# Coverage Summary

## Radiologic Diagnostic Procedures

<table>
<thead>
<tr>
<th>Policy Number: R-002</th>
<th>Products: UnitedHealthcare Medicare Advantage Plans</th>
<th>Original Approval Date: 04/02/2008</th>
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<tr>
<td>Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 08/20/2019</td>
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</tbody>
</table>

### Related Medicare Advantage Policy Guidelines:

- Computed Tomography (NCD 220.1)
- Infrared Therapy Devices (NCD 270.6)
- Magnetic Resonance Imaging (NCD 220.2)
- Magnetic Resonance Spectroscopy (NCD 220.2.1)
- Mammograms (NCD 220.4)
- Percutaneous Image-Guided Breast Biopsy (NCD 220.13)
- Portable Hand-Held X-Ray Instrument (NCD 220.10)
- Single Photon Emission Computed Tomography (SPECT) (NCD 220.12)
- Thermography (NCD 220.11)
- Transillumination Light Scanning or Diaphanography (NCD 30.9)
- Ultrasound Diagnostic Procedures (NCD 220.5)

### INDEX TO COVERAGE SUMMARY

<table>
<thead>
<tr>
<th>I. COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diagnostic Radiological Services (Inpatient or Outpatient)</td>
</tr>
<tr>
<td>a. Diagnostic X-Rays</td>
</tr>
<tr>
<td>b. X-Ray, Radium, and Radioactive Isotope Therapy</td>
</tr>
<tr>
<td>c. Screening Mammogram</td>
</tr>
<tr>
<td>d. Obstetrical Ultrasound</td>
</tr>
<tr>
<td>e. Bone Density Studies</td>
</tr>
<tr>
<td>f. Diagnostic Mammogram</td>
</tr>
<tr>
<td>g. Ultrasonography/Ultrasound</td>
</tr>
<tr>
<td>h. Computerized Tomography (CT scan)</td>
</tr>
<tr>
<td>i. Single Photon Emission Computed Tomography (SPECT)</td>
</tr>
<tr>
<td>j. Magnetic Resonance Imaging (MRI)</td>
</tr>
<tr>
<td>k. Magnetic Resonance Angiography (MRA)</td>
</tr>
</tbody>
</table>

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

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 is 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).
Ultra Fast or Multislice CT
m. Proton Emission Tomography
n. Percutaneous Image-Guided Breast Biopsy
o. Portable Hand-Held X-Ray Instrument

2. Examples of radiologic procedures that are not covered
a. Thermography
b. Infrared Devices
c. Ultra Fast CT Scanning for Screening Purposes
d. Experimental or Investigational Procedures
e. Transillumination Light Scanning or Diaphanography
f. Magnetic Resonance Spectroscopy
g. Ultrasound Elastography

II. DEFINITIONS

III. REFERENCES

IV. REVISION HISTORY

V. ATTACHMENTS

I. COVERAGE

Coverage Statement: 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 Medicare Solutions Cardiology & Radiology Imaging Guidelines. (Accessed April 3, 2019)

Guidelines/Notes:
1. Diagnostic radiological services (inpatient or outpatient) used for screening, detection or treatment of disease, are covered when such services are determined to be reasonable and necessary. Examples include, but are not limited to:
   a. Diagnostic X-Rays

   See the following:
   • Medicare Benefit Policy Manual, Chapter 15, §80 - Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests. (Accessed April 3, 2019)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. See the following LCDs/LCAs at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx:
   o Radiologic Examination., Chest
   o Chest X-ray Policy
   o Sinus X-rays

(Accessed August 1, 2019)
b. **X-Ray, Radium, and Radioactive Isotope Therapy**
   

c. **Screening Mammogram**
   
   See the *Coverage Summary for Preventive Health Services and Procedures*.

d. **Obstetrical Ultrasound**
   
   See the *NCD for Ultrasound Diagnostic Procedures (220.5)*. (Accessed April 3, 2019)
   
   Also see the *Coverage Summary for Maternity and Newborn Care*.

e. **Bone Density Studies**
   
   Bone density studies are covered when criteria are met; see the *Coverage Summary for Bone Density Studies/Bone Mass Measurements*.

f. **Diagnostic Mammogram**
   
   See the *NCD for Mammograms (220.4)*. (Accessed April 3, 2019)
   
   Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. See the LCDs/LCAs for Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductography and the LCDs/LCAs for Screening and Diagnostic Mammography 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). (Accessed August 1, 2019)

g. **Ultrasound/Ultrasound**
   
   See the *NCD for Ultrasound Diagnostic Procedures (220.5)*. (Accessed April 3, 2019)
   

h. **Computerized Tomography (CT scan)**
   
   See the *NCD for Computerized Tomography (220.1)*. (Accessed April 3, 2019)

   **Notes:**
   
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. See the LCDs/LCAs for CT Scan 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). (Accessed August 1, 2019)
   
   - For states with no LCDs/LCAs, for uses of CT scans not specifically addressed by the *NCD for Computerized Tomography (220.1)*, refer to the following for coverage guidelines:
      
      - For regions involved in the Radiology Prior Auth Program, see the *UnitedHealthcare Medicare Solutions Cardiology & Radiology Imaging Guidelines*.
      
      - For regions not involved in the Radiology Prior Auth Program, see the nationally recognized guidelines, i.e., MCG™ Care Guidelines.

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

Notes:

- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for SPECT and compliance with these policies is required where applicable. The LCDs/LCAs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed August 1, 2019)

- For states with no LCDs/LCAs, for uses of SPECT not specifically addressed by the NCD for SPECT (220.12), refer to the following for coverage guidelines:
  - For regions involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Solutions Cardiology & Radiology Imaging Guidelines.
  - For regions not involved in the Radiology Prior Auth Program, see the nationally recognized guidelines, i.e., MCG™ Care Guidelines.

j. Magnetic Resonance Imaging (MRI)

See the NCD for Magnetic Resonance Imaging (220.2). (Accessed April 3, 2019)

Notes:

- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for MRI 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 August 1, 2019)

- For states with no LCDs/LCAs, for uses of MRI not specifically addressed by the NCD for MRI (220.2), refer to the following for coverage guidelines:
  - For regions involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Solutions Cardiology & Radiology Imaging Guidelines.
  - For regions not involved in the Radiology Prior Auth Program, see the nationally recognized guidelines, i.e., MCG™ Care Guidelines.


- For payment rules for NCDs requiring CED, see the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials.

k. Magnetic Resonance Angiography (MRA)

See the NCD Magnetic Resonance Imaging (220.2). (Accessed April 3, 2019)

Notes:

- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for MRA 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 August 1, 2019)

- For states with no LCDs/LCAs, for uses of MRA not specifically addressed by the NCD for MRI (220.2), refer to the following for coverage guidelines:
  - For regions involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Solutions Cardiology & Radiology Imaging Guidelines.
  - For regions not involved in the Radiology Prior Auth Program, see the
nationally recognized guidelines, i.e., MCG™ Care Guidelines.

1. **Ultra Fast or Multislice CT**
   Ultra Fast or Multislice CT is covered when criteria are met. See the Coverage Summary for Computed Tomographic Angiography (CTA)/Electron Beam Computed Tomography (EBCT) of the Chest.

m. **Proton Emission Tomography**
   Proton Emission Tomography is covered when criteria are met; see the Coverage Summary for Positron Emission Tomography (PET)/Combined PET-CT (Computed Tomography) for coverage criteria and information.

n. **Percutaneous Image-Guided Breast Biopsy**
   See the NCD for Percutaneous Guided Breast Biopsy (220.13). (Accessed April 3, 2019)

o. **Portable Hand-Held X-Ray Instrument**
   See the NCD for Portable Hand-Held X-ray Instrument (220.10). (Accessed April 3, 2019)

2. The following are examples of radiologic procedures that are not covered. This is not an exhaustive list of non-covered radiologic procedures. Any test that is not reasonable or necessary to diagnose, treat or screen for an illness or injury is not covered.

a. **Thermography**
   See the NCD for Thermography NCD (220.11). (Accessed April 3, 2019)

b. **Infrared Devices**
   See the NCD for Infrared Therapy Devices (270.6). (Accessed April 3, 2019)

c. **UltraFast CT Scanning for Screening Purposes**
   See the Coverage Summary for Gastroesophageal and Gastrointestinal (GI) Services and Procedures and the Coverage Summary for Computed Tomographic Angiography (CTA)/Electron Beam Computed Tomography (EBCT) of the Chest.

   Note: This is never covered for screening, i.e., in the absence of signs, symptoms or disease.

d. **Experimental or Investigational Procedures**
   See the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials

e. **Transillumination Light Scanning or Diaphanography**
   See the NCD for Transillumination Light Scanning and Diaphanography (30.9). (Accessed April 3, 2019)

f. **Magnetic Resonance Spectroscopy**
   See the NCD for Magnetic Resonance Spectroscopy (MRS) (220.2.1). (Accessed April 3, 2019)

g. **Ultrasound Elastography (CPT Codes 76981, 76982 and 76983)**
   - Medicare does not have a National Coverage Determination (NCD) for elastography.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and

Page 5 of 7
UHC MA Coverage Summary: Radiologic Diagnostic Procedures
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compliance with these policies is required where applicable. For state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment A).

- For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Omnibus Codes for coverage guideline. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

- Committee approval date: August 20, 2019
- Accessed August 20, 2019

### II. 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. See the Medicare Benefit Policy Manual, Chapter 6, §20.4.1 Diagnostic Services Defined. (Accessed April 3, 2019)

### III. REFERENCES

See above
IV. REVISION HISTORY

08/20/2019 Guideline 2.g [Ultrasound Elastography (CPT Codes 76981, 76982 and 76983)]
(new to policy)

- Added coverage guidelines to indicate:
  - Medicare does not have a National Coverage Determination (NCD) for elastography
  - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required, where applicable
  - For state-specific LCDs/LCAs, see Attachment A: LCD Availability Grid
  - For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes for applicable coverage guidelines

Attachments
- Added Attachment A: LCD Availability Grid for Ultrasound Elastography (CPT Codes 76981, 76982 and 76983)

V. ATTACHMENT(S)

Attachment A - LCD Availability Grid

**Ultrasound Elastography**

(CPT Codes 76981, 76982 and 76983)

CMS website accessed August 1, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
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<th>Contractor</th>
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<td>L36954</td>
<td>Noncovered Services other than CPT® Category III Noncovered Services</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
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<td>A56506</td>
<td>Billing and Coding: Noncovered Services other than CPT® Category III Noncovered Services</td>
<td>A and B MAC</td>
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<td>AL, GA, NC, SC, TN, VA, WV</td>
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<td>L33777</td>
<td>Noncovered Services</td>
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<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
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End of Attachment A