

Imaging Services

Includes Radiology and Diagnostic Cardiac Imaging

Policy

Mass General Brigham Health Plan reimburses for medically necessary diagnostic and high-technology radiology services.

Policy Definition

- Diagnostic imaging services include diagnostic radiology, mammography, bone densitometry, and ultrasound procedures
- High technology imaging services include magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), computerized tomographic angiography (CTA), and positron emission tomography (PET)

Mass General Brigham Health Plan partners with eviCore for authorization requirements on high technology imaging services and cardiac studies.

Effective dates for the eviCore partnership and prior authorization process are as follows:

- 8/1/2016 High Technology Imaging and Cardiac Studies.

Provider portals for online prior authorization requests can be found here:

- [eviCore Provider Login](#)

Contact eviCore toll-free at **888-693-3211** between the hours of **8:00am – 9:00pm EST**

Prior authorization can be submitted via fax for High Technology Imaging, and Cardiac studies at **888-693-3210**. Inpatient diagnostic and high technology imaging does not require prior authorization.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the

provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located [here](#).

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Mass General Brigham Health Plan's [General Coding and Billing](#) for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Mass General Brigham Health Plan's reimbursement is based online of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type.

Mass General Brigham Health Plan Reimburses

- Outpatient diagnostic imaging including the following:
 - Diagnostic radiology;
 - Mammography;
 - Bone densitometry; and
 - Ultrasound procedures

- Outpatient high technology imaging including the following:
 - Magnetic resonance imaging (MRI);
 - Magnetic resonance angiography (MRA);
 - Computerized tomography (CT);
 - Computerized tomographic angiography (CTA); and
 - Positron emission tomography (PET)

- Low osmolar contrast for those services requiring contrast materials

Mass General Brigham Health Plan Does *Not* Reimburse

- Diagnostic ultrasound exam performed with a corresponding diagnostic ultrasound guidance procedure
- Dual energy x-ray absorptiometry (DXA); body composition study
- Fluoroscopic guidance and localization of needle/catheter tip for spinal injections (diagnostic or therapeutic) when billed with myelography, supervision and interpretation (S&I) codes
- Global radiology services to a physician when performed in a hospital inpatient/outpatient place of service
- Scintimammography
- Separate payment for the low osmolar contrast material billed for the second MRI when two MRI services are performed during the same session
- Experimental or investigational diagnostic or high technology imaging services

Provider Payment Guidelines and Documentation

- Facilities billing both the technical and the professional components of the radiologic service are reimbursed globally according to their contract with Mass General Brigham Health Plan
- High osmolar contrast media for CT scans that specify “with contrast” is included in the technical component
- Only one provider will be reimbursed for the interpretation and report for any one specific service provided
- The appropriate CPT/HCPCS procedure code(s) must be submitted with the revenue code on a UB-04

Billing Guidelines

Professional services should be submitted on a CMS-1500 or electronically on an 837P

- Claims should be billed with the appropriate CPT/HCPCS code(s)
- Append modifier 26 to indicate professional components that require the use of a modifier
- List the referring provider and NPI number in boxes 17 and 17b of the CMS-1500; refer to your 837P Companion Guide for specific fields
- Claims must be submitted with the appropriate diagnosis code(s)

Technical services should be billed on a UB-04 or electronically on an 837I

- Submit both the revenue code and the CPT/HCPCS code(s)
- Append modifier TC to indicate technical components that require the use of a modifier

Provider Payment Guidelines

- List the ordering provider and NPI number in box 78 on the UB-04; refer to your 837I Companion Guide for specific fields
- Claims must be submitted with the appropriate diagnosis code(s)

Global services can be billed on either a CMS-1500 or a UB-04

- Claims should be billed with the appropriate CPT/HCPCS code(s)
- The ordering provider and NPI number must be listed
- Claims must be submitted with the appropriate diagnosis code(s)

Procedure Codes

Please refer to the following eviCore links for the CPT codes which adhere to the guideline and authorization requirement [here](#).

MassHealth Reimbursement

The following procedure codes are deemed not reimbursable by MassHealth. Mass General Brigham Health Plan aligns its Medicaid plans with MassHealth guidelines. Therefore, for all Mass General Brigham Health Plan Medicaid members, no reimbursement will be made to providers for the codes below.

Code	Descriptor	Comments
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	Not Reimbursable per MassHealth
43752	Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)	
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	
76140	Consultation on X-ray examination made elsewhere, written report	
76390	Magnetic resonance spectroscopy	
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)	
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	

Provider Payment Guidelines

Code	Descriptor	Comments
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)	
95967	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)	

Multiple Imaging Reduction Procedures

Mass General Brigham Health Plan has adopted Centers for Medicare and Medicaid Services' (CMS) Multiple Procedure Payment Reduction (MPPR) guidelines. When multiple diagnostic imaging procedures are performed in a single session, the reduction of payment will be applied to the lower allowable radiological service. Equipment time and indirect costs are allocated based on clinical labor time. Therefore, these inputs should be reduced accordingly.

References

AMA-CPT Manual, 2016

AMA-HCPCS Level II Code Manual, 2016

CMS 2016 Medicare Physician Fee Schedule RVU Table Diagnostic Imaging Indicator

88 CPT Assistant published by the American Medical Association

Publication History

Topic: Radiology Services	Owner: Network Management
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April 27, 2010

Original documentation

May 19, 2011

Authorization grid, cost sharing, reimbursement grid, disclaimer updated

April 23, 2012

Updated 2012 CPT codes, MPFS radiology indicator 88 codes and payment methodology and referral grid

January 1, 2013

Added 2013 CPT codes and updated authorization grid and removed deleted codes

Provider Payment Guidelines

June 1, 2016	<i>Removed definitions, added new codes to MPR grid, removed modifiers/cost sharing table, added new reimbursement language, updated guidelines, and added Mass General Brigham Health Plan relationship with eviCore and the new authorization process</i>
February 1, 2017	<i>Added MassHealth Reimbursement table with codes not deemed payable</i>
June 4, 2018	<i>Removed non-OB ultrasound reference; updated links</i>
July 1, 2020	<i>Radiation Therapy and Ultrasound Services removed from PA List</i>
January 1, 2023	<i>Document rebrand</i>

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. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers' contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.