Radiologic Diagnostic Procedures

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Coverage Guidelines

Diagnostic radiologic procedures are covered when Medicare criteria are met.

Note: Radiology prior authorization programs exist for some markets for MRIs, MRAs, PET scans and nuclear medicine studies. Reference materials are available at UnitedHealthcare Radiology Prior Authorization and Notification.

Diagnostic X-Rays

For coverage guidelines, refer to the:
• Medicare Benefit Policy Manual, Chapter 15, §80 – Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests.
Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed April 1, 2021)

**X-Ray, Radium, and Radioactive Isotope Therapy**


**Bone (Mineral) Density Studies /Mass Measurements**

Refer to the Coverage Summary titled Bone Density Studies/Bone Mass Measurements.

**Diagnostic Mammogram**

For coverage guidelines for diagnostic mammogram, refer to the NCD for Mammograms (220.4).

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed April 1, 2021)

For coverage guidelines for screening mammogram, refer to the Coverage Summary titled Preventive Health Services and Procedures.

**Ultrasonography/Ultrasound**

For coverage guidelines, refer to the National Coverage Determination (NCD) for Ultrasound Diagnostic Procedures (220.5).

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed April 1, 2021)

**Computerized Tomography (CT scan)**

Refer to NCD for Computerized Tomography (220.1).

Notes:
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.
- For states/territories with no LCDs/LCAs, for uses of CT scans not specifically addressed by the National Coverage Determination (NCD) for Computerized Tomography (220.1), refer to the following for coverage guidelines:
  - For regions/states/territories not involved in the Radiology Prior Auth Program, refer to the nationally recognized guidelines, i.e., InterQual® Guidelines. (Accessed April 1, 2021)

**Single Photon Emission Computed Tomography (SPECT)**

For coverage guidelines, refer to the NCD for Single Photon Emission Computed Tomography (SPECT) (220.12).

Notes:
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

For states/territories with no LCDs/LCAs, for uses of SPECT not specifically addressed by the National Coverage Determination (NCD) for SPECT (220.12), refer to the following for coverage guidelines:

For regions/states/territories not involved in the Radiology Prior Auth Program, see the nationally recognized guidelines, i.e., InterQual® Guidelines. (Accessed April 1, 2021)

**Magnetic Resonance Imaging (MRI)**


**Notes:**
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).
- For states/territories with no LCDs/LCAs, for uses of MRI not specifically addressed by the National Coverage Determination (NCD) for MRI (220.2), refer to the following for coverage guidelines:
  - For regions/states/territories not involved in the Radiology Prior Auth Program, see the nationally recognized guidelines, i.e., InterQual® Guidelines.
- For payment rules for NCDs requiring CED, see the Coverage Summary titled [Experimental Procedures and Items, Investigational Devices and Clinical Trials](https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index) (Accessed April 1, 2021)

**Magnetic Resonance Angiography (MRA) (MRI for Blood Flow)**


**Notes:**
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).
- For states/territories with no LCDs/LCAs, for uses of MRA not specifically addressed by the National Coverage Determination (NCD) for MRI (220.2), refer to the following for coverage guidelines:
  - For regions/states/territories not involved in the Radiology Prior Auth Program, refer to the nationally recognized guidelines, i.e., InterQual® Guidelines.

**Ultra Fast or Multislice CT**

Refer to the Coverage Summary titled [Computed Tomographic Angiography (CTA)/Electron Beam Computed Tomography (EBCT) of the Chest](https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index).

**Proton Emission Tomography**


**Percutaneous Image-Guided Breast Biopsy**

Percutaneous image-guided breast biopsy is covered when criteria are met. Refer to the [NCD for Percutaneous Guided Breast Biopsy (220.13)](https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index). (Accessed April 1, 2021)
Portable Hand-Held X-Ray Instrument
Portable hand-held X-ray instrument is covered. Refer to the [NCD for Portable Hand-Held X-ray Instrument (220.10)](https://example.com). (Accessed April 1, 2021)

Thermography
Thermography for any indication is not covered. Refer to the [NCD for Thermography NCD (220.11)](https://example.com). (Accessed April 1, 2021)

Infrared Therapy Devices
Infrared devices therapy devices are not covered. Refer to the [NCD for Infrared Therapy Devices (270.6)](https://example.com). (Accessed April 1, 2021)

UltraFast CT Scanning for Screening Purposes
Refer to the Coverage Summaries titled Gastroesophageal and Gastrointestinal (GI) Services and Procedures and [Computed Tomographic Angiography (CTA)/Electron Beam Computed Tomography (EBCT) of the Chest](https://example.com).

Experimental or Investigational Procedures
Refer to the Coverage Summary titled Experimental Procedures and Items, Investigational Devices and Clinical Trials.

Transillumination Light Scanning or Diaphanography
Transillumination light scanning or diaphanography is not covered. Refer to the [NCD for Transillumination Light Scanning and Diaphanography (30.9)](https://example.com). (Accessed April 1, 2021)

Definitions

**Diagnostic Services**: A service is "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury. Refer to the [Medicare Benefit Policy Manual, Chapter 6, §20.4.1 Diagnostic Services Defined](https://example.com). (Accessed April 1, 2021)

### Policy History/Revision Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Summary of Changes</th>
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</table>
| 04/20/2021 | **Template Update**  
  - Reformatted policy; transferred content to new template  
**Coverage Guidelines**  
* **Obstetrical Ultrasound (removed)**  
  - Removed coverage guidelines [duplicative to language outlined in the referenced National Coverage Determination (NCD) titled Ultrasound Diagnostic Procedures (220.5); refer to the Ultrasonography/Ultrasound section]  
* **Bone (Mineral) Density Studies /Mass Measurements**  
  - Removed language indicating bone density studies are covered when criteria are met  
* **Diagnostic Mammogram**  
  - Added reference link to the Medicare Advantage Coverage Summary titled Preventive Health Services and Procedures  
* **Computerized Tomography (CT Scan)**  
  - Revised default guidelines for states with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) in regions not involved in the Radiology Prior Authorization Program; replaced reference to “MCG™ Care Guidelines” with “InterQual® Guidelines” |
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<td><strong>Ultrafast CT Scanning for Screening Purposes</strong></td>
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<td>• Removed notation indicating ultrafast CT scanning is never covered for screening (i.e., in the absence of signs, symptoms or disease)</td>
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**Instructions for Use**

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).
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