



Radiology/Diagnostic Imaging Procedures

Payment Policy

Policy

Fallon Community Health Plan (FCHP) reimburses for covered radiology services provided at a contracted facility.

Certain high technology imaging studies, including CT, MRI, MRA, PET, and nuclear cardiac studies, require prior notification or prior registration with FCHP's radiology management vendor.

When multiple imaging services are performed by the same provider on the same member on the same date of service and are in contiguous body areas, the procedure with the highest intensity will be reimbursed at 100% and the subsequent procedure(s) will be reimbursed at a reduced percentage of the provider's fee schedule rate. Reduction of reimbursement is for claims submitted for the technical (performance of the imaging service) component of an imaging procedure. Subsequent procedures will be reimbursed at 50% of the provider's fee schedule for Commercial or 75% of the provider's fee schedule for Senior Plan.

Definitions

Radiology (Diagnostic Imaging) services include the study of images of the human body using different techniques or modalities including but not limited to x-rays, ultrasound (US), computerized tomography (CT), computerized tomographic angiography (CTA), positron emission tomography (PET), magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA).

Benefits application

Commercial

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

Senior Plan

- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®

Reimbursement

Fallon Community Health Plan requires that providers refer patients to contracted radiology facilities and contracted physicians unless preauthorization is obtained. All non-emergent outpatient radiology services provided at a non-contracted facility without an authorization will be rejected.

Radiology consults for diagnostic procedures are not reimbursable.

Multiple Procedures on Contiguous Body Areas

When more than one of the imaging services listed below are performed by the same provider on the same member on the same date of service and are in contiguous body areas, the procedure with the highest intensity will be reimbursed at 100% and the subsequent procedure(s) will be reimbursed at either 50% or 75% of the provider's fee schedule, depending on the member's plan. Reduction of reimbursement is for claims submitted for the technical component of an imaging procedure.

Procedure	Contiguous body Areas	Code Combinations
CT and CTA	Chest/Thorax/Abdomen/Pelvis	71250, 71260, 71270, 71275, 72191, 72192, 72193, 72194, 74150, 74160, 74170, 74175, 75635, 0067T
	Head/Brain/Orbit/Maxillofacial/Neck	70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498
	Spine	72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133
	Lower Extremities	73700, 73701, 73702, 73706
	Upper Extremities	73200, 73201, 73202, 73206
	MRI and MRA	Chest/Abdomen/Pelvis
	Head/Brain/Neck	70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553
	Spine	72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158
	Lower Extremities	73718, 73719, 73720, 73721, 73722, 73723, 73725
	Upper Extremities/Joints	73218, 73219, 73220, 73221, 73222, 73223
Ultrasound	Chest/Abdomen/Pelvis – Non-Obstetrical	76604, 76700, 76705, 76770, 76775, 76778, 76831, 76856, 76857
	Breast/Chest	76604, 76645
	Soft Tissue Head/Neck/ Echoencephalography	76506, 76511-76513, 76536, 76516-76519
	Kidney/Retroperitoneal	76700, 76770, 76775, 76776
	Ophthalmic	76511-76513, 76516-76519, 76536
	Pregnant Uterus, first trimester/ Transabdominal/transvaginal	76801-76802, 76700, 76811-76812, 76830
	Pregnant Uterus, first trimester/ Transabdominal plus detail/ Transvaginal	76811-76812, 76700, 76801-76802, 76817, 76830
	Pregnant Uterus/ Transvaginal/ Pelvic	76805-76810, 76815-76816, 76856-76857, 76817, 76830

Procedure	Contiguous body Areas	Code Combinations
	Pregnant Uterus Transvaginal/ Abdomen	76817, 76700
	Scrotum/Transrectal	76870, 76942, 76872

Referral/notification/preauthorization requirements

Summit ElderCare requires that all non-emergency outside services, including radiology studies, be authorized in advance. Please contact the referring Summit ElderCare PACE site for assistance.

Prior notification or prior registration with MedSolutions is required for certain high technology studies as outlined in the FCHP Provider Manual.

The prior notification/prior registration program for imaging services does not apply to the following products: FCHP MassHealth, Major Medical, Fallon Preferred Care, Fallon Senior Preferred Care, Fallon Companion Care. PET scans, virtual colonoscopy and experimental/investigational imaging services for members enrolled in these products must be preauthorized by FCHP's Care Review Department prior to scheduling. FCHP's Care Review Department will review requests for PET scans, virtual colonoscopy and experimental/investigational imaging services and will provide an authorization or denial based on the terms of the plan member's Evidence of Coverage and/or MedSolution's medical necessity criteria, as applicable.

The prior notification/prior registration program for imaging services does not apply to non-contracted ordering providers. Any imaging services ordered by non-contracted providers must be preauthorized by FCHP's Care Review Department prior to scheduling. FCHP's Care Review Department will review non-contracted providers' requests for imaging services and will provide an authorization or denial based on the terms of the plan member's Evidence of Coverage and/or MedSolution's medical necessity criteria, as applicable.

Billing/coding guidelines

Technical services only should be billed on an UB-04 form

- Both revenue and CPT/HCPCS codes with appropriate modifier should be submitted.
- List the ordering physician in Box 78 on the UB-04 form.
- Claims must be submitted with the appropriate diagnosis code(s).
- Identify multiple units of radiological services in UB-04 Form Locator 46.

Professional services should be submitted on a CMS –1500 form

- Claims should be billed with appropriate CPT/HCPCS codes and modifiers.
- List the referring physician in Box 17 of the CMS-1500 form.
- Claims must be submitted with the appropriate diagnosis code(s).

When both a CPT code and a HCPCS code exist that describe the same service or procedure, bill with the CPT unless otherwise directed.

Modifiers

- Use modifier 52 in situations where two different physician specialties are reporting the S&I (supervision and interpretation)
- Use modifier 26 to indicate that only the interpretation and report were performed.
- Use modifier TC to indicate only technical services were provided.

- 26 or TC modifiers are not appropriate if the procedure code represents an inherently professional/technical service.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	05/28/03
Previous revision date(s):	05/26/04, 07/19/06, 07/18/07
Connection date & details:	September 2009 – Moved to new policy template and added description and codes describing reduced payment for multiple procedures on contiguous body areas.

This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.