

QUALCARE IPA

MCG Imaging and Diagnostic Testing

2026 Medicare Advantage Coverage Summary / Third-Party Clinical Criteria

Delegate Organization	QualCare IPA
Third-Party Criteria	MCG Care Guidelines, 30th Edition
Criteria Set	MCG Imaging and Diagnostic Testing
Population	UnitedHealthcare Medicare Advantage members for whom QualCare IPA performs delegated utilization management

1. Purpose and Scope

QualCare IPA uses MCG Imaging and Diagnostic Testing criteria to support utilization-management determinations for advanced and routine imaging and diagnostic testing, including selection of the appropriate modality, indication, sequencing, repeat testing, and safety considerations. MCG is used as a supplemental clinical decision-support resource only after applicable Original Medicare coverage requirements have been identified. Medicare statutes, regulations, NCDs, LCDs, LCAs, and CMS manual provisions control whenever they establish the applicable coverage requirement.

MCG criteria do not replace physician judgment and are not applied as an automatic denial rule. Reviewers consider the member's complete clinical record, treating-practitioner documentation, comorbidities, functional status, prior treatment, response to treatment, contraindications, and the capabilities of alternative settings.

2. Medicare Criteria Being Supplemented

- Social Security Act §1862(a)(1)(A): services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- 42 CFR §422.101: Medicare Advantage organizations must provide coverage consistent with Original Medicare coverage requirements; when coverage criteria are not fully established, permissible supplemental criteria must be based on current evidence in widely used treatment guidelines or acceptable clinical literature.
- 42 CFR §422.137: utilization management policies and procedures are subject to annual review and approval by the Medicare Advantage Utilization Management Committee.
- Applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and CMS Internet-Only Manual provisions are reviewed first and control when they establish the applicable coverage rule.
- CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, including diagnostic testing requirements as applicable.
- NCD 220.1 (Computed Tomography), when applicable.
- NCD 220.2 (Magnetic Resonance Diagnostic Services), when applicable.
- Other modality- or diagnosis-specific NCDs, LCDs, LCAs, and Medicare Claims Processing Manual requirements applicable to the requested test.

Medicare alignment rule: When Medicare has a fully established criterion for the requested item or service, QualCare applies that Medicare criterion. MCG is not used to create a more restrictive coverage rule. When Medicare criteria are absent or not fully established, MCG may be used to supply clinical specificity consistent with 42 CFR §422.101.

3. Explanation of the Need for Supplementation

Medicare may establish that a diagnostic modality is covered and reasonable and necessary in defined circumstances, but many imaging decisions require additional patient-specific interpretation regarding symptom pattern, pretest probability, prior imaging, timing, modality selection, contrast use, repeat testing, and whether the result is expected to change management. MCG imaging criteria are used to provide this additional clinical specificity only when Medicare criteria are absent or not fully established.

Supplementation is limited to clinical details necessary to interpret whether the requested service is reasonable and necessary for the individual member. Examples include severity, objective findings, prior treatment, treatment response, expected benefit, risk of delay, monitoring needs, site-of-service capability, and safe transition requirements.

4. Criterion-Specific Rationale Framework

QualCare does not rely on one generalized rationale for all determinations. The rationale is matched to the specific MCG guideline used. For each individual MCG guideline applied, the reviewer identifies the exact guideline title/number in the utilization-management record and applies the guideline-specific clinical indications, evidence summary, rationale, CMS coverage guidance, and references. The following table describes the distinct clinical questions within this criteria set that require criterion-specific analysis.

Clinical criterion/domain	Specific rationale question	Member-specific factors evaluated
CT	Clinical indication, urgency, prior imaging, expected effect on management, radiation exposure, and contrast-related risks.	Diagnosis and symptoms; objective findings; severity/trajectory; comorbidities and contraindications; prior treatment/testing; expected benefit; risk of delay/non-treatment; alternative services/settings; treating-practitioner documentation.
MRI	Clinical indication, diagnostic advantage over alternatives, prior testing, implanted-device/safety considerations, and expected impact on treatment.	Diagnosis and symptoms; objective findings; severity/trajectory; comorbidities and contraindications; prior treatment/testing; expected benefit; risk of delay/non-treatment; alternative services/settings; treating-practitioner documentation.
Ultrasound and vascular studies	Symptoms, examination findings, pretest probability, prior studies, and whether the test addresses a clinically meaningful diagnostic question.	Diagnosis and symptoms; objective findings; severity/trajectory; comorbidities and contraindications; prior treatment/testing; expected benefit; risk of delay/non-treatment; alternative services/settings; treating-practitioner documentation.
Nuclear medicine/PET and other advanced diagnostics	Disease-specific indication, staging or treatment-planning value, prior conventional imaging, expected management change, and cumulative testing burden.	Diagnosis and symptoms; objective findings; severity/trajectory; comorbidities and contraindications; prior treatment/testing; expected benefit; risk of delay/non-treatment; alternative services/settings;

Clinical criterion/domain	Specific rationale question	Member-specific factors evaluated
		treating-practitioner documentation.

5. Detailed Statement of Rationale

Clinical benefits

The criteria support selection of the right test at the right time and can reduce both missed diagnoses and low-value testing. They help reviewers evaluate whether imaging is likely to answer the clinical question, alter management, or appropriately exclude serious disease while considering prior studies and safer alternatives.

Potential clinical harms

Overly restrictive use can delay diagnosis and treatment, particularly for time-sensitive malignancy, neurologic, vascular, infectious, or cardiopulmonary disease. Overuse can expose members to ionizing radiation, contrast reactions or kidney injury, incidental or false-positive findings, anxiety, downstream procedures, and cumulative burden from repeat testing.

Benefit-versus-harm analysis

The expected clinical benefits of using evidence-based, criterion-specific MCG guidance are likely to outweigh the potential harms when the criteria are applied as supplemental decision support rather than as a substitute for Medicare coverage rules or individualized clinical review. The principal benefit is a more consistent and reproducible assessment of medical necessity. The principal risk is inappropriate restriction if a criterion is applied without considering the full record, atypical presentation, comorbidity, or controlling Medicare requirements. QualCare mitigates that risk through individualized review, consideration of treating-practitioner information, application of Medicare criteria first, and physician/qualified health-professional review of adverse medical-necessity determinations as required.

Medicare Advantage population tailoring

Older Medicare Advantage members may have reduced renal reserve, implanted devices, prior malignancy, vascular disease, osteoporosis, and multiple prior studies. Imaging criteria are applied with particular attention to renal function, contrast risk, radiation burden, device compatibility, prior results, pretest probability, and whether the result will change management.

Comparative outcomes and access considerations

The comparison is not simply service versus no service. Reviewers consider the expected outcome with timely medically necessary care versus delayed or absent care, and the expected outcome of the requested setting or intervention versus a clinically appropriate alternative. Factors include likelihood of diagnostic or therapeutic benefit, morbidity and mortality associated with delay, risk of emergency escalation or readmission, adverse-event burden, functional consequences, and whether a less intensive alternative can safely achieve the same clinical objective.

6. Summary of Clinical Evidence

MCG Imaging and Diagnostic Testing criteria draw on specialty-society guidelines, diagnostic-accuracy literature, outcomes research, and safety evidence cited within the individual MCG guideline. The MAP-TAC reference guide specifically uses CT as an example of the required benefit-harm analysis, including the harms of delayed diagnosis, false-positive findings, radiation exposure, contrast reactions, extravasation, and kidney injury. QualCare applies the corresponding MCG evidence summary and references for each imaging criterion used.

Consistent with the MAP-TAC submission instructions, QualCare relies on the supporting references and evidence summaries contained within the licensed MCG criteria and does not reproduce MCG's proprietary criterion text or full reference library in this public coverage summary. When QualCare relies on an external source beyond MCG and Medicare coverage authorities, the source should be added to the criterion-specific record with a full citation and a brief evidence summary.

7. Supporting References and Medicare Alignment

- Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Pub. 100-02, applicable chapters.
- CMS. Medicare Program Integrity Manual, Pub. 100-08, applicable medical-review provisions.
- CMS. Medicare Coverage Database: applicable NCDs, LCDs, and LCAs for the requested service.
- 42 CFR §§422.101 and 422.137; other service- and setting-specific Medicare regulations as applicable.
- Social Security Act §1862(a)(1)(A).
- MCG Health. MCG Care Guidelines, 30th Edition, MCG Imaging and Diagnostic Testing; individual guideline Evidence Summaries, Rationales, CMS Coverage Guidance, and References.
- CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, including diagnostic testing requirements as applicable.
- NCD 220.1 (Computed Tomography), when applicable.
- NCD 220.2 (Magnetic Resonance Diagnostic Services), when applicable.
- Other modality- or diagnosis-specific NCDs, LCDs, LCAs, and Medicare Claims Processing Manual requirements applicable to the requested test.

8. Transparency and Public Accessibility

Transparency Tool URL: <https://www.qualcareipa.com/MCG.aspx>

Coverage Summary URL: <https://www.qualcareipa.com/patientsmembers/>

Navigation Instructions: From the QualCare IPA public website, select <https://www.qualcareipa.com>, then Patients/Providers, select the applicable MCG criteria set, and follow the link to the MCG Transparency tool and this coverage summary.

Public-access statement: The public-facing materials identify the criteria used in utilization management and provide access to the applicable coverage summary. Proprietary MCG content is accessed through the authorized MCG transparency mechanism.

9. Operational Safeguards

- Apply applicable Medicare statutes, regulations, NCDs, LCDs, LCAs, and CMS manual provisions before supplemental MCG criteria.
- Document the exact MCG guideline title/number used for each medical-necessity determination.
- Do not deny solely because a member fails a single MCG element when Medicare coverage is otherwise established or when the total clinical record supports coverage.
- Consider treating-practitioner documentation and relevant member-specific circumstances, including comorbidities, functional status, contraindications, and atypical presentation.
- Route partially or fully adverse medical-necessity determinations for review by an appropriately licensed physician or other qualified health care professional with relevant experience and knowledge of Medicare criteria.
- Review and update this coverage summary at least annually and when there is a material change to the criteria set, Medicare requirements, or QualCare's utilization-management process.

10. Criterion-Level Submission Inventory

For MAP-TAC submission, QualCare should attach or maintain an inventory of every individual MCG guideline actually used within this criteria set. Each inventory entry should identify: MCG guideline title and number; applicable Medicare authority; whether Medicare criteria are absent or not fully established; the specific supplementation rationale; the criterion-specific benefit/harm rationale; the MCG evidence-summary/reference source; and the public transparency location. This inventory is the mechanism that converts the criteria-set summary into criterion-level documentation and avoids reliance on a single category-wide rationale.

MCG guideline title/ID	Medicare authority	Why supplementation is needed	Specific benefit/harm rationale	Evidence/reference source	Public access location
[Complete for each criterion used]	[Complete for each criterion used]	[Complete for each criterion used]	[Complete for each criterion used]	[Complete for each criterion used]	[Complete for each criterion used]

11. Approval and Review

Effective Date	[INSERT]
Annual Review Date	[INSERT]
Approved By	[INSERT UM Committee/MAP-TAC approval information]
Document Owner	QualCare IPA Utilization Management