



MISSISSIPPI DIVISION OF  
**MEDICAID**

## Administrative Code

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Title 23: Medicaid  
Part 220  
Radiology Services

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## **Title 23: Division of Medicaid**

### **Part 220: Radiology**

#### **Part 220 Chapter 1: General**

##### *Rule 1.1 Provider Enrollment Requirements*

- A. Radiology providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:
  - 1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
  - 2. Written confirmation from the IRS confirming the provider's tax identification number and legal name, and
  - 3. Clinical Laboratory Improvement Amendments (CLIA) certificate and completed Certification form, if applicable.
- B. Independent Diagnostic Testing Facility (IDTF) providers can only be enrolled for submission of crossover claims.
  - 1. IDTF providers cannot be enrolled for submission of straight Medicaid claims.
  - 2. A copy of the Medicare certification from the Medicare Intermediary is required.
  - 3. The Explanation of Medicare Benefits (EOMB) is not acceptable.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 455, Subpart E.

##### *Rule 1.2: Positron Emission Tomography (PET) Scans*

- A. Effective July 1, 2013, Positron Emission Tomography (PET) scans must be prior authorized by the radiology Utilization Management/Quality Improvement Organization (UM/QIO) as noted in Rule 1.10.
- B. PET Scans are covered by Medicaid for beneficiaries with the malignant cancers listed in Part 220, Rule 1.2.B for the following reasons:
  - 1. Initial diagnosis,
  - 2. Staging when there is documented evidence of a primary tumor by CT, MRI, X-ray, or tissue sample,
  - 3. Restaging after a course of treatment,

4. Evaluating recurrence prior to surgery as an alternative to gallium scan but is not covered for evaluating regional nodes, or
  5. In lieu of other modalities such as CT, MRI, and X-ray.
- C. PET scans are covered by Medicaid for beneficiaries with tumors with the following malignant cancers for the reasons listed in Part 220, Chapter 1, Rule 1.2.A:
1. Characterization of solitary pulmonary nodules (SPN's),
  2. Lung cancer, non-small cell,
  3. Colorectal cancer,
  4. Melanoma,
  5. Lymphoma when used as an alternative to gallium scan,
  6. Head and neck cancer, excluding thyroid and central nervous system, and
  7. Esophageal cancer.
- D. PET scans are covered for beneficiaries with breast cancer only for the following reasons:
1. Staging with distant metastasis,
  2. Restaging with loco-regional recurrence or metastasis, or
  3. Monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated.
- E. PET scans are covered for beneficiaries with thyroid cancer for staging of recurrent or residual thyroid cancers of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan.
- F. PET scans are not covered for the:
1. Initial diagnosing of breast cancer, or
  2. Initial diagnosing or restaging of thyroid cancer.
- G. PET scans are covered for the following myocardial imaging:
1. Perfusion of the heart, either at rest or with pharmacological stress, for the diagnosis and

management of beneficiaries with known or suspected coronary artery disease using the Federal Drug Administration (FDA)-approved radiopharmaceutical Rubidium 82 (Rb 82) or ammonia N-13 tracer when one (1) of the following criteria are met:

- a) The PET scan, whether at rest alone or at rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT) scan, or
  - b) The PET scan, whether at rest alone or at rest with stress, is performed following an inconclusive SPECT scan.
    - 1) The PET scan must be considered medically necessary to determine what medical or surgical intervention is required to treat the beneficiary.
    - 2) The Division of Medicaid defines an inconclusive SPECT scan as a test(s) whose results are equivocal, technically uninterpretable, or discordant with a beneficiary's other clinical data documentation in the beneficiary's medical record.
2. Myocardial viability using [18F]-fluorodeoxyglucose (FDG)-PET for the determination of myocardial viability or following an inconclusive SPECT prior to revascularization.
- a) A SPECT scan is not covered following an inconclusive PET scan.
  - b) Refer to Rule 1.2.F.(2).

G. FDG-PET scans are covered for refractory seizures only for pre-surgical evaluation of localization of a focus of refractory seizure activity.

H. Documentation for all PET scans must:

1. Include the referring physician's documentation of medical necessity and criteria met in Rule 2.1.A-G,
2. Not duplicate other covered diagnostic tests,
3. Be maintained in the referring physician's file.
4. Include documentation the procedure involved only FDA approved drugs and devices and did not involve investigational drugs, as determined by the FDA,
5. Support the referral to the PET scan provider, and
6. Be maintained in accordance with Part 200, Chapter 3, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.2.A. to correspond with approved SPA 2013-007 effective 07/01/2013

*Rule 1.3: Radiopharmaceuticals*

- A. The Division of Medicaid covers radiopharmaceuticals administered for diagnostic or therapeutic purposes separately from the diagnostic procedure or visit.
  - 1. Only the units administered are covered.
  - 2. Radiopharmaceuticals must be approved by the (FDA), used in accordance with FDA approved conditions, and be administered in dosages that meet FDA regulations.
  - 3. Radiopharmaceuticals considered experimental, investigative, or in clinical trial are not covered.
- B. The Division of Medicaid covers radiopharmaceuticals administered in a physician office, clinic or independent radiology facility.
- C. Radiopharmaceuticals administered in an outpatient hospital setting is reimbursed in accordance with the Division of Medicaid's outpatient hospital methodology.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.4: Teleradiology*

- A. The Division of Medicaid covers medically necessary teleradiology services.
- B. The Division of Medicaid defines a:
  - 1. Consulting provider as a licensed physician who interprets the radiological image, at the distant or hub site. The consulting provider must be licensed in the state within the United States in which he/she practices.
  - 2. Hub or distant site as the location of the teleradiology consulting provider. The hub site provider is reimbursed for the professional component of the service.
  - 3. Referring provider as a licensed physician, physician assistant, or nurse practitioner who orders the radiological service. The referring practitioner must be licensed in the state within the United States in which he/she practices.
  - 4. Spoke site, also referred to as the originating site, as the location where the beneficiary is receiving the teleradiology service. The spoke site provider is reimbursed for the technical component of the service.
  - 5. Store-and-forward as telecommunication technology for the transfer of medical data from one (1) site to another through the use of a camera or similar device that records or stores

an image which is transmitted or forwarded via telecommunication to another site for teleconsultation.

6. Teleradiology as the electronic transmission of radiological images, known as store-and-forward images, from one (1) location to another for the purposes of interpretation.
7. Transmission cost as the cost of the line charge incurred during the time of the transmission of a telehealth service.

C. The Division of Medicaid covers:

1. One (1) technical and one (1) professional component for each teleradiology procedure.
2. Medically necessary teleradiology only when the originating site, or spoke site, documents there are no local radiologists to interpret the images.
3. The technical component of the radiological service at the originating site for only providers enrolled as a Mississippi Medicaid provider.
4. The professional component of the radiological service at the hub site only for providers enrolled as a Mississippi Medicaid provider.
5. Hospitals for purchased or contractual teleradiology services, under their physician group provider number only.

D. The Division of Medicaid does not cover:

1. The transmission cost or any other associated cost of teleradiology.
2. Both the technical and professional component of teleradiology services for one (1) provider. A provider cannot bill for services performed by another provider.

E. The teleradiology service must:

1. Provide images without clinically significant loss of data from image acquisition through transmission to final image display to enable the consulting provider to accurately interpret the image.
2. Use equipment which provides image quality and availability appropriate to the clinical need.
3. Be performed at the originating site by qualified personnel trained in the performance of the specified radiological service and operating within the licensure and/or certification requirements of the state in which the service is being performed. Technicians must work under the supervision of a qualified licensed physician.

F. Teleradiology documentation must include at a minimum:

1. At the spoke site:
  - a) The reason teleradiology was utilized to deliver the service,
  - b) Date(s) of service,
  - c) Beneficiary demographic information,
  - d) Signed consent for treatment, if applicable,
  - e) Medical history,
  - f) Beneficiary's presenting complaint,
  - g) Diagnosis, and
  - h) Specific name/type of all diagnostic studies and results/findings of the studies.
2. At the hub site:
  - a) Date(s) of service,
  - b) Beneficiary demographic information,
  - c) Medical history,
  - d) Beneficiary's presenting complaint,
  - e) Diagnosis,
  - f) Specific name/type of all diagnostic studies and results/findings of the studies, and
  - g) Radiological images.

G. Teleradiology systems must provide network and software security protocols to protect the confidentiality of a beneficiary's identification and imaging data.

1. Measures must be implemented to safeguard the data and to ensure data integrity against intentional or unintentional corruption of the data.
2. All providers must ensure confidentiality in accordance with HIPAA privacy regulations.

Source: Miss. Code Ann. §§ 43-13-121, 43-13-117(3).

*Rule 1.5: Port Films*

- A. Medicaid does not cover the review and interpretation of port films, referred to as the professional component.
- B. Medicaid covers the taking of the port film, one (1) unit for every five (5) treatments, referred to as the technical component.
- C. Multiple treatments representing two (2) or more treatment sessions furnished on the same day are covered if the medical record contains documentation of a distinct break in therapy sessions and the treatments are of the character usually furnished on different days.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.6: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.7: Computed Tomography (CT) Scans*

Effective July 1, 2013, Computed Tomography scans must be prior authorized by the radiology UM/QIO as noted in Rule 1.10.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added to correspond with approved SPA 2013-007 effective 07/01/2013

*Rule 1.8: Magnetic Resonance Angiography (MRA)*

Effective July 1, 2013, Magnetic Resonance Angiography must be prior authorized by the radiology UM/QIO as noted in Rule 1.10.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added to correspond with approved SPA 2013-007 effective 07/01/2013

*Rule 1.9: Magnetic Resonance Imaging (MRI)*

Effective July 1, 2013, Magnetic Resonance Imaging must be prior authorized by the radiology UM/QIO as noted in Rule 1.10.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added to correspond with approved SPA 2013-007 effective 07/01/2013

*Rule 1.10: Prior Authorization*

- A. Effective July 1, 2013, prior authorization is required by the radiology UM/QIO for medical necessity and appropriateness of service for the following advanced imaging procedures:
  - 1. Computed Tomography (CT) Scans,
  - 2. Magnetic Resonance Imaging (MRI),
  - 3. Magnetic Resonance Angiography (MRA),
  - 4. Positron Emission Tomography (PET) Scans, and
  - 5. Nuclear Cardiac Studies.
- B. Prior Authorization for advanced imaging procedures listed in Rule 1.10 A is required in all settings except in an:
  - 1. Inpatient hospital,
  - 2. Emergency room, or
  - 3. Outpatient hospital twenty-three (23) hour observation period.
- C. The prior authorization must be requested by either the ordering or rendering provider.
- D. Prior authorization must be received prior to the procedure being rendered except in medically urgent situations.
- E. In the event of a medical emergent condition or situation a retrospective review may be requested.
  - 1. The request must be received by the radiology UM/QIO within three (3) business days from the date of service.
  - 2. The Division of Medicaid defines a medical emergent condition or situation as one which:
    - a) The patient faces immediate risk to loss of life or limb,
    - b) Could seriously jeopardize the life or health of the beneficiary or their ability to regain maximum function based on a prudent layperson's judgment, or

- c) In the opinion of a practitioner with knowledge of the beneficiary's medical condition, would subject the beneficiary to severe pain that cannot be adequately managed without the requested advanced imaging procedure.

Source: Miss. Code Ann. § 43-13-121, 42 CFR §§ 431.10(e), 440.230(d)

History: Added to correspond with approved SPA 2013-007 effective 07/01/2013.

## **Title 23: Division of Medicaid**

### **Part 220: Radiology**

#### **Part 220 Chapter 1: General**

##### *Rule 1.1 Provider Enrollment Requirements*

- A. Radiology providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:
1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
  2. Written confirmation from the IRS confirming ~~your~~ the provider's tax identification number and legal name, and
  3. Clinical Laboratory Improvement Amendments (CLIA) certificate and completed Certification form, if applicable.
- B. Independent Diagnostic Testing Facility (IDTF) providers can only be enrolled for submission of crossover claims.
1. IDTF providers cannot be enrolled for submission of straight Medicaid claims.
  2. A copy of the Medicare certification from the Medicare Intermediary is required.
  3. The Explanation of Medicare Benefits (EOMB) is not acceptable.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 455, Subpart E.

##### *Rule 1.2: Positron Emission Tomography (PET) Scans*

###### ~~A. Covered PET Scans~~

A. Positron Emission Tomography (PET) scans must be prior authorized by the radiology Utilization Management/Quality Improvement Organization (UM/QIO) as noted in Rule 1.10.

~~4B.~~ PET Scans are covered by Medicaid for beneficiaries with malignant cancers listed in Part 220-Rule 1.2.B for the following reasons: ~~diagnosing certain malignancies in these following situations:~~

1. Initial diagnosis,
  - a) When replacing an invasive procedure, or

~~b)2. For staging when there is documented evidence of a primary tumor by CT, MRI, X-ray, or tissue sample, or~~

~~e)3. Restaging after a course of treatment therapy, or~~

~~5. e)4. Evaluating recurrence prior to surgery as an alternative to gallium scan but is not covered for evaluating regional nodes, or~~

~~d)5. ~~When used~~ In lieu of other modalities such as CT, MRI, and X-ray.~~

2C. PET scans are covered by Medicaid for beneficiaries with the following malignant cancers for the in the situations reasons listed in Part 220, Chapter 1, Rule 1.2.A for these diagnoses only:

1. Characterization of solitary pulmonary nodules (SPN's),

2. Lung cancer, non-small cell,

3. Colorectal cancer,

4. Melanoma,

5. e) Evaluating recurrence prior to surgery as an alternative to gallium scan but is not covered for evaluating regional nodes. Move to Rule 1.2.A.4.

6. Lymphoma when used as an alternative to gallium scan,

7. Head and neck cancer, excluding thyroid and central nervous system, and

8. Esophageal cancer.

B. D. PET scans are covered for beneficiaries with Breast Cancer only for the following reasons:

1. Staging ~~patients~~ with distant metastasis, or

2. Restaging ~~patients~~ with loco-regional recurrence or metastasis, or

3. ~~For m~~Monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated.

~~4. PET Scans are not covered for the diagnosis of Breast Cancer.~~

CE. PET scans are covered for beneficiaries with Thyroid Cancer

~~1. For staging of recurrent or residual thyroid cancers of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan performed.~~

~~2. PET Scans are not covered for diagnosis or restaging of thyroid cancer.~~

F. PET scans are not covered for the:

~~1.4. PET scans are covered for the Initial diagnosings of Breast Cancer. or:~~

~~2. PET Scans are not covered for Initial diagnosis or restaging of thyroid cancer.~~

DG. PET scans are covered for the following Myocardial Imaging:

1. Perfusion of the Hheart

~~a) PET scans performed, either at rest or with pharmacological stress, used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients- beneficiaries with known or suspected coronary artery disease using the Federal Drug Administration (FDA)-approved radiopharmaceutical Rubidium 82 (Rb 82) or ammonia N-13 tracer are covered, when one (1) of these following criteria are met:~~

~~1a) The PET scan, whether at rest alone or at rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT);, or~~

~~2b) The PET scan, whether at rest alone or at rest with stress, is used performed following a inconclusive SPECT ~~that was found to be.~~~~

~~1) In these cases, ~~†~~The PET scan must ~~have been~~ be considered medically necessary in order to determine what medical or surgical intervention is required to treat the patient beneficiary.~~

~~2) For ~~purposed of~~ this requirement, The Division of Medicaid defines an inconclusive SPECT scan test is as a test(s) whose results are equivocal, technically uninterpretable, or discordant with a patient's beneficiary's other clinical data documentation and must be documented in the beneficiary's medical record file.~~

2. Myocardial Vviability a) using [18F]-fluorodeoxyglucose (FDG)-PET is covered for the determination of myocardial viability or following an inconclusive SPECT prior to revascularization.

~~ba) A SPECT scan will not be covered following an inconclusive PET scan.~~

b) Refer to Rule 1.2.F.(2).

FH. FDG-PET scans are covered for Refractory Seizures ~~FDG-PET is covered only for pre-surgical evaluation for the purpose of localization of a focus of refractory seizure activity.~~

FI. Documentation for all PET scans must:

~~1. Providers must maintain documentation that meets all the following criteria:~~

~~a)1. Documentation to assure the PET scans performed were~~ Include the referring physician's documentation of medically necessary and criteria met in Rule 2.1.A-G, did not

~~2. No unnecessary duplication~~ other covered diagnostic tests,

b) Beneficiary records are maintained for each beneficiary for whom a PET scan is done,

~~e)3. PET scan(s) must be~~ maintained in the referring doctor's physician's file.

~~4. Include and~~ documentation that the procedure involved only FDA approved drugs and devices and did not involve investigational drugs, as determined by the Food and Drug Administration FDA, and

~~d)5. The ordering physician is responsible for documenting the medical necessity of the PET scan and that it meets criteria as specified. The physician should have documentation in the beneficiary's medical record to~~ support the referral to the PET scan provider.

~~2. Records must~~ be maintained in accordance with Part 200, Chapter 3, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.2.A. to correspond with approved SPA 2013-007 effective 07/01/2013

### *Rule 1.3: Radiopharmaceuticals*

A. The Division of Medicaid covers radiopharmaceuticals administered for diagnostic or therapeutic purposes and are covered separately from the diagnostic procedure or visit, and with the appropriate procedure code that accurately describes the agent administered and

1. Only the units administered are covered.

2. Radiopharmaceuticals must be approved by the Federal Drug Administration (FDA), used in accordance with FDA approved conditions, and be administered in dosages that meet FDA regulations.

3. Radiopharmaceuticals ~~that are~~ considered experimental, investigative, or in clinical trial are not covered.

B. The Division of Medicaid covers radiopharmaceuticals administered in a physician office, clinic, or independent radiology facility, ~~at the lower of the provider's charge or the Medicaid fee for the date of service.~~

AC. Radiopharmaceuticals administered in an outpatient hospital setting facility ~~may be~~ is reimbursed in accordance with the Division of Medicaid's outpatient hospital methodology.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.4: Teleradiology*

A. The Division of Medicaid covers medically necessary teleradiology services.

B. The Division of Medicaid defines a: ~~the following as:~~

1. Consulting provider ~~means as~~ a licensed physician who ~~provides the interpretation of the radiological image, of the professional component, at the distant site, or hub site.~~ The consulting provider must be licensed in the state within the United States in which he/she practices.
2. ~~Hub site or distant site, means as~~ the location of the teleradiology consulting provider; ~~also referred to as the distant site.~~ The hub site providers is reimbursed for the professional component of the service.
3. Referring provider ~~means as~~ a licensed physician, physician assistant, or nurse practitioner who orders the radiological service. The referring provider practitioner must be licensed in the state within the United States in which he/she practices.
4. Spoke site, also referred to as the originating site, means as the location where the beneficiary is receiving the teleradiology service; ~~also referred to as the originating site.~~ The spoke site providers is reimbursed for the technical component of the service.
5. Store-and-forward ~~means as~~ telecommunication technology for the transfer of medical data from one (1) site to another through the use of a camera; or similar device that records; or stores; an image which is ~~then sent~~ transmitted, or forwarded, via telecommunication to another site for teleconsultation.
6. Teleradiology as is the electronic transmission of radiological images, known as store-and-forward images, ~~such as x rays, CTs, or MRIs, known as store and forward images,~~ from one (1) location to another for the purposes of interpretation.
7. Transmission Cost ~~means as~~ the cost of the line charge incurred during the time of the transmission of a telehealth service.

C. The Division of Medicaid Covered Services

1. ~~Medicaid covers for~~ One (1) technical and one (1) professional component for each teleradiology procedure services.
2. ~~Medicaid covers in~~ Medically necessary teleradiology only when the originating site, or spoke site, documents that there are no local radiologists to interpret the images.
3. ~~The provider at the originating site, or spoke, must be enrolled as a Mississippi Medicaid provider in order to bill for~~ The technical component of the radiological service at the originating site for only providers enrolled as a Mississippi Medicaid provider. The spoke site provider is covered using the appropriate procedure radiological code with the appropriate modifier.
4. ~~The provider at the distant site, or hub, must be enrolled as a Mississippi Medicaid provider in order to bill for~~ The professional component of the radiological service at the hub site only for providers enrolled as a Mississippi Medicaid provider. is covered using the appropriate procedure radiological code and modifier.
5. ~~Medicaid covers in~~ Hospitals for purchased or contractual teleradiology services, under their physician group provider number only.

D. The Division of Medicaid does not cover: Non covered services

1. ~~Medicaid does not cover~~ The transmission cost or any other associated cost of teleradiology.
2. ~~Hospitals, independent radiological clinics, or physician clinics are not covered for both the technical and professional component of teleradiology services under their own for one (1) provider number. A p~~ Providers may cannot bill for services performed by another providers.

E. The teleradiology service must Quality of Service

1. ~~The available teleradiology system must p~~ Provide images without clinically significant loss of sufficient quality to perform the indicated task. When a teleradiology system is used to render the official interpretation, there must not be a clinically significant loss of data from image acquisition through transmission to final image display.—For transmission of images for display use only, the image quality should be sufficient to satisfy the needs to the clinical circumstance to enable the consulting provider to accurately interpret the image.
2. ~~All Use equipment must~~ which provides image quality and availability appropriate to the clinical need.

3. ~~The radiologic examination at the originating site, or spoke, must be~~ performed at the originating site by qualified personnel trained in the performance of the specified radiological service and operating within the licensure and/or certification requirements of the state in which the service is being performed. Technicians must ~~be working~~ under the supervision of a qualified licensed physician.

F. Teleradiology Documentation must include at a minimum:

- ~~1. Services delivered via teleradiology are held to the same standard of documentation as non-teleradiology services.~~

~~1.2. In each instance, the provider file a~~At the spoke site location, must include at a minimum:

- a) Documentation of ~~t~~The reason that for the teleradiology was utilized to deliver the service,
- b) Date(s) of service,
- c) Beneficiary demographic information,
- d) Signed consent for treatment, if applicable,
- e) Medical history,
- f) ~~Patient's~~ Beneficiary's presenting complaint,
- g) Diagnosis, and
- h) Specific name/type of all diagnostic studies and results/findings of the studies.

~~2.3. In each instance, the provider file a~~At the hub site, location must include at a minimum:

- a) Date(s) of service,
- b) Beneficiary demographic information,
- c) Medical history,
- d) ~~Patient's~~ Beneficiary's presenting complaint,
- e) Diagnosis,
- f) Specific name/type of all diagnostic studies and results/findings of the studies, and
- g) Radiological images.

G. ~~Security~~—Teleradiology systems must provide network and software security protocols to protect the confidentiality of a beneficiary's~~sies'~~ identification and imaging data.

~~1. There must be m~~Measures must be implemented to safeguard the data and to ensure data integrity against intentional or unintentional corruption of the data.

1. All providers ~~are responsible for~~ must ensureing confidentiality in accordance with HIPAA privacy regulations.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(3).

*Rule 1.5: Port Films*

A. Medicaid ~~does not cover—considers~~ the review and interpretation, referred to as the professional component, of port films, ~~as part of the weekly clinical treatment management by the physician and does not cover.~~

B. ~~The technical component is covered for the provider who takes the films.~~ Medicaid covers the taking of the port film, referred to as the technical component, one (1) unit for every five (5) treatments.

C. Multiple treatments representing two (2) or more treatment sessions furnished on the same day ~~may~~ are covered if the medical record contains documentation ~~be counted as long as there has been~~ of a distinct break in therapy sessions and the treatments are of the character usually furnished on different days.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.6: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.7: Computed Tomography (CT) Scans*

Effective July 1, 2013, Computed Tomography scans must be prior authorized by the radiology UM/QIO as noted in Rule 1.10.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added to correspond with approved SPA 2013-007 effective 07/01/2013

Rule 1.8: Magnetic Resonance Angiography (MRA)

Effective July 1, 2013, Magnetic Resonance Angiography must be prior authorized by the radiology UM/QIO as noted in Rule 1.10.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added to correspond with approved SPA 2013-007 effective 07/01/2013

Rule 1.9: Magnetic Resonance Imaging (MRI)

Effective July 1, 2013, Magnetic Resonance Imaging must be prior authorized by the radiology UM/QIO as noted in Rule 1.10.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added to correspond with approved SPA 2013-007 effective 07/01/2013

Rule 1.10: Prior Authorization

A. Effective July 1, 2013, prior authorization is required by the radiology UM/QIO for medical necessity and appropriateness of service for the following advanced imaging procedures:

1. Computed Tomography (CT) Scans,
2. Magnetic Resonance Angiography (MRA),
3. Magnetic Resonance Imaging (MRI),
4. Positron Emission Tomography (PET) Scans, and
5. Nuclear Cardiac Studies.

B. Prior Authorization for advanced imaging procedures listed in Rule 1.10 A is required in all settings except in an:

1. Inpatient hospital,
2. Emergency room, or
3. Outpatient hospital twenty-three (23) hour observation period.

C. The prior authorization must be requested by either the ordering or rendering provider.

D. Prior authorization must be received prior to the procedure being rendered, except in medically urgent conditions or situations.

E. In the event of a medical emergent condition or situation a retrospective review may be requested.

1. The request must be received by the radiology UM/QIO within three (3) business days from the date of service.

2. The Division of Medicaid defines a medical emergent condition or situation as one which:

a) The patient faces immediate risk to loss of life or limb,

b) Could seriously jeopardize the life or health of the beneficiary or their ability to regain maximum function based on a prudent layperson's judgment, or

c) In the opinion of a practitioner with knowledge of the beneficiary's medical condition, would subject the beneficiary to severe pain that cannot be adequately managed without the requested advanced imaging procedure.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added to correspond with approved SPA 2013-007 effective 07/01/2013