Radiology/Diagnostic Imaging Services Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

The Plan covers medically necessary x-rays, fluoroscopy and mammography; computed tomography (CT), CT angiography (CTA) and CT-guided procedures; MRI, including MR angiography (MRA) and MRI-guided procedures; ultrasound (US), including Doppler imaging and US-guided procedures; nuclear medicine diagnostic imaging and procedures, including PET for certain conditions; and bone density (DEXA) scans.

Diagnostic radiology services provided to commercial or Medicare (Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare and PACE) plan members who are not hospital inpatients or outpatients must be ordered by the treating physician/practitioner. A “treating physician” is a physician, as defined in §1861(r) of the Social Security Act, who furnishes a consultation or treats a plan member for a specific medical problem, and who uses the results of a diagnostic test in the management of the member’s specific medical problem” " A "treating practitioner" is similarly defined as a nurse practitioner, clinical nurse specialist, or physician assistant, as defined in §1861(s)(2)(K) of the Act, who furnishes, pursuant to State law, a consultation or treats a beneficiary for a specific medical problem, and who uses the result of a diagnostic test in the management of the beneficiary’s specific medical problem." (Exception: an interpreting physician may order a diagnostic mammogram based on the results of a screening mammogram.)

- Ordering physicians are required to provide diagnostic information to the radiology facility at the time services are ordered. Radiology services not ordered by the physician who is treating the plan member are not covered.
- The order may be:
  - A written document, signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the radiiology facility;
  - A telephone call from the treating physician/practitioner or his/her office to the radiology facility; or
  - An e-mail from the treating physician/practitioner or his/her office to the testing facility.
- If the order is communicated via telephone, both the treating physician, and the testing facility must document the telephone call in their respective copies of the member’s medical records. While a physician order is not required to be signed, the physician must clearly document, in the medical record, his or her intent that the test be performed.

For commercial or Medicare plan members who are hospital inpatients or outpatients “radiololology services must be provided only on the order of practitioners with clinical privileges or, consistent with state law, of other practitioners authorized by the medical staff and the governing body to order the services (§ 482.26 Condition of participation: Radiologic services (b)(4)).” There must be an order for all radiology services in the member’s medical records, and the order must be dated, timed and authenticated by an authorized practitioner prior to the time the diagnostic radiology service is performed.

For MassHealth ACO members, radiology services are covered when provided at the written request of a licensed physician (130 CMR 433.436: Radiology Services).

Reimbursement

With the exception of urgent or emergent radiology/diagnostic imaging services, all outpatient radiology/diagnostic imaging services must be provided by a contracted facility. Prior authorization is required for elective outpatient high-tech imaging, including CT scans, CT angiography, MRI/MRA studies, nuclear cardiac imaging and PET scans.

Claims for non-urgent/emergent outpatient radiology/diagnostic imaging services provided at a non-contracted facility without an authorization will be denied vendor liable.

Radiology consults for diagnostic procedures are not reimbursable.

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.

Calcium Scoring

Calcium scoring (CPT code 75571) is not a covered service. Per National Government Services, Inc. LCD Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA) L33559, calcium scoring (CPT 75571) reported in isolation is considered a screening service. There is neither separate nor additional reimbursement for calcium scoring. Revision Effective Date For services performed on or after 04/01/2022.

CPT 75571 is nonpayable by MassHealth (MassHealth Transmittal Letter AOH-58; MassHealth Transmittal Letter PHY-170; MassHealth Transmittal Letter IDTF-25).

Referral/notification/prior authorization requirements

Radiology/diagnostic imaging services provided by non-contracted providers requires prior authorization.

Prior Authorization for Outpatient High-Tech Imaging

Prior authorization is required for elective outpatient high-tech imaging, including CT scans, CT angiography, MRI/MRA studies, nuclear cardiac imaging and PET scans.

eviCore healthcare (formerly MedSolutions, Inc.) reviews medical necessity and provides prior authorization on behalf of Fallon Health for elective outpatient high-tech imaging.

The ordering provider is responsible for obtaining prior authorization:

- Contracted ordering providers should contact eviCore directly at 1-888-693-3211 or at www.evicore.com to obtain prior authorization for high-tech imaging.
- Non-contracted ordering providers should not contact eviCore directly. Non-contracted ordering providers must contact the Plan’s UM Department prior to scheduling high-tech imaging.

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

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as approved by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed

care, all care and services provided to PACE plan members must be approved by the interdisciplinary team.

Billing/coding guidelines

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.

ICD-10-CM Diagnosis Coding

All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician or other qualified nonphysician practitioner who is treating the plan member for a specific medical problem and who uses the results in the management of the member's specific medical problem.

The Medicare Conditions of Participation for hospitals states in 42 CFR 482.26, that radiologic services must be provided only on the order of practitioners with clinical privileges or, consistent with State law, of other practitioners authorized by the medical staff and the governing body to order the services. Medical necessity is determined by the signs/symptoms provided by the ordering physician. Section 4317(b) of the Balanced Budget Act of 1997 specifies that the ordering physician must provide signs/symptoms or a reason for performing the test at the time it's ordered. Similarly, MassHealth regulations at 130 CMR 433.436 specify that MassHealth only pays for radiology services only when the services are provided at the written request of a licensed physician.

The provider submitting the claim may request additional diagnostic and other medical information from the ordering physician or nonphysician practitioner to document that the services it bills are reasonable and necessary.

Mammography exception: A physician who meets the qualification requirements for an interpreting physician as provided in § 410.34(a)(7) may order a diagnostic mammogram based on the findings of a screening mammogram even though the physician does not treat the member.

On claims for radiological services for diagnostic purposes, sequence first the diagnosis, condition, or problem chiefly responsible for the request for radiological services.

Resources:
Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services.

42 CFR 410.32 – Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

42 CFR 410.33 – Independent diagnostic testing facility.

42 CFR 482.26. Condition of participation: Radiologic services.

Balanced Budget Act of 1997, Section 4317(b). Available at: www.gpo.gov/fdsys/pkg/PLAW-105publ33/html/PLAW-105publ33.htm

MassHealth Physician Manual Program Regulations 130 CMR 433.436: Radiology Services.

MassHealth Independent Diagnostic Testing Facility Manual Program Regulations 130 CMR 431.409: Ordering of Tests.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2024 - Updated April 1, 2024. Section IV.Diagnostic Coding and Reporting Guidelines for Outpatient Services. K. Patients receiving diagnostic services only.

Mammography Services

Service Provided	Medicare (Fallon Medicare Plus/Plus Central, NaviCare, SEC/FHW PACE)	Community Care	MassHealth ACO
Screening mammography	CPT 77067	CPT 77067	CPT 77067
Screening digital breast tomosynthesis, bilateral	CPT 77063 (add-on code; cannot be reported as a stand-alone service)	CPT 77063 (add-on code; cannot be reported as a stand-alone service)	CPT 77063 (add-on code; cannot be reported as a stand-alone service)
Screening mammography with screening digital breast tomosynthesis	CPT 77067 + CPT 77063	CPT 77067 + CPT 77063	CPT 77067 + CPT 77063
Diagnostic mammography (unilateral)	CPT 77065	CPT 77065	CPT 77065
Diagnostic mammography (bilateral)	CPT 77066	CPT 77066	CPT 77066
Diagnostic digital breast tomosynthesis, unilateral	Use G0279 (add-on code; cannot be reported as a stand-alone service) + 77065	CPT 77061	CPT 77061
Diagnostic digital breast tomosynthesis, bilateral	Use G0279 (add-on code; cannot be reported as a stand-alone service) + 77066	CPT 77062	CPT 77062
Diagnostic mammography (unilateral) with diagnostic digital breast	CPT 77065 + HCPCS G0279	CPT 77065 + CPT 77061 or CPT 77065 +	CPT 77065 + CPT 77061 or CPT 77065 +

tomosynthesis		HCPCS G0279	HCPCS G0279
Diagnostic mammography (bilateral) with diagnostic digital breast tomosynthesis	CPT 77066 + HCPCS G0279	CPT 77066 + CPT 77062 or CPT 77066 + HCPCS G0279	CPT 77066 + CPT 77062 or CPT 77066 + HCPCS G0279

Screening Mammography
The following code describes screening mammography:

- 77067 Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

Diagnostic Mammography
The following codes describe diagnostic mammography:

- 77065 Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
- 77066 Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral

Digital Breast Tomosynthesis (DBT)
The following are the codes that describe DBT:

- 77061 Digital breast tomosynthesis, unilateral
- 77062 Digital breast tomosynthesis, bilateral
- 77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)
- G0279 Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066) (add-on code; cannot be reported as a stand-alone service)

Please note: CPT codes 77061 and 77062 are not valid codes for Medicare. Claims for CPT codes 77061 and 77062 submitted for Medicare plan members (Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare and PACE) will deny vendor liable effective for dates of service on or after September 1, 2023. In place of using CPT codes 77061 and 77062, CMS created the HCPCS Level II add-on code G0279 to describe diagnostic DBT, unilateral or bilateral.

CPT 77063 is an add-on code and cannot be reported as a standalone service.

Being an add-on code, G0279 must be submitted in addition to either CPT codes 77065 or 77066; it cannot be reported as a stand-alone service. Being unilateral or bilateral, HCPCS code G0279 has been assigned a bilateral indicator '2' in the Medicare Physician Fee Schedule Database (MPFSDB). A '2' indicator means special payment adjustment for bilateral does not apply. Because of this, bilateral modifiers (e.g., CPT modifier 50, HCPCS modifiers RT/LT) are not to be included and the units field should indicate a quantity of '1'.

The Current Procedural Terminology (CPT®) Editorial Panel created three Category I codes to describe mammography with computer-aided detection (CAD) when performed, which became effective January 1, 2017 (CPT 77065, 77066, 77067). This means that the payment for CAD is included in the base code's value and is not paid separately. These codes (77065, 77066, 77067) replaced CAD CPT codes 77051 and 77052 and mammography CPT codes 77055, 77056 and 77057. CPT codes 77065, 77066, 77067 are also used when CAD is not performed.

Modifier CT

To implement Section 218(a) of the Protecting Access to Medicare Act of 2014 (PAMA), "Quality Incentives to Promote Patient Safety and Public Health in Computed Tomography Diagnostic Imaging," CMS created modifier "CT" (Computed tomography services furnished using equipment

that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 Standard). Beginning January 1, 2016, claims for computed tomography (CT) scans furnished using equipment that does not meet the NEMA Standard and for which payment is made under the Medicare Physician Fee Schedule, must include modifier CT. Modifier CT will reduce the technical component (and the technical component of the global fee) by 5% in 2016 and 15% in 2017 and subsequent years, for which payment is made under the MPFS or the hospital OPPS (R3401CP; MM9250).

When billing for a CT scan furnished using equipment does not meet the NEMA equipment standard, append modifier CT to the appropriate code on claims for Medicare plan members (Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare and PACE). Use of HCPCS modifier CT for these services will result in the applicable payment reduction.

CT Modifier Reduction List:
70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71271, 71275, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194, 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74261, 74262, 74263, 75571, 75572, 75573, 75574

Modifier FX

To implement the incentive to transition to digital imaging included in the Consolidated Appropriations Act of 2015, CMS created modifier FX (X ray taken using film). Beginning January 1, 2017, claims for X-rays taken using film and for which payment is made under the Medicare Physician Fee Schedule (MPFS), must include modifier FX. Modifier FX will result in a 20% payment reduction to the technical component (and the technical component of the global fee), for which payment is made under the MPFS or the hospital OPPS (R3583CP; MM9727).

When billing for an X-ray that was done using film, append the FX modifier to the appropriate code on claims for Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, PACE and Community Care members. Use of HCPCS modifier FX will result in the applicable payment reduction. For example:

Service	Code	Modifier
Chest X-ray single view	71010	26
Chest X-ray single view	71010	TC FX
Chest X-ray single view	71010	FX

Modifier FY

Paragraph 1848 (b)(9) of the Social Security Act (SSA) provides that payments for imaging services that are X-rays taken using computed radiography (including the technical component portion of a global service), that would otherwise be made under the Medicare Physician Fee Schedule (MPFS) (without application of subparagraph (B)(i) and before application of any other adjustment), be reduced by 7% during calendar year 2018 through 2022, and if such X-ray services are furnished during CY 2023 or a subsequent year, by 10%, for which payment is made under the MPFS or the hospital OPPS (R3820CP, MM10188).

When billing for an X-ray taken using computed radiography, append the FX modifier to the appropriate code on claims for Fallon Medicare Plus, Fallon Medicare Plus Central, NaviCare, PACE and Community Care members. Use of HCPCS modifier FY will result in the applicable payment reduction.

Ordering/Referring Provider NPI

Effective December 1, 2020, all claims for items and services that are a result of an order or referral must include the applicable qualifier, ordering/referring provider's name, and valid NPI. On a CMS-1500 claim form (02-12) or electronic equivalent:

- Report the name of the referring or ordering provider in Item 17 and the appropriate qualifier to the left of the dotted line on the CMS-1500 (Version 02/12) claim form: DN (referring provider) or DK (ordering provider); report the name of the referring or ordering provider in 2310A Referring Provider Loop, segment NM1 Referring Provider Name (Segment NM101 (Qualifier), Segment NM103-NM105 (Name)).
- No information should appear in Item 17a. Item 17a was formerly used to report the Unique Physician Identification Number (UPIN), which is no longer used -- leave this item blank.
- Report the National Provider Identifier (NPI) of the referring/ordering provider in Item 17b or the 837P 2310A Referring Provider Loop, segment NM109 [NPI].

Qualifier	Provider Role
DN	Referring Provider
DK	Ordering Provider

Place of service

This policy applies to radiology/diagnostic imaging services rendered in 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.

October 2020 - Added requirement for ordering/referring provider's name, qualifier, and valid NPI.
January 2022 - Updated to include information on the use of HCPCS modifier CT and resultant payment reduction.
July 2023 – Updated Billing/coding guidelines to include information on billing for Mammography Services; added sections for Modifier FX and Modifier FY under Billing/coding guidelines.
October 2024 – Under Reimbursement, clarified that calcium scoring (CPT 75571) is not a covered service. Under Billing/coding guidelines, clarified that all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician or other qualified nonphysician practitioner who is treating the plan member for a specific medical problem and who uses the results in the management of the member's specific medical problem. On claims for diagnostic radiology services, sequence first the diagnosis, condition, or problem chiefly responsible for the request for radiological services.

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.