Imaging Services 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)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers, hospitals, and freestanding and mobile imaging centers.

In addition to the specific information contained in this policy, providers must adhere to the 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 but not limited to low-tech (e.g., radiographic x-rays, ultrasounds), high-tech (e.g., CT/CTA, MRI/MRA, PET), and nuclear cardiology, in accordance with the member's benefits.

Imaging Privileging Program (Commercial products)

Nonradiologists who provide imaging services in an office setting must meet imaging privileging requirements, as outlined in the Imaging Privileging Program chapter of the Commercial Provider Manual.

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 Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Authorization and Notification Policy.

A referral is not required for imaging services. However, imaging services submitted with other services that have prior authorization or notification requirements will deny if such requirements have not been met for other service(s) rendered.

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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] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

Commercial and Tufts Health Public Plans

Certain imaging services require prior authorization through National Imaging Associates, Inc. (NIA). Refer to the following for specific procedure codes and prior authorization requirements for facilities and ordering providers:

- High-Tech Imaging Prior Authorization Program (Commercial and Tufts Health Public Plans members)
- Cardiac Prior Authorization Program[3] (Commercial members)

CareLink℠

Prior authorization is required for 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** must obtain prior authorization through Cigna prior to scheduling a high-tech imaging service. The **rendering physician** is responsible for verifying 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

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

- Submit global services on one line. 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 in an office setting.
- Submit the date of service for the interpretation of the diagnostic test as the date of service of the diagnostic test
- Submit the provider identification number in both the Provider ID and Payee ID indicator fields (24J, 32 and 33) in order for the claim to be processed as a freestanding or mobile imaging center.
- Submit the ordering physician's name and provider identification number in the Referring Physician indicator fields (17 and 17a).

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

Senior Products facilities with an outpatient prospective payment system (OPPS) contract will be compensated according to the Medicare OPPS.

Facilities that provide both technical and professional components of an imaging service are compensated globally. If the professional component is billed by an independent radiologist, the facility is only compensated only for the technical component of the service. Compensation for the technical component of imaging services is included in the inpatient/outpatient 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, the technical component of the service should be billed directly to the SNF/TCU.

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.

Tufts Health Plan compensates 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.

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

Commercial members: Refer to the Multiple Imaging Procedures Lists for Professionals and Facilities for imaging procedure code combinations that are subject to multiple imaging procedures reduction.

All Products

Angiography

Tufts Health Plan does not routinely compensate abdominal aortography (75625) if billed with bilateral extremity angiography (75716).

Intracranial and Extracranial Imaging (Duplex, CT/CTA, MRI/MRA)

Tufts Health Plan does not routinely compensate duplex scan of extracranial arteries (93880, 93882), computed tomographic angiography (CTA) of the neck (70498), or magnetic resonance angiography (MRA) of the neck (70547, 70548, 70549) when billed and the only diagnosis on the claim is syncope and collapse.

Lung Cancer Screening with Low Dose Computed Tomography (LDCT)

Tufts Health Plan does 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 when billed by any provider more frequently than once within 365 days from the first date of service

Radiological Examinations

Tufts Health Plan does not routinely compensate for the following:

- 71100 (X-ray, ribs, unilateral; 2 views) if billed with modifier 50
- 71100 (X-ray, ribs, unilateral; 2 views) if billed with radiologic examination, ribs, unilateral; two views; right.
- 72020 (radiologic exam, spine, single view) when billed with a more comprehensive radiologic spine examination.

Ultrasounds

Tufts Health Plan does not routinely compensate for the following:

- 76856 (ultrasound, pelvic [nonobstetric], real time with image documentation; complete) when billed with code 76831 (Saline infusion sonohysterography).
- detailed fetal anatomic ultrasound (76811, 76812) when billed and the only diagnosis on the claim is supervision of normal pregnancy, routine screening for malformations using ultrasonics, fetal anatomic survey, or antenatal screening of mother.
- Initial obstetric ultrasound services when codes 76805 or 76810-76812 have been billed in the past five months.
- 76801 or 76802 (pregnant uterus ultrasound services) when 76801 or 76802 has been billed in the past three months.

Urodynamics

Tufts Health Plan does not routinely compensate ultrasound, pelvic (nonobstetric), limited or follow-up when billed on same date of service as simple or complex CMG, simple uroflowmetry, or complex uroflowmetry.

Commercial and Tufts Health Public Plans Only

Obstetrical Services

Tufts Health Plan adjusts maximum allowed units per day for obstetrical codes (59000, 59020, 76802, 76810, 76812, 76814, 76816, 76818, 76819, 76825-76828) based on diagnosis.

Senior Products Only

Intracranial and Extracranial Imaging (Duplex, CT/CTA, MRI/MRA)

Tufts Health Plan does not routinely compensate for the following when the only diagnosis on the claim is migraine:

- 70450-70470 (CT, head or brain)
- 70496 (CTA, head)
- 70544-70546 (MRA, head)
- 70551-70553 (MRI, brain)
- 76380 (CT follow-up)

Tufts Health Plan does not routinely compensate for the following if the only diagnosis on the claim is syncope and collapse:

- 70450-70470 (CT, head or brain)
- 70496 (CTA)
- 70544-70546 (MRA, head)
- 70551-70553 (MRI, brain)

ADDITIONAL RESOURCES

- Preventive Services
- Outpatient Payment Policy

DOCUMENT HISTORY

- July 2020: Policy reviewed by committee; removed NIA prior authorization requirements to redirect to landing page; consolidated individual Commercial, Senior Products and Tufts Health Public Plans policies into one document; updated policy to reflect existing processes for claim edits for all lines of business
- March 2020: Updated tomosynthesis billing requirements, effective for dates of service on or after January 1, 2020
- 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

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 a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/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.