Radiology

Policy

Harvard Pilgrim reimburses contracted providers for radiology services delivered in non-institutional settings such as an office or free-standing facility, and in institutional settings such as hospitals, or comprehensive outpatient rehabilitation facilities.

Policy Definition

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 ultrasound, computerized tomography (CT), magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA).

Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies and procedures apply. (Refer to *Referral, Notification and Authorization* for more information.)

HMO/POS/PPO

- Order required for radiology services.
- Authorization by the ordering physician to NIA is required for non-emergency, outpatient advanced imaging services. (Refer to *Outpatient Advanced Imaging Services Authorization* for specific requirements.)

Open Access HMO and POS

For *Open Access HMO and Open Access POS* products, no referral is required to see a contracted specialist.

Harvard Pilgrim Reimburses[1]

HMO/POS/PPO

- Facilities providing both the technical and professional components of a radiological service according to the contracted rates.
  - If the professional component is billed by an independent radiologist, the facility is reimbursed for the technical component only.
- Diagnostic angiography.
- Computerized tomography (CT); the technical payment (TC) for CT scans includes payment for high osmolar contrast media for CT scans that specify “with contrast.”
- Computerized tomographic angiography (CTA).
- Diagnostic and screening mammography.
- Diagnostic x-rays.
- Magnetic resonance angiography (MRA)
- Magnetic resonance imaging (MRI)
- Nuclear medicine scans and the radionuclide used in the scan
- Nuclear cardiology
- Obstetric ultrasound — Harvard Pilgrim will reimburse one complete ultrasound exam (real time documentation, fetal and maternal evaluation for routine anatomy screen and dating, per member, per routine pregnancy (See *Obstetrical/Maternity Care* policy for specific details.)
- Positron Emission Tomography (PET) scans
- Single photon emission computerized tomography
- Ultrasound
- Nuchal translucency ultrasounds
- Stress weight bearing films
- Photodensitometry, dual photodensitometry and dual energy x-ray absorptiometry
- Radiopharmaceutical diagnostic imaging agents
- Transportation and set up of portable x-rays

- Consultation on an x-ray made elsewhere when accompanied by a written report

Interpretation

The physician who interprets the x-ray and provides the written report. (Only one physician will be reimbursed for interpretation and report.)

Professional Radiology Component with an Evaluation and Management Service

The professional component (modifier 26) of a radiological service will not be reimbursed separately when performed on the same day as an E&M service when performed in the office setting. As the professional component is not distinct from the E&M service, only the E&M service will be reimbursed.

Contrast Material

- Payment for routine contrast material is included in the global inpatient rate and outpatient reimbursement rate.
- When two MRIs are performed at the same session, no separate payment is made for the contrast material used in the second MRI.

Professional Interventional Radiology Services

Both the procedural (surgical) and the radiological supervision and interpretation (S&I) service component are reimbursed; surgical component is subject to multi surgery payment reduction where applicable.

Multiple Imaging Reduction Procedures

Multiple procedure payment reduction will apply when two or more payable procedure codes (below) are rendered by the same provider (defined as the same physician, and/or other health care professionals with the same specialty, within the same group, reporting the same Federal Tax Identification number) to the same member, in the same session, on the same day. Payment reduction will be applied to the lower allowable radiological service, this includes bilateral services.

Procedure	Multiple Procedure Family Codes	Multiple Procedure Payment Reduction
CT, CTA, MRI, MRA, US	70336, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 71250, 71260, 71270, 71271, 71275, 71550, 71551, 71552, 71555, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74181, 74182, 74183, 74185, 74261, 74262, 74712, 75557, 75559, 75561, 75563, 75572, 75573, 75574, 75635, 76391, 76506, 76511, 76512, 76513, 76516, 76519, 76536, 76604, 76641, 76642, 76700, 76705, 76706, 76770, 76775, 76776, 76801, 76802, 76805, 76810, 76811, 76812, 76813*,76815, 76816, 76817, 76818*, 76819*, 76830, 76831, 76856, 76857, 76870, 76872, 76881, 76975, 76978, 76981, 76982, 77046, 77047, 77048, 77049, 77078, 91200*, C8900-C8906*, C8908-C8914*, C8918-C8920*, C8931-C8936*, C9762-C9763*	Global and Technical (TC-Modifier) services • 50% reduction will be applied to lower allowable radiology service Professional (26-Modifier) services • 25% reduction will be applied to lower allowable radiology service

*As of dates of service on or after January 1, 2022 multiple procedure payment reduction will apply.

A payment adjustment will not be considered when services are split billed, when the payment reduction was applied to the claim with the higher allowable.

Harvard Pilgrim Does *Not* Reimburse

HMO/POS/PPO

- 3D rendering with interpretation and reporting (CPT codes 76376,76377).
- CT of heart with evaluation of calcium scoring.
- Diagnostic ultrasound exam performed with corresponding diagnostic ultrasound guidance procedure unless documentation supports a separate and independent exam.
- Dual energy x-ray absorptiometry (DEXA); body composition study.
- EBCT scans (ultra-fast CT scans).
- Generation and interpretation of automated data when billed with nuclear medicine procedures.
- Global radiology services to a physician when performed in a hospital inpatient/outpatient location.
- Interpretation services when performed solely for the purpose of quality control.
- Magnetic resonance spectroscopy.
- Multiple interpretations of same x-ray.
- Nuchal translucency ultrasound separate from an obstetrical ultrasound, prior to January 1,2022.
- Obstetric ultrasound — more than one complete routine obstetric ultrasound (real time image documentation, fetal and maternal evaluation) per pregnancy.
- Separate imaging services rendered to a member during an inpatient admission are included as part of the inpatient reimbursement rate. This includes all imaging services (professional, technical or global services) when rendered at an outpatient imaging facility or by a mobile radiology provider.
- Scintimammography.
- Thermography.
- Total body scan, screening.
- Transabdominal ultrasound when performed during the same session as a transvaginal ultrasound as it is considered a redundant service.

Member Cost-Sharing

Services subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible).

Provider Billing Guidelines and Documentation

Coding[2]

Code	Description	Comments
032X	Diagnostic radiology	Bill with appropriate CPT HCPCS code
0333	Radiation therapy	
034X	Nuclear medicine	
035X	CT Scan	
040X	Other imaging services	
061X	Magnetic resonance technology	
74261, 74262	CT colonography, diagnostic, including image postprocessing; with and without contrast	Prior authorization is required
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Not reimbursed
76376, 76377	3D rendering with interpretation and reporting	Not reimbursed
76390	Magnetic resonance spectroscopy	Not reimbursed
77061, 77062	Diagnostic digital breast tomosynthesis, unilateral or bilateral	

Code	Description	Comments
G0279, 77063	Digital breast tomosynthesis (List separately in addition to code for primary procedure)	Prior to dates of service 4/1/2021 Payment included in the allowance of the primary procedure Reimbursed as of dates of service on or after April 1, 2021.
76801-76812, 76815-76817	Ultrasound pregnant uterus	One complete routine ultrasound exam (real time image documentation, fetal and maternal evaluation) per pregnancy will be reimbursed. Routine screening diagnoses: **ICD-10 Covered Indications**
76813, 76814	Ultrasound, pregnant uterus, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal, single or first gestation; each additional gestation	Reimbursed when performed separate from standard obstetrical ultrasound
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine diagnostic/ therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)	Not reimbursed when billed with myelography supervision and interpretation codes (CPT 72240, 72255, 72265, 72270)
77071	Manual application of stress performed by physician for joint radiography	Not reimbursed
77520–77525	Proton beam treatment delivery	No TC or 26 modifier required
Q9958–Q9964	High osmolar contrast material	Not reimbursed when billed with technical portion of CT procedures that state “with contrast”
R0070	Transportation of portable x-ray equipment and personnel to home or nursing home; per trip; one patient seen	Bill with Rev Code 329

Modifiers

- Use modifier 52 in situations where two different physician specialties are reporting the S&I (supervision and interpretation) services of the surgical component of an interventional radiology procedure (e.g., cardiologist bills for the supervision of the S&I code and radiologist bills for the 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.
- Refer to the Medicare Physician Fee Schedule database (MPFSDB) to determine when modifier 50, RT or LT is applicable for a procedure code.
  - The National Physician Fee Schedule is on the CMS Web site: *www.cms.hhs.gov*.

Bilateral Services

- Refer to the *Bilateral Services and CPT Modifier 50 Payment Policy* for billing directives.

Other Information

- For UB–04 or 837I, bill revenue codes with CPT/HCPCS.
- Identify multiple units of radiological services in Form Locator 46 of the paper UB04 or segment SV2, data element SV205 with UN qualifier in SV204 of loop 2400 of the 837I.
- Submit unlisted codes on paper with supporting documentation describing the service performed.

Multiple Same-Day Services Billed with a Count

Billing Example:

- To bill for two single view frontal chest x-rays done on the same day at different sessions, bill 71045 with a count of two, on one line.
- When both a CPT code and a HCPCS code exist that describe the same service or procedure, bill with the CPT unless otherwise directed.

Radiology services that are applicable to MPR for the same day, split billed across multiple claims, may result in the 50% reduction applied to the higher allowable code. No adjustment will be considered for split billed services.

Related Policies

Payment Policies

- Anesthesia
- Bilateral Services and CPT Modifier 50
- Evaluation and Management
- Obstetrical/Maternity Care
- Observation Stay Policy
- Outpatient Surgery Policy
- Radiation Oncology
- Rehabilitation/Long-Term Acute Care Hospitals (LTAC)
- Services Incidental to Admission
- Skilled Nursing Facility (SNF)

Billing & Reimbursement

- Claims Submission Guidelines

Clinical Policies

- New Technology Assessment and Non-Covered Services
- Outpatient Advanced Imaging Authorization Policy
- Outpatient Diagnostic Imaging (NIA)

Referral, Notification & Authorization

- Notification Policy

PUBLICATION HISTORY

09/01/00	original documentation
10/15/00	contiguous body areas policy effected
06/01/01	inpatient authorization requirement changed to notification
05/01/02	contiguous body areas clarified; contrast materials clarified, added acceptable outpatient-revenue code ranges; added equipment transport billing
07/15/02	added contiguous body areas coding
04/01/03	added modifier and multiple same-day services billing information; annual review; coding added
4/30/04	annual review; 2003 coding update; added virtual colonoscopy not reimbursed; added dynamic posturography not reimbursed for First Seniority
07/01/04	added specific items within reimbursement categories; updated codes for contiguous body area scan
04/30/05	annual coding review
01/01/06	annual review: added interventional radiology; contrast material not paid with CT that includes contrast material; 2006 coding update
10/31/06	annual review; added CTA and coronary CT codes to contiguous grid; removed virtual colonoscopy from not reimbursed
01/31/07	annual coding update
10/31/07	annual review; added reimbursement conditions for nuchal translucency and virtual colonoscopy; added RT/LT modifier clarification; corrected typo in pelvic ultrasound contiguous grid
01/31/08	annual coding update; duplicate code removed in CTA head grid; added cardiac magnetic imaging non-reimbursed codes

07/31/08	bilateral billing update added
10/31/08	added reciprocal relationships to CT grid, no coverage for DEXA body composition, total body scans, multiple interpretations of same x-ray; no payment for global x-ray by MD in hospital location; 0067T to be used to report virtual colonoscopy
01/15/09	annual coding update; added routine obstetric ultrasound criteria; clarified contiguous statement
03/15/09	clarified OB U/S policy
09/15/09	annual review; added no adjustment for split billed contiguous services
01/15/10	annual coding update; update to related policies
09/15/10	annual review, minor edits for clarity; added reciprocal relationships to MRI grid
01/15/11	annual coding update; prior authorization for virtual colonoscopy effective 04/01/11
08/15/11	annual review, minor edits for clarity; added 3-D mammography to not reimbursed section
01/01/12	removed First Seniority Freedom information from header
01/15/12	annual coding update
07/15/12	added cardiac MRI codes to contig coding grid; added recipricol relationship for 74174
10/15/12	annual review, minor edits for clarity; added new multiple procedure reduction rule–the professional component (modifier 26) of a radiological procedure is not reimbursed separately when performed with E&M in the office setting
01/15/13	annual coding update
10/15/13	annual review; removed contiguous body areas for services prior to 01/17/13; administrative edits
06/15/14	added *Connecticut Open Access HMO* referral information to prerequisites
10/15/14	annual review; administrative edits, added 76499 to coding grid; added CPT 76390 as no longer reimbursed for claims processed as of 01/01/15
01/15/15	annual coding update, added CPT 76810, 76812, 76815 & 76815 to multiple procedure reduction family of codes effective dates of service 04/01/15
04/15/15	removed screening CT's from HPHC does not reimburse, added Medical Policy CT Screening for Lung Cancer to related policies, added bilateral services are included in multiple imaging reductions
06/15/15	ICD-10 coding update
10/15/15	annual review; no changes
01/15/16	annual coding review
10/15/16	annual review; removed reference to skilled nursing as policy does not apply
01/15/17	annual coding review
02/15/17	removed moderate sedation from billing guidelines; added anesthesia as a related payment policy
04/15/17	Harvard Pilgrim will no longer reimburse A transabdominal ultrasound when performed during the same session as a transvaginal ultra sound as it is considered a redundant service as of 06/15/17
10/15/17	annual review; added Skilled Nursing Facility (SNF) payment policy as a related policy; added Rehabilitation/Long Term Acute Care Hospitals (LTAC) payment policy as a related policy
11/15/17	updated breast tomosynthesis as a covered service as of date of service 01/01/18
02/01/18	annual coding update; updated Open Access Product referral information under Prerequisites
05/01/18	replaced modifier RT or LT may be used on a procedure code with bilateral indicator of 1 or 3 with reference to MPFSDB to determine when mod 50, RT or LT is applicable; added CPT 76376/76377 not reimbursed as of date of service 07/01/18
09/04/18	updated definition of same provider when performing multiple radiology services subject to multiple procedure payment reduction; removed references to the Positron Emission Tomography and the Nuclear Cardiac Imaging and Myocardial Perfusion Study payment policies from the Imaging Procedures and the Related Policies sections
10/01/18	annual review; removed ICD-9 coding, administrative edits
02/01/19	annual coding update; CPT 74263 reimbursed as of date of service 01/01/19
10/01/19	annual review; archived CT Screening for Lung Cancer Medical Policy; removed CPT 77571 from coding grid
10/01/20	annual review; updated Provider Billing Guidelines and Documentation table
02/01/21	annual code update; CPT G0279/77063 reimbursed as of date of service 4/1/2021
08/02/21	removed 3D Mammography Medical Policy
10/01/21	annual review; revised HP Reimburses and HP does not Reimburse sections
11/01/21	added codes as of dates of service on or after January 1, 2022 will be subject to multiple imaging payment reduction

[1]This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

[2]The table may not include all provider claim codes related to radiology.