

The following payment policy applies to providers who render outpatient imaging services by Tufts Health Plan[®] commercial contracted freestanding and mobile imaging providers.

This policy applies to commercial¹ products. For information on Tufts Medicare Preferred HMO's policies and procedures, [click here](#).

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 performed in a contracted facility.

General Benefit Information²

Services and subsequent payment are based on the member's benefit plan document. Providers and their office staff are required to use self-service channels to verify effective dates and copayments for commercial members prior to initiating services.

Reference the [Electronic Services](#) section of our website for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our [website](#) or by contacting [Provider Services](#).

Member Responsibility

Copayments, deductible and/or coinsurance may apply depending upon the member's benefit plan specifics.

Note: Commercial members with a cancer diagnosis are exempt from copayments for high-tech imaging.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider's Statement of Account (SOA) and the Electronic Remittance Advice (ERA) will reflect the member's responsibility amount.

Authorization Requirements

Reference the [Authorization Policy](#) for specific referral and 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

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Reference the [Clinical Resources](#) section of our website for a list of procedures, services and items that require prior authorization. Reference the [CareLink Prior Authorization List](#) for a list of procedures, services and items requiring prior authorization for CareLink members.

For services requiring prior authorization, the ordering provider is responsible for submitting documentation of medical necessity and for obtaining approval of coverage. Because prior authorization

¹ Commercial products include [HMO, POS, PPO & CareLinkSM](#) when Tufts Health Plan is Primary Administrator

² Eligibility is subject to retroactive reporting of disenrollment.

is a condition of payment, the rendering and/or interpreting provider should confirm that the required authorization request has been submitted and that authorization for coverage has been obtained before the service is provided.

For a complete description of Tufts Health Plan's commercial authorization requirements, reference the Authorization section within the [Tufts Health Plan Commercial Provider Manual](#).

Outpatient High-Tech Imaging Program

Tufts Health Plan requires providers to obtain authorization prior to requesting high-tech imaging services in an outpatient setting for commercial members. The following services require prior authorization:

- CT/CTA
- PET Scan
- MRI/MRA
- Nuclear Cardiology

MRI/MRA, CT/CTA and PET procedures must be performed in a contracted designated free-standing imaging center or a contracted hospital. Depending on the member's product, providers must call either National Imaging Associates (NIA) or CIGNA HealthCare.

Note: Diagnostic imaging services performed in the emergency room, observation, and inpatient settings do not require prior authorization.

National Imaging Associates (NIA)

It is the **ordering** provider's responsibility to obtain prior authorization before scheduling appointments for Tufts Health Plan members. **Rendering** providers will need to ensure that all tests for Tufts Health Plan members have the required authorization number before the service is performed. Both professional and technical claims for which there is no authorization number will be denied and the member may not be billed for the service associated with the denied claim. Authorizations and corresponding numbers may be obtained by:

- Logging in to the secured portal of the [Tufts Health Plan website](#). Authorizations currently appear in the Authorization Inquiry screen. Authorization numbers beginning with a Y have been approved by NIA, and numbers beginning with an N have been denied. Authorizations that appear in this screen are for the service only and do not replace any referral requirements that may exist. (Status Only)
- Visiting the NIA website, www.radmd.com (Authorization and Status Available)
- Or by calling NIA at 866-642-9703 (Authorization and Status Available)

If the **rendering** provider identifies a need to extend the examination to a contiguous body area or identifies a need to perform a different examination than what was originally authorized, the radiologist or facility should notify NIA of the extended study or additional service within the same day. NIA will either update the authorization record to include the extended examination or issue a new authorization number for the additional service. Reference the [Imaging Program Prior Authorization Code Matrix](#) for additional information.

Note: Each test requires its own authorization number. At this time, the prior authorization program for high-tech imaging services does not apply to Uniformed Services Family Health Plan and MCP members.

NIA will gather member and provider demographic data and obtain clinical information, which will be put through clinical algorithms to determine the medical necessity of the requested test. Requests meeting clinical criteria will be given an authorization number. Requests not meeting clinical criteria will be reviewed by a nurse and/or physician reviewer. This further clinical review will result in either an approval for the requested service or a denial for lack of medical necessity. Claims will continue to be processed based on the terms of the Provider Agreement.

Reference the [Imaging Program Management Guide](#) for additional information on the prior authorization requirements for facilities and ordering providers. The [Sample Prior Authorization Indicators](#) list provides general guidelines for providers considering providing a high-tech imaging service.

CareLink Members

Prior authorization is required for CareLink members in need of high-tech imaging services. CIGNA HealthCare will perform utilization management for MA and RI contracting providers as part of this high-tech imaging program.

To identify if prior authorization is required, refer to the member's identification card. The back of the identification card indicates whether **outpatient procedures** require prior authorization. If outpatient prior authorization is required, high-tech imaging prior authorization applies. If the identification card is not available, contact CIGNA HealthCare directly at (800) CIGNA-24 ((800) 244-6224) to inquire whether prior authorization is required.

All **ordering providers** will be required to call CIGNA HealthCare at 800-CIGNA-24 ((800) 244-6224) prior to scheduling a high-tech imaging service. It is the **ordering provider's** responsibility to obtain authorization by calling CIGNA HealthCare.

CIGNA HealthCare will confirm member and provider demographic data and obtain clinical information. A nurse will review the request and apply CIGNA HealthCare's medical necessity criteria. Requests meeting clinical criteria will be approved and given an authorization number. If approval cannot be given, the nurse may request additional information, or the nurse will forward the request for review by a physician reviewer. This further clinical review will result in either an approval for the requested service, a request for additional information or a denial. Only a physician reviewer will issue a denial for lack of medical necessity.

Note: Reference the [CareLink Payment Dispute Overview](#) for information on the appeals process.

The **rendering physician** is responsible for making sure the authorization with CIGNA HealthCare is in place prior to rendering services. Contact CIGNA HealthCare at (800) CIGNA-24 to verify that the authorization is in place.

Reference the [CareLink Prior Authorization List](#) on the Tufts Health Plan website for additional services that require prior authorization. Reference the [CIGNA HealthCare website](#) for additional information regarding medical necessity criteria applicable to high-tech imaging.

Billing Information

- Submit the most updated industry-standard codes.
- Submit bilateral same day services on one line; the number of services/units should not exceed one.

Note: Annually and quarterly, HIPAA medical code sets³ undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-9 diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

EDI Claim Submitter Information

- Submit claims in appropriate HIPAA compliant 837P format. Claims billed with non-standard codes will reject if billed electronically.
- Append the appropriate modifier to indicate the portion of services rendered (professional or technical component).

³ HIPAA medical code sets include HCPCS, CPT Procedure and ICD-9 diagnosis codes.

- 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.
- Submit the provider ID number assigned by Tufts Health Plan in both the Provider ID and Payee ID indicator fields in order for the claim to be processed as a freestanding or mobile imaging center.

Paper Claim Submitter Information

- Submit claims on a CMS-1500 form. Claim line(s) billed with non-standard codes or modifiers will deny.
- Append the appropriate modifier to indicate the portion of services rendered (professional or technical component).
- 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.
- Submit the provider identification number in both the Provider ID and Payee ID indicator fields (24J, 32 and 33) in order for the claim to be processed as a freestanding or mobile imaging center.
- Submit the ordering physician's name and provider identification number in the Referring Physician indicator fields (17 and 17A).

Note: Freestanding and Mobile Imaging Provider Agreements pertain to imaging services rendered in an outpatient setting. The technical component of all imaging services provided to a member registered as inpatient within an acute care hospital and transported either within the hospital or outside of the hospital should be billed to the hospital. All imaging services rendered during a member's acute care hospital inpatient stay is included in the global all inclusive inpatient compensation rates.

When providing general x-rays (i.e. chest, abdomen, etc.) to a member registered as an inpatient at a skilled nursing facility or transitional care unit (SNF/TCU), the technical (performance of the imaging service) component of the service should be billed to the SNF/TCU, as general x-rays are included in the global inpatient compensation rate. If your contract pertains to the global (performance and interpretation) component, a separate claim for professional services only should be submitted to Tufts Health Plan.

Processing Information

Tufts Health Plan accepts modifier TC (technical component) for processing purposes.

Note: It is imperative that non-standard modifiers are not submitted to Tufts Health Plan. Claims that are submitted with non-standard modifiers will reject if submitted electronically.

Compensation/Reimbursement

Providers are compensated based on their contractual arrangements for outpatient imaging services.

Compensation for freestanding and mobile imaging centers is based on the provider's contracted payment schedule. Claims received for procedure codes that are not listed on the provider's fee schedule will deny as a non-contracted service.

Note: Commercial mobile imaging providers are subject to the privileging requirements of the physician who is requesting the imaging service(s). Mobile imaging providers should verify the privileging status of the requesting provider prior to rendering any services. Refer to the Tufts Health Plan Imaging Privileging Program chapter of the [Tufts Health Plan Commercial Provider Manual](#) for additional information regarding the privileging process.

Compensation for Multiple Imaging Procedures

A reduction in payment is applied to claims submitted for the technical (performance of the imaging service) or global (performance and interpretation) component of an imaging procedure when certain procedure code combinations are billed for a single member within the same visit.

In these instances, Tufts Health Plan will compensate the imaging service with the higher allowable compensation amount at 100% of the Tufts Health Plan compensation rate and subsequent procedure(s) that are subject to reduction logic will be compensated at 50% of the Tufts Health Plan compensation rate. Reference the [Multiple Imaging Procedures List](#) for the list of imaging procedure code combinations that are subject to multiple imaging procedures reduction.

Compensation/Reimbursement for Ultrasound Procedures

Claims submitted for the global or technical component of certain ultrasound procedures when billed in combination with other ultrasound procedures for a single member within the same visit will be denied since they are considered to be included within another procedure.

In these instances, Tufts Health Plan will compensate the imaging service with the highest allowable compensation amount at 100% of the Tufts Health Plan compensation rate and subsequent procedure(s) that are considered to be included in the other ultrasound procedure will be denied. Reference the [Multiple Imaging Procedures List](#) for the list of ultrasound procedure codes that are subject to this policy.

Statement of Account (SOA)

The SOA is sent to all providers to provide information on the status of the claim(s) submitted to Tufts Health Plan. The SOA indicates status of claims payments, denials and pending claims.

If the procedure code(s) submitted is not used in processing, the SOA will reflect the actual procedure code(s) utilized by Tufts Health Plan to process the claim.

Electronic Remittance Advice (ERA)

The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

When an industry standard code(s) is submitted and accepted by Tufts Health Plan, the electronic remittance advice will reflect the code(s) submitted and the actual procedure code(s) utilized by Tufts Health Plan for claims processing.

Document History

January 2008: Added note that explains Members with a cancer diagnosis are exempt from high-tech imaging copayments.

February 2008: Revised general benefit information with self-service channels information.

July 2009: Added information about the Multiple Imaging Procedures List

October 2009: The Multiple Imaging Procedures List effective November 15, 2009, have been delayed.

November 2009: Added the following: MRI/MRA, CT/CTA and PET procedures must be performed in a contracted designated free-standing imaging center or a contracted hospital.

December 2009: Added Effective January 10, 2010, the Multiple Imaging Procedures List is changing to more closely align with CMS's code groups subject to multiple imaging reductions.

August 2011: Reviewed policy. Template updates, minor content changes for clarity purposes.

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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is not a guarantee of payment nor a final prediction 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 guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Health Plan Medicare Preferred or Private Health Care Systems (PHCS) network also known as Multiplan members. [This policy applies to CareLink when CIGNA HealthCare is Primary Administrator for providers in Massachusetts and Rhode Island service areas for pricing purposes only.](#) Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink members.