testing is not covered when performed in the absence of symptoms or high-risk factors for an inheritable disease or when knowledge of genetic status will not affect treatment decisions. Genetic testing for conditions that are treated symptomatically are not appropriate since the treatment would not change based on the test results.

Pharmacogenetic testing is covered when **all** of the following conditions are met:

1. Testing is required by the drug label
2. The test will change the treatment course
3. A drug trial is considered impractical due to safety or other factors prior to genetic testing

Pharmacogenetic panel tests for therapy selection, such as panel tests for psychotropics, analgesics, or Attention-Deficit/Hyperactivity Disorder (ADHD) stimulant medication, are not covered.

IMCare covers genetic mutation testing for breast and cervical cancer susceptibility when certain criteria are met. Service Authorization is needed prior to BRCA genetic mutation testing.

Oncotype Dx Testing for Breast Cancer

Oncotype Dx testing is a 21 gene assay test, which aims to help breast cancer patients and their physicians determine whether adjuvant chemotherapy would be beneficial. Testing is considered medically indicated for members with all of the following breast cancer characteristics:

1. Stage I or II breast cancer
2. Breast tumor is estrogen-receptor positive
3. Breast tumor is HER2-receptor negative
4. Tumor size 0.6 – 1 cm with moderate/poor differentiation or unfavorable features, or tumor size is greater than 1 cm
5. Negative lymph nodes (nodes with micrometastases greater than 2 mm in size)
6. Test result will be used to guide decision making about adjuvant chemotherapy

Home Monitoring of Anticoagulant Therapy

Home use of Prothrombin Time (PT) testing and International Normalization Ratio (INR) monitoring may be covered for members taking oral anticoagulation and with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism if all the following medical indications are present and are prescribed by the treating physician. Home monitoring supplies must also be ordered by the treating physician.

1. The patient must have been anticoagulated for at least 3 months prior to use of the home INR device;
2. The patient must receive face-to-face education from the treating provider on anticoagulation management and must demonstrate the correct use of the device prior to its use in the home;
3. The patient must continue to correctly use the device in the context of the management of the anticoagulation therapy following the initiation of home monitoring;
4. Self-testing with the device should not occur more frequently than once a week.

Lead Toxicity Testing

The lead toxicity screening test consists of a capillary or venous blood lead test, hemoglobin (Hgb), hematocrit (HCT), and other age-appropriate exams or tests (as noted in the schedule of age-related screening standards). Refer to the *Child and Teen Checkups (C&TC)/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program* section of Chapter 9, Children's Services, for more information pertaining to lead toxicity testing.

The following lead testing services are **not** covered:

1. Paint chip, water, and soil testing
2. Assessments performed by a registered environmental health specialist/sanitarian

Laboratory Testing for HIV Tropism (Trofile)

HIV Tropism testing is considered medically necessary for selecting patients for treatment with HIV co-receptor antagonists.

Tropism testing is covered for patients who meet all of the following criteria:

1. Antiretroviral treatments have failed
2. There is evidence of viral replication
3. There is a diagnosis of HIV

Report HIV Tropism testing using CPT code 87999 with a description of HIV Tropism. Limit of once per lifetime.

Drug Testing

Drug screening for routine work-related issues and when court ordered is not covered. For services other than medication assisted therapy, drug testing costs are not included in the Consolidated Chemical Dependency Treatment Fund (CCDTF) rate.

IMCare accepts Healthcare Common Procedure Coding System (HCPCS) procedure codes, as follows:

- Screening/presumptive tests: 80305 – 80307
- Definitive drug testing: G0480 – G0483 and G0659

If sample validation tests are completed, include or bundle them with CPT Screening drug test codes 80305-80307 and HCPCS Definitive drug testing codes G0480 – G0483 and G0659.

Effective January 1, 2017, IMCare covers CPT Screening/Presumptive drug testing codes 80305-80307. IMCare only allows “G” HCPCS codes for Definitive drug testing.

When drug screening is considered medically indicated, IMCare follows the [Medicare Local Coverage Determination L36037](#). Report drug screening using codes 80305-80307 and G0480 – G0483 per encounter. Presumptive drug tests, codes G0477-G0479, cannot be billed with confirmatory drug tests, codes G0480 – G0483. Confirmatory drug tests can only be billed after presumptive drug tests if the presumptive drug test comes back as positive.

Drug screening/presumptive tests and definitive drug testing should be individualized to the treatment plan and should not exceed one presumptive/screening drug test every seven days at any time during treatment and one confirmatory/definitive drug test at any time during treatment. Medical documentation should include how the test results influence treatment and level of care decisions. Please review [CMS Local Coverage Determination \(LCD\): Urine Drug Testing \(L36037\)](#) for additional guidance on the medical necessity and frequency of drug testing.

Radiology/Diagnostic Services

Eligible Providers

To be eligible as a provider of independent X-ray services or portable X-ray services, a vendor must be certified by CMS for participation in the Medicare program.

Advanced Diagnostic Imaging Providers

To be eligible as a provider of the technical component (TC) of advanced diagnostic imaging (ADI) services for DOS on or after August 1, 2013, providers must be accredited through one of the organizations below. The accreditation requirements apply only to providers of the TC of the imaging service and not the physician’s interpretation (professional component) of the imaging service. The accreditation requirements apply to all suppliers of the TC who submit claims to IMCare. They do not apply to ADI services done in the hospital (inpatient or outpatient) or ambulatory surgical center settings licensed by [Minnesota Statutes](#).

Providers must be accredited for the modality, CPT, or HCPCS imaging service for which they are billing or their claim will be denied. ADI services include the following:

1. Magnetic resonance imaging (MRI)
2. Computed tomography (CT)
3. Nuclear medicine imaging including positive emission tomography (PET)

The following are the accrediting organizations:

1. [The American College of Radiology](#)
2. [The Intersocietal Accreditation Commission](#)
3. [The Joint Commission](#)

The billing entity or organization must do the following:

1. Complete and sign an [Advanced Diagnostic Imaging Accreditation Requirements – Assurance Statement](#) (DHS-3872)
2. Attach a copy of the organization's most current accreditation certificate(s)
3. Fax both documents to Minnesota Health Care Programs (MHCP) Provider Enrollment at **1-651-431-7462** upon receipt of accreditation

Each of the accredited organizations will notify providers when it is time to renew accreditation. Providers must submit a new copy of their recertification with a new [Advanced Diagnostic Imaging Accreditation Requirements – Assurance Statement](#) (DHS-3872) to MHCP Provider Enrollment. IMCare will track and verify the accreditation status of providers through DHS enrollment files.

Covered Services

To be eligible for IMCare payment for radiology or diagnostic services, the service must meet all of the following criteria:

1. Be ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of practice as defined by State law
2. Be provided in a facility other than a hospital outpatient department or clinic, if an independent service
3. Meet the requirements for certification by Medicare
4. Be directly related to the diagnosis and treatment of a member's health status

Professional Component

The professional component of a radiology procedure includes the professional services of the physician and the following:

1. Examination of patient when indicated
2. Performance or supervision of the procedure
3. Interpretation
4. Written report of the examination

The professional component is applicable in an encounter when the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities.

Technical Component

The technical component of a radiology procedure code includes the personnel and materials, including the following:

1. Contrast media and drugs
2. Film or xerography
3. Space
4. Equipment
5. Other facilities

Oral and/or rectal contrast administration alone does not qualify as a study “with contrast.”

Total Components

Total components include both technical and professional components and are covered by IMCare. Do not use modifiers when billing for the total components.

Mammography

IMCare covers medically necessary mammography services.

For Medicaid members, IMCare will cover a screening mammogram for women at age 40, and annually thereafter. Authorization is required for mammograms in females under age 40. Diagnostic mammograms do not require authorization.

For Medicare members, IMCare will cover one screening mammogram between the ages of 35 and 39, and annually after age 40. Authorization is required before age 35 and for more than one mammogram between ages 35 and 39. The authorization requirement is for both screening and diagnostic mammograms.

All facilities (hospital, outpatient department, clinic, radiology practice, mobile unit, physician’s office, or other facility) providing diagnostic and screening mammography services are required to have Food and Drug Administration (FDA) certification under the Mammography Quality Standards Act (MQSA). No facility may conduct an examination or procedure involving mammography unless the facility has obtained an MQSA certificate.

IMCare covers HCPCS code G0279 for Digital Breast Tomosynthesis (3-D Mammogram) as of February 1, 2016. G0279 is only covered when billed in conjunction with either G0204 or G0206.

Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)

IMCare covers medically necessary MRIs, CT scans, bone density studies, MRIs for angiography, magnetic resonance spectroscopy (MRS), positron emission tomography (PET), and brain mapping. IMCare will periodically perform audits of claims paid for this service. In the event it is determined medical necessity for the imaging was not met, IMCare will re-adjudicate the claim. If a facility continues to perform imaging services and medical necessity is not met, that facility will be required to obtain a Service Authorization **prior to** performing this service.

No Service Authorization is required for MRI, MRA, MR, or PET (per provider update # 2014-20).

Independent Diagnostic Testing Facility (IDTF)

IMCare follows [CMS General Coverage and Payment Policies](#) for IDTF providers.

Non-Covered Services

CPT or HCPCS procedure codes performed by an IDTF that are solely therapeutic are not covered.

Billing

Date of Service

Do not bill a date span for services defined as multiple treatments or units of service.

Independent Diagnostic Testing Facility (IDTF)

Submit the NPI assigned to the ordering physician on your 837P claim format.

When appropriate, bill the TC modifier on diagnostic procedures with a technical component. For diagnostic testing performed entirely at the patient's location, use that location as the POS. When one or more aspects of the diagnostic testing is performed at the IDTF, the IDTF is the POS.

Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)

When more than one provider is involved in providing and billing a procedure, the providers must establish a written agreement as to which component each provider will bill.

For example, a physician bills for the professional component of the service he/she provided (bill in the 837P format), while the hospital bills for the technical component (on the 837P or 837I format). Or, the hospital bills for the total component (professional and technical), and the physician does not bill, but rather is paid by the hospital. Both the physician and the hospital cannot be paid for both components.

When a physician or clinic is billing for services performed, and the equipment is owned by either the physician or clinic, the service cannot be separated into a technical and professional component.

CPT or HCPCS (level 1, 2, and 3 codes and modifiers when required) must be used on all claims.

Claims submitted for payment of CT and MRI scans must have a specific medical diagnosis. Use the most complete and highest level of specificity ICD diagnosis code. PET scans are billed using CPT coding.

Computerized Tomography (CT) Scanning Equipment Standards

Effective for dates of service on or after January 1, 2016, MHCP follows Medicare's requirement that providers must report modifier CT on all computed tomography scans performed on scanning equipment that does not meet the National Electrical Manufacturers Association (NEMA) standards. Refer to [MLN Matters MM9250](#) for more information.

For dates of service between January 1 and December 31, 2016, a payment reduction of 5 percent will apply to the technical component allowable. For dates of service on or after January 1, 2017, a payment reduction of 15 percent will apply to the technical component allowable.

X-rays taken using film

Effective for dates of service on or after January 1, 2017, X-rays taken by film must include modifier FX. IMCare follows Medicare's payment incentive to transition from film X-rays to digital radiography. Refer to [MLM Matters MM9727](#) for more information.

X-rays taken by film will have the technical component allowable reduced by 20 percent.

Professional Component

Inpatient professional component services should be billed on the 837P claim format using a 26 modifier. When a service is rendered to a hospital inpatient, use the inpatient hospital POS code following Medicare guidelines as defined in the [Medicare Claims Processing Manual](#).

For professional services that state supervision and interpretation only, use modifier 26 when appropriate. If the CPT code is defined as the professional component only, do not use modifier 26.

When a physician provides the professional component of an outpatient service, he/she may only bill the professional component using a 26 modifier.

The professional component is applicable in any duration in which the physician submits a charge for professional services.

Report the appropriate POS.

Technical Component

The technical component includes the charges for personnel, materials, usual contrast media, drugs, film or xenograft, space, equipment, and other facility charges, but excludes the cost of radioisotopes and low osmolar contrast materials.

The technical component of all inpatient services is included in the inpatient DRG and billed on the 837I claim form.

For a provider transporting his/her own equipment to another site, the technical components may be billed by the provider owning the equipment. To identify a charge for the technical component, enter the procedure code with a TC modifier.

Use the TC modifier only when appropriate. If a CPT code is defined as the technical component only (of a service), do not use the TC modifier.

Injection of contrast material is part of the "with contrast" for CT, CTA, MRI, and MRA procedures.

Total Components

Total components include the technical and professional component. Use the appropriate procedure code without a modifier.

Interventional Radiologic Procedures and Diagnostic Studies with Injection

These types of procedures include professional, technical, and injection components.

Use of radiopharmaceuticals is regulated by the Nuclear Regulatory Commission (NRC) under strict procedures and guidelines. People administering radiopharmaceuticals should have either a license from the NRC or be credentialed by an institution having a board license from the NRC.

Professional Component: Bill the appropriate procedure code that states supervision and interpretation only, and use modifier 26.

Technical Component: Bill the appropriate procedure code that states supervision and interpretation only, and use the TC modifier.

Injection Component: Bill radiology procedures using the appropriate CPT code that indicates “with contrast,” if available. Contrast media provided in a hospital must be billed with the appropriate CPT or HCPCS code on the 837I claim form.

Contrast Material: Bill separately using the most appropriate HCPCS code.

Contrast Media Provided in an Inpatient Hospital: Bill the appropriate CPT or HCPCS code on the 837I claim form.

Stereotactic Radiosurgery (SRS) Planning and Delivery

Effective on or after January 1, 2016, until December 31, 2017, outpatient hospitals with type of bill 13X must report modifier CP for any planning services provided within 30 days before or after any cranial single session SRS treatment delivery services. Refer to CMS [MLN Matters MM9486](#) for additional guidance.

Legal References

[MN Stat. sec. 144.123](#) – Fees for Diagnostic Laboratory Services; Exceptions

[MN Rules part 4605.7040](#) – Disease and Reports; Clinical Materials Submissions

[MN Rules part 9505.0305](#) – Laboratory and X-Ray Services

[MN Rules part 9505.0445](#) – Payment Rates

[Title 42 Code of Federal Regulations \(CFR\) Part 410.33](#) – Independent diagnostic testing facility

[42 CFR 440.30](#) – Other laboratory and X-ray services

[42 CFR 441.17](#) – Laboratory services

[42 CFR 441.56](#) – Required activities

[42 CFR 493](#) – Laboratory Requirements