



Florida Medicaid

Radiology and Nuclear Medicine Services
Coverage Policy

Agency for Health Care Administration



Table of Contents

1.0	Introduction	1
1.1	Florida Medicaid Policies	1
1.2	Statewide Medicaid Managed Care Plans	1
1.3	Legal Authority	1
1.4	Definitions	1
2.0	Eligible Recipient	2
2.1	General Criteria	2
2.2	Who Can Receive	2
2.3	Coinsurance and Copayments	2
3.0	Eligible Provider	2
3.1	General Criteria	2
3.2	Who Can Provide	2
4.0	Coverage Information	2
4.1	General Criteria	2
4.2	Specific Criteria	3
4.3	Early and Periodic Screening, Diagnosis, and Treatment	3
5.0	Exclusion	3
5.1	General Non-Covered Criteria	3
5.2	Specific Non-Covered Criteria	4
6.0	Documentation	4
6.1	General Criteria	4
6.2	Specific Criteria	4
7.0	Authorization	4
7.1	General Criteria	4
7.2	Specific Criteria	4
8.0	Reimbursement	4
8.1	General Criteria	4
8.2	Claim Type	4
8.3	Billing Code, Modifier, and Billing Unit	4
8.4	Diagnosis Code	4
8.5	Rate	5

1.0 Introduction

Florida Medicaid radiology and nuclear medicine services provide diagnostic radiology, diagnostic ultrasound, radiation therapy, and nuclear medicine services.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render radiology and nuclear medicine services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid radiology and nuclear medicine services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440 , 441, and 410.32
- Section 409.905, Florida Statutes (F.S.)
- Rule 59G-4.240, F.A.C.

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to Florida Medicaid's Definitions Coverage Policy.

1.4.1 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.2 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.4 High-Risk Pregnancy

A pregnancy in which the woman whose medical history and diagnosis indicates, without consideration of a previous cesarean section, that a normal uncomplicated pregnancy and delivery are unlikely to occur.

1.4.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.6 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.7 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary radiology and nuclear medicine services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments

Recipients are responsible for the following copayment(s) in accordance with section 409.9081, F.S., unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For information on copayment requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Coverage Policy.

- \$1.00 per portable X-ray service, per day
- \$2.00 per practitioner office visit, per day
- \$3.00 per federally qualified health center visit, per day
- \$3.00 per rural health clinic visit, per day

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid radiology and nuclear medicine services.

3.2 Who Can Provide

Services must be rendered by one of the following:

- County health departments administered by the Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Portable X-Ray providers certified by Medicare in accordance with 42 CFR 410.32(c)
- Practitioners licensed in accordance with Chapter 154, F.S. and working within the scope of their practice
- Rural health clinics certified by Medicare

Providers performing complex, detailed ultrasounds must be enrolled with Florida Medicaid as one of the following specialty types:

- Radiology
- Maternal/fetal

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary

- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following services in accordance with the American Medical Association's Current Procedural Terminology and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

- Bone and joint studies
- Diagnostic radiology (imaging)
- Mammography (breast)
- Nuclear medicine
- Portable X-Ray
- Radiation oncology
- Radiopharmaceuticals

4.2.1 Fetal Biophysical Profile

Up to two biophysical profiles per pregnancy.

4.2.2 Fetal Echocardiography

- One per pregnancy.
- Up to two follow-up, or repeat, services for recipients with a high-risk pregnancy.

4.2.3 Fetal Velocimetry

Up to two of each of the following for recipients with a high-risk pregnancy:

- Umbilical artery doppler velocimetry
- Middle cerebral artery doppler velocimetry

4.2.4 Mammography Screening

One per year, per recipient.

4.2.5 Nuchal Translucency Measurement

One ultrasound for nuchal translucency measurement per pregnancy for recipients with a high-risk pregnancy.

4.2.6 Ultrasounds

- Up to three obstetrical ultrasounds per pregnancy.
- Up to three transvaginal obstetrical ultrasounds for recipients with a high-risk pregnancy.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Coverage Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0

- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with Rule 59G-1.057, F.A.C.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Coverage Policy.

6.2 Specific Criteria

There is no coverage-specific documentation requirement for this service.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Coverage Policy.

7.2 Specific Criteria

Providers must obtain authorization for radiology and nuclear medicine services from the quality improvement organization when indicated on the applicable Florida Medicaid fee schedule(s), and for transvaginal obstetrical ultrasounds and obstetrical ultrasounds for high-risk pregnancies beyond the coverage specified in section 4.2.6

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Modifier

Providers must include the following modifiers, as appropriate, on the claim form:

- 26 Professional component performed by a different provider than the technical component
- TC Technical component performed by a different provider than the professional component
- TH Multiple gestations

Providers may not include both the TC and 26 modifiers for a single procedure on the claim form.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.