

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Medicare Coverage of Radiology and Other Diagnostic Services

Fact Sheet

This fact sheet provides basic information about Medicare coverage, billing and payment of radiology and other diagnostic services. This fact sheet is suggested for physicians, providers and suppliers.

Overview

Medicare covers radiology and other diagnostic services. Radiologist services are performed by, or under the direction or supervision of, a physician who is certified or eligible to be certified by the American Board of Radiology or for whom radiology services account for at least 50 percent of the total amount of charges made under Medicare. Further, effective for dates of service on or after January 1, 2012, Medicare requires that the technical component (TC) of Advanced Diagnostic Imaging e.g., Magnetic Resonance Imaging (MRI), Computed Tomography (CT), and Nuclear Medicine Imaging, including Positron Emission Tomography (PET)) be billed only by those providers/suppliers who are accredited by one of the following organizations:

- The American College of Radiology;
- The Intersocietal Accreditation Commission; or
- The Joint Commission.

More details on accreditation requirements are in the Medicare Learning Network® (MLN) article SE1122, which is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1122.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Medicare Coverage

Medicare generally covers: X-rays, including portable x-rays; Computerized Axial Tomography (CAT) procedures, including portable CT procedures; (MRI) procedures; Magnetic Resonance Angiography (MRA) procedures; Nuclear Medicine Imaging procedures and radionuclides used in the procedures; Diagnostic mammography and certain screening mammography; Ultrasound (US) diagnostic procedures; PET and diagnostic imaging agents; PET for certain oncologic conditions; Radiation Oncology; and Bone Mass Measurements.

Billing and Payment on Medicare Professional Claims

Radiology and other diagnostic services are billed under Medicare Part B to Medicare Carriers and A/B Medicare Administrative Contractors (A/B MAC) using acceptable Healthcare Common Procedure Coding System (HCPCS) codes for radiology and other diagnostic services taken primarily from the Current Procedural Terminology (CPT®) – 4 portion of HCPCS.

Note: Hospital outpatient radiology and other diagnostic services are Medicare Part B services.

Radiology services are generally paid under fee schedules where payment is the lower of the charge or the Medicare Physician Fee Schedule (MPFS) amount. Deductible and coinsurance apply, and coinsurance is based on the allowed amount.

Payment Conditions for Radiology Services

Medicare pays under the MPFS for the TC of radiology services furnished to Medicare beneficiaries who are not patients of any hospital, and who receive services in a physician's office, a freestanding imaging or radiation oncology center, Ambulatory Surgical Center (ASC), or other setting that is not part of a hospital.

Where procedures are furnished in a leased hospital radiology department to a beneficiary who is neither an inpatient nor an outpatient of any hospital, both the professional component (PC) and the TC of the services are payable under the physician fee schedule by the carrier or A/B MAC.



Definitions of Professional and Technical Components and Billing Codes

- The PC of a service is defined as the physician's work portion of a diagnostic test or radiology service, including the physician work, indirect practice expense and malpractice expense. It is a physician's interpretation of a diagnostic test. Because it is considered a physician service it is separately billable to the respective local Medicare contractor.
- Modifier 26 is used with the billing code to indicate that the PC is being billed.
- The TC of a service is defined as the staff and equipment costs of a diagnostic test or radiology service, which includes only the practice expense and malpractice expense. The TC of the test is, itself, considered a diagnostic test.
- Modifier TC is used with the billing code to indicate that the technical component is being billed.
- PC and TC do not apply to physician services that cannot be distinctly split into professional and technical components. No modifiers may be used with these billing codes.

Anti-Markup Payment Limitations for Professional and Technical Components

The Social Security Act established payment rules for certain diagnostic tests (other than clinical diagnostic laboratory tests) where the physician performing or supervising the test does not share a practice with the billing physician or other supplier.

- Effective January 1, 1994, the payment limit applies to the TC of the test.
- Effective January 1, 2003, the payment limit also applies to the PC.
- Examples of tests include: X-rays, EKGs, EEGs, cardiac monitoring, and ultrasound services.



Services Furnished in Skilled Nursing Facilities (SNF)

Payment for a SNF bill for radiology services furnished to its inpatients in a Part A covered stay is included in the SNF Prospective Payment System.

Radiology services furnished to outpatients of SNFs may be billed by the supplier performing the service or by the SNF under arrangements with the supplier.

The PC of radiology services performed by physicians for SNF inpatients and SNF outpatients may be separately billed and paid.

Billing and Payment on Medicare Institutional Claims

Services Furnished in Hospitals to Inpatients

Radiology and other diagnostic services are billed under Part A to Medicare Fiscal Intermediaries (FIs) and A/B MACs, using revenue codes, HCPCS code, line item dates of service, units, and applicable HCPCS modifiers. Charges must be reported by HCPCS code.

Payment for physicians' radiological services to the hospital, e.g., administrative or supervisory services, and for provider services needed to produce the radiology service, is made by the FI or A/B MAC to the hospital as a provider service.

FIs and A/B MACs include the TC of radiology services for hospital inpatients in the Inpatient Prospective Payment System payment to hospitals, except that payment to Critical Access Hospitals for inpatients is made at 101 percent of reasonable cost. Carriers may not pay for the TC of radiology services furnished to hospital patients.

The PC of radiology services performed by physicians for hospital inpatients may be separately billed by the physician and paid by the carrier or MAC.

Services Furnished in Hospitals to Outpatients

Radiology and other diagnostic services furnished to hospital outpatients are paid under the Outpatient Prospective Payment System to the hospital.

The PC of radiology services performed by physicians for hospital outpatients may be separately billed and paid.



Services Furnished by Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)

Independent and provider-based RHCs and FQHCs bill for the PC using revenue codes 52X. RHCs are not required to submit HCPCS codes for radiology services. However, FQHCs are required to submit HCPCS codes.

The TC is outside the scope of the RHC/FQHC benefit. Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to the carrier and A/B MAC.

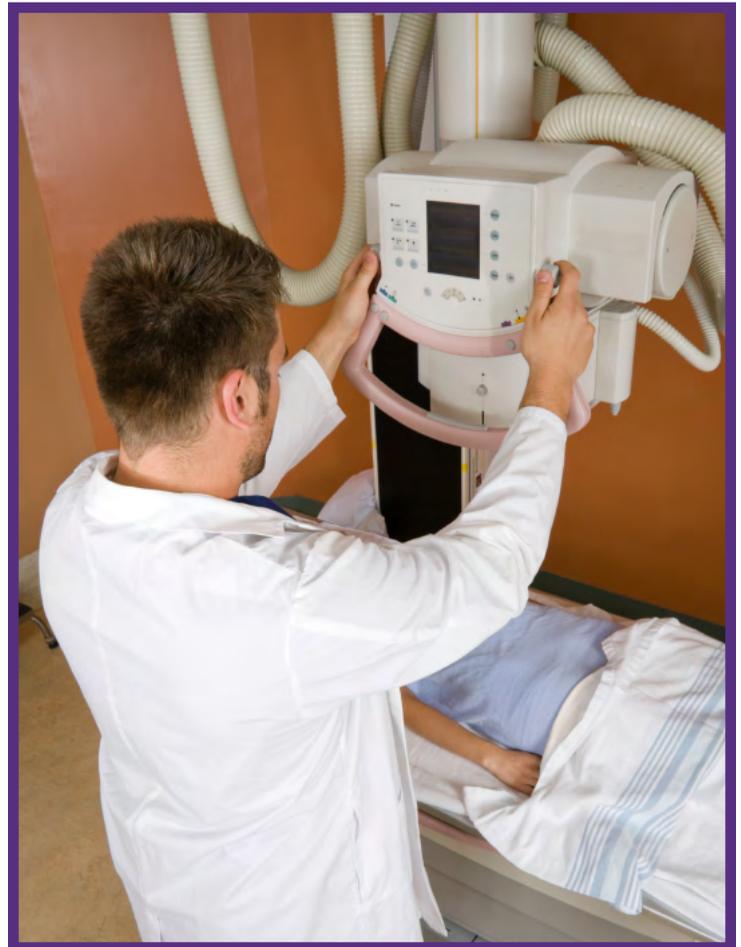
Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed to the FI and A/B MAC on the base-provider type of bill (TOB).

Resources

The Medicare Claims Processing Manual, Pub. 100-04, Chapter 13 – Radiology Services and Other Diagnostic Procedures, contains detailed information about billing and payment of radiology and other diagnostic services. This manual is available at, <http://www.cms.gov/manuals/downloads/clm104c13.pdf> on the CMS website.

The Medicare National Coverage Determinations (NCD) Manual, Pub. 100-03, Chapter 4, Paragraph 220, contains detailed coverage instructions for radiology and other diagnostic tests, including nationally covered and non-covered indications and coverage with evidence development. This manual is available at, http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf on the CMS website.

The Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions. This database is available at, <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website.



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