Freestanding and Mobile Imaging Payment Policy

The following payment policy applies to providers who render outpatient imaging services by Tufts Health Plan contracted freestanding and mobile imaging providers. This policy applies to Commercial\(^1\) and Tufts Health Freedom Plan products. For information Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

**Note:** Audit and disclaimer information is located at the end of this document.

### POLICY

Tufts Health Plan covers medically necessary imaging services including: diagnostic radiology, mammography, bone densitometry, nuclear medicine, magnetic resonance imaging/magnetic resonance angiography (MRI/MRA), computerized tomography/computerized tomographic angiography (CT/CTA), positron emission tomography (PET scan) and ultrasound procedures performed in a contracted facility.

### GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member’s benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to our secure Provider website or by contacting Provider Services.

### MEMBER RESPONSIBILITY

Members with a cancer diagnosis are exempt from copayments for high-tech imaging.

### AUTHORIZATION REQUIREMENTS

A referral is not required for imaging services; however, referrals are required for most specialty care services. Imaging services submitted with other services that do require a referral will deny if the referral requirements have not been met for the other service(s) rendered.

For services requiring prior authorization, the ordering provider is responsible for submitting documentation of medical necessity and for obtaining approval of coverage. Because prior authorization is a condition of payment, the rendering and/or interpreting provider should confirm that the required authorization request has been submitted and that authorization for coverage has been obtained before the service is provided.

### OUTPATIENT HIGH-TECH IMAGING PROGRAM

Tufts Health Plan requires providers to obtain authorization prior to requesting high-tech imaging services in an outpatient setting for Commercial members. The following services require prior authorization:

- CT/CTA
- MRI/MRA
- Echocardiography/stress echocardiography\(^2\)

MRI/MRA, CT/CTA and PET procedures must be performed in a contracted designated free-standing imaging center or a contracted hospital. Depending on the member's product, providers must call either National Imaging Associates (NIA) or Cigna.

**Note:** Diagnostic imaging services performed in the emergency department, observation, and inpatient settings do not require prior authorization.

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^3\) when Tufts Health Plan is the primary administrator.

\(^2\) Effective for dates of service on or after January 1, 2017. Prior authorization is not required for members under the age of 18.
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NIA

It is the ordering provider’s responsibility to obtain prior authorization before scheduling appointments for Tufts Health Plan members. Rendering providers will need to ensure that all tests for Tufts Health Plan members have the required authorization number before the service is performed. Both professional and technical claims for which there is no authorization number will be denied and the member may not be billed for the service associated with the denied claim. Authorizations and corresponding numbers may be obtained by:

- Logging in to Tufts Health Plan’s secure Provider website. Authorizations currently appear in the Authorization Inquiry screen. Authorization numbers beginning with a Y have been approved by NIA; numbers beginning with an N have been denied. Authorizations that appear in this screen are for the service only and do not replace any referral requirements that may exist.
- Visiting the NIA website
- Or by calling NIA at 866.642.9703

If the rendering provider identifies a need to extend the examination to a contiguous body area or identifies a need to perform a different examination than what was originally authorized, the radiologist or facility should notify NIA of the extended study or additional service within the same day.

NIA will either update the authorization record to include the extended examination or issue a new authorization number for the additional service. Refer to the Imaging Program Prior Authorization Code Matrix for additional information.

NIA’s prior authorization program for high-tech imaging services does not apply to Uniformed Services Family Health Plan, Medicare Complement Plan, Medicare Supplement Plan, PHCS or Cigna PPO out of area plans, or CareLink members.

NIA will gather member and provider demographic data and obtain clinical information, which will be put through clinical algorithms to determine the medical necessity of the requested test. Requests meeting clinical criteria will be given an authorization number. Requests not meeting clinical criteria will be reviewed by a nurse and/or physician reviewer. This further clinical review will result in either an approval for the requested service or a denial for lack of medical necessity. Claims will continue to be processed based on the terms of the Provider Agreement.

Refer to the Imaging Program Management Guide for additional information on the prior authorization requirements for facilities and ordering providers.

CareLink Members

Prior authorization is required for CareLink members in need of high-tech imaging services. Cigna will perform utilization management for MA and RI contracting providers as part of this high-tech imaging program.

To identify if prior authorization is required, refer to the member’s identification card. The back of the identification card indicates whether outpatient procedures require prior authorization. If prior authorization is required, high-tech imaging prior authorization applies. If the identification card is not available, contact Cigna directly at 800.CIGNA24 (800.244.6224) to inquire whether prior authorization is required.

All ordering providers will be required to call Cigna at 800.CIGNA24 (800.244.6224) prior to scheduling a high-tech imaging service. It is the ordering provider’s responsibility to obtain authorization by calling Cigna.

Cigna will confirm member and provider demographic data and obtain clinical information. A nurse will review the request and apply Cigna’s medical necessity criteria. Requests meeting clinical criteria will be approved and given an authorization number. If approval cannot be given, the nurse may request additional information, or the nurse will forward the request for review by a physician reviewer. This further clinical review will result in either an approval for the requested service, a request for additional information or a denial. Only a physician reviewer will issue a denial for lack medical necessity.

Note: Refer to the CareLink Payment Dispute Overview for information on the appeals process.
The **rendering physician** is responsible for making sure the authorization with Cigna is in place prior to rendering services. Contact Cigna at 800.CIGNA.24 to verify that the authorization is in place.

Refer to the CareLink Prior Authorization List on the Tufts Health Plan website for additional services that require prior authorization. Refer to the Cigna website for additional information regarding medical necessity criteria applicable to high-tech imaging.

**BILLING INSTRUCTIONS**

- Do not append a modifier when submitting claims for global services; providers should only bill globally when they have performed the imaging service and the interpretation.
- Submit the provider ID number in both the Provider ID and Payee ID indicator fields in order for the claim to be processed as a freestanding or mobile imaging center.
- Append the appropriate modifier to indicate the portion of services rendered (professional or technical component).
- Submit the ordering physician’s name and provider identification number in the Referring Physician indicator fields (17 and 17A).

Freestanding and mobile imaging provider agreements pertain to imaging services rendered in an outpatient setting. The technical component of all imaging services provided to a member registered as inpatient within an acute care hospital and transported either within the hospital or outside of the hospital should be billed to the hospital. All imaging services rendered during a member’s acute care hospital inpatient stay is included in the global all-inclusive inpatient compensation rates.

When providing general x-rays (e.g., chest, abdomen, etc.) to a member registered as an inpatient at a skilled nursing facility or transitional care unit (SNF), the technical (performance of the imaging service) component of the service should be billed to the SNF, as general x-rays are included in the global inpatient compensation rate. If your contract pertains to the global (performance and interpretation) component, a separate claim for professional services only should be submitted to Tufts Health Plan.

**COMPENSATION/REIMBURSEMENT**

Compensation for freestanding and mobile imaging centers is in accordance with the applicable financial exhibits of their provider agreements. Claims received for procedure codes that are not listed on the provider’s fee schedule will deny as a non-contracted service.

**Note:** Commercial mobile imaging providers are subject to the privileging requirements of the physician who is requesting the imaging service(s). Mobile imaging providers should verify the privileging status of the requesting provider prior to rendering any services.

For additional information regarding the imaging privileging process, refer to the Imaging Privileging Program chapter of the Tufts Health Plan Commercial Provider Manual.

**Professional/Technical Components**

Tufts Health Plan does not add or remove modifiers 26 (professional component) or TC (technical component) to procedure codes requiring the presence or absence of those modifiers in order to apply existing professional and technical component edits. Tufts Health Plan will not compensate for procedure codes requiring modifiers 26 and/or TC if they are not billed in accordance with the current payment policy.

**Multiple Imaging Procedures**

A reduction in payment is applied to claims submitted for the technical (performance of the imaging service) or global (performance and interpretation) component of an imaging procedure when certain procedure code combinations are billed for a member within the same visit.

In these instances, Tufts Health Plan will compensate the imaging service with the higher allowable compensation amount at 100% of the Tufts Health Plan compensation rate and subsequent procedure(s) that are subject to reduction logic will be compensated at 50% of the Tufts Health Plan compensation rate. Refer to the Multiple Imaging Procedures for Freestanding and Mobile Imaging for the list of imaging procedure code combinations that are subject to multiple imaging procedures reduction.
X-ray Transportation Services
Tufts Health Plan does not compensate for the transportation of portable x-ray equipment and personnel to a home or nursing home (R0075) unless the appropriate modifier is submitted to specify the exact number of members served.

Ultrasound Procedures
Claims submitted for the global or technical component of certain ultrasound procedures when billed in combination with other ultrasound procedures for a member within the same visit will be denied since they are considered to be included within another procedure.

In these instances, Tufts Health Plan will compensate the imaging service with the highest allowable compensation amount at 100% of the Tufts Health Plan compensation rate and subsequent procedure(s) that are considered to be included in the other ultrasound procedure will be denied. Refer to the Multiple Imaging Procedures for Freestanding and Mobile Imaging for the list of ultrasound procedure codes that are subject to this policy.

DOCUMENT HISTORY
- January 2017: Template updates; clarified prior authorization requirements for echocardiography services for members under the age of 18
- November 2016: Added cardiac prior authorization program information effective for dates of service on or after January 1, 2017
- September 2015: Template conversion, template updates
- May 2015: Policy reviewed. No content changes, template updates
- May 2013: Template conversion
- January 2013: Template updates.
- November 2012: Added claim edits effective for claims adjudicated on or after January 1, 2013.
- May 2012: Added that effective July 1, 2012, Tufts Health Plan will not compensate for the transportation of portable X-ray equipment and personnel to a home or nursing home (R0075) unless the appropriate modifier is submitted to specify the exact number of members served.
- March 2012: Updated CareLink disclaimer language
- August 2011: Reviewed policy. Template updates, minor content changes for clarity purposes.
- December 2009: Added Effective January 10, 2010, the Multiple Imaging Procedures List is changing to more closely align with CMS’s code groups subject to multiple imaging reductions.
- November 2009: Added the following: MRI/MRA, CT/CTA and PET procedures must be performed in a contracted designated free-standing imaging center or a contracted hospital.
- October 2009: The Multiple Imaging Procedures List effective November 15, 2009, have been delayed.
- July 2009: Added information about the Multiple Imaging Procedures List
- February 2008: Revised general benefit information with self-service channels information.
- January 2008: Added note that explains members with a cancer diagnosis are exempt from high-tech imaging copayments.

AUDIT AND DISCLAIMER INFORMATION
Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in the Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members.