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CHAPTER THIRTY FOUR
INDEPENDENT RADIOLOGY SERVICES

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Chapter 34. Independent Radiology Services

Rule No. 560-X-34-.01. Independent Radiology Services – General

The Alabama Medicaid Agency will pay for services provided by independent radiology facilities that are enrolled by contract under the following conditions:

- (a) The services must be medically necessary.
- (b) The patient must be eligible for Medicaid at the time the services are rendered.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30. Rule effective October 13, 1998.

Rule No. 560-X-34-.02. Covered Services

Radiology services are professional and technical radiological services – (a) ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law; (b) provided in an office or similar facility other than a hospital outpatient department or clinic; and (c) provided by a radiology facility that meets the requirements for participation in Medicare.

Radiology services are restricted to those that are described by procedures in the CPT manual (70010-79999) or one of the locally assigned HCPCS codes used only by Medicaid to supplement the listing in the CPT manual.

- (a) Providers will be paid only for covered services which they are certified to perform and which they actually perform.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30. Rule effective October 13, 1998.

Rule No. 560-X-34-.03. Participation Requirements

Independent radiology facilities must meet the following requirements for participation in the Alabama Medicaid Program:

- (a) Be certified for participation with Medicare.
- (b) Be independent of any hospital, clinic, or physician's office.
- (c) Be licensed in the state where located, when it is required by that state.
- (d) Submit to routine audits by Medicaid.
- (e) Complete an application with all required attachments.
- (f) Sign a provider agreement.
- (g) Sign a Direct Deposit Authorization.
- (h) Sign a Civil Rights Statement of Compliance.
- (i) Effective date of enrollment will be the date of Medicare certification.

However, providers who request enrollment more than 120 days after certification will be enrolled on the first day of the month the request for enrollment is received.

Author: Ginger Collum, Program Manager, Clinic/Ancillary Services

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30, 493.2.

History: Rule effective October 13, 1998. Amended: Filed December 17, 2001, effective March 15, 2002.

Rule No. 560-X-34-.04. Claims Filing Instructions

- (1) For time limits on claims submission, refer to the Radiology Services Billing Manual.
- (2) Claims for radiology services must contain a valid diagnosis code.
- (3) Claims submitted must contain the provider number of the radiology facility that actually performed the service. Claims must not be submitted using any other provider's number, such as the provider number of the referring physician or hospital.
- (4) Claims containing fragmentation of radiology services may be recouped through postpayment review.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30, 493.2. Rule effective October 13, 1998.

Rule No. 560-X-34-.05. Third Party Payment Procedures

For guidelines on submitting claims to Medicaid when a third party is involved, refer to the Radiology Services Billing Manual.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 13, 1998.

Rule No. 560-X-34-.06. Sending Bills and Statements to Medicaid Recipients

- (1) Providers should not send recipients bills or statements for covered services once the recipient has been accepted as a Medicaid patient.
- (2) Providers may send a notice to the recipient stating their claim is still outstanding if the notice indicates in bold letters, "**THIS IS NOT A BILL**".
- (3) Providers are responsible for follow-up with the fiscal agent or Medicaid on any billing problems or unpaid claims.
- (4) Providers agree to accept the amount paid by Medicaid as payment in full.
- (5) Recipients are not responsible for the difference between charges billed and the amount paid by Medicaid for covered services.
- (6) Recipients may be billed only for the allowable copayment amount, for services not covered by Medicaid, or when benefits have been exhausted.
- (7) Providers may not deny services to any eligible recipient due to the recipient's inability to pay the allowable copayment amount.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.15, 447.50, 447.55. Rule effective October 13, 1998.

Rule No. 560-X-34.07. Prior Authorization

(1) Prior authorization is required for certain radiology codes. The performing provider (facility) or the referring/ordering provider may request prior authorization. Prior authorization requests must be made prior to the test being performed. In the event of an urgent situation (when the prior authorization cannot be obtained before the test is performed), a PA may be requested within 14 days from the date of service. The case must then meet the “urgent” criteria before it will be considered for review. Providers are allowed 30 days from the date of service to submit a request to change or add a code to an approved case.

(2) If a request is denied, written notice will be sent to the provider and the recipient indicating the reason for denial. Information giving them their right to appeal is also included in this notice.

(3) For further information regarding prior authorization for radiology procedures refer to Chapter 22 (Independent Radiology) of the Alabama Medicaid Provider Billing Manual.

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Statutory Authority: State Plan 3.1-A; Title XIX, Social Security Act; 42 C.F.R. Section 440.30.

History: New Rule filed December 18, 2009; effective March 18, 2010.