



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 authorization 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.

Benefits application

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care
- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®
- NaviCareSM

Reimbursement

FCHP requires that providers refer Plan members to contracted radiology facilities and contracted physicians unless prior authorization is obtained. All claims for non-emergent outpatient radiology services provided at a non-contracted facility without an authorization will be denied vendor liable.

Radiology consults for diagnostic procedures are not reimbursable.

3D imaging services (CPT codes 76376 and 76377) are not separately reimbursed from the associated imaging services.

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 50% of the provider's fee schedule. Reduction of reimbursement is for claims submitted for the technical component and for the technical portion of a global payment of an imaging procedure. FCHP will consider the technical portion to be 60% of the global payment amount when calculating the amount of a global payment's reduction.

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	71550, 71551, 71552, 71555, 72195, 72196, 72197, 72198, 74181, 74182, 74183, 74185
	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
	pregnant uterus transvaginal/ abdomen	76817, 76700
scrotum/transrectal	76870, 76942, 76872	

Payments for multiple procedures on contiguous body areas are subject to post-payment audits and retraction of overpayments.

Referral/notification/prior authorization requirements

Summit ElderCare requires prior authorization for all non-emergency outside services, including radiology studies. Please contact the referring Summit ElderCare PACE site for assistance.

NaviCareSM requires that all non-emergency services be authorized in advance. Please contact an Enrollee Service Representative at 1-877-700-6996 for assistance.

Prior authorization with MedSolutions is required for certain high technology studies as outlined in the FCHP Provider Manual. MedSolutions can be contacted at 1-888-693-3211 or www.medsolutionsonline.com.

The prior authorization 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 require prior authorization by FCHP's Utilization Management (UM) Department prior to scheduling. FCHP's UM 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 medical necessity criteria, as applicable.

The prior authorization program for imaging services does apply to non-contracted ordering providers. Any imaging services ordered by non-contracted providers must have prior authorization from FCHP's UM Department prior to scheduling. FCHP's UM 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 medical necessity criteria, as applicable.

Billing/coding guidelines

Technical services only should be billed on a UB-04 form.

- Both revenue and CPT/HCPCS codes with appropriate modifier should be submitted.
- List the ordering physician and their NPI number 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 and their NPI number in Box 17b of the CMS-1500 form.
- Claims must be submitted with the appropriate diagnosis code(s).

Either a UB-04 or a CMS-1500 form can be used for global radiology services.

- Claims should be billed with appropriate CPT/HCPCS codes.
- List the referring physician in Box 17 and their NPI number in Box 17b of the CMS-1500 form.
- Claims must be submitted with the appropriate diagnosis code(s).
- List the ordering physician and their NPI number in Box 78 on the UB-04 form.
- Identify multiple units of radiological services in UB-04 Form Locator 46.

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 outpatient settings.

Policy history

Origination date:	05/28/2003
Previous revision date(s):	05/26/2004, 07/19/2006, 07/18/2007 11/01/2009 – Moved to new policy template and added description and codes describing reduced payment for multiple procedures on contiguous body areas. 03/01/2010 – Added description of reduction for technical portion of global payments and discussion of overpayment recoveries found through post payment audits. Updated language in the referral/notification/prior authorization section.
Connection date & details:	September 2010 – Consistent with CMS update, changed reduced payment for multiple procedures on contiguous body areas for Senior Plan from 75% to 50%. Added statement that 3D imaging services are not separately reimbursed.

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.