



MISSISSIPPI DIVISION OF  
**MEDICAID**

## Administrative Code

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Title 23: Medicaid  
Part 220  
Radiology Services

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## **Title 23: Division of Medicaid**

### **Part 220: Radiology**

#### **Part 220 Chapter 1: General**

##### *Rule 1.1: Provider Enrollment Requirements*

- A. Radiology providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:
1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
  2. Written confirmation from the IRS confirming the provider's tax identification number and legal name, and
  3. Clinical Laboratory Improvement Amendments (CLIA) certificate and completed Certification form, if applicable.
- B. Independent Diagnostic Testing Facility (IDTF) providers can only be enrolled for submission of crossover claims.
1. IDTF providers cannot be enrolled for submission of straight Medicaid claims.
  2. A copy of the Medicare certification from the Medicare Intermediary is required.
  3. The Explanation of Medicare Benefits (EOMB) is not acceptable.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 455, Subpart E.

##### *Rule 1.2: Prior Authorization*

- A. Effective July 1, 2013, prior authorization is required by the radiology Utilization Management/Quality Improvement Organization (UM/QIO) for medical necessity and appropriateness of the service for the following advanced imaging procedures:
1. Computed Tomography (CT) Scans and Computed Tomography Angiography (CTA),
  2. Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA),
  3. Positron Emission Tomography (PET) Scans, and
  4. Nuclear Cardiac Imaging Studies.

- B. Prior Authorization for the advanced imaging procedures listed in Rule 1.2.A. is required in all settings except in an:
1. Inpatient hospital,
  2. Emergency room, or
  3. Outpatient hospital twenty-three (23) hour observation period.
- C. The prior authorization request must be submitted by either the ordering or the rendering provider.
1. The provider must submit documentation indicating medical necessity and appropriateness of the service to the radiology UM/QIO, including, but not limited to, the:
    - a) Results of a recent clinical evaluation,
    - b) Diagnosis or clinical condition which the imaging evaluation is being ordered,
    - c) Treatment history related to the stated diagnosis or clinical condition,
    - d) Treatment plan related to the stated diagnosis or clinical condition, and
    - e) Previous imaging results related to the stated diagnosis or clinical condition.
  2. Medical necessity and appropriateness of the service is based on nationally-accepted guidelines and radiology protocols based on peer reviewed literature for urgent, emergent and non-emergent services including, but not limited to, the:
    - a) Division of Medicaid's radiology UM/QIO Clinical Decision Support Tool for Advanced Diagnostic Imaging,
    - b) American College of Radiology's Appropriateness Criteria,
    - c) American Academy of Neurology,
    - d) American Academy of Orthopedic Surgeons,
    - e) American College of Cardiology,
    - f) American Heart Association, and/or
    - g) National Comprehensive Cancer Care Network.

- D. Prior authorization must be received by the provider before the procedure is rendered except in medically urgent situations.
- E. In the event of a medical emergent condition or situation a retrospective review may be requested.
  - 1. The request must be received by the radiology UM/QIO within three (3) business days from the date of service.
  - 2. The Division of Medicaid defines a medical emergent condition or situation as one which:
    - a) The patient faces immediate risk of loss of life or limb,
    - b) Could seriously jeopardize the life or health of the beneficiary or their ability to regain maximum function based on a prudent layperson's judgment, or
    - c) In the opinion of a practitioner with knowledge of the beneficiary's medical condition, would subject the beneficiary to severe pain that cannot be adequately managed without the requested advanced imaging procedure.

Source: Miss. Code Ann. § 43-13-121, 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.2.C. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.3: Radiopharmaceuticals*

- A. The Division of Medicaid covers radiopharmaceuticals administered for diagnostic or therapeutic purposes separately from the diagnostic procedure or visit.
  - 1. Only the units administered are covered.
  - 2. Radiopharmaceuticals must be approved by the (FDA), used in accordance with FDA approved conditions, and be administered in dosages that meet FDA regulations.
  - 3. Radiopharmaceuticals considered experimental, investigative, or in clinical trial are not covered.
- B. The Division of Medicaid covers radiopharmaceuticals administered in a physician office, clinic or independent radiology facility.
- C. Radiopharmaceuticals administered in an outpatient hospital setting is reimbursed in accordance with the Division of Medicaid's outpatient hospital methodology.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.4: Teleradiology [Refer to Part 225, Chapter 3]*

History: Moved with Revisions to Miss. Admin. Code Part 225, Chapter 3 eff. 07/01/2015.

*Rule 1.5: Port Films*

- A. Medicaid does not cover the review and interpretation of port films, referred to as the professional component.
- B. Medicaid covers the taking of the port film, one (1) unit for every five (5) treatments, referred to as the technical component.
- C. Multiple treatments representing two (2) or more treatment sessions furnished on the same day are covered if the medical record contains documentation of a distinct break in therapy sessions and the treatments are of the character usually furnished on different days.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.6: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.7: Computed Tomography (CT) Scans and Computed Tomography Angiography (CTA)*

- A. Effective July 1, 2013, Computed Tomography (CT) scans and Computed Tomography Angiography (CTA), with or without contrast, must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.
- B. The Division of Medicaid does not cover:
  - 1. A limited or follow-up CT scan for any given area of the body during the same encounter as a full diagnostic CT scan,
  - 2. A two (2)-dimensional rendering after a three (3)-dimensional rendering of a CT scan,
  - 3. A CT/SPECT (Single Photon Emission Computed Tomography) nuclear medicine imaging only for:
    - a) Localization, or
    - b) Attenuation correction purposes,

3. A whole body CT for screening of asymptomatic beneficiaries, or
4. The performance of CT screenings in healthy beneficiaries.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.7.B. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.8: Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI)*

- A. Effective July 1, 2013, Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI), with or without contrast, must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.
- B. The Division of Medicaid covers a functional MRI when used as part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, which might potentially be put at risk during the proposed surgery.
- C. The Division of Medicaid does not cover an MRA or MRI for:
  1. Screening of asymptomatic beneficiaries,
  2. Screening of healthy beneficiaries, or
  3. A two (2)-dimensional rendering after a three (3)-dimensional rendering has been performed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.8.B. and C. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.9: Positron Emission Tomography (PET) Scans*

- A. Effective July 1, 2013, Positron Emission Tomography (PET) scans must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.
- B. The Division of Medicaid covers one (1) fluorodeoxyglucose (FDG) PET scan for solid tumors, myeloma or lymphoma that are biopsy proven or strongly suspected based on other diagnostic testing for the following therapeutic purposes related to the initial treatment strategy to determine:
  1. Whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure,

2. Optimal anatomic location for an invasive procedure, or
  3. The anatomic extent of a tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.
- C. The Division of Medicaid covers PET scans for initial anti-tumor treatment strategy, formerly “diagnosis” and “staging”, for the following oncologic conditions:
1. Thyroid cancer,
  2. Non-small cell, lung cancer,
  3. Colorectal cancer,
  4. Melanoma,
  5. Lymphoma,
  6. Head and neck cancer, excluding thyroid and central nervous system,
  7. Esophageal cancer,
  8. Male and female breast cancer when used in staging distant metastasis,
  9. Cervical cancer that is newly diagnosed following conventional imaging that is negative for extra-pelvic metastasis,
  10. Ovarian cancer,
  11. Testicular cancer,
  12. Brain cancer,
  13. Pancreatic cancer, or
  14. Soft tissue carcinoma,
- D. The Division of Medicaid does not cover PET scans for the initial anti-tumor treatment strategy, formerly “diagnosis” and “staging”, for the:
1. Initial diagnosing of breast cancer or the initial staging of axillary nodes,
  2. Initial diagnosing of cervical cancer,
  3. Evaluation of regional lymph nodes in melanoma, or



4. Diagnosis of adenocarcinoma of the prostate.
- E. The Division of Medicaid covers PET scans for subsequent anti-tumor treatment strategy, formerly “restaging” and “monitoring response to treatment”, after the completion of the initial treatment course for the following oncologic conditions:
1. Breast cancer,
  2. Colorectal cancer,
  3. Esophageal cancer,
  4. Head and neck (non-CNS/thyroid), excluding thyroid and central nervous system,
  5. Lymphoma,
  6. Melanoma,
  7. Non-small cell lung cancer,
  8. Thyroid cancer,
  9. Ovarian cancer,
  10. Cervical cancer, or
  11. Myeloma.
- F. The Division of Medicaid covers FDG-PET scans for refractory seizures only for pre-surgical evaluation of localization of a focus of refractory seizure activity.
- G. The Division of Medicaid does not cover PET scans for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Revised Rule 1.9. B. – E. and added G. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

*Rule 1.10: Nuclear Cardiac Imaging Studies*

- A. Effective July 1, 2013, nuclear cardiac imaging studies must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.
- B. The Division of Medicaid covers the following nuclear cardiac imaging:

1. Perfusion of the heart, either at rest or with pharmacological stress, for the diagnosis and management of beneficiaries with known or suspected coronary artery disease when one (1) of the following criteria are met:
  - a) The PET scan, whether at rest alone or at rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT) scan, or
  - b) The PET scan, whether at rest alone or at rest with stress, is performed following an inconclusive SPECT scan.
    - 1) The PET scan must be considered medically necessary to determine what medical or surgical intervention is required to treat the beneficiary.
    - 2) The Division of Medicaid defines an inconclusive SPECT scan as a test(s) whose results are equivocal, technically uninterpretable, or discordant with a beneficiary's other clinical data documentation in the beneficiary's medical record.
2. For the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization or following an inconclusive SPECT.
  - a) A SPECT scan is not covered following an inconclusive PET scan.
  - b) Refer to Rule 1.10.B.1.b) 2).

C. The Division of Medicaid does not cover a SPECT/CT (Single Photon Emission Computed Tomography) which involves a SPECT multi-planar imaging (MPI) nuclear medicine scan only for:

- 1) Localization,
- 2) Accuracy, and
- 3) Attenuation correction purposes.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.10.C. eff. 01/01/2014.

*Rule 1.11: Documentation*

A. Documentation for advanced imaging procedures must:

1. Include the referring physician, nurse practitioner or physician's assistant documentation of medical necessity and criteria met in Rule 1.2,

2. Not duplicate other covered diagnostic tests,
  3. Be maintained in the referring provider's file,
  4. Include documentation the procedure involved only FDA approved drugs and devices and did not involve investigational drugs, as determined by the FDA,
  5. Support the referral to the rendering provider, and
  6. Be maintained in accordance with Part 200, Chapter 3, Rule 1.3.
- B. Providers and facilities are subject to on-site and documentation reviews of technical and professional imaging services and are reimbursed only for procedures, products, and services within the scope of the provider's clinical practice.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 431.10(e).

History: Added Rule 1.11 eff. 01/01/2014.