Radiology Imaging Services Payment Policy

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 who render imaging services, and to contracting hospitals that render outpatient imaging services for Tufts Health Public Plans products.

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 radiology imaging services, in accordance with the member's benefits.

DEFINITION

Professional radiology imaging services include diagnostic ultrasound, diagnostic radiology imaging, and nuclear cardiology services that a radiologist uses to evaluate and/or treat a medical condition, injury, or illness.

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 Tufts Health Public Plans Provider Services.

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

REFERRAL/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.

Prior authorization is not required for in-network outpatient nonemergency radiology imaging services, except for advanced imaging services. Prior authorization is also not required for emergency services or poststabilization care.

Tufts Health Plan requires prior authorization for the following:

- Outpatient nonemergency radiology imaging services rendered by nonpreferred in-network and out-of-network providers
- Outpatient nonemergency, advanced radiology imaging services (MRA, MRI, CT, PET, nuclear cardiology) from National Imaging Associates (NIA)
- Inpatient hospital services, which include authorization for both radiology imaging services and the radiologist's professional services
- Hospital, specialty, and ancillary care services rendered by nonpreferred in-network providers

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows AMA 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 or applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Tufts Health Plan compensates for radiology imaging services in accordance with applicable regulations or contracted compensation rates.

Tufts Health Plan reimburses for many outpatient radiology imaging services, including, but not limited to:

- X-ray interpretation and written report
- Transvaginal ultrasound, when performed in conjunction with pelvic ultrasound
- Ultrasound performed during pregnancy
- Digital mammography services
- Bone density testing (see our medical benefit summary grids for coverage limits and conditions)
- Radiopharmaceutical diagnostic imaging agents
- Consultation on an X-ray performed elsewhere, when accompanied by a written report

Tufts Health Plan compensates for inpatient radiology imaging services as part of the inpatient hospital stay only when we have granted prior authorization for the inpatient hospital stay.

Tufts Health Plan compensates for outpatient nonemergency, advanced radiology imaging (MRA, MRI, CT, PET, nuclear cardiology) services only when NIA has granted prior authorization.

Tufts Health Plan does not routinely compensate for several inpatient radiology imaging services:

- Interpretation services performed solely for the purpose of quality control
- Fluoroscopic guidance and localization of needle/catheter tip for diagnostic or therapeutic spinal injections, when billed with myelography supervision and interpretation codes
- Generation of automated data from diagnostic testing (78890)
- Scintimammography (no CPT/HCPCS codes available)

Providers must bill professional radiology imaging services on a CMS-1500 form using the appropriate CPT codes and modifiers:

- Professional component services (modifier 26): When billing with modifier 26 in conjunction with any other modifier, including right or left modifiers, report modifier 26 in the first modifier field on the CMS-1500 form.
- Technical component services (TC): When billing with a TC modifier in conjunction with any other modifier, including right or left modifiers, report the TC modifier in the first modifier field on the CMS-1500 form.
- Repeat services: When billing for the same service performed multiple times in one day, providers must bill the number of repeat services on one line.

Diagnostic Mammography

Effective for dates of service on or after January 1, 2020, providers should bill for 3D diagnostic mammography/diagnostic breast tomosynthesis using the following codes:

- 77061 or 77062 (diagnostic breast tomosynthesis codes)
- 77065 or 77066 (diagnostic mammography codes) in conjunction with G0279

COMPENSATION/REIMBURSEMENT INFORMATION

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

Angiography

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

Computed Tomography (CT) of the Abdomen and Pelvis

Tufts Health Plan does not routinely compensate for CTs of the abdomen/pelvis (72192-72194, 74150-74170, or 74176-74178) if billed and the member's age is less than 18 years on the date of service and abdominal pain is the only diagnosis on the claim, unless one of the following has been billed on the same day or in the previous 14 days by any provider:

- Radiological examinations of the abdomen (74000-74022) or pelvis (72170-72190)
- MRI of the abdomen (74181-74183) or pelvis (72195-72197)
- Ultrasound, abdominal (76700-76705), transvaginal (76830) or pelvic (76856-76857)

Duplicate/Multiple Technical Components for the Same Service
Tufts Health Plan only compensates for one technical component-only code for the same service when billed by different providers.

Electroencephalogram (EEG)
Tufts Health Plan does not routinely compensate codes 95812, 95813, 95816, 95819, 95822, or 95827 (EEG) when billed with a diagnosis of headache or migraine.

Intracranial and Extracranial Imaging (Duplex, CT, CTA, MRA, MRI) for Simple Syncope
Tufts Health Plan does not routinely compensate 70450, 70460, 70470 (CT, head or brain), 70496 (CTA), 70544, 70545, 70546 (MRA, head) or 70551, 70552, 70553 (MRI, brain) when the only diagnosis on the claim is syncope and collapse.

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

Tufts Health Plan does not routinely compensate 70450-70470 (CT, head or brain), 70496-70498 (CTA, head or neck), 70544-70546 (MRA, head), 70547-70549 (MRA, neck), 70551-70553 (MRI, brain [including brainstem], or 93880-93882 (duplex scan of extracranial arteries) when billed with a diagnosis of syncope and collapse and 93000-93010 (Electrocardiogram) has not been billed for the same day or in the previous 90 days by any provider.

Mammography
Tufts Health Plan does not routinely compensate diagnostic mammography (77065 and 77066) when submitted for the same date of service as diagnostic breast tomosynthesis (77061 and 77062).

Professional Components Billed in an Office Setting
Tufts Health Plan does not routinely compensate separate reimbursement for radiology services with a modifier 26 when billed with an E&M service in the office.

Tufts Health Plan does 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.

Professional Components of Radiology Services in Facility Places of Service
Tufts Health Public Plans will not routinely compensate professional radiology services when billed by a cardiologist or radiation oncologist in the inpatient or outpatient hospital setting.

Professional, Technical, and Global Services Policy
Tufts Health Public Plans will not routinely compensate:

- Global only codes when billed in place of service 11 (office) by a professional provider and the technical component of the service was billed by any outpatient hospital for the same date of service.
- Diagnostic tests or radiology services when 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 when billed in place of service 11 (office) by a professional provider and the same code was billed by any outpatient hospital for the same date of service.

Radiological Examinations
Chest
Tufts Health Plan does not routinely compensate 71100 (X-ray, ribs, unilateral; 2 views) if billed with modifier 50.

Tufts Health Plan does not routinely compensate radiologic examination, ribs, unilateral; two views; left when billed with radiologic examination, ribs, unilateral; two views; right.

Tufts Health Plan does 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.

Tufts Health Plan does 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.

Tufts Health Plan does 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.

Spine
Tufts Health Plan does not routinely compensate code 72020 (radiologic exam, spine, single view) when billed with a more comprehensive radiologic spine examination.

Tomosynthesis
Tufts Health Plan applies a multiple procedure payment reduction when 3D breast tomosynthesis (77063) is billed in conjunction with mammography codes.

Ultrasounds
Non-obstetric
Tufts Health Plan does not routinely compensate code 76856 (ultrasound, pelvic [nonobstetric], real time with image documentation; complete) when billed with code 76831 (Saline infusion sonohysterography).

Tufts Health Plan does not routinely compensate abdominal ultrasounds (76700-76705) if the only diagnosis on the claim is infectious mononucleosis.

Obstetric
Tufts Health Plan does not routinely compensate 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.

Tufts Health Plan does not routinely compensate initial obstetric ultrasound services when codes 76805 or 76810-76812 has been billed in the past five months.

Tufts Health Plan does not routinely compensate 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.

DOCUMENT HISTORY

- March 2020: Updated tomosynthesis billing instructions, effective for dates of service on or after January 1, 2020
- November 2018: Added edits for professional components of radiology services in facility places of service; and professional, technical, and global services policy, effective for dates of service on or after January 1, 2019
- August 2018: Added claim edits for professional components billed in an office setting, radiological 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
- March 2018: Template updates
- November 2017: Added edits for duplicate/multiple technical components for the same service and radiological examination – chest, and ultrasound (obstetric) effective for dates of service on or after January 1, 2018
- August 2017: Updated to include RITogether; added previously communicated edits for computed tomography (CT) of the abdomen and pelvis, intracranial and extracranial imaging (duplex, CT, CTA, MRA, MRI) for simple syncope

- July 2017: Added edits for angiography, electroencephalogram (EEG), professional component billed in the office setting, radiological examination (chest, spine) ultrasound (non-obstetric, obstetric), urodynamics
- February 2017: 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.