Imaging Services Facility Payment Policy

The following payment policy applies to Tufts Health Plan contracting hospitals where outpatient imaging services are rendered. This policy applies to Commercial\textsuperscript{1} products (including Tufts Health Freedom Plan). For 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: 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 performed in a contracting hospital.

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.

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 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 Prior Authorization Program for more information.

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.

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:

- CT/CTA
- MRI/MRA
- Echocardiography/stress echocardiography\textsuperscript{2}
- PET scan
- Nuclear cardiology

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 (NIAMagellan\textsuperscript{SH}) or Cigna.

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

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

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\textsuperscript{1} Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\textsuperscript{SM} when Tufts Health Plan is the primary administrator.

\textsuperscript{2} Effective for dates of service on or after January 1, 2017, prior authorization is not required for members under the age of 18.
OUTPATIENT HIGH-TECH IMAGING: NIA
It is the ordering provider’s responsibility to obtain prior authorization before scheduling appointments. Each test requires its own authorization number. Rendering providers need to ensure that all tests 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. The member may not be billed for the service associated with the denied claim. Authorizations and corresponding numbers may be obtained by:

- Visiting the NIA website
- Calling NIA at 866.642.9703
- 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.

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, CareLink members, or members using the Cigna PPO or PHCS networks.

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 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.

OUTPATIENT HIGH-TECH IMAGING: CARELINK
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, then the high-tech imaging prior authorization program applies. If the identification card is not available, contact Cigna directly at 800.CIGNA.24 (800.244.6224) to inquire if prior authorization is required.

It is the ordering provider’s responsibility to obtain authorization. All ordering providers are required to call Cigna prior to scheduling a high-tech imaging service. 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 obtain authorizations and verify that authorizations are in place.

Cigna will confirm member and provider demographic data and obtain clinical information. A nurse reviews the request and applies Cigna’s medical necessity criteria. Requests meeting clinical criteria are 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 results 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. Refer to the CareLink Payment Dispute Overview for information on the appeals process.

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.
**COMPENSATION/REIMBURSEMENT INFORMATION**

Compensation for the technical component of imaging services performed during a member’s inpatient stay is included in the all-inclusive inpatient compensation rate regardless of where the service is provided (inpatient or outpatient setting).

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 to the SNF, as general x-rays are included in the global inpatient compensation rate.

**Bone Density Studies**

Effective for dates of service on or after April 1, 2017, Tufts Health Plan will deny DXA (bone density study) when 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.

**Duplex Scans and Doppler Studies**

Tufts Health Plan covers duplex scans of the neck and transcranial doppler only when billed with an appropriate diagnosis code.

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

Tufts Health Plan does not compensate for duplex scans of extracranial arteries (93880-93882) when billed only with a diagnosis of syncope and collapse.

Tufts Health Plan does not compensate for duplex scans of extracranial arteries (93880-93882) if billed and an electrocardiogram (93000-93010) has not been billed for the same day or in the previous 90 days by any provider.

**Professional/Technical Components**

- Tufts Health Plan does not add or remove modifiers 26 or TC to procedure codes requiring the presence or absence of those modifiers in order to apply existing professional and technical component edits. Tufts Health Plan does not compensate for procedure codes requiring modifiers 26 and/or TC if they are not billed in accordance with the current policy.
- Tufts Health Plan does not compensate for a procedure code requiring modifier TC if a facility bills without modifier TC.

**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 compensates the imaging service with the higher allowable compensation amount at 100% of the Tufts Health Plan compensation rate. 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 Facilities for the list of imaging procedure code combinations that are subject to multiple imaging procedures reduction.

**Tomosynthesis**

Tufts Health Plan currently covers 3D breast tomosynthesis (77063). Effective for dates of service on or after April 1, 2017, a multiple procedure payment reduction will apply when 77063 is billed in conjunction with mammography codes.

**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 compensates the imaging service with the highest allowable compensation amount at 100% of the Tufts Health Plan compensation rate. Subsequent procedure(s) that are considered to be included in the other ultrasound procedure will be denied. Refer to the Multiple Imaging Procedures List for Facilities for the list of ultrasound procedure codes that are subject to this policy.
DOCUMENT HISTORY
- 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 (duplex, CT, CTA, MRA, MRI) and duplex scans and doppler studies edits effective for dates of service on or after October 1, 2016
- September 2015: Template conversion, template updates
- May 2015: Policy reviewed, No content changes, template updates
- January 2015: Template updates
- November 2014: Added revenue codes 0681-0684, 0689, 1000-1002 accepted when submitted electronically without a corresponding CPT and/or HCPCS procedure code, template updates
- August 2014: Added SCO
- May 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
- October 2011: Policy reviewed, template updates, no content changes
- 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 changes effective November 15, 2009 regarding the Multiple Imaging Procedures List has 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
- 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 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.