Administrative Code

Title 23: Medicaid
Part 220
Radiology Services

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.