

DIAGNOSTIC IMAGING AND THERAPEUTIC RADIOLOGY SERVICES

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## DIAGNOSTIC IMAGING AND THERAPEUTIC RADIOLOGY SERVICES

**TITLE 8 SOCIAL SERVICES**  
**CHAPTER 324 ADJUNCT SERVICES**  
**PART 3 DIAGNOSTIC IMAGING AND THERAPEUTIC RADIOLOGY SERVICES**

**8.324.3.1 ISSUING AGENCY:** New Mexico Human Services Department.  
[2/1/95; 8.324.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3/1/12]

**8.324.3.2 SCOPE:** The rule applies to the general public.  
[2/1/95; 8.324.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3/1/12]

**8.324.3.3 STATUTORY AUTHORITY:** The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).  
[2/1/95; 8.324.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3/1/12]

**8.324.3.4 DURATION:** Permanent  
[2/1/95; 8.324.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3/1/12]

**8.324.3.5 EFFECTIVE DATE:** February 1, 1995  
[2/1/95; 8.324.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 3/1/12]

**8.324.3.6 OBJECTIVE:** The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.  
[2/1/95; 8.324.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3/1/12]

**8.324.3.7 DEFINITIONS:** [RESERVED]

**8.324.3.8 MISSION STATEMENT:** The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.  
[2/1/95; 8.324.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3/1/12]

**8.324.3.9 DIAGNOSTIC IMAGING AND THERAPEUTIC RADIOLOGY SERVICES:** The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including diagnostic imaging and therapeutic radiology services [42 CFR Section 440.30]. This part describes eligible providers, covered services, service limitations, and general reimbursement methodology.  
[2/1/95; 8.324.3.9 NMAC - Rn, 8 NMAC 4.MAD.752, 3/1/12]

**8.324.3.10 ELIGIBLE PROVIDERS:**

A. Upon approval of medical assistance program provider participation agreements by MAD, the following providers are eligible to furnish imaging and radiology services:

(1) Radiological laboratories that qualify to participate under Title XVIII (medicare) of the Social Security Act or that are certified by the health care financing administration (HCFA) upon recommendation by the licensing and certification bureau of the department of health (DOH);

(2) Individual physicians licensed to practice medicine or osteopathy, podiatrists or the groups providers form; and

(3) Hospitals. See 8.311.2 NMAC, *Hospital Services*. The professional component of radiology services in hospitals is subject to the limitations specified in this section.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[2/1/95; 8.324.3.10 NMAC - Rn, 8 NMAC 4.MAD.752.1, 3/1/12]

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[Compiler's note: Section MAD-720 does not exist. The correct citation for Hospital Services is MAD-721, now 8.311.2 NMAC.]

**8.324.3.11 PROVIDER RESPONSIBILITIES:** Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See 8.302.1 NMAC, *General Provider Policies*. [2/1/95; 8.324.3.11 NMAC - Rn, 8 NMAC 4.MAD.752.2, 3/1/12]

**8.324.3.12 COVERED SERVICES:** Medicaid covers medically necessary imaging, blood flow measurement, plethysmographic examinations and radiology services ordered by physicians or other licensed practitioners, which are either performed by the ordering providers or under their supervision in their office or furnished by a radiology laboratory which meets the requirements for medicaid participation. Medicaid also covers medically necessary related services, including treatment planning, minor surgical procedures and injections.

A. **Professional component:** Medicaid covers interpretations of diagnostic imaging, the professional component. The complete procedure includes the technical radiology component and a professional component. Medicaid covers one (1) professional component per imaging procedure.

B. **Professional component for recipients in hospital settings:** If a service is furnished in a hospital setting, the physician is paid only for the professional component, unless both the following conditions are met:

- (1) the recipient is not an inpatient or outpatient of the hospital facility; and
- (2) the hospital does not bill medicaid for any component of the imaging service and does not include the costs associated with producing those services in cost reports.

C. Providers are paid the professional component if they do not request an interpretation from the hospital radiologist. Without a provider request for an interpretation, neither the hospital nor the hospital radiology physician can bill for the professional component.

[2/1/95; 8.324.3.12 NMAC - Rn, 8 NMAC 4.MAD.752.3, 3/1/12]

**8.324.3.13 NONCOVERED SERVICES:**

A. Therapeutic radiology and diagnostic imaging services are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services*.

B. Medicaid does not pay an additional amount for contrast media except in the following instances:

- (1) radioactive isotopes;
- (2) non-ionic radiographic contrast material; or
- (3) gadolinium salts used in magnetic resonance imaging.

C. Reimbursement for imaging procedures includes all materials and minor services necessary to perform the procedure. Medicaid does not pay for kits, films or supplies, as separate charges.

[2/1/95; 8.324.3.13 NMAC - Rn, 8 NMAC 4.MAD.752.4, 3/1/12]

**8.324.3.14 PRIOR APPROVAL AND UTILIZATION REVIEW:** All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. **Prior approval:** Certain procedures or services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration of Utilization Review Decisions*.

[2/1/95; 8.324.3.14 NMAC - Rn, 8 NMAC 4.MAD.752.5, 3/1/12]

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**8.324.3.15 REIMBURSEMENT:** Radiology providers must submit claims for reimbursement on either the HCFA-1500 or UB-92 claim form or their successor depending on the provider type. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

- A. Reimbursement to non-institutional providers is made at the lesser of the following:
    - (1) the provider's billed charge; or
    - (2) the MAD fee schedule for the specific service or procedure.
  - B. The provider's billed charge must be their usual and customary charge for services.
  - C. "Usual and customary charge" refers to the amount which the provider charges the general public in the majority of cases for a specific procedure or service.
  - D. Reimbursement to institutional providers is based on medicare reimbursement principles.
- [2/1/95; 8.324.3.15 NMAC - Rn, 8 NMAC 4.MAD.752.6, 3/1/12]

**8.324.3.16 REIMBURSEMENT LIMITATIONS:**

A. **Services performed at separate facilities:** Medicaid does not reimburse physicians and other private practitioners diagnostic or therapeutic radiology, diagnostic imaging, ultrasound or nuclear medicine services furnished at a separate facility. Reimbursement for the actual performance of services is not made to the practitioner, unless the services were furnished by the practitioner.

B. **Non-profit licensed diagnostic and treatment centers and state facilities:** Non-profit licensed diagnostic and treatment centers which contract for radiological services can bill for services provided that the charge does not exceed the amount paid to the contractor by the licensed diagnostic and treatment center. State facilities which contract with other state operated radiology facilities can bill for those services provided the amount billed for these services does not exceed the amount paid by the state facility to the contractor.

C. **Reimbursement for additional charges:** Reimbursement for performance of a radiology procedure is considered paid in full when payment is made for the procedure. Additional services such as office visits, home visits, and nursing home visits are not reimbursed separately.

D. **Reimbursement for single anteroposterior radiograph of the abdomen:** Additional reimbursement is not made for a single anteroposterior radiologic examination of the abdomen, referred to as a KUB, when any one of the following procedures is performed:

- (1) upper gastrointestinal tract series;
- (2) small bowel series; and
- (3) barium enema.

E. **Reimbursement for inclusive procedures:** Reimbursement for certain radiological procedures is included in the reimbursement for other procedures. Reimbursement for the lesser procedure is always considered to be included in the payment for the more comprehensive procedure for a specified group.

F. **Professional components for specified procedures:** For services furnished in a hospital setting, the technical components of diagnostic and therapeutic radiology, diagnostic imaging, ultrasound, peripheral vascular flow study and non-invasive diagnostic procedures are considered to be paid in the payment to the hospital. For inpatients, the professional components of these services are the only services for which Medicaid pays a separate payment. Professional components can only be billed by the non-institutional provider. Non professional components for radiology services performed within a hospital setting can only be billed by the institutional provider. Reimbursement for the professional component of a radiology service does not exceed forty percent (40%) of the amount allowed for the complete procedure.

(1) A professional component or interpretation is not payable to the same provider who bills for the complete procedure.

(2) A claim for "supervision and interpretation only" is not payable in addition to a claim for the complete procedure.

[2/1/95; 8.324.3.16 NMAC - Rn, 8 NMAC 4.MAD.752.7, 3/1/12]

**HISTORY OF 8.324.3 NMAC:** [RESERVED]