

DIAGNOSTIC IMAGING SERVICES

Policy

NHP reimburses contracted providers for medically necessary diagnostic imaging services delivered in non-institutional settings such as an office or free-standing facility, and in institutional settings such as a hospital, skilled nursing facility or comprehensive rehabilitation facility including: diagnostic radiology, mammography, bone densitometry, nuclear medicine, magnetic resonance imaging/magnetic resonance angiography, computerized tomography/computerized tomographic angiography, position emission tomography and ultrasound procedures.

Prerequisites

Authorization, Notification and Referral

Service	Requirement
Outpatient “high-tech” advanced imaging procedures	Prior Authorization Required by the ordering provider from MedSolutions
Diagnostic imaging procedures performed in an inpatient place of service , or in the emergency department	No Prior Authorization Required
Radiology codes not called out by MedSolutions	No Prior Authorization Required
For HVMA Members	A referral number for most specialists is required for NHP members with a Harvard Vanguard Medical Associates PCP seeking non-emergency care outside of the Harvard Vanguard Medical Associates Network. Please verify that the member has the appropriate referral number prior to rendering care.

Limitations

NHP’s reimbursement of these procedures is subject to benefit coverage and the provider’s compliance with NHP’s prior authorization requirements.

Outpatient Advanced “High-Tech” Imaging Program

NHP requires that providers obtain authorization prior to requesting advanced, high-tech imaging services in an outpatient setting. The following services require prior authorization:

- CT/CTA
- MRI/MRA
- PET Scan

CT/CTA, MRI/MRA, and PET Scans must be performed in a NHP contracted designated free-standing imaging center or a contracted hospital.

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

For a list of procedures with their codes, please refer to the Prior Authorization Codes for High-Tech Radiology Services list posted at:

<http://www.nhp.org/PDFs/Providers/PriorAuthorizationCodesforHigh-techRadiologyServices.pdf>

It is the ordering provider's responsibility to obtain prior authorization before scheduling appointments for NHP members. Rendering providers are responsible for ensuring that all imaging services for NHP members have the required authorization number prior to the service being 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 services associated with the denied claims. Authorization and corresponding authorization numbers may be obtained by:

- Visiting the MedSolutions website www.medsolutionsonline.com After a quick and easy one-time registration, you can initiate a request, check status, review guidelines, and more.
- Calling MedSolutions toll-free, 8 AM to 9 PM ET at: **1-888-693-3211**
- Faxing MedSolutions toll-free at: **1-888-693-3210** Complete the appropriate fax form and fax to the number above. MedSolutions will respond by fax when the authorization decision is complete. (You can obtain body part and modality specific forms on the MedSolutions website (www.medsolutionsonline.com) or by calling the MedSolutions Customer Service Department at **888-693-3211**.)

Should the rendering provider determine that an imaging study different than that which was originally authorized is warranted, the rendering facility **must** contact MedSolutions for review and authorization prior to claim submission. Please contact MedSolutions by faxing information to 1-888-693-3210.

Exceptions to Policy Criteria

Member Cost-Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any.

Definitions

Imaging: See radiology, below.

Computed tomographic angiography (CTA): A non-invasive technique for imaging vessels. The information obtained from the CTA is used in evaluation of vascular anatomy (e.g. renal or liver transplant donors, congenital anomalies), vascular disorders (e.g. aortic or intracranial aneurysms, renal artery or carotid stenosis), and vascular trauma (e.g. aortic laceration) and in follow-up of organ transplantation. The key distinction between CTA and computed tomography (CT) is that CTA includes reconstruction post-processing of angiographic images and interpretation. If reconstruction is not done, it is not a CTA study.

Dual-energy x-ray absorptiometry (DXA): An enhanced form of x-ray technology used to measure bone loss, most often performed on the lower spine and hips. DXA is today’s established standard of measuring bone mineral density (BMD).

Radiology: Radiology services include the study of images of the human body performed by a radiologist using different techniques or modalities, including but not limited to bone densitometry, computed tomography/tomographic angiography, magnetic resonance imaging/angiography, mammography, nuclear medicine, position emission tomography and ultrasound procedures.

X-ray (radiograph): A non-invasive medical test that helps physicians diagnose and treat medical conditions. Imaging with x-rays involves exposing a part of the body to a small dose of ionizing radiation to produce pictures of the inside of the body. X-rays are the oldest and most frequently used form of medical imaging.

Neighborhood Health Plan Reimburses

- Outpatient radiologic services using the CPT code representing the services rendered.
- Facilities billing both the technical and professional components of radiologic service are reimbursed globally according to their contract with NHP.
- Computerized tomography (CT), excluding screening CT with or without contrast; in general the technical component includes payment for high osmolar contrast media for CT scans that specify “with contrast”.
- Diagnostic and screening mammography, standard and digitalized.
- Diagnostic x-rays.
- The physician who interprets the x-ray and provides the written report. (Only one physician will be reimbursed for interpretation and report.).
- Low osmolar contrast when billed with the appropriate HCPCS code; when two MRIs are performed at the same session, in general, no separate reimbursement is made for the contrast material used in the second MRI.
- Both the surgical (procedural) and the radiological supervision and intervention (S&I) service components are reimbursed; the technical component is subject to the multiple surgery reimbursement reduction where applicable.
- Effective July 1, 2012, when two or more reimbursable imaging services are performed on the same date of service, at the same encounter, in all places of service, a 50% reduction of the lower priced radiologic services will be taken on the technical only (performance of the imaging), and technical performance of the global (performance and interpretation) services-when certain imaging procedure code combinations are billed for a single member at the same encounter. The following codes when submitted at the same encounter are subject to the reimbursement reduction.

<i>Diagnostic Imaging Procedures Subject to Payment Reduction</i>				
<u>CPT</u>	<u>Short Descriptor</u>		<u>CPT</u>	<u>Short Descriptor</u>
70336	Magnetic image jaw joint		72196	Mri pelvis w/dye
70450	Ct head/brain w/o dye		72197	Mri pelvis w/o & w/dye
70460	Ct head/brain w/dye		72198	Mr angio pelvis w/o & w/dye

Diagnostic Imaging Services

70470	Ct head/brain w/o & w/dye		73200	Ct upper extremity w/o dye
70480	Ct orbit/ear/fossa w/o dye		73201	Ct upper extremity w/dye
70481	Ct orbit/ear/fossa w/dye		73202	Ct uppr extremity w/o&w/dye
70482	Ct orbit/ear/fossa w/o&w/dye		73206	Ct angio upr extrm w/o&w/dye
70486	Ct maxillofacial w/o dye		73218	Mri upper extremity w/o dye
70487	Ct maxillofacial w/dye		73219	Mri upper extremity w/dye
70488	Ct maxillofacial w/o & w/dye		73220	Mri uppr extremity w/o&w/dye
70490	Ct soft tissue neck w/o dye		73221	Mri joint upr extrem w/o dye
70491	Ct soft tissue neck w/dye		73222	Mri joint upr extrem w/dye
70492	Ct sft tsue nck w/o & w/dye		73223	Mri joint upr extr w/o&w/dye
70496	Ct angiography head		73225	Mr angio upr extr w/o&w/dye
70498	Ct angiography neck		73700	Ct lower extremity w/o dye
70540	Mri orbit/face/neck w/o dye		73701	Ct lower extremity w/dye
70542	Mri orbit/face/neck w/dye		73702	Ct lwr extremity w/o&w/dye
70543	Mri orbt/fac/nck w/o & w/dye		73706	Ct angio lwr extr w/o&w/dye
70544	Mr angiography head w/o dye		73718	Mri lower extremity w/o dye
70545	Mr angiography head w/dye		73719	Mri lower extremity w/dye
70546	Mr angiograph head w/o&w/dye		73720	Mri lwr extremity w/o&w/dye
70547	Mr angiography neck w/o dye		73721	Mri jnt of lwr extre w/o dye
70548	Mr angiography neck w/dye		73722	Mri joint of lwr extr w/dye
70549	Mr angiograph neck w/o&w/dye		73723	Mri joint lwr extr w/o&w/dye
70551	Mri brain w/o dye		73725	Mr ang lwr ext w or w/o dye
70552	Mri brain w/dye		74150	Ct abdomen w/o dye
70553	Mri brain w/o & w/dye		74160	Ct abdomen w/dye
70554	Fmri brain by tech		74170	Ct abdomen w/o & w/dye
71250	Ct thorax w/o dye		74174	Ct angio abd&pelv w/o&w/dye
71260	Ct thorax w/dye		74175	Ct angio abdom w/o & w/dye
71270	Ct thorax w/o & w/dye		74176	Ct abd & pelvis
71275	Ct angiography chest		74177	Ct abd & pelv w/contrast
71550	Mri chest w/o dye		74178	Ct abd & pelv 1/> regns
71551	Mri chest w/dye		74181	Mri abdomen w/o dye
71552	Mri chest w/o & w/dye		74182	Mri abdomen w/dye
71555	Mri angio chest w or w/o dye		74183	Mri abdomen w/o & w/dye

Diagnostic Imaging Services

72125	Ct neck spine w/o dye		74185	Mri angio abdom w orw/o dye
72126	Ct neck spine w/dye		74261	Ct colonography dx
72127	Ct neck spine w/o & w/dye		74262	Ct colonography dx w/dye
72128	Ct chest spine w/o dye		75557	Cardiac mri for morph
72129	Ct chest spine w/dye		75559	Cardiac mri w/stress img
72130	Ct chest spine w/o & w/dye		75561	Cardiac mri for morph w/dye
72131	Ct lumbar spine w/o dye		75563	Card mri w/stress img & dye
72132	Ct lumbar spine w/dye		75571	Ct hrt w/o dye w/ca test
72133	Ct lumbar spine w/o & w/dye		75572	Ct hrt w/3d image
72141	Mri neck spine w/o dye		75573	Ct hrt w/3d image congen
72142	Mri neck spine w/dye		75574	Ct angio hrt w/3d image
72146	Mri chest spine w/o dye		75635	Ct angio abdominal arteries
72147	Mri chest spine w/dye		76604	Us exam chest
72148	Mri lumbar spine w/o dye		76700	Us exam abdom complete
72149	Mri lumbar spine w/dye		76705	Echo exam of abdomen
72156	Mri neck spine w/o & w/dye		76770	Us exam abdo back wall comp
72157	Mri chest spine w/o & w/dye		76775	Us exam abdo back wall lim
72158	Mri lumbar spine w/o & w/dye		76776	Us exam k transpl w/doppler
72159	Mr angio spine w/o&w/dye		76831	Echo exam uterus
72191	Ct angiograph pelv w/o&w/dye		76856	Us exam pelvic complete
72192	Ct pelvis w/o dye		76857	Us exam pelvic limited
72193	Ct pelvis w/dye		76870	Us exam scrotum
72194	Ct pelvis w/o & w/dye		77058	Mri one breast
72195	Mri pelvis w/o dye		77059	Mri both breasts

Neighborhood Health Plan Does Not Reimburse

- Diagnostic ultrasound exam performed with a corresponding diagnostic ultrasound guidance procedure unless documentation supports a separate and independent exam.
- Dual energy x-ray absorptiometry (DXA); body composition study.
- EBCT scans (ultra fast CT scans).
- Fluoroscopic guidance and localization of needle/catheter tip for spinal injections (diagnostic or therapeutic) when billed with myelography supervision and interpretation (S&I) codes.
- Generation and interpretation of automated data when billed with nuclear medicine procedures.
- Generation of automated data.

- Global radiology services to a physician when performed in a hospital inpatient/outpatient place of service.
- Scintimammography.
- Screening CTs (low dose).
- Total body scan, screening.
- Routine contrast material, in general, which is included in the global inpatient rate and outpatient reimbursement rate.
- Separately for the low osmolar contrast material billed for the second MRI when two MRIs are performed at the same session.

Codes Applicable to Guideline

Note: This list of codes may not be all-inclusive.

Code	Descriptor	Comment: Billing instructions when detailed specificity required
032X	Diagnostic radiology	Submit appropriate CPT/HCPCS code
0333	Radiation therapy	
034X	Nuclear medicine	
035X	CT Scan	
040x	Other imaging	
061X	Magnetic resonance technology	
70010-76499	Diagnostic radiology/imaging CPT codes	
75572, 75573	CT heart with contrast for evaluation of cardiac structure and morphology	
75574	CT angiography, heart, coronary arteries and by-pass graft when present, w contrast materials including 3D image post processing.	
76506-76999	Diagnostic Ultrasound	
76801-76812, 76815-76817	Ultrasound pregnant uterus	
76813, 76814	Ultrasound, pregnant uterus, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal, single or first gestation; each additional gestation	
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures	Not reimbursed when billed with myelography supervision and interpretation codes (CPT 72240-72270)
77051	Computer aided detection with further physician review for interpretation, w/wo digitization of film radiographic images; diagnostic mammography	Bill with 77055, or 77056
77052	Computer aided detection with further physician review for interpretation, w/wo digitization of film radiographic images; screening mammography	Bill with 77057, or G0202
77055, 77056	Mammography ; unilateral and bilateral	

Diagnostic Imaging Services

77057	Screening mammography, bilateral (2 view film study of each breast)	
77080, 77081, 77082	Dual energy x-ray absorptiometry (DXA) , bone density study, one or more sites	
78000-79999	Nuclear medicine	
78350, 78351	Bone density (bone mineral content) study, 1 or more sites; single or dual photon absorptiometry	
A4642	Indium In-111 satumomab pendetide, diagnostic, per study dose, up to 6 millicuries	
A9536-A9698	Supply of radiopharmaceuticals	
G0202	Screening mammography, producing direct digital image, bilateral, all views	
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views	
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views	
Q0092	Set up portable x-ray	
R0070	Transportation of portable x-ray equipment and personnel to home or nursing home; per trip, one patient seen	Bill with Rev code 0329

Modifiers

- Use modifier 52 (Reduced services) when two different physician specialties report the supervision and interpretation (S&I) services of the surgical component of an interventional radiology procedure. (E.g. a cardiologist bills for the supervision of the S & I code, and a radiologist bills for the interpretation of the S & I code.
- Use modifier 26 (professional component) when only the interpretation and report were performed.
- Use modifier TC (technical component) when only the technical services were provided.
- Report modifiers 26 or TC in the first modifier field.

Payment Guidelines and Documentation

- Imaging Privileges: Providers must meet NHP’s requirements in order to be reimbursed for imaging services.
- When both a CPT code and a HCPCS Level II code exist that describe the same procedure or service, bill with the CPT code unless otherwise directed.
- For UB-04, the appropriate **CPT/HCPCS** procedure code(s) **must be submitted** with the revenue code.
- Identify multiple units of radiologic services in UB-04 Form Locator 46.
- When a procedure with multiple components, described by CPT to be reported with a single code, is reported with individual codes for each of the components, the unbundled procedure codes are re-bundled and reimbursed as a single procedure. (E.g. CT with dye, and CT without dye is reimbursed with one code, CT without and with dye)
- With regard to reporting 3D reconstruction procedure codes 76376 and 76377, NHP adheres to CPT coding guidelines.
- Documentation in the medical record, including but not limited to the appropriate diagnosis code(s) must support the medical necessity of the imaging procedure(s) performed.

- Diagnosis coding on the claim form (CMS-1500 or UB-04) must support the medical necessity of the imaging procedure(s) performed.

References

AMA-CPT Manual, current year

AMA-HCPCS Level II Code Manual, current year

CMS 2012 Medicare Physician Fee Schedule RVU Table Diagnostic Imaging Indicator 88

CPT Assistant published by the American Medical Association

NHP Obstetrical Services-Professional Provider Payment Guidelines

Publication History

Topic: Diagnostic Imaging Services	Owner: Provider Network Management
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April 27, 2010 Original documentation

May 19, 2011 Authorization grid, cost sharing, NHP Reimburses grid, disclaimer updated

April 23, 2012 Updated 2012 CPT codes, MPFS radiology indicator 88 codes and payment methodology effective 07/01/2012, and referral grid.

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Neighborhood Health Plan utilizes McKesson’s claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the “appropriate set” of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Please refer to Neighborhood Health Plan’s Provider Manual Billing Guidelines section for additional information on NHP’s billing guidelines and administration policies. Questions may be directed to Provider Network Management at prweb@nhp.org.