**Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options 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)\(^1\)
- 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 hospitals where outpatient imaging services are rendered as well as freestanding and mobile imaging centers. For information on Commercial products, 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 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 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 Senior Products Provider Relations.

**Note:** There is no member responsibility for covered services for Tufts Health Plan SCO members.

**AUTHORIZATION REQUIREMENTS**

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

**BILLING INSTRUCTIONS**

- Append modifier TC to indicate technical services whether in an office, inpatient or outpatient setting.
- 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**

Tufts Medicare Preferred HMO and Tufts Health Plan SCO facilities with an outpatient prospective payment system (OPPS) contract will be compensated according to the Medicare OPPS.

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).

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^{SM}\) when Tufts Health Plan is the primary administrator.
When providing general x-rays (chest, abdomen, etc.) to a member registered as an inpatient at a skilled nursing facility (SNF), 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 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.

**Diagnostic/Therapeutic Imaging Radiopharmaceutical and Contrast Agents**
Effective for dates of service on or after October 1, 2017, Tufts Health Plan will not routinely compensate imaging agents when billed without the requisite imaging procedures.

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

**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.

**Incorrect Global and Technical Coding in the Office Setting**
Effective for dates of service on or after October 1, 2018, Tufts Health Plan will not routinely compensate diagnostic tests or radiology services when billed in place of service 11 without modifier 26 by a professional provider and the same service was billed by any outpatient hospital for the same date of service.

**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

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will 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)

**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 lung cancer [screening (LDCT)]) or G0297 (low dose CT scan [LDCT] for lung cancer screening) when billed and the member is less than 55 or greater than 80 years of age
- G0297 [low dose CT scan (LDCT) for lung cancer screening] when billed by any provider more frequently than once within 365 days from the first date of service

**Maximum Units per Day for Obstetrical Services**
Effective for dates of service on or after January 1, 2018, Tufts Health Plan will adjust maximum allowed units per day for obstetrical codes (59000, 59020, 76802, 76810, 76812, 76814, 76816, 76818, 76819, 76825-76828) based on diagnosis.

**Obstetrical Ultrasound Services**
Effective for dates of service on or after January 1, 2018, Tufts Health Plan will not routinely compensate for obstetrical ultrasound codes (76802, 76810, 76812, 76814) when billed without the requisite diagnosis.

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1 Currently effective for Commercial members. Effective for dates of service on or after October 1, 2018 for Tufts Medicare Preferred HMO and Tufts Health Plan SCO members.
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) 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 or the only diagnosis on the claim is for lung cancer screening or nicotine use/dependence.

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

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 chest x-rays, incorrect global and technical coding, and ultrasounds, intracranial and extracranial imaging, effective for dates of service on or after October 1, 2018
- June 2018: Template updates
- 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 duplex CT/CTA, MRA/MRI, duplicate/multiple technical components for the same service, maximum units per day for OB services, OB ultrasound services, 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
- July 2017: Added edits for diagnostic/therapeutic imaging, effective for dates of service on or after October 1, 201
- February 2017: Added bone density edit effective for dates of service on or after April 1, 2017
- January 2017: Template updates
- July 2016: Added intracranial and extracranial imaging and duplex scans and Doppler studies edits effective October 1, 2016
- September 2015: Template conversion
- May 2015: Policy reviewed; no content changes; template updates
- April 2015: 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 Tufts Health Plan SCO information; template updates
- May 2013: Template updates
- October 2011: Reviewed policy; no content changes
- March 2011: Reviewed document for clarity; no content changes made
- January 2010: Removed references to Tufts Medicare Preferred PPO product
- March 2009: Moved Tufts Medicare Preferred information to its own document
- December 2008: Deleted refer to checking detailed benefit coverage on the Tufts Health Plan website for Tufts Health Plan Medicare Preferred members
- September 2008: Added Tufts Medicare Preferred information

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 CareLinkSM 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.