Coverage Summary

Radiologic Diagnostic Procedures

Policy Number: R-002  Products: UnitedHealthcare Medicare Advantage Plans  Original Approval Date: 04/02/2008
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 11/19/2019

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)
- 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)

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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

1. Diagnostic Radiological Services (Inpatient or Outpatient)
   a. Diagnostic X-Rays
   b. X-Ray, Radium, and Radioactive Isotope Therapy
   c. Screening Mammogram
   d. Obstetrical Ultrasound
   e. Bone Density Studies
   f. Diagnostic Mammogram
   g. Ultrasonography/Ultrasound
   h. Computerized Tomography (CT scan)
   i. Single Photon Emission Computed Tomography (SPECT)
   j. Magnetic Resonance Imaging (MRI)
   k. Magnetic Resonance Angiography (MRA)
   l. Ultra Fast or Multislice CT
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.
      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
      See the Medicare Benefit Policy Manual Chapter 15, §90 - X-Ray, Radium and...
Radioactive Isotope. (Accessed April 3, 2019)
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. (Accessed August 1, 2019)
g. Ultrasonography/Ultrasound
See the NCD for Ultrasound Diagnostic Procedures (220.5). (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 Bone Mass Measurement, Bone Mineral Density Studies, Non-vascular Extremity Ultrasound, Transrectal Ultrasound, at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed August 1, 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.
• 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:
  o For regions/states involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Solutions Cardiology & Radiology Imaging Guidelines.
  o For regions/states 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

- 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/states involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Solutions Cardiology & Radiology Imaging Guidelines.
  - For regions/states not involved in the Radiology Prior Auth Program, see the nationally recognized guidelines, i.e., MCG™ Care Guidelines.

j. Magnetic Resonance Imaging (MRI)


**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](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

- 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/states involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Solutions Cardiology & Radiology Imaging Guidelines.
  - For regions/states 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)


**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](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

- 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/states involved in the Radiology Prior Auth Program, see the UnitedHealthcare Medicare Solutions Cardiology & Radiology Imaging Guidelines.
  - For regions/states 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 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 ultrasound 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 the LCD/LCA Availability Grid (Attachment A).
      • For states with no LCDs/LCAs, refer to the following for coverage guidelines:
         o For regions/states involved in the Radiology Prior Auth Program see the UnitedHealthcare Medicare Solutions Cardiology & Radiology Imaging Guidelines.
         o For regions/states not involved in the Radiology Prior Auth Program, see the Palmetto LCD for Non-covered Services other than CPT® Category III Non-covered Services (L36954). (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
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

11/19/2019 Guideline 2. g [Ultrasound Elastography (CPT Codes 76981, 76982 and 76983)]

- Updated default guidelines for states with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs):
  - Added reference link to the:
    - Palmetto LCD for Non-covered Services other than CPT® Category III Non-covered Services (L36954) for regions not involved in the Radiology Prior Authorization Program
  - Removed reference link to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes

Attachment

- Updated LCD Availability Grid to reflect the most current reference links

V. ATTACHMENT

Attachment A – LCD/LCA Availability Grid

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L36954 (A56506)</td>
<td>Non-covered Services other than CPT® Category III Non-covered Services</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
</tr>
<tr>
<td>L33777 (A57743)</td>
<td>Non-covered Services</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
</tbody>
</table>

End of Attachment A