Medicaid covers radiology and non-invasive diagnostic tests necessary to establish a diagnosis, prescribe treatment and provide progressive follow-up or staging.

Services must be directly related to an illness or injury, or to improve the functioning of a malformed body part.

Services must be provided in accordance with written orders from a physician, physician’s assistant or an advanced practitioner of nursing.

Chapter 300 of the Nevada Medicaid Services Manual (MSM) provides state policy, service limitations and additional requirements for provider type 27.

**Covered Services**

Please refer to the appendix in MSM Chapter 300 to verify coverage and prior authorization requirements not listed below. The following are common diagnostic services that Medicaid covers:

- **An annual mammogram** for women age 40+ and for women ages 35-39 who are considered at high risk for breast cancer. For all women ages 35-39, a baseline mammogram is allowed once (see MSM section 303.2 for coverage and limitations). Prior authorization is not required.
- **Electrodiagnostic testing** when preceded by a neurological evaluation (see MSM section 303.3 for coverage and limitations).
- **Electromyography (EMG), Nerve Conduction Studies (NCS), F-wave studies, H-reflex tests and neuromuscular junction testing** (see MSM section 303.4 for coverage and limitations).
- **Evoked Potentials** (SEP, SSEP, VEP and AEP) for certain diagnoses (see MSM section 303.5 for coverage and limitations).
- **Magnetoencephalography** (MEG) (see MSM section 303.6 for coverage and limitations).
- **Sleep testing** in a certified sleep disorder clinic (see MSM section 303.7 for coverage and limitations).
- **Radiopharmaceuticals and Contrast Agents** (see MSM section 303.8 for coverage and limitations). Bill the wholesale invoice cost of the radiopharmaceutical or contrast agent. Keep the invoice in your records. Do not attach it to the claim.
Non-Covered Services

Medicaid does not cover:

- Investigational testing
- Experimental testing
- Duplicative testing when results of previous testing are still pertinent

Prior Authorization Requirements

You can request prior authorization using the Online Prior Authorization System (OPAS) or by submitting the paper form FA-6.

For questions regarding prior authorization, call the Magellan Medicaid Administration Prior Authorization Department at (800) 525-2395.

Please refer to the appendix in MSM Chapter 300 to verify prior authorization requirements for services not listed in these guidelines.

The following services always require prior authorization:

- Non-emergency services provided outside of Nevada (MSM 301A.8)
- Twenty-four hour EEG recordings and EEG mapping (MSM 303.3A)
- Electromyography (codes 95860-95875)
- Nerve Conduction Studies (NCS) (codes 95900-95904)
- H-reflex tests (codes 95934, 95936 and 95937)
- Short-latency Somatosensory Evoked Potential Study (codes 95925-95929)
- MEG testing (codes 95965-95967)
- Unlisted Magnetic Resonance Procedures (code 76498)

For sleep studies, polysomnograms and multiple sleep latency testing, prior authorization is required to exceed 2 instances in a 12-month period.

PET scans, MRIs, MRAs, MRSs, CAT scans, X-rays, bone scans and ultrasounds do not require prior authorization. For OB ultrasound requirements, please refer to MSM Chapter 600, section 603.4.A.

Billing

Radiology and non-invasive diagnostic centers (provider type 27) must use the CMS-1500 claim to bill for services. Services provided through an outpatient hospital (provider type 12) must be billed using the UB-04 claim form.