MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 21, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 300 – RADIOLOGY SERVICES

## BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 300 – Radiology Services was changed to state that CPT code 95937 (neuromuscular junction testing) is part of a series of H-reflex tests that needs a Prior Authorization (PA). The MMIS system requires a PA and Chapter 300 needs to clarify and reflect this PA requirement.

These policy changes are effective July 22, 2011.

| MATERIAL TRANSMITTED | MATERIAL SUPERSEDED |
|---|---|
| MTL 07/11<br>CHAPTER 300 – RADIOLOGY SERVICES | MTL 02/11<br>CHAPTER 300 – RADIOLOGY SERVICES |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **302** | **Definitions** | All Definitions were removed and placed in the Addendum. |
| **305** | **References and Cross References** | Removed reference section. |
| **Appendix A** | | Change PA to yes for CPT code 95937. |

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

RADIOLOGY SERVICES

# 300 INTRODUCTION

Diagnostic testing and Radiologic services are federally mandated Division of Health Care Financing and Policy (DHCFP) Medicaid and Children's Health Insurance Program (CHIP) benefits. This chapter presents policy diagnostic services provided in outpatient hospitals, diagnostic centers or mobile units.

DHCFP reimbursement is based on the need to establish a diagnosis and to prescribe treatment. Reimbursement is also provided for progressive follow-up or staging. Diagnostic studies are rendered according to the written orders of the Physician, Physician's Assistant, or an Advanced Practitioner of Nursing (APN), and must be directly related to the presenting symptoms.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Manual, Chapter 1000.

# 301 REGULATORY AUTHORITY

301.1 The citation denoting the amount, duration, and scope of services are found in 42 Code of Federal Regulations (CFR), Part 435 and sections 1902 (a) (10) (A) (I) (IV), and (VI), 1902 (a) (10) (A) (ii) (XI), 1902 (a) (10) (E), 1902 (1) and (m), 1905 (p), (q) and (s), 1920, and 1925 of the Act. Title XVIII of the Social Security Act, 1862 (a) (1) (A), 411.15 et.seq. Title XVIII of the Social Security Act, 1862 (a) (7), 405.1411-1416.

301.2 The State Legislature sets forth standards of practice for licensed professionals in the following Nevada Revised Statures (NRS):

Chapter 454 - Poisons; Dangerous Drugs and Hypodermics, (Section 454.213);

Chapter 457 – Cancer;

Chapter 630 - Physicians and Assistant;

Chapter 639 - Pharmacists and Pharmacy, (Section 639.008, 639.0095, 639.0097, 639.0105, 639.0125, and 639.0143.)

301.3 Also cited, Title XXI State Plan Attachment 1.2-B, 101.9,E (page 7) of Title XIX State Plan.

301.4 The Food and Drug Administration (FDA), Mammography Quality Standards Act (MQSA) of 1992.

302 RESERVED

# 303 MEDICAID POLICY

## 303.1 RADIOLOGICAL STUDIES

Division of Health Care Financing and Policy (DHCFP) medical assistance programs will reimburse for those covered services that are considered to be medically necessary for the diagnosis and treatment of a specific illness, symptom, complaint, or injury or to improve the functioning of a malformed body part without prior payment authorization. The investigational use for any radiological test is not a Medicaid covered benefit

## 303.1A COVERAGE AND LIMITATIONS

1. A licensed physician or other licensed persons working within the scope of their practice must request radiology services (e.g., Advanced Nurse Practitioner, Physician's Assistant, Podiatrist, etc.).

2. Payment for X-rays and other radiological examinations will only be allowed for those services that are considered to be reasonable and necessary for the diagnosis and treatment of a specific illness, symptom, complaint, or injury or to improve the functioning of a malformed body part.

3. An annual screening mammography is a covered benefit without prior authorization for women age 40 and older and/or a woman between the ages of 35-39, considered a high risk for breast cancer. High risk is defined as one or more of the following conditions:

   a. Personal history of breast cancer;

   b. Personal history of biopsy – proven beginning breast disease;

   c. A mother, sister or daughter had breast cancer; and/or

   d. A woman who has not given birth prior to age 30

4. Diagnostic and/or treatment mammography's are not restricted to age or sex and do not require prior authorization.

5. The choice of the appropriate imaging modality or combination of imaging modalities should be determined on an individual level. Prior authorization will not be required for medically necessary Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), or Positron Emission Tomography (PET) scans. Always use other modalities or less expensive tests such as CT, ultrasound or standard X-ray, etc., when they will achieve the required results. Use of approved modalities for investigational/experimental reasons are not a Medicaid benefit.

Prior authorization will not be required for initial testing and tumor staging. Other repeated testing will require prior authorization.

6. DHCFP Medical Assistance Programs cover certain types of X-rays, DHCFP medical assistance programs cover skeletal films for arms, legs, pelvis, vertebral column, skull, chest and abdominal films that do not involve the contrast material and electro cardiograms furnished by a portable x-ray supplier in a residence used as a recipient's home. These services must be performed under the general supervision of a physician. All licensing conditions and health and safety conditions must be met. Coverage of portable services are defined in 42 Code of Federal Regulation (CFR) 405.1401(c).

   Payment for transportation is based on a single trip to a particular address. No transportation charge is allowed when the x-ray equipment is stored in a site for use as needed (e.g., a nursing facility). A set up component is payable for each radiologic procedure, other than a retake of the same procedure, during single recipient and multiple recipient trips under Healthcare Common Procedure Coding System (HCPCS) code. Set up payments are not paid for echocardiograph (EKG) services furnished by a portable x-ray supplier.

7. Documentation must be available in the clinical record to support the reasonable and necessary indications for all testing.

8. The following exception requires prior authorization:

   All non-emergency services referred and/or provided out-of-state.

9. See Appendix for Diagnostic Test prior authorization schedule.

303.1B PROVIDER RESPONSIBILITY

Providers are responsible for the following:

1. Verify program eligibility each month, (e.g., Qualified Medicaid Beneficiary (QMB), Managed Care Organization (MCO), etc.) and comply with the program requirements. Example: A QMB only recipient never requires a Medicaid payment authorization.

2. The provider must allow, upon the request of proper representatives of the DHCFP, access to all records which pertain to Medicaid or Children's Health Insurance Program (CHIP) recipients for regular review, audit, or utilization review.

3. Evidence to support medical necessity for the procedures must be clearly documented in the clinical record. Duplicative testing when previous results are still pertinent is not a covered benefit.

4. The ordering physician is responsible for forwarding appropriate clinical data to the diagnostic facility.

303.1C RECIPIENT RESPONSIBILITY

The DHCFP medical assistance program recipient must:

1. present a current Medicaid card to service providers at each encounter.

2. notify providers immediately for any change in eligibility status, e.g., pending status to eligible or fee for service to managed care.

303.1D AUTHORIZATION PROCESS

Providers must submit the following documentation to substantiate a prior authorization request: the date, place, and results of previous diagnostic tests performed. Fax or mail all information to the Quality Improvement Organization (QIO)-like vendor.

303.2 SCREENING MAMMOGRAPHY

Screening mammograms are radiological procedures furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and include a physician's interpretation of the results. The service must be at a minimum, a two-view exposure (that is, a cranio-caudal and medial lateral oblique view) of each breast.

DHCFP pays for routine screening mammograms annually for women over age 40. For women aged 35-39, a baseline mammogram is allowed once during this period of time. All facilities providing mammography services are required to have a certificate issued by the Food and Drug Administration (FDA), assuring the mammography provider meets national quality standards in accordance with the Mammography Quality Standards Act (MQSA) of 1992. When the professional component of mammography services is billed separately, the radiologist who interpreted the mammogram produced by an FDA certified facility must also be FDA certified.

303.2A COVERAGE AND LIMITATIONS

A doctor's prescription or referral is not necessary for the procedure to be covered. It is required that there be 365 days from the date of the last mammogram until the next mammogram.

Claims for mammography services provided by facilities or radiologists not on the FDA certified list will be denied with the message "Provider not authorized for this service."

303.3 ELECTRODIAGNOSTIC TESTING/NEUROPHYSIOLOGICAL STUDIES

Payment will not be made for selected tests which are not medically necessary. A neurological evaluation must proceed diagnostic testing. The examination and testing may be billed when both occur with the same provider on the same day.

a. ELECTROENCEPHALOGRAM (EEG)

Routine EEG tests measure and record the electrical impulses from the cortex of the brain. A diagnosis can only be made with correlating clinical findings.

b. 24 HOUR ELECTROENCEPHALOGRAPHIC RECORDING

Intensive EEG recording (24 hours) is a safe and clinically effective method of diagnosis, classification, and localization for seizure disorders, and other factors precipitating individual seizures. Results can indicate which category of medication may be the most successful.

c. EEG BRAIN MAPPING

EEG brain mapping is a term commonly used for several quantitative EEG techniques. These include:

1. EEG frequency analysis;

2. topographic display;

3. statistical comparisons to a normative database; and

4. other similar computer-based calculations based on EEG or evoked potentials.

Prior authorization requests must be reviewed by a Physician Advisor highly skilled in clinical electroencephalographic testing for services which are provided by physician specialists in clinical electroencephalography. A specific correlating diagnosis has not been established.

303.3A COVERAGE AND LIMITATIONS:

Payment for EEG testing must be supported by sufficient information (on the claim form) that its use was medically appropriate considering the patient's symptoms and preliminary diagnosis.

24 hour EEG recordings and EEG mapping require prior payment authorization.

303.4 ELECTROMYOGRAPHY (EMG), NERVE CONDUCTION STUDIES (NCS) DESCRIPTION:

Electromyoneurography is the combined use of electromyography (EMG) and eletroneurography/NCS. These studies are done to detect neuromuscular abnormalities by measuring the nerve conduction and muscle potentials. F-wave studies assess motor nerve function along each nerve. An impulse generated at the stimulating electrode travels up the motor nerves to the motor neuron cell bodies in the spinal cord, on to the neuromuscular junction and the muscle. H-reflex studies are entirely separate from F-wave studies. H-reflex studies assess sensory and motor nerve function and their connections in the spinal cord. The EMG/NCS testing in combination with evaluating the range of motion, motor power, sensory defects, and reflexes, can differentiate between neuropathy and myopathy.

303.4A COVERAGE AND LIMITATIONS:

1. EMG - The service descriptor bundles all single fiber needle EMG electrode insertions performed in a single muscle into one unit of the code. Thus, although twenty “pairs” (motor units with two or more muscle fibers activated near enough to the single fiber EMG electrode to be recorded) must be analyzed in order to reach statistical significance in each muscle studied, all electrode insertions necessary to complete the study on a single muscle are to be coded using a single unit.

2. NCS - Diagnostic nerve conduction studies include amplitude which differentiates nerve conduction studies from screening studies performed with devices which only measure latency. Report the diagnostic codes only once when multiple sites on the same nerve are stimulated or recorded.

3. F-wave studies are usually performed in conjunction with conventional motor nerve conductions studies of the same nerve. Because the F-wave studies assess motor nerve function along the entire extent of each selected nerve, bill code only once when multiple sites on the same nerve are stimulated or recorded.

4. Reflex Tests - H-reflex testing is unilateral and usually involves assessment of the tibial motor nerve and the gastrocnemius-soleus muscle complex. They are not often performed in conjunction with conventional nerve conduction studies of this nerve-muscle pair. Typically only one or two H-reflex studies are performed on a patient during a given encounter. Bilateral studies on the same muscle are reported using the bilateral procedure code modifier.

5. Neuromuscular junction testing

   COVERED DIAGNOSIS:

   Carpal Tunnel Syndrome Neuritis

| | |
|---|---|
| Diabetic Neuropathy | Neuromuscular conditions |
| Disorders of the Peripheral Nervous System | Pain in Limb |
| Disturbance of Skin Sensation | Plexopathy |
| Fasciculation Joint Pain | Radiculopathy |
| Muscle Weakness | Spinal Cord Injury |
| Myopathy | Swelling and Cramps |
| Myositis | Trauma to Nerves |
| Nerve Root Compression | Weakness |

See Appendix for prior authorization requirements.

303.5 EVOKED POTENTIALS (EPs):
SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY (SSEP)
VISUAL EVOKED POTENTIAL (VEP)
AUDITORY EVOKED POTENTIALS (AEP)

DESCRIPTION: EPs are time-locked responses of the nervous system to external stimuli. Somatosensory evoked potentials (SEPs) are one type of EP, which are generated by stimulation of afferent peripheral nerve fibers elicited by electrical, tactile, or other stimuli. "Short-latency" SEP (SSEP) refers to that portion of the waveform of an SEP normally occurring within a specific time lapse variable after nerve stimulation. SEP abnormalities are not disease specific, but can indicate afferent conduction impairments associated with certain disorders.

303.5A COVERAGE AND LIMITATIONS

1. The SEP study is separated into upper and lower limbs to recognize that switching from the upper to lower limbs requires an increase in work because many stimulating and recording electrodes must be moved and the patient must be stimulated many more times to perform the additional testing.

2. Multiple nerves and dermatomes studied in a single limb are bundled together. A maximum of two codes are to be submitted for all upper or lower limb studies performed on a given patient on a given day. (For example, multiple dermatomal SEP studies would be bundled into the two codes for upper and lower limb studies regardless of how many dermatomes are studied.)

3. SEP studies performed on the trunk or head are completely separate tests from the upper and lower limb studies.

4. The SEP study codes are defined as bilateral studies. Thus the modifier for partially reduced services should be used for billing.

5. The visual evoked potential codes are clinical neurophysiologic studies.

6. The auditory evoked potential procedure codes can be a clinical neurophysiologic study as well as an audiology study.

COVERED DIAGNOSIS

| SEP/SSEP: | VER: |
|---|---|
| Spinal Cord Lesions | Lesions of Optic Nerve/Optic Tracts |
| Stroke | Multiple Sclerosis (MS) |
| Extremity numbness and weakness | |

| ABR: | |
|---|---|
| Lesions in the Brain Stem including Tumor | Cerebellopontine Angle Lesions |
| Evaluate Hearing in Infants, Children, Adults | Infarctions |
| Evaluation for peripheral Hearing Loss | Multiple Sclerosis |

See Appendix for prior authorization requirements

## 303.6 MAGNETOENCEPHALOGRAPHY (MEG) INTRAOPERATIVE NEUROPHYSIOLOGY MONITORING

DESCRIPTION: MEG is a highly refined noninvasive technique that measures the magnetic fields generated by active groups of nerve cells in the brain which would obviate the need for depth electrodes in the precise localization of epileptogenic foci. MEG Non-invasive use of MEG and MEG - EEG have been able to help focus subdural electrodes for a chronic intracranial presurgical evaluation in recipient's with medically intractable epilepsy and comparison of epileptic activity with normal evoked responses may help localize epileptic zones.

Intraoperative neurophysiology/electrophysiologic monitoring of the nervous system is now widely used to help prevent complications and to identify structures during neurosurgical and other procedures. These techniques include EEG, evoked potentials, EMG and nerve conduction velocity (NCV) testing and monitoring.

## 303.6A COVERAGE AND LIMITATIONS:

MEG- The procedure is limited to localization of the seizure zone in medically intractable partial epilepsy for recipients being considered for surgical intervention.

Intraoperative electrophysiologic monitoring – EEG or SEP to monitor for cerebral ischemia; electrocorticography (ECoG) and SEP sensory cortex identification to define the limits of cortical resection; SEP spinal cord monitoring; Brainstem Auditory Evoke Potential (BAEP) and cranial nerve EMG monitoring during posterior fossa procedures; functional localization of cortex with direct cortical stimulation in expert hands; and EMG and compound muscle and nerve action

potential measurements of various peripheral nervous system structures.

1. COVERED DIAGNOSIS:

   Partial intractable epilepsy, without mention of impairment of consciousness.

   See Appendix for prior authorization requirements.

2. DOCUMENTATION REQUIRED

   Documentation supporting the reasonableness and necessity for any of the above procedures must be in the patient's record and submitted with the Prior Authorization (PA) when required.

303.7 SLEEP STUDIES, POLYSOMNOGRAPHY, MULTIPLE SLEEP LATENCY TEST (MSLT)

DHCFP will reimburse covered medically necessary testing in a certified sleep disorder clinic. These facilities in which certain conditions are diagnosed through the study of sleep are either affiliated with a hospital or are under the direction and control of physicians. Sleep studies, polysomnograms, and multiple sleep latency testing are limited to 2 services in a 12 month period without prior authorization. If the services exceed the limitations, a prior authorization is required from the QIO like vendor.

303.7A COVERAGE AND LIMITATIONS

1. A licensed physician or other licensed professionals working within the scope of their practice must request the appropriate test.

2. The need for diagnostic testing is confirmed by medical evidence, e.g., patient history, physician examination and other laboratory type tests.

3. Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered.

   Diagnostic Testing Facilities for Sleep Disorders may be covered even in the absence of direct supervision by a physician, however, a trained qualified attendant must be present to assess and monitor the patient. A licensed physician must review and sign reports.

4. Diagnostic testing is covered only if the recipient has symptoms or complaints of one of the conditions:

| ICD-9 CODE | DESCRIPTION |
|---|---|
| • 278.01 | Morbid obesity |
| • 278.8 | Pickwickian syndrome |
| • 347 | Cataplexy and narcolepsy |
| • 80.51 – 780.56 | Various Insomnia's |

5. Obstructive sleep apnea (OSA) requires documentation of at least 30 episodes of apnea, each lasting a minimum of 10 seconds, and hypopnea with oxygen saturation levels below 85% during 6-7 hours of recorded sleep.

6. Polysomnography is distinguished from sleep studies by the inclusion of sleep staging.

   a. The following are included:

      1. EEG;

      2. Electro-oculography (EOG); and

      3. EMG.

   b. Additional parameters of sleep which may be monitored include:

      1. EKG;

      2. Airflow;

      3. Ventilation and respiratory effort;

      4. Gas exchange by oximetry, transcutaneour monitoring, or end tidal gas analysis;

      5. Extremity muscle activity, motor activity-movement;

      6. Extended EEG monitoring;

      7. Penile tumescence;

      8. Gastroesophageal reflux;

9. Continuous blood pressure monitoring;

10. Snoring; and

11. Body positions, etc.

7. For a study to be reported as a polysomnogram, sleep must be recorded and staged. Adult testing includes a half night with continuous positive airway pressure (CPAP). Testing for children (0-12) must be reviewed and scored by physician to determine need for follow-up with CPAP. Prior authorization may be included for this age group in the initial authorization.

8. Multiple Sleep Latency studies are covered only if the symptoms or complaints suggest a diagnosis for Narcolepsy.

9. Prior authorization for MSLT includes authorization for a polysomnogram performed on the preceding night to be valid. For each nap, the latency between "lights out" and sleep onset is determined.

303.7B PROVIDER RESPONSIBILITY

1. Verify program eligible each month, (e.g., QMB, MCO's, etc) and comply with the program requirements. Example: A QMB only recipient does not require a prior authorization to receive service.

2. The provider will allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid and CHIP recipients for regular review, audit or utilization review.

3. Documentation to support medically necessity for the procedures must be clearly documented in the clinical record. Submit documentation with the prior authorization request.

4. The ordering provider is responsible for forwarding appropriate clinical data to the diagnostic facility.

303.7C RECIPIENT RESPONSIBILITY

1. Present Medicaid or CHIP Card to Provider of Service at each encounter.

2. Notify providers immediately for any change in eligibility status, e.g., pending status changed to eligible or fee for service status changed to enrollment in a managed care organization.

303.7D AUTHORIZATION PROCESS

1. Submit the following documentation when prior authorization is required:

   a. Completed request form with all blanks filled and questions answered;

   b. Attachments required to substantiate the request, e.g., history and physical.

2. Submit claims for payment on a Centers for Medicare and Medicaid Services (CMS) 1500 form to the DHCFP fiscal agent.

303.8 RADIOPHARMACEUTICALS AND CONTRAST AGENTS

Radiopharmaceuticals and contrast agents are used to diagnose certain medical problems or treat certain diseases. They may be given to the patient in several different ways. For example, they may be given by mouth, given by injection, or placed into the eye or into the bladder. They may also be used for nuclear medicine. Intended to be included in the policy, but not limited to, are all radioactive compounds used for either imaging, diagnosis or treatment as well as other non-radioactive agents used to enhance radiologic imagining including x-ray, CT scans, MRI, PET and other modalities.

303.8A COVERAGE AND LIMITATIONS

DHCFP will reimburse covered, medically necessary radiopharmaceuticals and contrast agents at 100% of wholesale invoice price. It is not necessary to attach an invoice to the claim, but the provider must bill the wholesale invoice cost.

The provider will allow, upon request of proper representative, access to all records that pertain to Medicaid recipients for fiscal review, audit or utilization review.

303.8B PROVIDER RESPONSIBILITY

1. Verify program eligibility each month, (e.g., QMB, MCO, etc.) and comply with the program requirements. Example: A QMB only recipient never requires a Medicaid payment authorization.

2. The provider must allow, upon the request of proper representatives of the DHCFP, access to all records which pertain to Medicaid or SCHIP recipients for regular review, audit, or utilization review.

3. Evidence to support medical necessity for the procedures must be clearly documented in the clinical record. Duplicative testing when previous results are still pertinent is not a covered benefit.

4. The ordering physician is responsible for forwarding appropriate clinical data to the diagnostic facility.

304 HEARINGS

Please reference Nevada Medicaid Services Manual (MSM), Chapter 3100, for Hearings process and policy.

| CPT | DESCRIPTION | CURRENT PA REQUIREMENT |
|---|---|---|
| **Diagnostic Imagining (MRI, MRA, MRS, PET)** | | |
| 70336 | MRI, temporomandibular joint(s) | No |
| 70540 | MRI, orbit, face, neck; without contrast | No |
| 70542 | MRI, orbit, face, neck; with contrast | No |
| 70543 | MRI, orbit, face, neck; without followed by contrast | No |
| 70544 | MRA, head; without contrast | No |
| 70545 | MRA, head; with contrast | No |
| 70546 | MRA, head; without followed by contrast | No |
| 70547 | MRA, neck; without contrast | No |
| 70548 | MRA, neck; with contrast | No |
| 70549 | MRA, neck; without followed by contrast | No |
| 70551 | MRI, brain; without contrast | No |
| 70552 | MRI, brain; with contrast | No |
| 70553 | MRI, brain; without followed by contrast | No |
| 71550 | MRI, chest; without contrast | No |
| 71551 | MRI, chest; with contrast | No |
| 71552 | MRI, chest; without followed by contrast | No |
| 71555 | MRA, chest; with or without contrast | No |
| 72141 | MRI, cervical spine; without contrast | No |
| 72142 | MRI, cervical spine; with contrast | No |
| 72146 | MRI, thoracic spine; without contrast | No |
| 72147 | MRI, thoracic spine; with contrast | No |
| 72148 | MRI, lumbar spine; without contrast | No |
| 72149 | MRI, lumbar spine; with contrast | No |
| 72156 | MRI, cervical spine; without followed by contrast | No |
| 72157 | MRI, thoracic spine; without followed by contrast | No |
| 72158 | MRI, lumbar spine; without followed by contrast | No |
| 72159 | MRA, spinal; with or without contrast | No |
| 72195 | MRI, pelvis; without contrast | No |
| 72196 | MRI, pelvis; with contrast | No |
| 72197 | MRI, pelvis; without followed by contrast | No |
| 72198 | MRA, pelvis; with or without contrast | No |
| 73218 | MRI, upper extremity; without contrast | No |
| 73219 | MRI, upper extremity; with contrast | No |
| 73220 | MRI, upper extremity; without followed by contrast | No |
| 73221 | MRI, upper extremity, joint; without contrast | No |
| 73222 | MRI, upper extremity, joint; with contrast | No |
| 73223 | MRI, upper extremity, joint; without contrast followed by contrast | No |
| 73225 | MRA, upper extremity; with or without contrast | No |
| 73718 | MRI, lower extremity; without contrast | No |
| 73719 | MRI, lower extremity; with contrast | No |
| 73720 | MRI, lower extremity; without followed by contrast | No |
| 73721 | MRI, lower extremity, joint; without contrast | No |
| 73722 | MRI, lower extremity, joint; with contrast | No |
| 73723 | MRI, lower extremity, joint; without followed by contrast | No |
| 73725 | MRA, lower extremity; with or without contrast | No |
| 74181 | MRI, abdomen; without contrast | No |
| 74182 | MRI, abdomen; with contrast | No |
| 74183 | MRI, abdomen; without followed by contrast | No |
| 74185 | MRA, abdomen; with or without contrast | No |

| CPT | DESCRIPTION | CURRENT PA REQUIREMENT |
|---|---|---|
| 75552 | MRI, cardiac;without contrast | No |

| | | |
|---|---|---|
| 75553 | MRI, cardiac; with contrast | No |
| 75554 | MRI, cardiac, with or without morphology; complete | No |
| 75555 | MRI, cardiac, with or without morphology; limited | No |
| 75556 | MRI for velocity flow mapping | No |
| 76093 | MRI, breast with or without contrast; unilateral | No |
| 76094 | MRI, breast with or without contrast; bilateral | No |
| 76390 | MRS | No |
| 76393 | Magnetic resonance guidance for needle placement | No |
| 76394 | Magnetic resonance guidance for,and monitoring of, tissue ablation | No |
| 76400 | MRI, bone marrow blood supply | No |
| 76498 | Unlisted magnetic resonance procedure | Yes |
| 78459 | PET, metabolic evaluation | No |
| 78491 | PET, perfusion; single study at rest or stress | No |
| 78492 | PET, perfusion; multiple studies at rest and/or stress | No |
| 78608 | PET, brain; metabolic evaluation | No |
| 78609 | PET, brain; perfusion evaluation | No |
| 78810 | PET, tumor imaging; metabolic evaluation | No |

| **Proton Beam Treatment** | | |
|---|---|---|
| 77520 | Proton treatment delivery; simple, without compensation | Yes |
| 77522 | Proton treatment delivery; simple, with compensation | Yes |
| 77523 | Proton treatment delivery; intermediate | Yes |
| 77525 | Proton treatment delivery; complex | Yes |

| **Sleep Testing** | | |
|---|---|---|
| 95805 | MSLT | Yes |
| 95806 | Sleep study; unattended by a technologist | Yes |
| 95807 | Sleep study; attended by a technologist | Yes |
| 95808 | Polysomnography; sleep staging with 1-3 additional parameter of sleep | Yes |
| 95810 | Polysomnography; sleep staging with 4 + additional parameters of sleep | Yes |
| 95811 | Polysomnography; sleep staging with 4 + additional parameter of sleep & initiation of CPAP or BiPAP | Yes |

| **Electromyography and Nerve Conduction Tests** | | |
|---|---|---|
| 95860 | EMG, needle; one extremity | Yes |
| 95861 | EMG, needle; two extremities | Yes |
| 95863 | EMG, needle; three extremities | Yes |
| 95864 | EMG, needle; four extremities | Yes |
| 95867 | EMG, needle; cranial nerve supplied muscle(s) unilateral | Yes |
| 95868 | EMG, needle; cranial nerve supplied muscle(s) bilateral | Yes |
| 95869 | EMG, needle; thoracic paraspinal muscles | Yes |
| 95870 | EMG, needle; limited study | Yes |
| 95872 | EMG, needle; using single fiber electrode | Yes |
| 95900 | NCS, each nerve; motor, without F-wave | Yes |
| 95903 | NCS, each nerve; motor, with F-wave | Yes |
| 95904 | NCS, each nerve; sensory | Yes |
| 95920 | Intraoperative neurophysiology testing, per hour | Yes |

| CPT | DESCRIPTION | CURRENT PA REQUIREMENT |
|---|---|---|
| **Evoked Potentials and Reflex Tests** | | |
| 95925 | SSEP; upper limbs | Yes |
| 95926 | SSEP: lower limbs | Yes |
| 95927 | SSEP; trunk or head | Yes |

| | | |
|---|---|---|
| 95930 | Visual evoked potential testing CNS, checkerboard/flash | No |
| 95933 | Orbicularis oculi reflex, by electrodiagnostic | No |
| 95934 | H-reflex,amplitude and latency; gastrocnemius/soleus muscle | Yes |
| 95936 | H-reflex, amplitude and latency; muscle other than gastrocnemius/soleus | Yes |
| 95937 | Neuromuscular junction , each nerve, any one method | Yes |
| **Special EEG Tests** | | |
| 95950 | 24 Hr EEG, electroencephalographic | Yes |
| 95951 | 24 Hr EEG, electroencephalographic and video | Yes |
| 95953 | 24 Hr EEG, computerized protable electroencephalographic | Yes |
| 95954 | Pharmacological/physical activation with physician attendance | Yes |
| 95956 | 24 Hr EEG, cable/radio electroencephalographic | Yes |
| 95957 | EEG, digital | Yes |
| 95958 | EEG, Wada activation | Yes |
| 95961 | EEG, mapping; 1st hr | Yes |
| 95962 | EEG, mapping; each additional hr | Yes |
| 95965 | MEG; spontaneous brain magnetic activity | Yes |
| 95966 | MEG; evoked magnetic vields, single modality | Yes |
| 95967 | MEG; evoked magnetic fields, each additional modality | Yes |