Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options
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 imaging services. 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, 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 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 26 to indicate professional services whether in an office, inpatient or outpatient setting.
- 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.

COMPENSATION/REIMBURSEMENT INFORMATION

Bone Density Studies
Tufts Health Plan does not routinely compensate 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/Therapeutic Imaging Radiopharmaceutical and Contrast Agents
Tufts Health Plan does not routinely compensate imaging agents billed without the requisite imaging procedures.

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink when Tufts Health Plan is the primary administrator.
**Duplex Scans and Doppler Studies**
Tufts Health Plan covers duplex scans of the neck and transcranial doppler studies 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 only compensates 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 does not routinely compensate diagnostic tests or radiology services if 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 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)

Effective for dates of service on or after October 1, 2018, 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)

**Lung Cancer Screening with Low Dose Computed Tomography (LDCT)**
Effective for dates of service on or after April 1, 2018, Tufts Health Plan does 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) if billed and the member is less than 55 or greater than 80 years of age
- G0297 (LDCT for lung cancer screening) if 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.

**Professional/Technical Components**
Tufts Health Plan will not compensate for codes reported with modifier 26 or modifier TC when the professional/technical component concept does not apply.

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

**Radiological Chest Examinations**
Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate 71010, 71015 or 71020 (chest x-ray) 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 does not routinely compensate 71045 or 71046 (chest x-rays) if the only diagnosis on the claim is an encounter for screening for respiratory tuberculosis, lung cancer screening or nicotine use/dependence.

**Screening Mammograms**
Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate 77067, 77063, or G0202 (screening mammography, bilateral) if billed under the following circumstances:
• If the member’s age is less than 35 years on the date of service; or
• If billed more than once by any provider and the member’s age is between 35 and 39 years on the date of service

**Ultrasound**
Effective for dates of service on or after October 1, 2018, Tufts Health Plan does 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, effective for dates of service on or after January 1, 2019
• August 2018: Added claim edits for incorrect global and technical coding, radiological chest examinations and ultrasounds, and 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 reviewed by committee for clarity. 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 and professional/technical components, effective for dates of service on or after October 1, 2017
• February 2017: Added bone density edits 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/doppler studies edit effective October 1, 2016
• September 2015: Template conversion
• March 2015: Policy reviewed; no content changes; template updates
• August 2014: Added Tufts Health Plan SCO information; template updates
• May 2013: Template updates
• August 2011: Reviewed policy; no content changes
• April 2011: Reviewed document for clarity; no content changes made
• January 2010: Removed references to the Tufts Medicare Preferred PPO product
• March 2009: Moved Tufts Medicare Preferred to its own document
• December 2008: Deleted reference 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.