MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

October 25, 2018

TO: Custodians of Medicaid Services Manual

FROM: Lynne Foster, Chief of Division Compliance

SUBJECT: Medicaid Services Manual Changes
Chapter 300 – Radiology Services

## BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 300 – Radiology Services, Section 303.1A.5 Coverage and Limitations is proposed to change the implementation date from August 1, 2018 to November 1, 2018 for prior authorization requirements for Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS) and Positron Emission Tomography (PET) scans.

Entities Financially Affected: The proposed change affects Medicaid-enrolled providers delivering MRI, MRA, MRS and PET scan services. Those provider types (PT) include, but are not limited to: Outpatient Hospitals (PT 12), Physician, M.D., Osteopath (PT 20), Advanced Practice Registered Nurse (PT 24), Radiology (PT 27) and Physician Assistant (PT 77).

Financial Impact on Local Government: Overall impact will be budget neutral.

These changes are effective November 1, 2018.

| MATERIAL TRANSMITTED | MATERIAL SUPERSEDED |
|---|---|
| MTL 16/18<br>Chapter 300 – Radiology Services | MTL 10/18<br>Chapter 300 – Radiology Services |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
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DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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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.

The 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 (SSA), 1862 (a) (1) (A), 411.15 et.seq. Title XVIII of the SSA, 1862 (a) (7), 405.1411-1416.

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

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

Chapter 457 – Cancer;

Chapter 630 – Physicians and Assistant;

Chapter 639 – Pharmacists and Pharmacy (Sections 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

The 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 is required for medically necessary Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS) or Positron Emission Tomography (PET) scans, and the determination of medical necessity is based on nationally recognized evidenced based clinical guidelines. Examples include but are not limited to: MCG/McKesson/Interqual Criteria. All clinical information supporting the medical necessity for the imaging modality requested should be provided at the time of the request.

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. The DHCFP medical assistance programs cover certain types of X-rays and 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 CFR 486.

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 Billing Manual 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 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 PRIOR AUTHORIZATION

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.

The 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 FDA, assuring the mammography provider meets national quality standards in accordance with the MQSA of 1992.

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.

303.3 ELECTRODIAGNOSTIC TESTING/NEUROPHYSIOLOGICAL STUDIES

A neurological evaluation must proceed diagnostic testing.

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:

EEG testing is covered when supported by sufficient information 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 electroneurography/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 measures the electrical activity of muscles at rest and during contractions.

2. NCS – Diagnostic nerve conduction studies include amplitude which differentiates nerve conduction studies from screening studies performed with devices which only measure latency.

3. F-wave studies are usually performed in conjunction with conventional motor nerve conductions studies of the same nerve. F-wave studies assess motor nerve function along the entire extent of each selected nerve.

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.

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

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

4. 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 | MS |

See Billing Manual 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 recipients 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 Billing Manual for prior authorization requirements.

2. DOCUMENTATION REQUIREMENTS

   Documentation supporting medical necessity for any of the above procedures must be clearly documented in the recipient's medical record and submitted when a prior authorization is required.

303.7 SLEEP STUDY SERVICES

303.7A SLEEP STUDY DESCRIPTION

1. According to the U.S. Department of Health and Human Services, National Institutes of Health (NIH), sleep studies are tests that measure how well someone sleeps and how the body responds to sleep problems. Sleep studies are necessary because untreated sleep disorders can raise risk for heart disease, high blood pressure, stroke and other medical conditions. Sleep disorders have also been linked to an increased risk of injury, such as falling in the elderly and automobile accidents.

   a. The following sleep study tests are covered benefits: Polysomnography (PSG) is the scientific evaluation of sleep that involves a physiologic recording of brain waves, oxygen level in blood, heart rate and breathing and eye and leg movements.

b. The multiple sleep latency test (MSLT) is performed to measure daytime sleepiness. Also known as a daytime nap study, the MSLT is the standard tool used to diagnose narcolepsy and idiopathic hypersomnia.

2. Sleep study services are performed with physician review, interpretation and report.

303.7B PRIOR AUTHORIZATION

1. The PSG and MSLT sleep study tests are limited to two services in a 12-month period without prior authorization. If the services exceed limitations, a prior authorization is required.

2. Prior authorization for MSLT includes authorization for a PSG performed on the preceding night to be valid.

3. Documentation supporting medical necessity for sleep study services must be clearly documented in the recipient's medical record and submitted when a prior authorization is requested.

303.7C COVERAGE AND LIMITATIONS

1. Sleep studies are covered services in the following settings:

a. a certified or accredited sleep disorder facility; or

b. an in-home (unattended) setting in conjunction with a comprehensive sleep evaluation by a physician board certified in sleep medicine.

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

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

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

5. Reference Medicaid Services Manual (MSM) Chapter 1300, Durable Medical Equipment, for coverage and limitation guidelines for the positive airway pressure device services.

6. Polysomnography (PSM) minimum requirements include the following:

a. EEG;

b. Electro-oculography (EOG); and

c. EMG.

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

a. EKG;

b. Airflow;

c. Ventilation and respiratory effort;

d. Gas exchange by oximetry, transcutaneous monitoring or end tidal gas analysis;

e. Extremity muscle activity, motor activity-movement;

f. Extended EEG monitoring;

g. Penile tumescence;

h. Gastroesophageal reflux;

i. Continuous blood pressure monitoring;

j. Snoring; and

k. Body positions, etc.

8. A PSG must be recorded and staged.

9. MSLT's are covered only when symptoms suggest a diagnosis of narcolepsy.

303.7D UNATTENDED SLEEP STUDIES

1. Portable monitoring (PM) for the diagnosis of obstructive sleep apnea (OSA) should be performed only in conjunction with a comprehensive sleep evaluation.

2. Clinical sleep evaluations following PM must be supervised and evaluated by a physician board certified in sleep medicine.

3. PM may be used as an alternative to PSG for the diagnosis of OSA in recipients with a high pretest probability to moderate to severe OSA.

4. PM should not be used for the following recipients:

   a. with significant comorbid medical conditions that may degrade the accuracy of PM, including moderate to severe pulmonary disease, neuromuscular disorders, asthma, stroke, severe hypertension or congestive heart failure.

   b. suspect of having other sleep disorders, including central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders or narcolepsy.

5. PM should not be used for general screening of asymptomatic recipients.

6. PM may be indicated for the diagnosis of OSA in recipients for whom in-laboratory PSG is not possible by virtue of immobility, safety or critical illness.

7. At a minimum, the PM must record airflow, respiratory effort and blood oxygenation. The type of biosensors used to monitor these parameters for in-laboratory PSG are recommended for use in PM.

8. Unattended sleep studies are considered medically necessary using one of the following diagnostic techniques for recipients with symptoms suggestive of OSA when the home sleep study is used as part of a comprehensive sleep evaluation:

   a. Sleep monitoring using a Type II device, minimum of seven channels (e.g. EEG, EOG, EMG, ECG, airflow, respiratory effort, oxygen saturation);

   b. Sleep monitoring using a Type III device, minimum of four monitored channels including ventilation or airflow (at least two channels of respiratory movement or airflow), heart rate or ECG and oxygen saturation; or

   c. Sleep monitoring using a Type IV device, measuring at least three channels. Type IV devices must allow channels that allow direct calculation of an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) as the result of measuring airflow or thoracoabdominal movement.

9. An experienced sleep technician, sleep technologist or appropriately trained healthcare provider must perform the application of PM sensors or directly educate the recipient in correct application of the sensors.

10. Due to the known rate of false negative PM tests, in-laboratory PSG should be performed in cases where PM is technically inadequate or fails to establish the diagnosis of OSA in recipients with a high pretest probability.

11. If a PM test is technically inadequate or does not provide the expected result, in-laboratory PSG should be performed. Documentation supporting medical necessity for the repeat services must be clearly documented in the recipient's medical record.

303.7E NON-COVERED SLEEP STUDY SERVICES

1. Actigraphy and SleepStrip® are considered investigational/experimental and are not covered benefits.

2. Repeat studies are not covered when documentation for a repeat study does not indicate medical necessity (e.g. no new clinical documentation indicating the need for a repeat study).

303.8 RADIOPHARMACEUTICALS AND CONTRAST AGENTS

303.8A RADIOPHARMACEUTICALS AND CONTRAST AGENTS DESCRIPTION

1. According to the FDA, radiopharmaceuticals and contrast agents are used in diagnostic imaging procedures or for therapeutic purposes. Agents enhance the quality of MRI, MRA, CT scans, PET, x-ray and other modalities. Agents are also used to monitor treatment effect. Radiopharmaceuticals and contrast agents may be dispensed to the recipient in several different ways, i.e. by mouth or injection or placed into the eye or bladder. They may also be used for nuclear medicine.

303.8B COVERAGE AND LIMITATIONS

1. The DHCFP will reimburse covered, medically necessary radiopharmaceuticals and contrast agents.

# 304 HEARINGS

Please reference MSM, Chapter 3100, for Hearings process and policy.