Radiologic Diagnostic Procedures

Policy Number: MCS076.09
Approval Date: April 10, 2024

Instructions for Use

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Related Policies
None

Coverage Guidelines

Diagnostic radiologic procedures are covered when Medicare criteria are met.

Note: For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.

Computerized Tomography (CT Scan)

For coverage guidelines, refer to NCD for Computerized Tomography (220.1).

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.

For states/territories with no LCDs/LCAs, for determination of when a CT scan is reasonable and necessary as required by the National Coverage Determination (NCD) for Computerized Tomography (220.1), refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging).

Click here to view the InterQual® criteria.

UnitedHealthcare uses the criteria in the InterQual® guidelines to supplement the general Medicare criteria regarding when a Computerized Tomography (CT) Scan is reasonable and necessary. UnitedHealthcare uses the criteria noted above in order to

ensure consistency in reviewing the conditions to be met for coverage of a CT Scan, as well as reviewing when such services may be medically necessary. Use of this criteria to supplement the general provisions noted above provides clinical benefits by helping ensure CT scans are not incorrectly denied when medically appropriate for a particular patient nor incorrectly approved when not reasonable and necessary for a patient. The potential clinical harms of using this criteria may include inappropriately denying a CT Scan when it is otherwise indicated, which could lead to diagnostic and treatment errors. The clinical benefits of using this criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services, because the criteria is unlikely to lead to circumstances where CT Scans are inappropriately denied. In addition, use of the criteria may decrease inappropriate denials by creating a consistent set of review criteria. Further, use of the criteria should limit the circumstances where CT Scans are incorrectly approved, which itself provides benefits because performing the test when it is not indicated can lead to false positive findings requiring otherwise unnecessary testing and or procedures and downstream complications. Additionally, unnecessary exposure to radiation may modestly elevate a person's lifetime risk of developing cancer. The administration of intravenous contrast commonly used to highlight both normal anatomy and pathologic conditions may have untoward effects including allergic reactions, leakage around the vein causing tissue damage, and injury to the kidneys.
(Accessed March 19, 2024)

Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)

Multi-detector (multi-detector-row/multi-slice) computed cardiac tomography (MDCT) is also known as cardiac computed tomographic coronary angiography (CCTA) or computed tomography of the heart and coronary arteries.

Medicare does not have an NCD for CCT and CCTA. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Cardiac Computed Tomography and Coronary Computed Tomography Angiography.

For plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging).

Click here to view the InterQual® criteria.

Note: After checking the Cardiac Computed Tomography and Coronary Computed Tomography Angiography table and the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed March 19, 2024)

Single Photon Emission Computed Tomography (SPECT) (CPT Codes 78071, 78072, 78451, 78452, 78469, 78494, and 78803)

For coverage guidelines, refer to the NCD for Single Photon Emission Computed Tomography (SPECT) (220.12).

Notes:

- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.
- **For states/territories with no LCDs/LCAs, for uses of SPECT not specifically addressed by the National Coverage Determination (NCD) for SPECT (220.12)**, refer to the following for coverage guidelines:
    - **For regions/states/territories involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program**, refer to the Medicare Advantage Plans Radiology and Cardiology Clinical Guidelines at https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html.
    - **For plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program**, refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging).
      (Accessed March 19, 2024)

      Click here to view the InterQual® criteria.

Magnetic Resonance Imaging (MRI) & Magnetic Resonance Angiography (MRA) (MRI for Blood Flow)

For coverage guidelines, refer to the NCD for Magnetic Resonance Imaging (220.2).

Notes:

- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.
- **For states/territories with no LCDs/LCAs, for indications of MRI/MRA not specifically addressed by the National Coverage Determination (NCD) for MRI (220.2)**, refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging).
  (Accessed March 19, 2024)

Click here to view the InterQual® criteria.

Positron Emission Tomography (CPT Codes 78429, 78430, 78431, 78432, 78433, 78434, 78459, 78491, 78492, 78608, 78811, 78812, 78813, 78814, 78815, and 78816)

Notes:

- **For regions/states/territories involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program**, refer to the Medicare Advantage Plans Radiology and Cardiology Clinical Guidelines at https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html.
- **For plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program**, refer to the nationally recognized guidelines (i.e., InterQual® guidelines).

Click here to view the InterQual® criteria.

Positron Emission Tomography (PET) (FDG) for Oncologic Conditions

Positron emission tomography (PET) (FDG) for oncologic conditions may be covered when criteria are met. For up to three PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy, refer to the NCD for Positron Emission Tomography (FDG) for Oncologic Conditions (220.6.17). Coverage of more than three FDG PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy, Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Positron Emission Tomography (PET) (FDG) for Oncologic Conditions.

For greater than three FDG PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy, for states/territories with no LCDs/LCAs refer to the Medicare Advantage Plans Radiology and Cardiology Clinical Guidelines at https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html.

Note: After checking the Positron Emission Tomography (PET) (FDG) for Oncologic Conditions table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed March 19, 2024)

Positron Emission Tomography (PET) for Other Conditions

PET for other specific conditions may be covered when criteria are met. Refer to the following National Coverage Determinations (NCDs):

- NCD for PET for Perfusion of the Heart (220.6.1)
- NCD for FDG PET for Dementia and Neurodegenerative Diseases (220.6.13)
  - The list of Medicare approved clinical trials is available at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/FDG-PET-and-Other-Neuroimaging-Devices-for-Dementia.html.
  - For payment rules for NCDs requiring CED, refer to the Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED).

- NCD for FDG PET for Myocardial Viability (220.6.8)
- NCD for FDG PET for Refractory Seizures (220.6.9)
- NCD - Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer (220.6.19)

Note: Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.
(Accessed March 19, 2024)

Computed Tomographic Colonography (CTC) for Screening Purposes

Refer to the Coverage Summary titled Gastroesophageal and Gastrointestinal (GI) Services and Procedures.

Other Nuclear Medicine (CPT Codes 78012, 78013, 78014, 78015, 78016, 78018, 78070, 78071, 78072, 78075, 78099, 78199, 78226, 78227, 78299, 78399, 78499, 78579, 78580, 78582, 78597, 78598, 78599, 78699, 78799, 78800, 78801, 78802, 78804, 78830, 78831, 78832, and 78999)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.

- **For regions/states/territories involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program** refer to the Medicare Advantage Plans Radiology and Cardiology Clinical Guidelines at https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html.
- **For plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program**, r refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging).
  (Accessed March 19, 2024)

  Click here to view the InterQual® criteria.

3D Rendering (CPT Codes 76376 and 76377)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.

- **For regions/states/territories involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program** refer to the Medicare Advantage Plans Radiology and Cardiology Clinical Guidelines at https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html.
- **For plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program**, refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging).
  (Accessed March 19, 2024)

  Click here to view the InterQual® criteria.

Definitions

Diagnostic Services: A service is “diagnostic” if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury. Refer to the Medicare Benefit Policy Manual, Chapter 6, §20.4.1 Diagnostic Services Defined. (Accessed March 19, 2024)

Supporting Information

Positron Emission Tomography (PET)(FDG) for Oncologic Conditions Accessed March 19, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L35391 (A56848)	Multiple Imaging in Oncology	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
Back to Guidelines				

Cardiac Computed Tomography (CCT) and Cardiac Computed Tomography Angiography (CCTA) Accessed March 19, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
L33947 (A56451)	Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)	Part A and B MAC	CGS Administrators, LLC	KY, OH
L33559 (A56737)	Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L33423 (A56691)	Cardiac Computed Tomography & Angiography (CCTA)	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L35121 (A57552)	Coronary Computed Tomography Angiography (CCTA)	Part A and B MAC	*Wisconsin Physicians Service Insurance Corporation	IN, IA, KS, MI, MO, NE
Back to Guidelines				

MACs with Corresponding States/Territories	
MACs	**States/Territories**
CGS	KY, OH
First Coast	FL, PR, VI
NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
Noridian	AK, AS, AZ, CA, GU, HI, ID, MT, ND, Northern Mariana Islands, NV, OR, SD, UT, WA, WY
Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
Palmetto	AL, GA, NC, SC, TN, VA, WV
WPS*	IA, IN, KS, MI, MO, NE
*__Note__: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 - applies only to WPS Legacy Mutual of Omaha MAC A Providers	

References

Hemaya M, Hemaya M, Habeeb A. The Risks Associated With Computed Tomography Scans: An Assessment of the Readability and Reliability of Online Text Available for Patient Information and Guidance. Cureus. 2022 Oct 27;14(10):e30758.

Müskens JLJM, Kool RB, van Dulmen SA, et al. Overuse of diagnostic testing in healthcare: a systematic review. BMJ Quality & Safety 2022;31:54-63.

Schmidt CW. CT scans: balancing health risks and medical benefits. Environ Health Perspect. 2012 Mar;120(3):A118-21.

What are the benefits of CT scans? Radiology Info. Refer to the following website for more information: https://www.radiologyinfo.org/en/info/safety-hiw_04.

White Paper: Initiative to Reduce Unnecessary Radiation Exposure from Medical Imaging. FDA. Refer to the following website for more information: https://www.fda.gov/radiation-emitting-products/initiative-reduce-unnecessary-radiation-exposure-medical-imaging/white-paper-initiative-reduce-unnecessary-radiation-exposure-medical-imaging#_Toc253092875.

D4Policy History/Revision Information

Date	Summary of Changes

04/10/2024	**Coverage Guidelines**
	• Removed notation indicating radiology prior authorization programs exist for some markets for MRIs, MRAs, PET scans, and nuclear medicine studies
	• Removed content/language addressing:
	  ○ Diagnostic x-rays
	  ○ X-ray, radium, and radioactive isotope therapy
	  ○ Bone (mineral) density studies/mass measurements
	  ○ Beta amyloid positron emission tomography in dementia and neurodegenerative disease
	Computerized Tomography (CT Scan)
	• Revised language to indicate:
	  ○ For coverage guidelines, refer to the National Coverage Determination (NCD) for *Computerized Tomography (220.1)*
	  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database
	  ○ For states/territories with no LCDs/LCAs, for determination of when a CT scan is reasonable and necessary as required by the NCD for *Computerized Tomography (220.1)*, refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging)
	  ○ UnitedHealthcare uses the criteria in the InterQual® guidelines to supplement the general Medicare criteria regarding when a computerized tomography (CT) scan is reasonable and necessary
	  ○ UnitedHealthcare uses the criteria noted above in order to ensure consistency in reviewing the conditions to be met for coverage of a CT scan, as well as reviewing when such services may be medically necessary
	  ○ Use of this criteria to supplement the general provisions noted above provides clinical benefits by helping ensure CT scans are not incorrectly denied when medically appropriate for a particular patient nor incorrectly approved when not reasonable and necessary for a patient
	  ○ The potential clinical harms of using this criteria may include inappropriately denying a CT scan when it is otherwise indicated, which could lead to diagnostic and treatment errors
	  ○ The clinical benefits of using this criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services, because the criteria is unlikely to lead to circumstances where CT Scans are inappropriately denied
	  ○ In addition, use of the criteria may decrease inappropriate denials by creating a consistent set of review criteria; further, use of the criteria should limit the circumstances where CT Scans are incorrectly approved, which itself provides benefits because performing the test when it is not indicated can lead to false positive findings requiring otherwise unnecessary testing and or procedures and downstream complications
	  ○ Additionally, unnecessary exposure to radiation may modestly elevate a person's lifetime risk of developing cancer
	  ○ The administration of intravenous contrast commonly used to highlight both normal anatomy and pathologic conditions may have untoward effects including:

Date	Summary of Changes
	▪ Allergic reactions ▪ Leakage around the vein causing tissue damage ▪ Injury to the kidneys ***Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)*** • Removed language pertaining to states/territories with no LCDs/LCAs in regions involved in the Radiology Prior Authorization Program • Modified language pertaining to plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; added instruction to refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) ***Single Photon Emission Computed Tomography (SPECT) (CPT Codes 78071, 78072, 78451, 78452, 78469, 78494, and 78803)*** • Modified language pertaining to plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; added instruction to refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) ***Magnetic Resonance Imaging (MRI) & Magnetic Resonance Angiography (MRA) (MRI for Blood Flow)*** • Modified service heading • Revised language to indicate: ~~o~~ For coverage guidelines, refer to the NCD for *Magnetic Resonance Imaging (220.2)* o LCDs/LCAs exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database o For states/territories with no LCDs/LCAs, for indications of MRI/MRA not specifically addressed by the National Coverage Determination (NCD) for *Magnetic Resonance Imaging (220.2)*, refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) ***Positron Emission Tomography (CPT Codes 78429, 78430, 78431, 78432, 78433, 78434, 78459, 78491, 78492, 78608, 78811, 78812, 78813, 78814, 78815, and 78816)*** • Added language to indicate: o For regions/states/territories involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, refer to the Medicare Advantage Radiology & Cardiology Clinical Guidelines at UHCprovider.com > Radiology Prior Authorization and Notification o For plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, refer to the nationally recognized guidelines (i.e., InterQual® guidelines) ***Other Nuclear Medicine (CPT Codes 78012, 78013, 78014, 78015, 78016, 78018, 78070, 78071, 78072, 78075, 78099, 78199, 78226, 78227, 78299, 78399, 78499, 78579, 78580, 78582, 78597, 78598, 78599, 78699, 78799, 78800, 78801, 78802, 78804, 78830, 78831, 78832, and 78999)*** • Modified language pertaining to plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; added instruction to refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) ***3D Rendering (CPT Codes 76376 and 76377)*** • Modified language pertaining to plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; added instruction to refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) **Supporting Information** • Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories* • Updated lists of applicable *Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)* to reflect the most current information: o Added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers

Date	Summary of Changes
	○ Modified reference information for *Positron Emission Tomography (PET) (FDG) for Oncologic Conditions* ○ Updated *References* section **Administrative** ● Archived previous policy version MCS076.08

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. UnitedHealthcare utilizes the additional criteria noted above to supplement Medicare coverage guidelines in order to determine medical necessity consistently. The additional coverage criteria was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.