Radiology: Diagnostic

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This section describes policies and guidelines for billing diagnostic radiology (diagnostic imaging) procedures. For additional help, refer to the *Radiology Billing Example* section of this manual.

National Correct Coding Initiative Impact

A number of diagnostic radiology procedures are subject to National Correct Coding Initiative (NCCI) edits. To process correctly, claims submitted for multiple diagnostic radiology procedures on the same day may require addition of an NCCI-associated modifier. Information about NCCI-associated modifiers is included in the *Correct Coding Initiative: National* section of this manual.

Gender Override

‹‹Instructions for overriding gender differences for procedures are in the *Transgender and Gender Diverse Services* section in the appropriate Part 2 provider manual.››

Computed Tomography Scan Guidelines

Providers may be reimbursed for Computed Tomography (CT) scan procedures when performed on patients where other noninvasive and less costly diagnostic measures have been attempted or are not appropriate.

Multiple (Different) Anatomic Sites/Same Session

Reimbursement for CT scans of multiple (different) anatomic sites performed at the same session/time on the same date are as follows:

- Reimbursement for the professional component (modifier 26) is 100 percent for the CT scan with the highest reimbursement price and 75 percent for all other CT scans.
- Reimbursement for the technical component (modifier TC) is 100 percent for the CT scan with the highest reimbursement price and 50 percent for all other CT scans, reflecting the reduction in time for the technical component.
- Providers must document the times of the CT scans performed, the CPT® codes and a notation that the scans were performed in the “same session.” For example, “0800 - CPT code 74150, 0815 - CPT code 70450, same session.” In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided.

Repeat CT/Same Date

Reimbursement for a subsequent CT session for the same anatomical area(s) as previously studied, same date of service, same provider is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For second and subsequent sessions performed on same day, enter the CPT code(s) and time of both the initial and repeat CT scans stating “repeat CT scan, different session” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, the documentation must be attached to the claim. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT codes and evidence or statement that this is a “repeat CT/same date” scan will result in the claim being reimbursed according to the “same session” policy.

Different Anatomic Site/Different Time/Same Date

Reimbursement for a subsequent session for a CT scan of (a) different anatomic site(s) than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) component. For second or subsequent sessions performed on the same day, enter the CPT code(s) and time of the earlier session(s) and the subsequent CT scan(s) stating “different sessions” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim. If more than one CT scan is performed in the second or subsequent session(s), cutbacks to reimbursement will be applied as stated previously. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT codes and evidence or statement that this is a “different anatomic site/different time/same date” scan will result in the claim being reimbursed according to the “same session” policy.

Bilateral Services

Providers must document bilateral services when claiming more than one unit for codes 73200 thru 73202 and 73700 thru 73702.

CT Abdomen and Pelvis Methodologies

When submitting claims for CT abdomen and pelvis codes 74176 thru 74178, do not submit codes 72192 thru 72194 or 74150 thru 74170. Combined reimbursement for more than one methodology (with contrast material; without contrast material; with/without contrast material) per recipient and same anatomical area, for the same session and date of service will not exceed the maximum amount of the highest-priced methodology (with/without contrast material).

Anesthesia

Anesthesia billed with modifier P1 (anesthesia services, normal, uncomplicated) in conjunction with a CT scan procedure code is a benefit. These services should be billed using the appropriate five-digit CPT anesthesia code. However, justification of the need for anesthesia with this procedure must be entered in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim.

Mobile and Non-Mobile CT Scans

Medi-Cal reimburses providers for mobile CT scan services at the same reimbursement rate as for non-mobile CT scans. No additional reimbursement is made for mileage or out-of-office calls.

Lung Cancer Screening

‹‹The United States Preventative Services Task Force (USPSTF) recommends annual screening for lung cancer with low dose CT (LDCT) scan for lung cancer screening in adults 50 to 80 years of age who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.››

Screening should be discontinued once a recipient has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

‹‹CPT code 71271 (computed tomography, thorax, low dose for lung cancer screening, without contrast material[s]) may be billed for ages 50 to 80.›› ICD-10-CM codes include: F17.200, F17.210, F17.211, F17.213, F17.218, F17.219, F17.220, F17.221, F17.223, F17.228, F17.229, F17.290, F17.291, F17.293, F17.298, F17.299, Z12.2, Z87.891.

Computed Tomography Angiography

Computed tomography angiography (CTA) is a computed tomography technique that provides high-resolution vascular images and detailed images of the adjacent bone and soft tissue. It is non-invasive, with injection of the contrast medium through a peripheral vein. Providers may be reimbursed for the following CPT codes:

Table of CPT Codes for Computed Tomography Angiography

CPT Code	Description
70496	CTA, head, with contrast material(s), including non-contrast images, if performed and image postprocessing
70498	CTA, neck, with contrast material(s), including non-contrast images, if performed and image postprocessing
71275	CTA, chest, [noncoronary] with contrast material[s], including non-contrast images, if performed, and image postprocessing
72191	CTA, pelvis, with contrast material(s), including non-contrast images, if performed and image postprocessing
73206	CTA, upper extremity, with contrast material(s), including non-contrast images, if performed and image postprocessing
73706	CTA, lower extremity, with contrast material(s), including non-contrast images, if performed and image postprocessing
74174	CTA, abdomen and pelvis, with contrast material(s), including non-contrast images, if performed, and image postprocessing
74175	CTA, abdomen, with contrast material(s), including non-contrast images, if performed and image postprocessing
75635	CTA, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing
‹‹0877T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging››

‹‹**Table of CPT Codes for Computed Tomography Angiography (Continued)**

CPT Code	Description
0878T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained with concurrent CT examination of the same structure
0879T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; radiological data preparation and transmission
0880T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; physician or other qualified health care professional interpretation and report››

Multiple (Different) Anatomic Sites/Same Session

Reimbursement for CTA scans of multiple (different) anatomic sites performed at the same session/time on the same date are as follows:

- Reimbursement for the professional component (modifier 26) is 100 percent for the CTA scan with the highest reimbursement price and 75 percent for all other CTA scans.
- Reimbursement for the technical component (modifier TC) is 100 percent for the CTA scan with the highest reimbursement price and 50 percent for all other CTA scans reflecting the reduction in time for the technical component.
- Providers must document the times of the CTAs performed, the CPT codes and a notation that the CTAs were performed in the “same session.” For example, “0800 - CPT code 74174, 0815 - CPT code 70496, same session.” In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided.

Repeat CTA/Same Date

Reimbursement for a subsequent CTA session for the same anatomical area(s) as previously studied, same date of service, same provider is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For second and subsequent sessions performed on same day, enter the CPT code(s) and time of both the initial and repeat CTA scans stating “repeat CTA scan, different session” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, the documentation must be attached to the claim. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT codes and evidence or statement that this is a “repeat CTA/same date” scan will result in the claim being reimbursed according to the “same session” policy.

Different Anatomic Site/Different Time/Same Date

Reimbursement for a subsequent session for a CTA scan of (a) different anatomic site(s) than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) component. For second or subsequent sessions performed on the same day, enter the CPT code(s) and time of the earlier session(s) and the subsequent CTAs stating different sessions in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim. If more than one CTA scan is performed in the second or subsequent session(s), cutbacks to reimbursement will be applied as stated previously. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT codes and evidence or statement that this is a “different anatomic site/different time/same date” scan will result in the claim being reimbursed according to the “same session” policy.

Bilateral Services

Providers must document bilateral services when claiming more than one unit for codes 73206 and 73706.

Do Not Report Codes

Computed Tomographic Angiography codes may not be reimbursed on the same date of service as the following CT codes:

Table of CTA and CT Codes that May Not Be Reimbursed on the Same Date of Service

CTA Code	Do not Report With CT Code
70496	70450, 70460 or 70470 (head) May be reimbursed on the same date for services that are provided during different sessions (different times) with documentation of medical necessity. Radiology reports are required and must be submitted with the claim to substantiate medical necessity.
70498	70490, 70491 or 70492 (neck)
71275	71250, 71260 or 71270 (chest)
72191	72192, 72193 or 72194 (pelvis)
73206	73200, 73201 or 73202 (upper extremity)
73706	73700, 73701 or 73702 (lower extremity)
74174	72191 thru 72194, 73706, 74175 thru 74178 or 75635 (abdomen and pelvis) 72192 is allowable with code 72194 with documentation of medical necessity
74175	74150, 74160, 74170, 74176, 74177 or 74178 (abdomen/abdomen and pelvis)
75635	74150, 74160, 74170, 74176, 74177, 74178 or CTA code 74175 (aorta)

Coronary Computed Tomography Angiography and Cardiac Magnetic Resonance Imaging

Coronary computed tomography angiography (CCTA) is a heart imaging test that helps determine if plaque buildup has narrowed the coronary arteries. Cardiac magnetic resonance imaging (CMRI) uses a powerful magnetic field, radio waves and a computer to produce detailed pictures of the structures within the heart.

Providers may be reimbursed for CCTA and CMRI with the following CPT codes and modifiers:

Table of CPT and HCPCS Codes for CCTA and CMRI

CPT Code	Description
75561 *	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences
75565 * †	Cardiac magnetic resonance imaging for velocity flow mapping
75571 ‡	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium
75572 ‡	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)
75573 ‡	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of left ventricular [LV] cardiac function, right ventricular [RV] structure and function and evaluation of vascular structures, if performed)
75574 ‡	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional

Table of CPT and HCPCS Codes for CCTA and CMRI (continued)

CPT Code	Description
0721T	Quantitative computed tomography (CT scan) tissue characterization with interpretation and report
0722T	Quantitative computed tomography (CT scan) tissue characterization with interpretation and report and concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset
‹‹0899T	Noninvasive determination of absolute quantitation of myocardial blood flow (AQMBF), derived from augmentative algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)
0900T	Noninvasive estimate of absolute quantitation of myocardial blood flow (AQMBF), derived from assistive algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)

HCPCS codes 0899T and 0900T are approved for recipients 18 years of age or older.››

An approved *Treatment Authorization Request* (TAR) is required for reimbursement of CCTA and CRMI with the following criteria:

- Noninvasive coronary angiography is reasonable for symptomatic recipients who are at intermediate risk for Coronary artery disease (CAD) after initial risk stratification, including recipients with Electrocardiogram (ECG) uninterpretable for ischemic changes (baseline ST segment abnormalities, Left bundle branch block [LBBB]), recipients who are unable to exercise, and recipients with equivocal stress test results. Diagnostic accuracy currently favors CCTA over CMRI for these recipients.
- In recipients with known or suspected congenital or acquired coronary anomalies, CCTA or CMRI is suggested. CMRI is preferred in younger recipients, given concerns about potential long-term effects of radiation associated with CCTA.

- In recipients with coronary artery bypass grafts in whom it is not possible to selectively engage clinical important grafts during invasive angiography, CCTA or CMRI is suggested for evaluation of coronary artery bypass graft patency.
- In recipients with contraindications to beta blockers or iodinated contrast, CMRI is preferred to CCTA.

Note: In recipients with no signs or symptoms suggestive of CAD, neither CCTA nor CMRI should be used to screen for coronary disease.

Table of HCPCS Codes and Modifiers for Cardiac Imaging

CPT Code	Description
0716T	Acoustic waveform recording of heart with automated analysis and generation of coronary artery disease risk score. (allowable modifiers 99, TC, 26)
3100F	Carotid imaging study report (includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement) (str, rad). (allowable modifiers 99 and 26)

Trabecular Bone Score (TBS)

Trabecular bone score (TBS) is an analytical tool that performs novel grey-level texture measurements on lumbar spine dual X-ray absorptiometry (DXA) images, and thereby captures information relating to trabecular microarchitecture.

Table of CPT Codes for TBS

CPT Code	Description
77089	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual X-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture-risk
77090	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere
77091	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only
77092	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture-risk only by other qualified health care professional

Magnetic Resonance Imaging (MRI)

Magnetic resonance imaging (MRI) is a method of visualizing and imaging internal structures of the body. It is an important tool in the diagnosis and evaluation of diseases. MRI is based upon the magnetization properties of atomic nuclei and was developed in 1946. Over the years, refinements in image acquisition and processing allowed sharper visualization of anatomic detail and broader clinical applications of MRI.

Table of HCPCS Codes for Magnetic Resonance Imaging

HCPCS Code	Description
0723T	Quantitative magnetic resonance (MR scan) imaging of gallbladder, bile ducts, pancreas and pancreatic duct cholangiopancreatography (QMRCP), with data preparation and transmission, interpretation and report. (allowable modifiers 99, TC and 26)
0724T	Quantitative magnetic resonance (MR scan) imaging of gallbladder, bile ducts, pancreas and pancreatic duct cholangiopancreatography (QMRCP), with data preparation and transmission, interpretation and report and with diagnostic magnetic resonance imaging (MRI) examination of same anatomy. (allowable modifiers 99, TC and 26)
‹‹0888T	Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance
0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting location, neuronavigation files and target report, review and interpretation
0890T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day
0891T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day
0892T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day››
70554 * †	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration

Table of HCPCS Codes for Magnetic Resonance Imaging (Continued)

HCPCS Code	Description
70555	MRI, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing
96020	Neurofunctional testing selection and administration during brain mapping
‹‹A9610	Xenon xe-129 hyperpolarized gas, diagnostic, per study dose››
C9789	Instillation of antineoplastic pharmacologic/biologic agent into renal pelvis, any method, including all imaging guidance, including volumetric measurement if performed
C9791	Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent
C9794	Therapeutic radiology simulation-aided field setting; complex, including acquisition of pet and ct imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)
C9795	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions
C9797	Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction

HCPCS codes 0889T through 0892T are approved for recipients 18 years of age or older. ICD-10-CM codes I63.19 or I69.320 are required.

General Guidelines

Providers may be reimbursed for the following CPT codes:

Table of CPT Codes for Magnetic Resonance Imaging

CPT Code	Description
70540, 70542, 70543	Orbit, face and/or neck
70551 thru 70553	Brain including brainstem
70557 thru 70559 §	Brain, intraoperative
71550 thru 71552	Chest
72141, 72142, 72156	Cervical spine
72146, 72147, 72157	Thoracic spine
72148, 72149, 72158	Lumbar spine
72195 thru 72197	Pelvis
73218 thru 73220	Upper extremity, other than joint
73221 thru 73223	Upper extremity, joint
73718 thru 73720	Lower extremity, other than joint
73721 thru 73723	Lower extremity, joint
74181 thru 74183	Abdomen
74712	Magnetic resonance imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
74713	Magnetic resonance imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation
76391	Magnetic resonance, elastography
77046 §, 77047 §	Magnetic resonance imaging, breast, without contrast material
77048 §, 77049 §	Magnetic resonance imaging, breast, without and with contrast material

CPT codes 70557 thru 70559 are split-billable, so one professional component and one technical component may be reimbursable to allow full reimbursement of the code.

CPT codes 76391, 77047 and 77049 must be billed with modifier TC or 26.

CPT codes 77046 and 77048 must be billed with modifiers TC or 26 and LT or RT.

Authorization

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Multiple (different) Anatomic Sites/Same Session

Reimbursements for MRIs of multiple (different) anatomic sites performed at the same session/time on the same date are as follows:

- Reimbursement for the professional component (modifier 26) is 100 percent for the MRI with the highest reimbursement price and 75 percent for all other MRIs.
- Reimbursement for the technical component (modifier TC) is 100 percent for the MRI with the highest reimbursement price and 50 percent for all other MRIs reflecting the reduction in time for the technical component.
- Providers must document the times of the MRIs performed, the CPT codes and a notation that they were performed in the "same session." For example, "0800 – CPT code 71550, 0815 – CPT code 74183, same session." In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided.

Repeat MRI/Same Date

Reimbursement for a subsequent MRI session for the same anatomical area(s) as previously studied, same date of service, same provider is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For second and subsequent sessions performed on same day, enter the CPT code(s) and time of both the initial and repeat MRI scans stating "repeat MRI scan, different session" in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, the documentation must be attached to the claim.

In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT codes and evidence or statement that this is a "repeat MRI/same date" scan will result in the claim being reimbursed according to the "same session" policy.

Different Anatomic Site/Different Time/Same Date

Reimbursement for a subsequent session for an MRI of (a) different anatomic site(s) than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) component. For second or subsequent sessions performed on the same day, enter the CPT code(s) and time of the earlier session(s) and the subsequent MRIs stating "different sessions" in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim.

If more than one MRI scan is performed in the second or subsequent session(s), cutbacks to reimbursement will be applied as stated previously. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT codes and evidence or statement that this is a "different anatomic site/different time/same date" scan will result in the claim being reimbursed according to the "same session" policy.

Bilateral Services

Providers must document bilateral services when billing more than one unit for CPT codes 73218 thru 73223 and 73718 thru 73723.

MRI Methodologies

One MRI per anatomical area is reimbursable for one session for the same recipient and date of service. Combined reimbursement for more than one methodology (with contrast material; without contrast material; without/with contrast material) per recipient and same anatomical area, for the same session and date of service will not exceed the maximum amount of the highest-priced methodology (without/with contrast material).

For example, 72148 (MRI lumbar spine without contrast) + 72149 (MRI lumbar spine with contrast) = 72158 (MRI lumbar spine without contrast, followed by with contrast).

Repeat MRI

Reimbursement for a subsequent MRI session for the same anatomical area as previously studied, same date of service, will be 100 percent for both the technical (modifier TC) and professional (modifier 26) components. For subsequent sessions performed on the same day, enter the times of the initial and the subsequent MRI sessions and the corresponding CPT code(s) and state “different sessions same anatomic site” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim.

Different Anatomic Site/Same Date

Reimbursement for a subsequent session for an MRI of a different anatomic site than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For subsequent sessions performed on the same day, enter the CPT code(s) and times of the initial and the subsequent MRI scans and state “different sessions” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim. Failure to provide the documentation of the times and codes and “different sessions” will result in denial of the claim.

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Modifiers

The only modifiers to be used for MRI CPT codes are modifier TC (technical component) and 26 (professional component). Use one of the following scenarios when submitting a TAR:

- One TAR and one provider for both the professional (26) and technical (TC) components of service in which the TAR must be submitted with two lines of service. The first line must have the CPT code and one of the two modifiers (26 or TC). The

second line must have the same CPT code and the corresponding modifier (26 and TC).

- One TAR and two different providers for the professional (26) and technical (TC) components of service with one of the providers submitting the TAR on behalf of both providers of the two components of service (26 and TC) and both providers should use the same TAR for claim submission. The TAR must be submitted with two lines of service. The first line must have the CPT code and one of the two modifiers (26 or TC). The second line must have the same CPT code and corresponding modifier (26 or TC). This is the preferred method for two different providers.
- Two TARs and two different providers for the professional (26) and technical (TC) components of service with each provider submitting their own TAR with one line of service and the appropriate modifier designating the service (26 or TC) they will provide or have provided.

Claim Completion

Providers use one of the following methods when submitting a claim for MRI services:

- The facility and physician each bill for their service components, respectively, with modifiers 26 or TC. Each facility/provider submits their own claim with one line of service and the appropriate modifier. When billing only for the professional component, use modifier 26. When billing for only the technical component, use modifier TC.
- Physician Billing – The physician bills for both the professional and technical components and later reimburses the facility for the technical component, according to their mutual agreements. The physician submits a *CSM-1500* claim form, completing two separate claim lines. The first line contains the split-billable procedure code and one of the two modifiers (26 or TC). The second line contains the same procedure code and the other of the two modifiers (26 or TC).
- Facility Billing – The facility bills for both the technical and professional components and reimburses the physician for the professional component, according to their mutual agreements. The facility submits a *UB-04* claim form and completes two separate claim lines. The first line contains the split-billable procedure code and one of the two modifiers (26 or TC). The second line contains the same procedure code and the other of the two modifiers (26 or TC).

Magnetic Resonance Angiography

Magnetic Resonance Angiography (MRA) is a non-invasive diagnostic test that is an application of magnetic resonance imaging. By analyzing the amount of energy released from tissues exposed to a strong magnetic field, MRA provides images of normal and diseased blood vessels, as well as visualization and quantification of blood flow through these vessels.

Authorization

A *Treatment Authorization Request* (TAR) is required for reimbursement.

General Guidelines

Providers may be reimbursed for the following CPT codes:

Table of CPT Codes for Magnetic Resonance Angiography

CPT Code	Description
70544 thru 70546	Head
70547 thru 70549	Neck
71555	Chest
72159	Spinal canal
72198	Pelvis
73225	Upper extremity
73725	Lower extremity
74185	Abdomen

Multiple (Different) Anatomic Sites/Same Session

Reimbursement for MRAs of multiple (different) anatomic sites performed at the same session/time on the same date is as follows:

- Reimbursement for the professional component (modifier 26) is 100 percent for the MRA with the highest reimbursement price and 75 percent for all other MRAs.
- Reimbursement for the technical component (modifier TC) is 100 percent for the MRA with the highest reimbursement price and 50 percent for all other MRAs reflecting the reduction in time for the technical component.
- Providers must document the times of the MRAs performed the CPT codes and a notation that they were performed in the “same session.” For example, “0800 – CPT code 71555, 0815 − CPT code 74185, same session.” In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided.

Repeat MRA/Same Date

Reimbursement for a subsequent MRA session for the same anatomical area(s) as previously studied, same date of service, same provider is 100 percent for both the professional (modifier 26) and technical (modifier TC) components. For second and subsequent sessions performed on same day, enter the CPT code(s) and time of both the initial and repeat MRA scans stating “repeat MRA scan, different session” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, the documentation must be attached to the claim.

In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT codes and evidence or statement that this is a “repeat MRA/same date” scan will result in the claim being reimbursed according to the “same session” policy.

Different Anatomic Site/Different Time/Same Date

Reimbursement for a subsequent session for an MRA scan of (a) different anatomic site(s) than was previously studied, different time, same day is 100 percent for both the professional (modifier 26) and technical (modifier TC) component. For second or subsequent sessions performed on the same day, enter the CPT code(s) and time of the earlier session(s) and the subsequent MRAs stating “different sessions” in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. If space is not available, attach this documentation to the claim.

If more than one MRA scan is performed in the second or subsequent session(s), cutbacks to reimbursement will be applied as stated previously. In lieu of documentation, the actual imaging reports may be submitted as proof of the separate services provided. Failure to document the times, CPT codes and evidence or statement that this is a “different anatomic site/different time/sane date” scan will result in the claim being reimbursed according to the “same session” policy.

Bilateral Services

Providers will need to document bilateral services when billing for more than one unit for CPT codes 73225 and 73725.

MRA Methodologies

One MRA per anatomical area is reimbursable for one session for the same recipient and date of service. Combined reimbursement for more than one methodology (with contrast material; without contrast material; without/with contrast material) per recipient and same anatomical area, for the same session and date of service will not exceed the maximum amount of the highest-priced methodology (without/with contrast material). For example, 70544 (MRA head without contrast) + 70545 (MRA head with contrast) = 70546 (MRA head without contrast, followed by with contrast).

Modifiers

The only modifiers to be used for MRA CPT codes are modifier TC (technical component) and 26 (professional component). Use one of the following scenarios when submitting a TAR:

- One TAR and one provider for both the professional (26) and technical (TC) components of service in which the TAR must be submitted with two lines of service. The first line must have the CPT code and one of the two modifiers (26 or TC). The second line must have the same CPT code and the corresponding modifier (26 and TC)
- One TAR and two different providers for the professional (26) and technical (TC) components of service with one of the providers submitting the TAR on behalf of both providers of the two components of service (26 and TC) and both providers should use the same TAR for claim submission. The TAR must be submitted with two lines of service. The first line must have the CPT code and one of the two modifiers (26 or TC). The second line must have the same CPT code and corresponding modifier (26 or TC). This is the preferred method for two different providers.
- Two TARs and two different providers for the professional (26) and technical (TC) components of service with each provider submitting their own TAR with one line of service and the appropriate modifier designating the service (26 or TC) they will provide or have provided.

Organized Outpatient Clinics

Organized outpatient clinics exempt from licensure pursuant to *Health and Safety Code*, Section1206, may provide services limited to diagnostic magnetic resonance imaging (MRI), diagnostic magnetic resonance angiography (MRA), and other diagnostic (but not therapeutic) radiological services. Please refer to “Magnetic Resonance Angiography (MRA)” and “Magnetic Resonance Imaging (MRI)” on a previous page in this section and refer to *Radiology: Nuclear Medicine* in the appropriate Part 2 manual for Positron Emission Tomography (PET) scan services.

Magnetic Resonance Cholangiopancreatography (MRCP)

Magnetic Resonance Cholangiopancreatography (MRCP) is a Medi-Cal benefit when billed with HCPCS Level II code S8037. MRCP procedures may, in certain situations, provide information similar to endoscopic retrograde cholangiopancreatography (ERCP), but offer some advantages:

- Iodine-based contrast is not used, avoiding allergic and osmolar risks
- Avoids ERCP with its potential attendant medical complications
- Avoids risk of sedation and/or anesthesia
- May be less costly

Authorization is required for MRCP. In addition to a TAR, providers must submit documentation of at least one of the following medical indications:

- The recipient has undergone an unsuccessful ERCP procedure and requires further evaluation.
- The recipient has altered biliary tract anatomy from prior disease or surgery that contraindicates ERCP.
- The recipient requires evaluation of a suspected congenital defect of the pancreaticobiliary tract.
- The recipient has a pancreaticobiliary medical problem suspected to present a low probability for therapeutic intervention with ERCP but requires diagnostic work-up to direct medical management.
- The recipient has a proximal pancreaticobiliary anatomic defect that cannot be reached by ERCP, due to obstruction.
- The recipient is a young child or compromised adult where ERCP may be unsafe or cannot be performed.
- The recipient is allergic to or has a contraindication to receive iodine-based contrast media for an ERCP.

Providers may bill code S8037 with no modifier (professional and technical component combined) or with modifiers 26 (professional component) and/or TC (technical component).

Endoscopic Retrograde Cholangiopancreatography

For more information on Endoscopic Retrograde Cholangiopancreatography (ERCP), refer to the *Surgery: Digestive System* section of this manual.

Contrast Media

The Radiology section of the CPT code book provides two different codes for billing each radiologic procedure involving injection of contrast media defined as follows:

Complete Procedure

The complete procedure is performed in full by a single physician and includes all usual pre-injection and post-injection services (for example, necessary local anesthesia, placement of needle or catheter and injection of contrast media).

Supervision and Interpretation Only Procedure

A supervision and interpretation only procedure is performed by more than one physician (for example, a radiologist-clinician team) and the injection procedure is billed separately using the appropriate code from the Surgery section of the CPT book.

Medi-Cal-Only Billing

However, when billing Medi-Cal for such procedures:

- Use only the CPT procedure codes for “Supervision and Interpretation Only” procedures, even if the procedure is performed by one physician. Claims received for “Complete Procedures” will be denied.
- Continue using split-billing modifiers on claims to denote billings for professional component only (26) and technical component only (TC). When billing for both the professional and technical components, a modifier is neither required nor allowed and the CPT code must be billed without a modifier for proper reimbursement. For Medi-Cal billing purposes, the term “Supervision and Interpretation Only,” as used in the CPT book does not exclude the technical component of radiological billings.
- To bill for the separate injection procedure, use the appropriate code from the Surgery section of the CPT book.

Medicare/Medi-Cal Crossover Billing

These special instructions do not apply to Medicare/Medi-Cal crossover billings. These claims should be submitted according to current Medicare instructions which permit billings for either “Complete Procedures” or “Supervision and interpretation Only” procedures. Crossover claims for “Complete Procedures” will be accepted by Medi-Cal.

Paramagnetic Contrast Material

Paramagnetic contrast material HCPCS codes A9575 thru A9579, A9581, A9583, A9585, Q9953 and Q9954 are separately reimbursable for MRI or MRA procedures. These codes are not split-billable and must not be billed with any modifier, with the exception of HCPCS code A9579, which may be billed with modifier UD.

An invoice is required when billing for codes A9575 thru A9579.

HCPCS code A9581 (injection, gadoxetate disodium, 1 ml), one unit equals 1 ml; may be billed for a maximum dosage of 14 ml (quantity of 14). Claims billed for greater quantities require documentation that the recipient’s weight exceeds 140 kg.

HCPCS code A9583 (injection, gadofosveset trisodium, 1 ml), one unit equals 1 ml; may be billed for a maximum dosage of 18 ml (quantity of 18) for recipients age 18 and older. Claims billed for greater quantities require documentation that the recipient's weight exceeds 150kg. This code is not split-billable.

HCPCS code A9585 (injection, gadobutrol, 0.1 ml), one unit equals 0.1 ml; may be billed for a maximum dosage of 18 ml (quantity of 180) for recipients age 2 and older. Claims billed for greater quantities require documentation that the recipient's weight exceeds 180 kg. This code is reimbursable "By Report."

Low Osmolar Radiographic Contrast Media Guidelines

The following guidelines are for appropriate use and reimbursement of non-ionic radiographic contrast media services:

- Provision of low osmolar contrast media (HCPCS codes Q9951 and Q9965 thru Q9967) is not split-billable. HCPCS code Q9951 must not be billed with any modifier. HCPCS codes Q9965 thru Q9967 may be billed with modifier UD. The provider who supplies the contrast media should bill for this service. An invoice is required when billing for code Q9951.
- Low osmolar contrast media may be used instead of metrizamide for myelography.

High Osmolar Radiographic Contrast Media

High osmolar contrast material (HCPCS codes Q9958 thru Q9964) is not split-billable. These codes may be billed with modifier UD. Only one code in the range is reimbursable, per date of service, any provider, unless medical justification is attached.

Diagnostic Radiopharmaceutical Agents

Reimbursement for the following HCPCS codes is limited to one unit (one study dose): A4642, A9500 thru A9504, A9507, A9510, A9520, A9521, A9526, A9536 thru A9542, A9546, A9550 thru A9554, A9557, A9559 thru A9562, A9566, A9567, A9569 thru A9572, A9575, A9580, A9582, A9584, Q9982 and Q9983. These codes are not split-billable and must not be billed with any modifier.

When billing for diagnostic radiopharmaceutical agents, services that include the acquisition of both the rest and stress data sets/images are considered one study and the billed amount includes the total dose administered to the recipient for their acquisition. For example, if a provider administers the radiopharmaceutical agent for the rest data set/image and then administers the same agent for the stress component, the total dose administered should be billed as one unit.

‹‹HCPCS code A9506 (graphite crucible for preparation of technetium tc 99m-labeled carbon aerosol, one crucible) is approved for patients aged 6 years of age and older.››

HCPCS code A9520 (technetium tc-99m, tilmanocept, diagnostic, up to 0.5 millicuries) requires an invoice for reimbursement.

HCPCS code A9552 (fluorodeoxyglucose F-18 FDG, diagnostic, per study dose) will be reimbursed only if a positron emission tomography (PET) scan code is billed on the same date of service.

HCPCS codes C2698 (brachytherapy source, stranded, not otherwise specified, per source) and C2699 (brachytherapy source, nonstranded, not otherwise specified, per source) are non-specific. Providers must attach an invoice for reimbursement.

Copper Cu 64 dotatate (Detectnet)

Copper Cu 64 dotatate binds to somatostatin receptors with highest affinity for subtype 2 receptors (SSTR2). It binds to cells that express somatostatin receptors including malignant neuroendocrine cells, which overexpress SSTR2 receptors. Copper Cu 64 is a positron (β+) emitting radionuclide with an emission yield that allows positron emission tomography (PET) imaging.

Indications

Detectnet is a radioactive diagnostic agent indicated for use with positron emission tomography (PET) for localization of somatostatin receptor positive neuroendocrine tumors (NETs) in adult patients.

Dosage

The recommended amount of radioactivity to be administered for PET imaging is 148 MBq (4 mCi) administered as an intravenous injection over a period of approximately one minute.

Begin acquiring images 45 to 90 minutes after drug administration.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

The TAR should include clinical documentation that demonstrates the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient must have an approval for a PET scan and the PET scan code must be billed on the same date of service.
- Patient must have at least one of the following:
  - Confirmed or suspicion of neuroendocrine tumor (NET) based on histology/biopsy report
  - Confirmed or suspicion of NET based on conventional imaging scans of affected area such as MRI and/or contrast enhanced CT and/or an FDG PET-CT scan and/or NaF PET-CT scan and/or OctreoScan® and/or clinical symptoms performed within eight weeks prior to administration of Copper Cu 64 Dotatate
- Patient must not be a pregnant or breast-feeding female.
  - Breast feeding patients to interrupt breastfeeding for 12 hours after Detectnet administration
- Patient does not have either of the following:
  - Therapeutic use of any somatostatin analogue, including Sandostatin® LAR and Lanreotide (within 28 days) and Sandostatin (within two days) prior to administration with Copper Cu 64 Dotatate
  - History or presence of significant hematological abnormalities or immunodeficiency or any condition that might compromise the immune system (infections, vaccinations), of any etiology as indicated by clinically significantly abnormal values of any of the following hematologic parameters: platelets, hemoglobin, WBC count and ANC

Approval is for three months.

Age Limit

Must be 18 years or older.

Billing

HCPCS code A9592, Copper cu-64, dotatate, diagnostic, 1 millicurie.

- A9592 is separately billable and not split-billable.

Prescribing Restriction(s)

Maximum billing unit(s) equals 4 mCi / 4 units

Air Polymer-Type A Intrauterine Foam (Exem® Foam)

Reconstituted air polymer-type A foam creates a contrast agent that appears echogenic within the fallopian tubes and peritoneal cavity when visualized with ultrasound.

Indication

ExEm Foam is an ultrasound contrast agent indicated for sonohysterosalpingography to assess fallopian tube patency in women with known or suspected infertility.

Dosage

- Confirm the patient is not pregnant prior to ExEm Foam administrations.
- The recommended initial dose of ExEm Foam is 2 mL to 3 mL by intrauterine infusion using a 5-Fr or larger catheter with luer connection.
- The dose may be repeated in increments of 2 mL to 3 mL, as needed, to achieve visualization of the fallopian tubes.
- Maximum total dose is 10 mL.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Must submit clinical documentation to substantiate the following:

- Must be used for FDA approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient must have a known or suspected infertility.
- Patient must have a negative pregnancy test within the 24 hours before ExEm Foam administration.
- Patient does not have a known or suspected lower genital tract inflammation or infection.
- Patient has not had a gynecologic procedure within the 30 days prior.
- Patient does not have vaginal bleeding.
- Patient does not have known or suspected reproductive tract neoplasia.

Authorization is for three months.

Age Limit

Must be 18 years of age or older.

Billing

HCPCS code: A9574, (air polymer-type a intrauterine foam, 0.1 ml).

Prescribing Restriction(s)

Maximum billing unit(s) equals 10 ml/100 units.

Florbetaben f18

Florbetaben f18 is a radioactive diagnostic agent used in positron emission tomography (PET) imaging in the brain.

Indications

Florbetaben f18 is indicated for estimating β-amyloid neuritic plaque density in adult patients with cognitive impairment who are being evaluated for Alzheimer’s disease and other causes of cognitive decline.

Authorization

An approved TAR for a PET scan of the brain is required.

Dosage

Administer 300 megabecquerels (MBq) (8.1 millicuries) as a slow single intravenous bolus (six seconds/ml) in a total volume of up to 10 ml. Obtain 15- to 20-minute PET images beginning 45 to 130 minutes after intravenous administration.

Billing

HCPCS code Q9983 (florbetaben f18 diagnostic).

Flortaucipir F 18 (Tauvid™)

Flortaucipir F 18 binds to aggregated tau protein. In the brains of patients with Alzheimer's disease (AD), tau aggregates combine to form neurofibrillary tangles (NFTs), one of two components required for the neuropathological diagnosis of AD. In vitro, flortaucipir F 18 binds to paired helical filament (PHF) tau purified from brain homogenates of donors with AD. The dissociation constant (Kd) of flortaucipir F 18 binding to PHFs is 0.57 nM. In vivo, flortaucipir F 18 is differentially retained in neocortical areas that contain aggregated tau. In vitro, tritiated flortaucipir has been reported to bind with low nanomolar affinity to monoamine oxidase-A and monoamine oxidase-B, which could contribute to off target binding.

Indications

TAUVID is a radioactive diagnostic agent indicated for positron emission tomography (PET) imaging of the brain to estimate the density and distribution of aggregated tau neurofibrillary tangles (NFTs) in adult patients with cognitive impairment who are being evaluated for Alzheimer's disease (AD).

Limitations of Use

TAUVID is not indicated for use in the evaluation of patients for chronic traumatic encephalopathy (CTE).

Dosage

- Recommended dose is 370 MBq (10 mCi), administered as a bolus intravenous injection.
- Initiate imaging approximately 80 minutes after drug administration.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 50 years of age or older.
- Patient is being evaluated for Alzheimer's Disease.
- Patient is cognitively-impaired.
- Patient has mild cognitive impairment (MCI) or dementia with suspected neurodegenerative cause.
- Patient has mini-mental status exam (MMSE) score of 20-27.
- Patient is not known to have a structural brain lesion that would interfere either with PET imaging or pathological assessment.
- Patient is not being evaluated for chronic traumatic encephalopathy (CTE).

Authorization is for three months.

Age Limits

Must be 50 years of age or older.

Billing

HCPCS code: A9601 (injection, flortaucipir f 18, diagnostic, 1 millicurie).

Prescribing Restriction (s)

Frequency of billing equals 370 MBq (10 mCi) / 10 units administered as a single dose.

Maximum billing unit(s) equals 370 MBq (10 mCi) / 10 units.

Fluoroestradiol F-18 (Cerianna)

Fluoroestradiol F-18 (FES) is an imaging agent used with positron emission tomography (PET) to detect estrogen receptor-positive breast cancer lesions. The ability to image ER-positive tumors in vivo is advantageous in that, while helping to visualize tumor progression/regression, it may also be used to assess for heterogeneity in estrogen receptor (ER) expression across metastases (i.e. to identify sites that no longer express ER) without the need for multiple biopsies. Fluoroestradiol F-18 binds ER. The following binding affinity: Kd = 0.13 ± 0.02 nM, Bmax = 1901 ± 89 fmol/mg, and IC50 = 0.085 nM, was determined in an ER-positive human breast cancer cell line (MCF-7).

Indications

Cerianna is a radioactive diagnostic agent indicated for use with positron emission tomography (PET) imaging for the detection of ER-positive lesions as an adjunct to biopsy in patients with recurrent or metastatic breast cancer.

Limitations of Use Tissue biopsy should be used to confirm recurrence of breast cancer and to verify ER status by pathology. Cerianna is not useful for imaging other receptors, such as human epidermal growth factor receptor 2 (HER2) and the progesterone receptor (PR).

Dosage

- Recommended dose is 222 MBq (6 mCi), with a range of 111 MBq to 222 MBq (3 mCi to 6 mCi), administered as an intravenous injection over one to two minutes.
- Recommended imaging start time is 80 minutes (range 20 minutes to 80 minutes) after drug administration.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

The TAR should include clinical documentation that demonstrates the following:

- Must be used for FDA approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient must have an approval for a PET scan and the PET scan code must be billed on the same date of service.

- Patient has first recurrence of breast cancer or stage IV disease as defined by the American Joint Committee on Cancer staging system for breast cancer.
- Patient had documented histologically confirmed invasive breast carcinoma.
- Patient is scheduled to undergo core needle biopsy or surgery for histological confirmation and determination of ER status of recurrent or distant metastatic cancer within 15 days after FES scan; or
  - Patient had core needle biopsy of recurrent or distant metastatic cancer within 30 days before FES scan and biopsy specimens are available for determination of ER status
- Patient discontinued selective ER modulators or fulvestrant for at least 60 days prior to FES scan.
- Patient has Eastern Cooperative Oncology Group performance status of equal to or less than two.

Approval is for three months.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code A9591 (Fluoroestradiol f18, diagnostic, 1 mci).

- Code A9591 is separately billable and is not split-billable.
- Providers must complete a *CMS-1500* form, including the medically justified ICD-10-CM diagnosis code(s).
- Providers must include an invoice showing the acquisition cost of the product to the claim.
- The invoice must have a date prior to the date of service or the claim will be denied.

Prescribing Restrictions

Maximum billing unit(s) equals 6 mci / 6 units.

Fluorodopa F 18 Injection

In dopaminergic nerve terminals in the brain, Fluorodopa (FDOPA) F 18 is decarboxylated by amino acid decarboxylase to Fluorodopamine (FDA) F 18 and stored in presynaptic vesicles in the brain. The accumulation of F 18 FDA in the striatum is visually detected in the positron emission tomography (PET) scan.

Indications

Fluorodopa F 18 Injection is a radioactive diagnostic agent indicated for use in (PET) to visualize dopaminergic nerve terminals in the striatum for the evaluation of adult patients with suspected Parkinsonian syndromes (PS). Fluorodopa F 18 PET is an adjunct to other diagnostic evaluations.

Dosage

185 megabecquerels (MBq) [5 millicuries (mCi)] by intravenous injection infused over one minute.

- Use aseptic techniques and radiation shielding to maintain sterility during all operations involved in the manipulation and administration of Fluorodopa F 18 Injection.
- Instruct patients to void immediately before imaging and start imaging at approximately 80 minutes post administration (with a nine second computed tomography [CT] scan for attenuation correction) followed by 3D PET scan from 80 to 100 minutes post administration.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Fluorodopa F 18 is medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient is being evaluated for Parkinsonian syndromes (PS).

- Patient has possible PS as evidenced by at least two of the cardinal features of PS: bradykinesia, rigidity, tremor, and/or gait disorder.
- The diagnosis was based on United Parkinson's Disease Rating Scale (UPDRS), either confirmed or amended as the referral diagnosis based on treatment response.
- Patient is free from neurological or psychological problems and not on any medication known to affect the dopaminergic system.
- Fluorodopa F 18 PET is an adjunct to other diagnostic evaluations.

Authorization is for three months.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code: A9602, (fluorodopa F 18, diagnostic, per millicurie).

Prescribing Restrictions (s)

Frequency of billing equals 185 megabecquerels (MBq) [5 millicuries (mCi)]/5 units for one dose.

Maximum billing unit(s) equals 185 megabecquerels (MBq) [5 millicuries (mCi)]/5 units

Flutemetamol F18

Flutemetamol F18 is a radioactive diagnostic agent used in positron emission tomography (PET) imaging in the brain.

Indications

Flutemetamol F18 is indicated for estimating β-amyloid neuritic plaque density in adult patients with cognitive impairment who are being evaluated for Alzheimer's disease and other causes of cognitive decline.

Authorization

An approved TAR for a PET scan of the brain is required.

Dosage

Administer 185 megabecquerels (MBq) (5 millicuries) within 40 seconds as a single intravenous bolus in a total volume of 10 ml or less. Obtain 15- to 20-minute PET images beginning 45 to 130 minutes after intravenous administration.

Billing

HCPCS code Q9982 (flutemetamol F18 diagnostic).

Ga 68 Dotatoc

Ga 68 Dotatoc binds to somatostatin receptors, with highest affinity (Ki equals 2.5± 0.5 nanomolar) for subtype 2 receptors (sstr2). Ga 68 Dotatoc binds to cells that express somatostatin receptors including malignant neuroendocrine cells, which overexpress sstr2 receptors. Gallium 68 is a β+ emitting radionuclide with associated 511 keV annihilation photons that allow positron emission tomography (PET) imaging.

Indications

Ga 68 Dotatoc Injection is a radioactive diagnostic agent indicated for use with positron emission tomography (PET) for localization of somatostatin receptor positive neuroendocrine tumors (NETs) in adult and pediatric patients.

Dosage

In adults, the recommended amount of radioactivity to be administered for PET imaging is 4 mCi (148 MBq) with a range of 3 mCi to 5 mCi (111 MBq to 185 MBq) administered as an intravenous injection with an injection rate of approximately 10 seconds per mL.

In pediatric patients, the recommended amount of radioactivity to be administered for PET imaging is 0.043 mCi/kg of body weight (1.59 MBq/kg) with a range of 0.3 mCi (11.1 MBq) to 3 mCi (111 MBq) as an intravenous injection with an injection rate of approximately 10 seconds per mL.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

The TAR should include clinical documentation that demonstrates the following:

- Must be used for FDA-approved indications and dosages.
- Must be used with PET for localization of somatostatin receptor positive neuroendocrine tumors (NETs).
- Patient must have an approval for a PET scan and the PET scan code must be billed on the same date of service.

Approval is for three months.

Billing

HCPCS code C9067 (Gallium ga-68, dotatoc, diagnostic, 0.01 mci).

- C9067 is separately billable and is not split-billable.
- Providers must complete CMS 1500 form including the medically justified ICD-10-CM diagnosis code(s).
- Providers must include an invoice showing the acquisition cost of the product to the claim.
- The invoice must have a date prior to the date of service, or the claim will be denied.

Suggested ICD-10-CM Diagnosis Codes

C7A.00 thru C7A.8, C7B.00 thru C7B.8, D3A.00 thru D3A.8, J84.841.

Prescribing Restriction(s)

Maximum billing unit(s) equals 5 mci/500 units.

Gallium Ga 68 Gozetotide Injection (Illuccix® Preparation Kit)

Gallium Ga 68 gozetotide binds to prostate specific membrane antigen (PSMA). It binds to cells that express PSMA, including malignant prostate cancer cells, which usually overexpress PSMA. Gallium 68 (Ga 68) is a β+ emitting radionuclide that allows positron emission tomography.

Indications

Illuccix, after radiolabeling with Ga 68, is a radioactive diagnostic agent indicated for positron emission tomography (PET) of prostate-specific membrane antigen (PSMA) positive lesions in men with prostate cancer:

- with suspected metastasis who are candidates for initial definitive therapy
- with suspected recurrence based on elevated serum prostate-specific antigen (PSA) level

Dosage

- Use appropriate aseptic technique and radiation safety handling measures to maintain sterility during all operations involved in the manipulation and administration of Gallium Ga 68 Gozetotide Injection.
- The recommended amount of radioactivity for adults is 111 MBq to 259 MBq (3 mCi to 7 mCi) as a bolus intravenous injection.
- A diuretic expected to act within the uptake time period may be administered at the time of radiotracer injection.
- Initiate imaging 50 minutes to 100 minutes after administration. The patient should void immediately prior to initiation of imaging. The scan should begin caudally and proceed cranially.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient has a diagnosis of biopsy-proven prostate cancer that meets at least one of the following criteria:
  - Has suspected metastasis and is a candidate for initial definitive therapy such as prostatectomy and pelvic lymph node dissection

  - Has a biochemical recurrence (BCR) after initial definitive therapy defined by serum PSA of greater than 0.2 ng/mL more than six weeks after prostatectomy or by an increase in serum PSA of at least 2 ng/mL above nadir after definitive radiotherapy
  - Has nonmetastatic castration-resistant prostate cancer (nmCRPC) with increasing PSA or radiographic evidence of metastases
  - Has suspected recurrence of prostate cancer based on elevated serum prostate-specific antigen (PSA) level
  - Has progression of disease on androgen deprivation therapy (ADT), or localized on observation
  - Has progression of nonmetastatic and metastatic castration-naïve prostate cancer
  - Has an initial staging of unfavorable intermediate, high or very high-risk prostate cancer; and
- Patient meets at least one of the following criteria:
  - Has a serum prostate-specific antigen (PSA) of at least 10 ng/ml
  - Has a tumor stage ct2b or greater
  - Has a Gleason score greater than six

Authorization is for three months.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code: A9596, (Gallium ga-68 gozetotide, diagnostic, [illuccix], 1 millicurie).

Prescribing Restriction (s)

Maximum billing unit(s) equals 259 MBq (7 mCi/)7 units.

Gallium Ga 68 Gozetotide Injection (Locametz® Preparation Kit)

Gallium Ga 68 gozetotide binds to prostate-specific membrane antigen (PSMA). It binds to cells that express PSMA, including malignant prostate cancer cells, which usually overexpress PSMA. Gallium 68 is a β+ emitting radionuclide that allows positron emission tomography (PET).

Indications

Locametz after radiolabeling with Ga 68, is a radioactive diagnostic agent indicated for PET of (PSMA)-positive lesions in men with prostate cancer:

- with suspected metastasis who are candidates for initial definitive therapy
- with suspected recurrence based on elevated serum prostate-specific antigen (PSA) level
- for selection of patients with metastatic prostate cancer, for whom lutetium Lu 177 vipivotide tetraxetan PSMA-directed therapy is indicated

Dosage

The recommended amount of radioactivity is 111 MBq to 259 MBq (3 mCi to 7 mCi). Administered as slow intravenous injection.

- Use appropriate radiation safety measures and aseptic precautions while handling and administering gallium Ga 68 gozetotide injection.
- Advise patients to be well hydrated prior to the administration and to void immediately prior to and frequently after image acquisition.
- A diuretic expected to act within the uptake time period may be administered at the time of radiotracer injection.
- Acquire PET whole body images 50 minutes to 100 minutes after administration.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Patients must be 18 years of age or older.

- Patient has biopsy-proven prostate adenocarcinoma that meets at least one of the following criteria
  - Has suspected metastasis and is a candidate for initial definitive therapy such as prostatectomy and pelvic lymph node dissection
  - Has suspected recurrence based on elevated serum prostate-specific antigen (PSA) level
  - Has metastatic prostate cancer, and lutetium Lu 177 vipivotide tetraxetan PSMA-directed therapy is indicated
- Patient has intermediate to high-risk disease as determined by at least one of the following criteria:
  - Serum PSA of at least 10 ng/ml
  - Tumor stage ct2b or greater
  - Gleason score greater than six
- Karnofsky performance status of greater than or equal to 50 (or Eastern Cooperative Oncology Group [ECOG]/World Health Organization [WHO] equivalent).
- Patient has not had androgen deprivation therapy or other neoadjuvant treatments prior to PET imaging and surgery.

Authorization is for three months.

Age Limit

Must be 18 years of age or older.

Billing

HCPCS code: A9800, (gallium ga-68 gozetotide, diagnostic, [locametz], 1 millicurie).

- Codes A9800 is separately billable and not split-billable.
- Providers must complete a *CMS-1500* form including the medically justified ICD-10-CM diagnosis code.
- Providers must include an invoice showing the acquisition cost of the product to the claim. The invoice must have a date prior to the date of service, or the claim will be denied.

Prescribing Restriction (s)

Frequency of billing equals 259 MBq (7 mCi)/7 units for one dose.

Maximum billing unit(s) equals 259 MBq (7 mCi)/7 units.

Gallium Ga 68 PSMA-11 (UCSF/UCLA)

Ga 68 PSMA-11 binds to prostate-specific membrane antigen (PSMA). It binds to cells that express PSMA, including malignant prostate cancer cells, which usually overexpress PSMA. Gallium-68 (Ga 68) is a β+ emitting radionuclide that allows positron emission tomography (PET).

Indications

Ga 68 PSMA-11 injection is a radioactive diagnostic agent indicated for positron emission tomography (PET) of prostate-specific membrane antigen (PSMA) positive lesions in men with prostate cancer:

- with suspected metastasis who are candidates for initial definitive therapy
- with suspected recurrence based on elevated serum prostate-specific antigen (PSA) levels

Dosage

- Use appropriate aseptic technique and radiation safety handling measures to maintain sterility during all operations involved in the manipulation and administration of Ga 68 PSMA-11 injection.
- The recommended adult dose is 111 MBq to 259 MBq (3 mCi to 7 mCi) as a bolus intravenous injection.
- A diuretic expected to act within the uptake time period may be administered at the time of radiotracer injection.
- Initiate imaging 50 to 100 minutes after administration. The patient should void immediately prior to initiation of imaging. Scan should begin caudally and proceed cranially.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient has a diagnosis of prostate cancer:
  - with suspected metastasis who are candidates for initial definitive therapy
  - with suspected recurrence based on elevated serum prostate-specific antigen (PSA) level
- Patient had biopsy-proven prostate cancer and considered a candidate for prostatectomy and pelvic lymph node dissection, and meets at least one of the following criteria:
  - Patient has a serum (PSA) of at least 10 ng/mL
  - Patient has a tumor stage cT2b or greater
  - Patient has a Gleason score greater than six; or
- Patient has a biochemical evidence of recurrent prostate cancer after definitive therapy, defined by serum PSA of greater than 0.2 ng/mL, more than six weeks after prostatectomy or by an increase in serum PSA of at least 2 ng/mL above nadir after definitive radiotherapy.

Approval is for three months.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS codes:

A9593 (gallium ga-68 psma-11, diagnostic, [ucsf], 1 millicurie).

A9594 (gallium ga-68 psma-11, diagnostic, [ucla], 1 millicurie).

- Codes A9593 and A9594 are separately billable and not split-billable.
- Providers must complete a *CMS-1500* form including the medically justified ICD-10-CM diagnosis code.
- Providers must include an invoice showing the acquisition cost of the product to the claim. The invoice must have a date prior to the date of service or the claim will be denied.

Prescribing Restriction(s)

Maximum billing unit(s) equals 7 mCi/7 units.

Lutetium Lu 177 vipivotide tetraxetan (Pluvicto™)

Lutetium Lu 177 vipivotide tetraxetan is a radioligand therapeutic agent. The active moiety of lutetium Lu 177 vipivotide tetraxetan is the radionuclide lutetium-177 which is linked to a moiety that binds to PSMA, a transmembrane protein that is expressed in prostate cancer, including mCRPC. Upon binding of lutetium Lu 177 vipivotide tetraxetan to PSMA-expressing cells, the beta-minus emission from lutetium-177 delivers radiation to PSMA-expressing cells, as well as to surrounding cells, and induces DNA damage which can lead to cell death.

Indications

All FDA-approved indications.

Dosage

FDA-approved dosages.

TAR Requirement

An approved Treatment Authorization Request (TAR) is required for reimbursement.

TAR Criteria

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Must be prescribed by or in consultation with an oncologist or urologist.
- Patient has a diagnosis of Prostate Cancer - Metastatic Castration Resistant (mCRPC).
- Disease is prostate specific membrane antigen (PSMA)-positive.
- Patient meets both of the following criteria:
  - Has tried at least one androgen receptor pathway inhibitor (for example, abiraterone, abiraterone acetate tablets, enzalutamine apalutamide or darolutamide).
  - Has tried at least one taxane-based chemotherapy regimen (for example: docetaxel, cabazitaxe, etc.)
- The medication will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog (for example leuprolide acetate, triptorelin pamoate, goserelin acetate, etc.); or patient has had a bilateral orchiectomy.

Initial authorization is for six months.

Continued therapy

- Patient continues to meet initial approval criteria.
- Patient has experienced positive clinical response such as lack of disease progression or lack of increase in tumor size or spread.
- Patient has no evidence of unacceptable toxicity.

Reauthorization is for 12 months.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code: A9607, (lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie).

Prescribing Restriction (s)

Frequency of billing equals 7.4 GBq (200 mCi)/200 units every six weeks for up to six doses.

Maximum billing unit(s) equals 7.4 GBq (200 mCi)/200 units.

Piflufolastat F 18 (Pylarify®)

Piflufolastat F 18 binds to cells that express Prostate-Specific Membrane Antigen (PSMA), including malignant prostate cancer cells, which usually overexpress PSMA. Fluorine-18 (F 18) is a β+ emitting radionuclide that enables positron emission tomography.

Indications

Pylarify is a radioactive diagnostic agent indicated for positron emission tomography (PET) of prostate-specific membrane antigen (PSMA) positive lesions in men with prostate cancer with:

- suspected metastasis who are candidates for initial definitive therapy, or
- suspected recurrence based on elevated serum prostatespecific antigen (PSA) level

Dosage

Recommended dose is 333 MBq (9 mCi) with an acceptable range of 296 MBq to 370 MBq (8 mCi to 10 mCi), administered as a bolus intravenous injection.

Initiate imaging approximately 60 minutes after Pylarify administration. The patient should void immediately prior to initiation of imaging. Image acquisition should start from mid-thigh and proceed to the skull vertex.

TAR Requirement

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

TAR Criteria

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be 18 years of age or older.
- Patient has a diagnosis of biopsy-proven prostate cancer with subsequent definitive therapy.
- Patient has a suspected recurrence of prostate cancer based on rising PSA after definitive therapy on the basis of:
  - Post-radical prostatectomy: Detectable or rising PSA that is equal to or greater than 0.2 ng/mL with a confirmatory PSA greater than or equal to 0.2 ng/mL, or
  - Patient had post-radiation therapy, cryotherapy, or brachytherapy with increase in PSA level that is elevated by at least 2 ng/mL above the nadir

- Patient has a negative or equivocal standard-of-care imaging (with CT scan or MRI) within 60 days prior to the PET scan with Pylarify.
- Patient does not have ongoing treatment with any systemic therapy (for example, androgen deprivation therapy [ADT], antiandrogen, gonadotropin-releasing hormone [GnRH], luteinizing hormone-releasing hormone [LHRH] agonist or antagonist) for prostate cancer.

Approval is for three months.

Age Limits

Must be 18 years of age or older.

Billing

HCPCS code A9595 (piflufolastat f-18, diagnostic, 1 millicurie).

- A9595 is separately billable and not split billable. Providers must complete *CMS 1500* form including the medically justified ICD-10-CM diagnosis code(s).
- Providers must include an invoice showing the acquisition cost of the product for the claim.
- The invoice must have a date prior to the date of service, or the claim will be denied.

Prescribing Restriction(s)

Maximum billing unit(s) equals 370 MBq (10 mCi)/10 units.

Chest X-Rays

Medi-Cal policy restricts the use of routine chest X-ray examinations to individuals or selected populations whose history, physical examination or need for diagnosis specifically indicates the necessity for a chest X-ray. An example of a selected population would be newly arrived immigrants from Central America or Southeast Asia.

The yield of unsuspected disease (for example, lung cancer, heart disease and tuberculosis) found by routine chest X-ray examinations of unselected populations, pregnant recipients or recipients admitted to inpatient hospitals has been shown to be of insufficient clinical value to justify the monetary cost, added radiation exposure, and inconvenience to the patient.

Restrictions on Routine Chest X-Rays

Therefore, chest X-rays should not be performed routinely:

- As part of prenatal testing,
- On members of unselected populations, or
- On recipients on admission to hospitals or Long Term Care facilities.

Restrictions on Recipients with Tuberculosis

Repeat chest X-rays should not be performed routinely on recipients with tuberculosis:

- Who are reactors, or
- Who are involved in therapy, or
- Who have completed therapy and are asymptomatic.

There is no legal requirement for acute hospital inpatients to have chest X-rays. However, state licensing requirements mandate evidence of tuberculosis screening on patients in Long Term Care facilities. Annual chest X-rays are recommended only when clinically indicated, as noted on a previous page.

Radiologic Examination

Most conditions do not require more than one radiologic examination per day. Occasionally it is medically necessary to repeat chest X-rays for medical conditions such as, but not limited to, the evaluation of pleural effusions, thoracic trauma, post thoracentesis, post pneumothorax evacuation and post central venous catheter placement.

Under these circumstances, the following applies:

- CPT code 71045 (radiologic examination, chest; single view) is reimbursable more than once on the same day, for the same recipient and same provider.
- CPT code 71046 (radiologic examination, chest; 2 views) is reimbursable more than once on the same day, for the same recipient and same provider.
- The combination of CPT codes 71045 and 71046 is reimbursable on the same day, same recipient and same provider.

When billing for CPT code 71045 or code 71046 with a quantity greater than one, providers should include supporting information or an explanation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. Failure to supply supporting information may result in claim denial or a reduction in payment. Additionally, quantities greater than one must be billed on a single claim line.

CPT codes 71045 thru 71048, 74018, 74019 and 74021 are split-billable and must be billed with modifier TC when billing only for the technical component, and modifier 26 when billing only for the professional component. When billing for both the technical and professional component, no modifier is required.

Note: Modifier 99 must not be billed in conjunction with modifier 26 or modifier TC. The claim will be denied.

Portable Imaging Transportation

Non-emergency services performed by portable imaging providers require authorization in all Places of Service except Nursing Facility (NF) Level B, NF Level A and subacute care facilities. Regardless of location, if an emergency service is rendered, the claim must be accompanied by a copy of a written order by the attending physician, podiatrist or dentist.

Important: For information about portable imaging billing for recipients in a free-standing pediatric subacute facility, refer to "Free-standing Pediatric Subacute Per Diem Rate" in the *Subacute Care Programs: Pediatric* section of the appropriate Part 2 manual.

Emergency Certification

When attaching an emergency certification to the claim, enter an "81" in the *Condition Codes* field (Boxes 18 thru 28) on the *UB-04 Claim* form or an "X" in the *EMG* field (Box 24C) on the *CMS-1500*. A statement documenting the emergency nature of the service must also be entered either in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of a claim or submitted as an attachment.

Reimbursement

Reimbursement for portable imaging transportation includes transportation of the imaging equipment and personnel to the patient's home or a skilled nursing facility. The following codes are used:

Table of HCPCS Codes for Portable Imaging Transportation

HCPCS Code	Patient Per Trip
R0070	One
R0075	More than one

HCPCS code R0075 must be billed with national modifiers UN (two patients), UP (three patients), UQ (four patients), UR (five patients), or US (six or more patients). Portable imaging service providers may bill R0070 and R0075 for the same recipient a second time on the same date of service only if justification is documented in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or on an attachment. Failure to justify the second visit on the same patient for the same date of service will result in denial of the claim.

Portable Imaging Set-Up

Providers should use HCPCS code Q0092 (set-up portable X-ray equipment) when billing for portable imaging set-up.

Fluoroscopy and Esophagus Studies

When fluoroscopy (CPT procedure code 76000) or esophagus study (CPT code 74220) is performed at the same time as an upper G.I. study (CPT codes 74240, 74241 and 74245) and billed separately, a copy of the X-ray report and a statement of the need for fluoroscopy or esophagus study must accompany the claim. Only the upper G.I. study is paid if these reports are not attached to the claim.

Fluoroscopy: "By Report" Billing

When billing for fluoroscopy services, providers must include the clock time as part of the "By Report" information in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim (for example, "13:15 to 14:45, totaling 1.5 hours").

Mammography With Xeroradiography

Providers must use CPT codes 77065 for unilateral diagnostic mammography and 77066 for bilateral diagnostic mammography whether or not xeroradiography was used in the examination. CPT codes 77065 and 77066 may be billed with modifiers U7 or 99 as appropriate and cannot both be billed on the same day for the same recipient.

Screening Mammography

Screening mammography must be billed with CPT code 77067 (screening mammography, bilateral [2-view study of each breast], including computer-aided detection when performed). CPT code 77067 may be billed with modifiers U7 or 99 as appropriate. This code has a frequency limit of one screening per year, any provider. A TAR may override the frequency limit. Code 77067 will not be reimbursed in the same year for the same recipient, by any provider.

Diagnostic Mammography

Diagnostic mammography must be billed with one of the following codes:

Table of CPT Codes for Diagnostic Mammography

CPT Code	Description
77065	Diagnostic mammography, including computer-aided detection when performed; unilateral
77066	Diagnostic mammography, including computer-aided detection when performed; bilateral

Diagnostic mammography is reimbursable if one of the following applies:

- The recipient has distinct signs and symptoms for which a mammogram is indicated; or
- The recipient has a history of breast cancer; or
- The recipient is asymptomatic, but on the basis of the recipient's history and other significant factors in the physician's judgment, a diagnostic mammogram is indicated and appropriate.

CPT codes 77065 and 77066 are limited to two screenings per year. Any provider is allowed to submit a claim for these codes with a TAR override.

Digital Breast Tomosynthesis

Digital breast tomosynthesis must be billed with one of the following codes:

Table of HCPCS and CPT Codes for Breast Tomosynthesis

HCPCS/CPT Code	Description
G0279 ∞	Diagnostic digital breast tomosynthesis, unilateral or bilateral
77061	Digital breast tomosynthesis; unilateral
77062	Digital breast tomosynthesis; bilateral
77063 ∞	Screening digital breast tomosynthesis, bilateral

CPT code 77063 is restricted to females 40 years of age and older, with a frequency limit of one screening per year. There are no diagnostic restrictions for screening mammograms. A *Treatment Authorization Request* (TAR) may override age restrictions. A TAR will override gender restrictions.

Bone Density Studies for Osteoporosis

Bone mineral density studies are recommended to confirm the presence of osteoporosis before beginning treatment with pharmacologic regimens. A bone mineral density study may help manage patients who fail to respond or continue to deteriorate on pharmacologic treatment or who need adjustment of medication dosage.

The following codes are benefits for recipients with osteoporosis.

Bone Density Studies Table

CPT Code	Description
0743T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density, with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and bone mineral density and classification of any vertebral fractures, with overall fracture risk assessment, interpretation and report
0749T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X ray data, assessment of bone strength and fracture-risk and BMD, interpretation and report
0750T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X ray data, assessment of bone strength and fracture-risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD
0558T	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis

Bone Density Studies Table (continued)

CPT Code	Description
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; appendicular skeleton (peripheral)
77085 ∞	Dual-energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton, including vertebral fracture assessment
77086 ∞	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)

DXA test codes 77080 or 77081 are limited to one test (code 77080 or 77081) per recipient, per year, for any provider. Authorization is not required.

CPT code 0558T is restricted to recipients 50 years of age and older. The frequency limit is one per recipient, once every 365 days, for any provider. This code is billed “By Report”. An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Note: CPT codes 78350 (bone density [bone mineral content] study, one or more sites; single photon absorptiometry) and 78351 (…dual photon absorptiometry, one or more sites) are not reimbursable and claims for these procedures will be denied.

Note: CPT code 77078 (computed tomography, bone mineral density study, one or more sites; axial skeleton) is a non-benefit. The code is split-billable with a TAR and must be billed with modifier 26 when billing only for the professional component, and modifier TC when billing only for the technical component. When billing for both the professional and technical service components, a modifier is neither required nor allowed.

DXA Restrictions

DXA studies are not reimbursable when ordered solely for bone density screening. The test should be used only for recipients with at least one of the following medical conditions:

- Significant risk of developing osteoporosis, including:
  - Primary osteoporosis: Postmenopausal (Type I) vertebral crush fracture syndrome, senile (Type II) fracture of the proximal femur, idiopathic (juvenile and adult)
  - Endocrine osteoporosis: Hyperparathyroidism, Cushing's syndrome or glucocorticoid administration, hyperthyroidism, hypogonadism
  - Nutritional osteoporosis: Vitamin C deficiency; malabsorption: calcium deficiency, protein-calorie malnutrition
  - Hematopoietic osteoporosis: Multiple myeloma, systemic mastocytosis
  - Immobilization
  - Genetic disorders: Osteogenesis Imperfecta, homocystinuria, Ehlers-Danlos syndrome, Marfan's syndrome, Menke's syndrome
  - Miscellaneous: Rheumatoid arthritis, alcoholism, liver disease, diabetes mellitus, prolonged heparin therapy, chronic obstructive pulmonary disease
- A fracture clinically suspected to be a result of undiagnosed osteoporosis.
- Established osteoporosis that may require pharmacologic treatment of osteoporosis.
- Receiving a medication approved by the FDA for the treatment of osteoporosis.

Angiographic Procedures by Serialography

The CPT book contains basic CPT procedure codes for angiographic procedures performed by serialography (CPT codes 75605, 75625 and 75630). These codes are defined as being applicable to the initial projection of each serialographic procedure. Providers are advised to use CPT code 75774 to bill Medi-Cal for each additional serialographic projection or run performed at the time of the initial examination. Do not report code 75774 in conjunction with CPT codes 36221 thru 36228.

Catheter Placement for Renal Angiography

CPT codes 36251 thru 36254 are billed for catheter placement for renal angiography. CPT code 36253 is not reimbursable in conjunction with 36251 when performed for the same kidney. Providers must document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) or on a claim attachment when performed on a different kidney.

Placement of Proximal Extension Prosthesis

Claims for CPT code 75958 (placement of proximal extension prosthesis, radiological supervision and interpretation) require medical justification when billed for more than three procedures on the same date of service.

Placement of Distal Extension Prosthesis

Reimbursement for CPT code 75959 (placement of distal extension prosthesis, radiological supervision and interpretation) is limited to once per date of service, regardless of the number of modules deployed.

Spine and Pelvis

The following CPT codes may be split billed with modifiers 26 and TC: When billing for both the professional and technical components, a modifier is neither required nor allowed.

Table of CPT Codes for Spine and Pelvis

CPT Code	Description
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed; one view
72082	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed; 2 or 3 views
72083	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed; 4 or 5 views
72084	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed; minimum of 6 views

Lower Extremities

The following CPT codes may be split billed with modifiers 26 and TC: When billing for both the professional and technical components, a modifier is neither required nor allowed.

Table of CPT Codes for Lower Extremities

CPT Code	Description
73501	Radiologic examination, hip, unilateral, with pelvis when performed; 1 view
73502	Radiologic examination, hip, unilateral, with pelvis when performed; 2 or 3 views
73503	Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views
73521	Radiologic examination, hips, bilateral, with pelvis when performed; 2 views
73522	Radiologic examination, hips, bilateral, with pelvis when performed; 3 or 4 views
73523	Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views
73551	Radiologic examination, femur; 1 view
73552	Radiologic examination, femur; minimum 2 views

Gastrointestinal Tract

The following CPT codes may be split billed with modifiers 26 and TC: When billing for both the professional and technical components, a modifier is neither required nor allowed.

Table of CPT Codes for the Gastrointestinal Tract

CPT Code	Description
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed images, without KUB
74241	Radiologic examination, gastrointestinal tract, upper; with or without delayed images, with KUB
74245	Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial images
74246	Radiologic examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, without KUB
74247	Radiologic examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, with KUB
74249	Radiologic examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through
74250	Radiologic examination, small intestine, includes multiple serial images;
74251	Radiologic examination, small intestine, includes multiple serial images; via enteroclysis tube
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Modifier required: TC (technical only) and/or 26 (professional only)
†	Modifier allowed: U7 (Medicaid level of care 7) and/or 99 (multiple modifiers)
‡	Modifier allowed: TC, 26, U7 and/or 99
§	These CPT codes for MRI services will not be subject to the reimbursement reduction of services provided during the same session. These codes may be reimbursed when billed in any combination for services on the same day or when billed for one of these services more than once on the same day.
∞	This code is split-billable and must be billed with modifiers 26 and TC