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## Medicare Coverage of Imaging Services

This fact sheet provides basic information about Medicare coverage, billing and payment of all imaging services, to include radiology and non-radiology diagnostic imaging and image-guided procedures. This fact sheet is suggested for physicians, providers and suppliers.

### Overview

Medicare covers imaging services that are performed or supervised by a physician who is certified or eligible to be certified by the American Board of Radiology or for whom radiology services account for at least 50 percent of the total amount of charges made under Medicare.

Further, effective for dates of service on or after January 1, 2012, Medicare requires that the technical component (TC) of advanced diagnostic imaging (ADI), for example, magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging, including positron emission tomography (PET), be billed only by those suppliers who are accredited by one of the CMS-approved Accrediting Organizations for the ADI program.

More details on accreditation requirements are in the Medicare Learning Network® (MLN) article SE1122, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1122.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

### Medicare Coverage

Medicare generally covers: x-rays, including portable x-rays, fluoroscopy and mammography; CT, including portable CT, CT angiography (CTA) and CT-guided procedures; MRI, including MR angiography (MRA) and MRI-guided procedures; ultrasound (US), including diagnostic grey-scale and vascular Doppler imaging, and US-guided procedures; nuclear medicine diagnostic imaging and procedures, including radionuclides and PET for certain conditions; radiation oncology; and bone density (DEXA) scans. Coverage may be limited to certain indications.

### Billing and Payment on Medicare Professional Claims

Imaging services are billed under Medicare Part B to Medicare Carriers and A/B Medicare Administrative Contractors (A/B MACs) using acceptable Healthcare Common Procedure Coding System (HCPCS) codes for imaging and other diagnostic services taken primarily from the Current Procedural Terminology

(CPT®) – 4 portion of HCPCS and the supporting ICD diagnosis codes.

**Note:** Hospital outpatient imaging services are Medicare Part B services.

Imaging services are generally paid based on the lower of the charge or the Medicare Physician Fee Schedule (MPFS) amount. Deductible and coinsurance apply, and coinsurance is based on the allowed amount.

### Payment Conditions for Imaging Services

Generally, imaging services are split into technical and professional components (the TC and PC), each separately billable to the local Medicare contractor. Medicare pays under the MPFS for the TC of imaging services furnished to Medicare beneficiaries who are not patients of any hospital, and who receive services in a physician's office, a freestanding imaging or radiation oncology center, ambulatory surgical center (ASC), or other setting that is not part of a hospital.

When imaging services are furnished in a leased hospital radiology department to a beneficiary who is neither an inpatient nor an outpatient of any hospital, both the PC and the TC of the services are payable under the MPFS by the carrier or A/B MAC.

### Definitions of Professional and Technical Components and Billing Codes

- The PC of a service is for physician work interpreting a diagnostic test or performing a procedure, and includes indirect practice and malpractice expenses related to that work. Modifier 26 is used with the billing code to indicate that the PC is being billed.



- The TC is for all non-physician work, and includes administrative, personnel and capital (equipment and facility) costs, and related malpractice expenses. Modifier TC is used with the billing code to indicate that the TC is being billed.

PC and TC do not apply to physician services that cannot be distinctly split into professional and technical components. Modifiers PC and TC may not be used with these billing codes. For example: A diagnostic service or test that cannot be distinctly split between TC and PC is considered to be a global test or service. Examples of global tests/services are radiation treatment delivery (CPT codes 77401-77416).

### Anti-Markup Payment Limitations for Professional and Technical Components

Medicare payment rules for certain diagnostic tests (other than clinical diagnostic laboratory tests) ordered by a billing physician or other supplier (or by a party related to the billing physician or other supplier through common ownership or control) limit the amount of payment where the physician performing or supervising the diagnostic test does not share a practice with the billing/ordering physician or other supplier. Pursuant to this “anti-markup” rule, Medicare payment must not exceed the lowest of:

- The performing/supervising physician's net charge to the billing physician or other supplier;
- The billing physician or other supplier's actual charge;
- The fee schedule amount for the test that would be allowed if the performing/supervising physician billed directly

Both the TC and PC of certain diagnostic tests (other than clinical diagnostic laboratory tests) are subject to the anti-markup payment limitation. Examples of services subject to the anti-markup payment limitations include: x-rays, EKGs, EEGs, cardiac monitoring, and ultrasound services.



## Billing and Payment on Medicare Institutional Claims

### Services Furnished in Hospitals to Inpatients

Imaging services provided under arrangement are billed under Part A to Medicare Fiscal Intermediaries (FIs) and A/B MACs, using revenue codes.

Payment for physicians' imaging services to the hospital, for example, administrative or supervisory services, and for provider services needed to produce the imaging service, are made by the FI or A/B MAC to the hospital as a provider service.

FIs and A/B MACs include the TC of imaging services for hospital inpatients in the Inpatient Prospective Payment System (IPPS) payment to hospitals, except that payment to Critical Access Hospitals (CAHs) for inpatients is made at 101 percent of reasonable cost. Carriers may not pay for the TC of imaging services furnished to hospital patients.

The PC of imaging services performed by physicians for hospital inpatients may be separately billed by the physician and paid by the carrier or A/B MAC.

### Services Furnished in Hospitals to Outpatients

Imaging services provided either directly or under arrangement are billed under Part B to Medicare FIs and A/B MACs, using revenue codes, HCPCS code, line item dates of service, units, and applicable HCPCS modifiers. Charges must be reported by HCPCS code.

Imaging services furnished to hospital outpatients are paid under the Outpatient Prospective Payment System (OPPS) to the hospital, except that payment to CAHs for outpatients is made at 101 percent of reasonable cost.

Mammograms furnished to inpatients or outpatients are paid under the MPFS to the hospital.

The PC of imaging services performed by physicians for hospital outpatients may be separately billed by the physician and paid by the local carrier or A/B MAC.



### Services Furnished in Method II CAH Hospitals

In addition to the TC mentioned above, the PC of imaging services are billed under Part B to Medicare FIs and A/B MACs, using revenue codes series 0960 thru 0989, HCPCS code, line item dates of service, units, and applicable HCPCS modifiers. Charges must be reported by HCPCS code.

The PC of imaging services furnished to CAH patients is made at 115 percent of the MPFS.

### Services Furnished in Skilled Nursing Facilities (SNF)

Payment for a SNF bill for imaging services furnished to its residents in a Part A covered stay is included in the SNF Prospective Payment System. However, certain types of ADI, such as MRI and CT, are separately payable under Part B when performed in the outpatient hospital setting, as discussed in Section 20.1.2 of the "Medicare Claims Processing Manual," Pub. 100-04, Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated

Billing. This manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf> on the CMS website

Imaging services furnished on an ambulatory basis to residents of SNFs may be billed by the supplier performing the service or by the SNF under arrangements with the supplier.

The PC of imaging services performed by physicians for SNF residents, on either an inpatient or ambulatory basis, may be separately billed and paid.

Mammograms furnished to SNF residents are paid under the MPFS to the SNF.

### Services Furnished by Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)

Independent and provider-based RHCs and FQHCs bill for the PC using revenue codes 52X. RHCs are not required to submit HCPCS codes for imaging services. However, FQHCs are required to submit HCPCS codes.

The TC is outside the scope of the RHC/FQHC benefit. Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to the carrier and A/B MAC.

Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed to the FI and A/B MAC on the base-provider type of bill.

## Resources

The “Medicare Claims Processing Manual,” Pub. 100-04, Chapter 13 – Radiology Services and Other Diagnostic Procedures, contains detailed information about billing and payment of imaging services. This manual is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf> on the CMS website.

The “Medicare National Coverage Determinations (NCD) Manual,” Pub. 100-03, Chapter 4, Paragraph 220, contains detailed coverage instructions for radiology and other diagnostic tests, including nationally covered and non-covered indications and coverage with evidence development. This manual is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1\\_Part4.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf) on the CMS website.

The Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions. This database is available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website.



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