Radiology and Non-invasive Diagnostic Centers

Medicaid covers radiology and non-invasive diagnostic tests necessary to establish a diagnosis, prescribe treatment and provide progressive follow-up or staging.

Services must be directly related to an illness or injury, or to improve the functioning of a malformed body part.

Services must be provided in accordance with written orders from a physician, physician's assistant or an advanced practitioner of nursing.

Chapter 300 of the Nevada Medicaid Services Manual (MSM) provides state policy, coverage and service limitations and additional requirements for provider type 27.

Billing

Radiology and non-invasive diagnostic centers (provider type 27) must use the 837P Professional Health Care Claim to bill for services. Services provided through an outpatient hospital (provider type 12) must be billed using the 837I Institutional Health Care Claim. See Provider Web Portal (PWP) User Manual Chapter 3 Claims for billing instructions and the EDI companion guides.

Rates

Provider type 27 reimbursement rates are provided on the Nevada Medicaid Rates webpage.

Prior authorization requirements

You can request prior authorization online at medicaid.nv.gov (select "PA Login" from the "Prior Authorization" tab) and submitting the Outpatient Medical/Surgical Services Prior Authorization Request (FA-6) form.

For questions regarding prior authorization, call the Gainwell Technologies Prior Authorization Department at **(800) 525-2395.**

The following services always require prior authorization:

- **Non-emergency** services provided outside of Nevada (MSM 301A.8)
- **Twenty-four hour electroencephalogram (EEG) recordings and EEG mapping** (MSM 303.3A)
- **Electromyography** (codes 95860-95875)
- **Nerve Conduction Studies** (NCS) (codes 95907-95913)
- **H-reflex** tests (code 95937)
- **Short-latency Somatosensory Evoked Potential Study** (codes 95925-95927)
- **Magnetoencephalography (MEG)** testing (codes 95965-95967)

For **sleep studies, polysomnograms** and **multiple sleep latency testing**, prior authorization is required to exceed 2 instances in a 12-month period.

Computed tomography (CAT) scans, X-rays, bone scans and **ultrasounds** do not require prior authorization. For OB ultrasound requirements, please refer to MSM Chapter 600, section 603.4.A.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Radiology and Non-invasive Diagnostic Centers

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Electronic Claims instructions: When reporting the provider who ordered services such as diagnostic and lab, use Loop ID-2310A. For ordered services such as Durable Medical Equipment, use Loop ID-2420E. For detailed information, refer to the 837P FFS Companion Guide located at: medicaid.nv.gov/providers/edi.aspx

Direct Data Entry/Provider Web Portal instructions: On the Service Detail line enter the OPR provider's NPI in the Referring/Ordering Provider ID field, and select "Yes" or "No" to indicate it if is an Ordering Provider. For further instructions, see the Provider Web Portal (PWP) User Manual Chapter 3.

Covered services

Medicaid covers the following common diagnostic services:

- An **annual mammogram** for women age 40+ and for women ages 35-39 who are considered at high risk for breast cancer. For all women ages 35-39, a baseline mammogram is allowed once. Prior authorization is not required. When the professional component of mammography services is billed separately, the radiologist who interpreted the mammogram produced by an FDA-certified facility must also be FDA certified.
- **Electrodiagnostic testing** when preceded by a neurological evaluation. The examination and testing may be billed when both occur with the same provider on the same day.
- **Electromyography** (EMG). The service descriptor bundles all single fiber needle EMG electrode insertions performed in a single muscle into one unit of the code. Thus, although 20 "pairs" (motor units with two or more muscle fibers activated near enough to the single fiber EMG electrode to be recorded) must be analyzed in order to reach statistical significance in each muscle studied, all electrode insertions necessary to complete the study on a single muscle are to be coded using a single unit.
- **Nerve Conduction Studies** (NCS). Report the diagnostic codes only once when multiple sites on the same nerve are stimulated or recorded.
- **F-wave** studies. Bill the code only once when multiple sites on the same nerve are stimulated or recorded, because the F-wave studies assess motor nerve function along the entire extent of each selected nerve.
- **Reflex test**. Bilateral studies on the same muscle are reported using the bilateral procedure code modifier.
- **Neuromuscular junction testing**.
- **Evoked Potentials** (SEP, SSEP, VEP and AEP) for certain diagnoses. When billing SEP codes, multiple nerves and dermatomes studied in a single limb are bundled. A maximum of two codes can be submitted for all upper or lower limb studies performed on a given recipient on the same day. For example, multiple dermatomal SEP studies would be bundled into the two codes for upper and lower limb studies regardless of how many

dermatomes are studied. The SEP study codes are defined as bilateral studies; thus, the modifier for partially reduced services should be used for billing.

- **Magnetoencephalography** (MEG) (see MSM Section 303.6 for coverage and limitations).
- **Sleep testing** in a certified sleep disorder clinic (see MSM section 303.7 for coverage and limitations).
- **Radiopharmaceuticals and Contrast Agents** (see MSM section 303.8 for coverage and limitations). Reimbursement rates are on the Nevada Medicaid Rates webpage.
- **Payment for transportation** is based on a single trip to a particular address. No transportation charge is allowed when the x-ray equipment is stored in a site for use as needed (e.g., a nursing facility). A set-up component is payable for each radiologic procedure, other than a retake of the same procedure, during single recipient and multiple recipient trips under Healthcare Common Procedure Coding System (HCPCS) code. Set-up payments are not paid for echocardiograph (EKG) services furnished by a portable x-ray supplier.

Providers are encouraged to use the following online tools, which are available through the secured and unsecured areas of the Provider Web Portal, to search fee schedules and authorization criteria.

- Search Fee Schedule: This tool allows providers and their delegates the ability to search fee schedules online for specific procedure codes.
- Authorization Criteria: This tool allows providers and their delegates the ability to search authorization criteria for specific procedure codes.

Non-covered services

Medicaid does not cover:

- **Investigational** testing.
- **Experimental** testing.
- **Duplicative** testing when results of previous testing are still pertinent.