PROVIDER REIMBURSEMENT GUIDANCE			
Radiology Services			
Original Date Approved	Effective Date Senior Care Options/One Care	Effective Date Medicare Advantage*	Revision Date
09/01/2022	11/01/2022	11/01/2022	

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options MA
☒ One Care MA
☒ Medicare Preferred – (PPO) MA*
☒ Medicare Value - (PPO) MA*
☒ Medicare Preferred – (PPO) RI*
☒ Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance® (CCA) covers medically necessary radiology imaging services, in accordance with the member's benefits. Radiology services include, but are not limited to; diagnostic ultrasound, diagnostic radiology imaging, MRI, MRA, CT, CTA, PET, and nuclear cardiology services that a radiologist uses to evaluate and/or treat a medical condition, injury, or illness.

Note: All contracted providers in the CCA network are required to direct members to in-network CCA providers when arranging for covered services related to a member's care. A list of In-network CCA providers can be found in the Provider Directory or by contacting CCA Provider Services at 866-420-9332.

AUTHORIZATION REQUIREMENTS:

Applicable CCA referral, notification and authorization policies and procedures apply. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

REIMBURSEMENT GUIDELINES:

CCA covers both the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. Coverage is based on the following:

- The applicable fee schedule or contracted/negotiated rate
- Physician specialty and the place of service code submitted with the claim
- Facilities paid under Outpatient Prospective Payment Systems (OPPS) will be compensated in accordance with the Medicare OPPS system

Facilities that provide both technical and professional components of an imaging service are compensated globally. If the professional component is billed by an independent radiologist, the facility is only compensated only for the technical component of the service. Compensation for the technical component of imaging services is included in the inpatient/outpatient compensation rates.

REIMBURSEMENT GUIDELINES (cont.):

When providing general x-rays (e.g., chest, abdomen, etc.) to a member registered as an inpatient at a skilled nursing facility or transitional care unit, the technical component of the service should be billed directly to the SNF/TCU.

Multiple Imaging Procedures: Will apply when two or more payable procedure codes are rendered by the same provider (same physician, and/or health care professionals within the same specialty, within the same group) to the same member in the same session on the same day. Payment reduction will be allowable radiological service, to include bilateral services.

For additional information on Multiple Procedure Payments please refer to the Multiple Procedure Payment Reduction for Diagnostic Services Payment Policy and Modifier Payment Policy for radiology reduction modifiers.

Tomosynthesis Procedures/Services: CCA applies a multiple procedure payment reduction when 3D breast tomosynthesis (77063) is billed in conjunction with mammography screening codes.

Mammography Procedures/Services: CCA does not routinely compensate diagnostic mammography (77065 and 77066) when submitted for the same date of service as diagnostic breast tomosynthesis (77061 and 77062).

Professional Interventional Radiology Services: Both the procedural (surgical) and the radiological supervision and interpretation (S&I) service component are covered; surgical component is subject to multiple surgery payment reduction where applicable.

BILLING and CODING GUIDELINES:

Unless otherwise stated, CCA follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage.

CCA requires providers to submit all professional charges using EDI 837P/CMS-1500 form and all hospital charges using EDI 837I/UB04 form, including appropriate CPT/HCPCS codes and the following modifiers: professional component (26), technical component (TC), left (LT), or right (RT). Providers are encouraged to submit charges via HIPAA-compliant electronic formats.

When billing multiple modifiers, CC requires Modifiers TC and 26 to be billed in the first position.

RELATED SERVICE POLICIES:

Add-On Payment Policy

Modifier Payment Policy

Multiple Procedure Payment Reduction for Diagnostic Services Payment Policy

Skilled Nursing Facilities Payment Policy

Referring Provider NPI Payment Policy

AUDIT and DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Please refer to CPT/HCPCS for complete and updated list of codes. 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, procedures, and claims editing logic. CCA has 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, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

- CCA Website
- CMS Website
- Provider Manuals: Massachusetts / Rhode Island
- Prior Authorization Forms: Massachusetts / Rhode Island

POLICY TIMELINE DETAILS:

1. Effective 11/01/2022