

## Imaging Services Facility and Freestanding/Mobile Payment Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)<sup>1</sup>
- Tufts Medicare Preferred HMO (a Medicare Advantage product)
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

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The following payment policy applies to Tufts Health Plan contracting hospitals where outpatient imaging services are rendered, as well as freestanding/mobile imaging centers. 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 performed in a contracting hospital, as described below.

### 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 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](#)<sup>2</sup> 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:

- CT/CTA
- MRI/MRA
- Echocardiography/stress echocardiography<sup>3</sup>
- 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

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<sup>1</sup> Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink<sup>SM</sup> when Tufts Health Plan is the primary administrator.

<sup>2</sup> The high-tech imaging program 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.

<sup>3</sup> Effective for dates of service on or after January 1, 2017, prior authorization is not required for members under the age of 18.

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<sup>SM</sup>**

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](#) or contact Cigna at 800.CIGNA.24 (800.244.6224) for more information.

## **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**

Tufts Health Plan does not routinely compensate for 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 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:

- When 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**

#### **Screening Mammograms**

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will not routinely compensate 77067, 77063, or G0202 (screening mammography, bilateral) when billed under the following circumstances:

- If the patient's age is less than 35 years; or
- If billed more than once by any provider and the patient's age is between 35 and 39 years.

#### **Diagnostic Mammography**

Effective for dates of service on or after July 1, 2018, Tufts Health Plan will 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 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.

### **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.

#### **Duplicate/Multiple Technical Components for the Same Service**

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.

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.

### **Radiological Chest Examinations**

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will not routinely compensate chest x-rays (71010, 71015 or 71020) if billed and 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, 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.

### **Tomosynthesis**

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 July 1, 2018, Tufts Health Plan provides coverage for diagnostic digital breast tomosynthesis codes 77061 and 77062.

## **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**

- 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 reviewed for clarity; added freestanding/mobile 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 (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: 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 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<sup>SM</sup> 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.