

## **Radiology/Diagnostic Services**

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- [Eligible Providers](#)
- [Eligible Members](#)
- [Covered Services](#)
- [Authorization Requirements](#)
- [Noncovered Services](#)
- [Billing](#)
- [Definitions](#)
- [Legal References](#)

### **Eligible Providers**

A vendor must be certified by Centers for Medicare and Medicaid Services for participation in the Medicare program to be eligible as a provider of independent X-ray services or portable X-ray services.

### **Eligible Members**

Radiology or diagnostic services are covered for Medical Assistance and MinnesotaCare eligible members. Refer to the [MHCP Benefits at-a-glance](#) section of the MHCP Provider Manual for more information.

### **Advanced Diagnostic Imaging Providers**

Providers must be accredited through one of the accrediting organizations to be eligible as a provider of the technical component (TC) of advanced diagnostic imaging (ADI) services. The accreditation requirements apply only to providers of the TC of the imaging service and not the physician's interpretation (professional component) of the imaging service. The accreditation requirements apply to all suppliers of the TC who submit claims to MHCP, except for the following organizations' settings licensed by [Minnesota Statutes](#):

- Outpatient and inpatient hospitals
- Ambulatory surgical centers
- Provider-based clinics

Providers must be accredited for the modality, Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) imaging service for which they are billing, or their claim will deny. ADI services include the following:

- Magnetic Resonance Imaging (MRI)
- Computed Tomography (CT)
- Nuclear medicine imaging including positive emission tomography (PET)

The accrediting organizations are:

- [The American College of Radiology](#)
- [The Intersocietal Accreditation Commission](#)
- [The Joint Commission](#)
- [RadSite Quality](#)

The billing entity or organization must do the following:

- Complete and sign an [Advanced Diagnostic Imaging Accreditation Requirements – Assurance Statement \(DHS-3872\) \(PDF\)](#)

- Attach a copy of the organization's most current accreditation certificates
- Fax both documents to MHCP Provider Eligibility and Compliance at 651-431-7462

Allow 30 days for MHCP to process the accreditation before submitting TC imaging service claims for services provided to fee-for-service MHCP members. Resubmit any claims following [timely billing](#) requirements for claims denied before MHCP receives your required information.

[Contact the MCO](#) directly for accreditation requirements and coverage policy.

Each of the accredited organizations will notify providers when it is time to renew accreditation. Providers must submit a new copy of their recertification with a new [Advanced Diagnostic Imaging Accreditation Requirements – Assurance Statement \(DHS-3872\) \(PDF\)](#) to MHCP Provider Eligibility and Compliance.

### **Covered Services**

To be eligible for MHCP payment for radiology or diagnostic services, the service must:

- Be ordered and provided by or under the direction of a member's treating physician (MD, DO, DPM, DDS, chiropractor) or practitioner (nurse practitioner, clinical nurse specialist, physician assistant or certified nurse-midwife), within the scope of practice as defined by state law. The physician or practitioner must provide a consultation or treat a member for a specific medical problem
- Yield results that must be used by the treating physician or practitioner in screening, diagnosis or management of a member's specific health problem
- Meet Medicare or Minnesota Department of Human Services (DHS) coverage criteria

### **Professional Component**

The professional component of a radiology procedure includes the professional services of the physician and the following:

- Examination of member when indicated
- Performance or supervision of the procedure
- Interpretation
- Written report of the examination

The professional component is applicable in an encounter when the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities.

### **Technical Component**

The technical component of a radiology procedure code includes the personnel and materials, including:

- Contrast media and drugs
- Film or xerography
- Space
- Equipment
- Other facilities

Oral or rectal contrast administration alone does not qualify as a study "with contrast."

### **Mammography**

MHCP covers medically necessary mammography services. All facilities (hospital, outpatient department, clinic, radiology practice, mobile unit, physician's office, or other facility) providing

diagnostic and screening mammography services are required to have FDA certification under the Mammography Quality Standards Act (MQSA). No facility may conduct an examination or procedure involving mammography unless the facility has obtained an MQSA certificate.

### **Coverage and Cost Sharing for Additional Diagnostic Services Following Mammogram**

Per legislation, if a provider determines an enrollee needs additional diagnostic services after a mammogram, the health plan must cover these services with no cost-sharing (including copay, deductible, or coinsurance). Medically necessary follow-up services should be billed with the appropriate codes and the TS modifier.

### **Authorization Requirements**

Prior authorization is required for some covered imaging services. Refer to the Prior Authorization indicator column (PA IND) on the [MHCP fee schedule](#) for imaging procedures that require authorization. Submit authorization requests to the [medical review agent](#).

### **Exceptions to Services Requiring Authorization**

MHCP no longer requires authorization for fee-for-service (FFS) radiology imaging services for the:

- Professional component
- Technical component if provided to a member who is one of the following:
  - Medicare and MCHP eligible
  - MinnesotaCare eligible
  - MHCP eligible and receives radiology imaging services in an ambulatory surgical center (ASC); licensed trauma center or hospital; or outpatient hospital setting where the priority type of admission is a 1 (emergency), 2 (urgent) or 5 (Trauma).

MHCP continues to require authorization for the technical component or global claim when a FFS Medicaid member accesses services in a setting other than those defined under the Exceptions to Services Requiring Authorization heading.

Imaging services that require PAs will need to use the standard PA procedure of going through the medical review agent.

### **Independent Diagnostic Testing Facility (IDTF)**

MHCP follows [CMS General Coverage and Payment Policies \(PDF\)](#) for IDTF providers.

### **Noncovered Services**

CPT or HCPCS procedure codes performed by an IDTF that are solely therapeutic are not covered.

### **Billing**

#### **Date of Service**

Do not bill a date span for services defined as multiple treatments or units of service.

### **Independent Diagnostic Testing Facility (IDTF)**

Refer to the following when billing for IDTF services:

- Report the NPI assigned to the ordering physician on the claim. Use the claim services line under the Other Providers tab in MN-ITS to report the ordering physician.
- When appropriate, bill the TC modifier on diagnostic procedures with a technical component.
- For diagnostic testing performed entirely at the patient's location, use that location as the place of service. When one or more aspects of the diagnostic testing are performed at the IDTF, the IDTF is the place of service.

## **Computerized Tomography (CT) and MRI**

Refer to the following when billing for CT and MRI together:

- When more than one provider is involved in providing and billing a procedure, the providers must establish a written agreement as to which component each provider will bill. For example, a physician bills for the professional component of the service he or she provided, while the hospital bills for the technical component. Or, the hospital bills for the total component (professional and technical) and the physician would not bill, but rather be paid by the hospital. The physician and the hospital cannot both be paid for both components.
- When a physician or clinic is billing for services performed and the equipment is owned by either the physician or clinic, the service cannot be separated into a technical and professional component.
- Use CPT or HCPCS codes and modifiers, when required, on all claims.
- Claims submitted for payment of CT and MRI scans must have a specific medical diagnosis. Use the ICD diagnosis code that is most complete and has the highest level of specificity. Bill PET scans using CPT coding.

## **Computerized Tomography (CT) Scanning Equipment Standards**

MHCP follows Medicare's requirement that providers must report modifier CT on all computed tomography scans performed on scanning equipment that does not meet the National Electrical Manufacturers Association (NEMA) standards. Refer to [MLN Matters MM9250](#) for additional information.

A payment reduction of 15 percent will apply to the technical component allowable.

## **X-rays taken using film**

X-rays taken by film must include modifier FX. MHCP follows Medicare's payment incentive to transition from film X-rays to digital radiography. Refer to [MLM Matters MM9727](#) for additional information.

X-rays taken by film will have the technical component allowable reduced by 20 percent.

## **Computed Radiography Technology Payment Changes**

Effective for dates of service on or after Jan. 1, 2018, all X-rays taken using computed radiography technology, defined as cassette-based imaging, must include modifier FY. Refer to [MLN Matters MM10417](#) for additional details.

Payment will be reduced on the technical components allowed amount or the technical component of the global fee allowed amount for the following dates of service:

- On or after Jan. 1, 2018, through Dec. 31, 2022, a payment reduction of 7 percent will apply
- On or after Jan. 1, 2023, a payment reduction of 10 percent and will apply

## **Components**

### **Professional**

Refer to the following when billing for the professional component:

- Only use modifier 26 when appropriate for professional services that state supervision and interpretation. Do not use modifier 26 if the CPT code is defined as the professional component only.
- Report the appropriate place of service.
- When a service is rendered to a hospital inpatient, use the inpatient hospital place of service code following Medicare guidelines as defined in the [Medicare Claims Processing Manual](#).

## Technical

The technical component includes the charges for the following:

- Personnel
- Materials
- Usual contrast media
- Drugs
- Film or xenograft
- Space
- Equipment and other facility charges

The technical component of all inpatient services is included in the inpatient DRG and billed electronically on the 837I.

For a provider transporting their own equipment to another site, the provider who owns the equipment may bill the technical components. Enter the procedure code with a TC modifier to identify a charge for the technical component.

Use modifier TC only when appropriate. Do not use the TC modifier if a CPT code is defined as the technical component only (of a service).

Injection of contrast material is part of the "with contrast" for CT, CTA, MRI and MRA procedures.

## Total

Total components include the technical and professional component. Use the appropriate procedure code without a modifier.

## Interventional Radiologic Procedures and Diagnostic Studies with Injection

These types of procedures include professional, technical, and injection components. The Nuclear Regulatory Commission (NRC), under strict procedures and guidelines, regulates use of radiopharmaceuticals. People administering radiopharmaceuticals should have either a license from the NRC or be credentialed by an institution having a board license from the NRC.

**Injection Component:** Bill radiology procedures using the appropriate CPT code that indicates "with contrast," if available. Bill contrast media provided in a hospital with the appropriate CPT or HCPCS code on the 837I.

**Contrast Material:** Bill separately using most appropriate HCPCS code.

**Contrast Media provided in an Inpatient Hospital:** Bill the appropriate CPT or HCPCS code on the 837I.

## Definitions

**Contrast Material:** The phrase "with contrast" represents contrast material administered intravascularly, or intra-articularly injections for imagine enhancement.

**Professional Component:** A physician's exam (when indicated), performance or supervision, interpretation, or written report of a radiology procedure.

**Radiology:** Radioactive substance's radiant energy and with the diagnostic and treatment of diseases by means of both ionizing and nonionizing radiation.

**Legal References**

[Minnesota Statutes, 256B.0625](#), subdivision 25a

[Minnesota Statutes, 144.1225](#) (Advanced Diagnostic Imaging Services)

[Minnesota Rules, 9505.0305](#) (Laboratory and X-ray Services)

[Minnesota Rules, 9505.0445](#) (Payment Rates)

[Code of Federal Regulations, title 42, section 410.33](#) (Independent Diagnostic Testing Facility)

[Code of Federal Regulations, title 42, section 410.34](#) (Mammography Service)

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