Radiology/Diagnostic Imaging Procedures Payment Policy

Policy

The Plan 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 the Plan's radiology management vendor.

When multiple imaging services are performed by the same provider on the same member on the same date of service, 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.

Reimbursement

The Plan 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 Mammography:

- 77061 Digital breast tomosynthesis; unilateral – considered experimental/investigational and only covered with an approved prior authorization until May 31, 2018. Covered for Medicaid and Commercial products effective June 1, 2018 without prior authorization. Not covered for Plan Medicare products
- 77062 Digital breast tomosynthesis; bilateral – considered experimental/investigational and only covered with an approved prior authorization until May 31, 2018. Covered for Medicaid and Commercial products effective June 1, 2018 without prior authorization. Not covered for Plan Medicare products.
- 77063 Screening digital breast tomosynthesis; bilateral: Covered for Medicare, Medicaid, Dual Enrolled, and Commercial products effective June 1, 2018
- G0279 Diagnostic digital breast tomosynthesis; unilateral or bilateral – considered experimental/investigational and only covered with an approved prior authorization until May 31, 2018. Covered for Medicare, Medicaid, Dual Enrolled, and Commercial products effective June 1, 2018 without prior authorization.

Multiple Procedures Payment Reduction:
When multiple imaging services are performed by the same provider on the same member on the same date of service, the procedure with the highest intensity will be reimbursed at 100% and the subsequent procedure(s) will be reimbursed at a reduced rate. The Plan follows the rules set forth in the Centers for Medicare and Medicaid Services (CMS) Multiple Radiology Payment Reduction (MRPR).

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

Referral/notification/prior authorization requirements

Prior authorization with eviCore (formerly MedSolutions) is required for certain high-technology studies, including lung cancer screening with low-dose computed tomography, as outlined in the Plan Provider Manual. EviCore can be contacted at 1-888-693-3211 or at https://myportal.medsolutions.com.

Effective July 1, 2016, this prior authorization program for imaging services will also apply to **NaviCare®**.

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 the Plan's UM Department prior to scheduling. The Plan's UM Department will review non-contracted provider's 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.

Fallon Health Weinberg and NaviCare models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

No member cost-sharing will apply for low-dose computed tomography for lung cancer screening when the service is authorized by eviCore. Please bill using code G0297.

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

- Both revenue and CPT/HCPCS codes with appropriate modifier(s) should be submitted.
- List the ordering physician with 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 modifier(s).
- List the referring physician in Box 17 with 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 with NPI number in Box 17b of the CMS-1500 form.
- Claims must be submitted with the appropriate diagnosis code(s).
- List the ordering physician with 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 supervision and interpretation (S&I).
- 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. 11/01/2010 - 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. 05/01/2012 - Removed Fallon Preferred Care and Fallon Senior Preferred Care from MedSolutions prior authorization program's product exclusion list. These are now subject to the prior authorization program. 03/01/2013 – Updated discussion about reduction in payment for multiple procedures to reflect FH's implementation of CMS Multiple Procedures Payment Reduction rules. 09/01/2014 - Moved to Fallon Health logo and template. Updated discussion about reduction in payment for multiple procedures to remove the limitation that the reduction only applied to technical components. Removed MassHealth from the list of programs exempt from the MedSolutions prior authorization requirement. 01/01/2015 - added discussion about low-dose computed tomography for lung cancer screening (S8032) for commercial members. 11/01/201 - Moved to new Plan template and updated the reimbursement, prior auth, and billing/coding guidelines sections. 09/01/2016 - Updated instructions for billing for low-dose CT and added NaviCare to high-tech radiology prior auth program.
Connection date & details:	July 2017 - Updated coverage of codes 77061 and 77062. July 2018 – Updated 3D Mammography Coverage. July 2019 – Annual review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. 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. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.