**Section 140.438 Diagnostic Imaging Services**

a) Payment for diagnostic and imaging services may be made to the following providers that are independent of both a physician's office and a hospital:

1) Imaging Centers that are distinct entities operating primarily for the purpose of providing diagnostic imaging services.

2) Mammography Screening Centers.

3) Portable X-ray Facilities.

4) Independent Diagnostic Testing Facilities (IDTFs) that are a fixed location, a mobile entity, or an individual non-physician practitioner.

b) Participation Requirements

1) To participate in the Illinois Medical Assistance program, an Imaging Center must, in addition to any other Department requirements, be licensed or certified:

A) for participation in the Medicare program; or

B) by the Joint Commission; or

C) by a state public health department; or

D) by any government agency having jurisdiction over the services provided and/or the equipment being used.

2) Portable X-ray Facilities shall be approved and certified for participation in the Medicare program.

3) Mammography Screening Centers shall be certified by the Illinois Emergency Management Agency or the certifying agency in the state where the center is located.

4) Independent Diagnostic Testing Facilities shall be approved and certified for participation in the Medicare program.

c) Reimbursement

1) Diagnostic and imaging services shall be reimbursed on a fee-for-service basis only.

2) Reimbursement may include the technical services, the professional services or both the technical and professional services.

3) Reimbursement shall be made for only those diagnostic or imaging services that have been ordered in writing by the referring practitioner as being essential to diagnosis and treatment. The practitioner must include the diagnosis or condition on the written request.

4) Reimbursement shall be made only to providers who meet all applicable license, enrollment and reimbursement conditions of the Department.

5) Reimbursement to IDTFs shall be made for only those diagnostic and imaging tests certified by Medicare.

6) Except for mammograms, reimbursement shall not be made for routine screening x-rays.

7) Reimbursement for a mammography facility provider that does not qualify under subsection (c)(8) of this Section shall be the lesser of charges or the Department's fee screen.

8) For services rendered on or after June 1, 2013, a mammography facility provider that meets the qualifications for and participates in the Department's Breast Cancer Quality Screening and Treatment Initiative shall be paid for mammography services at the effective Chicago Metropolitan Area Medicare Level established rate (Established Rate). To qualify for this Established Rate, a mammography facility provider shall:

A) Enter into a Supplemental Provider Agreement with the Department; and

B) Provide mammography services to participants in the Department's Medical Programs with the same timeliness as the facility provides to patients with other forms of insurance; and

C) Within 30 days after submitting the Supplemental Provider Agreement, and annually thereafter on or before August 31, submit a completed mammography capacity survey, using the Department's survey form; and

D) Submit facility-based mammography quality data using the Department's data collection forms; and

E) Provide the Department with access to patient and service data upon request; and

F) Assist the Department with the development and implementation of a plan to improve the quality of services.

d) Record Requirements

1) In addition to the record requirements specified in Section 140.28, providers of diagnostic and imaging services must comply with the administrative rules of the Illinois Department of Public Health governing the maintenance of medical records (77 Ill. Adm. Code 450, Illinois Clinical Laboratories Code).

2) The basic records that must be retained include:

A) Patient identification.

B) Medical records containing the dates of service and the name of the referring physician.

C) The referring practitioner's written orders.

D) Copies of reports to referring practitioners.

E) The report of the reading by the professional practitioner if both professional and technical components are billed.

F) The report of the reading by the professional practitioner that must be retained in the professional practitioner's office if only the professional component is billed by the practitioner.

G) Records that verify usual and customary charges to the general public.

3) Medical records for Medical Assistance program clients must be made available to the Department or its designated representative in the performance of audits or investigations.

(Source: Amended at 37 Ill. Reg. 7985, effective May 29, 2013)