

Coverage Summary

Radiologic Diagnostic Procedures

Policy Number: R-002	Products: UnitedHealthcare Medicare Advantage Plans	Original Approval Date: 04/02/2008
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Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee	Last Review Date: 07/21/2020
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Related Medicare Advantage Policy Guidelines:

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| <ul style="list-style-type: none"> • Computed Tomography (NCD 220.1) • Infrared Therapy Devices (NCD 270.6) • Magnetic Resonance Imaging (NCD 220.2) • Mammograms (NCD 220.4) • Percutaneous Image-Guided Breast Biopsy (NCD 220.13) | <ul style="list-style-type: none"> • Thermography (NCD 220.11) • Transillumination Light Scanning or Diaphanography (NCD 30.9) • Ultrasound Diagnostic Procedures (NCD 220.5) |
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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 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](#)).

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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 Radiology Prior Authorization and Notification](#).

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, §10 – Supplementary Medical Insurance \(SMI\) Provisions.](#)
- [Medicare Benefit Policy Manual, Chapter 15, §80 – Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests.](#)
- [Medicare Benefit Policy Manual, Chapter 15, §80.4 – Coverage of Portable X-Ray Services Not Under the Direct Supervision of a Physician.](#)

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 14, 2020)

- b. X-Ray, Radium, and Radioactive Isotope Therapy

See the [Medicare Benefit Policy Manual Chapter 15, §90 – X-Ray, Radium and Radioactive Isotope](#). (Accessed April 14, 2020)

- 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 14, 2020)

Also see the [Coverage Summary for Maternity and Newborn Care](#).

- e. Bone (Mineral) Density Studies /Mass Measurements
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 14, 2020)
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>.
- g. Ultrasonography/Ultrasound
See the [NCD for Ultrasound Diagnostic Procedures \(220.5\)](#). (Accessed April 14, 2020)
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>.
- h. Computerized Tomography (CT scan)
See the [NCD for Computerized Tomography \(220.1\)](#). (Accessed April 14, 2020)

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 NCD for Computerized Tomography (220.1), refer to the following for coverage guidelines:***
 - ***For regions/states/territories involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Advantage Plans Radiology & Cardiology Clinical Guidelines at <https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html>.***
 - ***For regions/states/territories 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)
See the [NCD for Single Photon Emission Computed Tomography \(SPECT\) \(220.12\)](#). (Accessed April 14, 2020)

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 NCD for SPECT (220.12), refer to the following for coverage guidelines:***
 - ***For regions/states/territories involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Advantage Plans Radiology & Cardiology Clinical Guidelines at <https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html>.***

[notification/radiology-prior-authorization.html](#).

- **For regions/states/territories 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 14, 2020)

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 MRI not specifically addressed by the NCD for MRI (220.2), refer to the following for coverage guidelines:**
 - **For regions/states/territories involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Advantage Plans Radiology & Cardiology Clinical Guidelines at <https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html>.**
 - **For regions/states/territories not involved in the Radiology Prior Auth Program, see the nationally recognized guidelines, i.e., MCG™ Care Guidelines.**
- *The list of Medicare approved clinical trials is available at <https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index>. (Accessed April 14, 2020)*
- *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 14, 2020)

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 MRA not specifically addressed by the NCD for MRI (220.2), refer to the following for coverage guidelines:**
 - **For regions/states/territories involved in the Radiology Prior Auth Program see the UnitedHealthcare Medicare Advantage Plans Radiology & Cardiology Clinical Guidelines at <https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html>.**
 - **For regions/states/territories not involved in the Radiology Prior Auth Program, see the nationally recognized guidelines, i.e., MCG™ Care Guidelines.**

l. 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 14, 2020)
 - o. Portable Hand-Held X-Ray Instrument
See the [NCD for Portable Hand-Held X-ray Instrument \(220.10\)](#). (Accessed April 14, 2020)
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 14, 2020)
 - b. Infrared Devices
See the [NCD for Infrared Therapy Devices \(270.6\)](#). (Accessed April 14, 2020)
 - 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 14, 2020)
 - f. Magnetic Resonance Spectroscopy
See the [NCD for Magnetic Resonance Spectroscopy \(MRS\) \(220.2.1\)](#). (Accessed April 14, 2020)

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 14, 2020)*

III. REFERENCES

See above.

IV. REVISION HISTORY

07/21/2020 **Guideline 1.h [Computerized Tomography (CT scan)]**

Guideline 1.i [Single Photon Emission Computed Tomography (SPECT)]

Guideline 1.j [Magnetic Resonance Imaging (MRI)]

Guideline 1.k [Magnetic Resonance Angiography (MRA)]

- Replaced reference to:
 - “States with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)” with “states/*territories* with no LCDs/LCAs”
 - “Regions/states [involved/not involved] in the Radiology Prior Authorization Program” with “regions/states/*territories* involved in the Radiology Prior Authorization Program”

Guideline 2.g [Ultrasound Elastography (CPT codes 76981, 76982 and 76983)]

- Removed coverage guidelines (no CMS reference available)

Attachments

- Removed *LCD/LCA Availability Grid for Ultrasound Elastography (CPT codes 76981, 76982 and 76983)*