Imaging Services Professional Payment Policy

Applies to the following Tufts Health Plan products:

☒Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]

☐Tufts Medicare Preferred HMO (a Medicare Advantage product)

☐Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers who render professional services in an outpatient or office setting. For Tufts Medicare Preferred HMO and Tufts Health Plan SCO, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

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

POLICY

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

Imaging Privileging Program

Providers who are not radiologists but provide imaging services within an office setting must meet Tufts Health Plan privileging requirements in order to be compensated for imaging services. Privileging applies to all in-plan providers and is based on the scope of practice within the provider's specialty and/or certification. Credentialing and privileging are two separate processes. A physician may be a credentialed Tufts Health Plan provider but not privileged to render imaging services. Privileging applies to all components of the imaging service (global, technical or professional). Refer to the Tufts Health Plan Imaging Privileging Program chapter of the Commercial Provider Manual for more information.

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 the secure Provider website or by contacting Commercial Provider Services.

Commercial members are exempt from copayments for high-tech imaging when the imaging is required as part of an active treatment plan for a cancer diagnosis or preventive screenings. Refer to the Preventive Services list for a complete list of services deemed preventive in nature.

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. Refer to the High-Tech Imaging and Cardiac Prior Authorization Program[2] for more information.

The ordering provider is responsible for obtaining prior authorization. Because prior authorization is a condition of payment, the rendering and/or interpreting provider should confirm that prior authorization has been obtained before the service is provided.

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

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] The high-tech imaging program does not apply to Uniformed Services Family Health Plan, Medicare Complement Plan, Medicare Supplement Plan, CareLink members, or PPO members using the Cigna or PHCS networks.

- CT/CTA
- MRI/MRA
- Echocardiography/stress echocardiography[3]
- PET scan
- Nuclear cardiology

MRI/MRA, CT/CTA and PET procedures must be performed in a contracting hospital or designated free-standing imaging center. Depending on the member's product, providers must contact either National Imaging Associates (NIA) or Cigna to request prior authorization. Refer to the Imaging Program Management Guide for more information on the prior authorization requirements.

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

NIA

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. Approved authorization numbers begin with a **Y**. Denied authorization numbers begin with an **N**. Authorizations that appear in this screen are for that service only and do not replace any referral requirements that may exist.
- Visiting RadMD
- 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 High-Tech Imaging and Cardiac Program Prior Authorization Code Matrix for additional information.

Requests meeting clinical criteria are given an authorization number. Requests not meeting clinical criteria are reviewed by a nurse and/or physician reviewer. This further clinical review results 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.

CareLink℠

Prior authorization is required for CareLink members in need of high-tech imaging services. Cigna performs utilization management for CareLink members and will apply medical necessity criteria for high-tech imaging services. The **ordering provider** is required to call Cigna prior to scheduling a high-tech imaging service to obtain prior authorization. The **rendering physician** is responsible for making sure the authorization with Cigna is in place prior to rendering services. Refer to the CareLink Prior Authorization List on the Tufts Health Plan website for more information or contact Cigna at 800.CIGNA.24 (800.244.6224).

BILLING INSTRUCTIONS

Tufts Health Plan follows AMA CPT/HCPCS coding guidelines and accepts all standard modifiers submitted in accordance with the appropriate CPT/HCPCS procedure code(s). Refer to current industry standard coding guidelines for a complete list of modifiers and their usage as well as content-specific payment policies for more information.

- Append modifier 26 to indicate professional components that require the use of a modifier, whether in an office, inpatient or outpatient setting.
- Submit bilateral same-day services on one line. The number of services/units should not exceed one.
- Submit the date of service for the interpretation of the diagnostic test as the date of service of the diagnostic test.

COMPENSATION/REIMBURSEMENT INFORMATION

Compensation for providers who are not radiologists is based on privileging requirements. Claims received for services that do not meet privileging requirements are denied and the member may not be held responsible for payment. Tufts Health Plan does not compensate for any component of MRI/MRA,

[3] Prior authorization is not required for members under the age of 18.

CT/CTA, or PET services performed by a participating provider who is not credentialed by Tufts Health Plan as a radiologist. Refer to the Imaging Privileging Program for more information.

Professional/Technical Components
Tufts Health Plan does not compensate procedure codes requiring modifiers 26 and/or TC if they are not billed in accordance with the current policy.

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will only compensate for one technical component-only code for the same service when billed by different providers.

Professional, Technical, and Global Services Policy
Effective for dates of service on or after January 1, 2019, Tufts Health Plan will not routinely compensate:

- Global-only codes billed in place of service 11 (office) by a professional provider if the technical component of the service was billed by any outpatient hospital for the same date of service.
- Diagnostic tests or radiology services if billed in place of service 11 (office) without modifier 26 by a professional provider and the same service was billed by an outpatient hospital for the same date of service.
- Technical-only codes billed in place of service 11 (office) by a professional provider if the same code was billed by any outpatient hospital for the same date of service.

Bone Density Studies
Tufts Health Plan does not routinely compensate for DXA (bone density study) if the only diagnosis on the claim is osteoporosis screening and the member is either a female less than 65 years of age or a male less than 70 years of age on the date of service.

Diagnostic and Radiology Services
Tufts Health Plan does not routinely compensate a diagnostic test or radiology service billed with modifiers 26 (professional component) and TC (technical component) if the technical and professional components of the service are performed by the same provider billed on the same or different claim on the same date of service. According to AMA, it is not appropriate to report the components of the professional and technical service separately.

Tufts Health Plan does not routinely compensate for diagnostic tests and radiology services having a professional component performed in a home, assisted living facility, nursing facility or skilled nursing facility if those services are billed without modifier 26 to indicate the professional component and transportation of portable x-ray equipment (R0070-R0075) is not also submitted.

Tufts Health Plan does not routinely compensate for the professional component or consultation (76140) if billed with a radiology procedure performed in the office setting and in conjunction with an E&M service.

Tufts Health Plan does not routinely compensate professional services when billed by a provider other than an anesthesiologist, neurologist, physical medicine specialist, radiologist or radiation oncologist in the inpatient, outpatient or ER setting.

Duplex Scans and Doppler Studies
Tufts Health Plan provides coverage for duplex scans of the neck and transcranial dopplers only when billed with an appropriate diagnosis code.

Intracranial and Extracranial Imaging (Duplex, CT/CTA, MRI/MRA)
Tufts Health Plan does not routinely compensate for duplex scans of extracranial arteries (93880-93882) in the following circumstances:

- If billed only with a diagnosis of syncope and collapse
- If billed and an electrocardiogram (93000-93010) has not been billed for the same day or in the previous 90 days by any provider

Lung Cancer Screening with Low Dose Computed Tomography (LDCT)
Effective for dates of service on or after April 1, 2018, Tufts Health Plan will not routinely compensate for the following:

- G0296 (counseling visit to discuss need for LDCT) or G0297 (LDCT for lung cancer screening) when billed and the member is less than 55 or greater than 80 years of age
- G0297 (LDCT for lung cancer screening) when billed by any provider more frequently than once within 365 days from the first date of service

Mammography/Tomosynthesis

Screening Mammograms

Tufts Health Plan currently covers 3D breast tomosynthesis (77063) and applies a multiple procedure payment reduction when 77063 is billed in conjunction with mammography codes.

Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate bilateral screening mammography codes (77067, 77063 or G0202) if the member's age is less than 35 years; or if billed more than once by any provider and the member's age is between 35 and 39 years.

Diagnostic Mammography

Effective for dates of service on or after July 1, 2018, Tufts Health Plan provides coverage for diagnostic digital breast tomosynthesis codes 77061 and 77062.

Effective for dates of service on or after July 1, 2018, Tufts Health Plan does not routinely compensate diagnostic mammography codes (77065, 77066) when submitted for the same date of service as diagnostic breast tomosynthesis codes (77061, 77062).

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 single 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 List for Professionals for the list of imaging procedure code combinations that are subject to multiple imaging procedures reduction.

Radiological Chest Examinations

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will not routinely compensate chest x-ray (71010, 71015 or 71020) the only diagnosis on the claim is a general medical exam, pre-admission, administrative or pre-operative exam.

Effective for dates of service on or after October 1, 2018, Tufts Health Plan will not routinely compensate chest x-rays (71045 or 71046) if the only diagnosis on the claim is an encounter for screening for respiratory tuberculosis or the only diagnosis on the claim is for lung cancer screening or nicotine use/dependence.

Effective for dates of service on or after October 1, 2018, Tufts Health Plan will not routinely compensate chest x-rays (71045 or 71046) for members 21 years of age or younger on the date of service if the only diagnosis is uncomplicated asthma.

Ultrasound

Effective for dates of service on or after October 1, 2018, Tufts Health Plan will not routinely compensate abdominal ultrasounds (76700-76705) if the only diagnosis on the claim is infectious mononucleosis.

DOCUMENT HISTORY

- November 2018: Added claim edits for professional, technical, and global services policy, effective for dates of service on or after January 1, 2019
- August 2018: Added claim edits for radiological chest examinations and ultrasounds, effective for dates of service on or after October 1, 2018
- June 2018: Template updates
- May 2018: Added claim edits for digital breast tomosynthesis and diagnostic mammography services, effective for dates of service on or after July 1, 2018
- February 2018: Added claim edits for lung cancer screening, effective for dates of service on or after April 1, 2018
- November 2017: Policy review by committee; added freestanding/mobile policy content. Added edits for duplicate/multiple technical components for the same service, radiological chest examinations, and screening mammograms effective for dates of service on or after January 1, 2018.
- August 2017: Clarified intracranial and extracranial imaging edit

- February 2017: Added bone density claim edit, and multiple procedures reduction logic for 77063, effective for dates of service on or after April 1, 2017.
- January 2017: Template updates; clarified prior authorization requirements for echocardiography services
- November 2016: Added cardiac prior authorization program information effective for dates of service on or after January 1, 2017
- July 2016: Added intracranial and extracranial imaging and duplex scans and doppler studies edit effective for dates of service on or after October 1, 2016
- September 2015: Template conversion, template updates
- March 2015: Policy reviewed. No content changes, template updates
- August 2014: Added SCO
- June 2014: Template updates.
- March 2014: Removed outdated language regarding modifier 26, template language
- September 2013: Template conversion
- January 2013: Template updates
- November 2012: Added claim edits effective for claims adjudicated on or after January 1, 2013
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- October 2011: Template updates, moved modifier details to the Modifier Payment Policy, added information regarding paper SOAs and the Summary of Account on Tufts Health Plan's secure Provider website, removed the term multispecialist from the information regarding diagnostic and radiology services for clarification purposes
- July 2011: Added information regarding provider role and responsibilities related to prior authorization. Also added effective October 1, 2011, Tufts Health Plan will not compensate for the professional component (modifier 26) or consultation (76140) when billed with a radiology procedure performed in the office setting and in conjunction with an E & M service and effective October 1, 2011 Tufts Health Plan will not compensate professional services when billed by a provider other than an anesthesiologist, multispecialist, neurologist, physical medicine specialist, radiologist, or radiation oncologist in the inpatient or outpatient hospital setting
- 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: Multiple Imaging Procedure List changes effective November 15, 2009 have been delayed
- July 2009: Added Effective November 15, 2009, the Multiple Imaging Procedures List is changing to more closely align with CMS's code groups subject to multiple imaging reductions
- November 2008: Clarified copayment exception for members with a cancer diagnosis and in active treatment. Added diagnostic and radiology services edit that will be effective for dates of service on or after February 1, 2009
- 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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in 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. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.