Imaging Services Payment Policy

Applies to the following CarePartners of Connecticut products:

- ☒ CareAdvantage Premier
- ☒ CareAdvantage Prime
- ☒ CareAdvantage Preferred
- ☒ CarePartners Access

The following payment policy applies to providers, hospitals, and freestanding and mobile imaging centers who render imaging services to members of the CarePartners of Connecticut plans selected above.

In addition to the specific information contained in this policy, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut covers medically necessary imaging services including but not limited to low-tech (e.g., radiographic x-rays, ultrasounds), high-tech (e.g., CT/CTA, MRI/MRA, PET), and nuclear cardiology, in accordance with the member's benefits.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

No referrals, authorizations or inpatient notifications are required for imaging services. However, imaging services submitted with other services that have prior authorization or notification requirements will deny if such requirements have not been met for other service(s) rendered.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut 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. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

- Submit global services on one line. Do not append a modifier when submitting claims for global services; providers should only bill globally when they have performed the imaging service and the interpretation in an office setting.
- Submit the date of service for the interpretation of the diagnostic test as the date of service of the diagnostic test.
- Submit the provider identification number in both the Provider ID and Payee ID indicator fields (24J, 32 and 33) in order for the claim to be processed as a freestanding or mobile imaging center.
- Submit the ordering physician's name and provider identification number in the Referring Physician indicator fields (17 and 17a).

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

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.

CarePartners of Connecticut facilities with an outpatient prospective payment system (OPPS) contract will be compensated according to the Medicare OPPS.

Compensation for the technical component of imaging services is included in the inpatient or outpatient compensation rates.

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

Multiple Imaging Procedures

A reduction in payment is applied to claims submitted for the technical (performance of the imaging service) or global (performance and interpretation) component of an imaging procedure when certain procedure code combinations are billed for a single member within the same visit.

CarePartners of Connecticut compensates the imaging service with the higher allowable compensation amount at 100% of the CarePartners of Connecticut compensation rate and subsequent procedure(s) that are subject to reduction logic will be compensated at 50% of the CarePartners of Connecticut compensation rate.

Angiography

CarePartners of Connecticut does not routinely compensate abdominal aortography (75625) if billed with bilateral extremity angiography (75716).

Intracranial and Extracranial Imaging (Duplex, CT/CTA, MRI/MRA)

CarePartners of Connecticut does not routinely compensate for duplex scans of extracranial arteries (93880-93882) in the following circumstances:

- When billed only with a diagnosis of syncope and collapse
- If billed and an 93000-93010 (electrocardiogram) has not been billed for the same day or in the previous 90 days by any provider

CarePartners of Connecticut does not routinely compensate for the following when the only diagnosis on the claim is migraine:

- 70450-70470 (CT, head or brain)
- 70496 (CTA, head)
- 70544-70546 (MRA, head)
- 70551-70553 (MRI, brain)
- 76380 (CT follow-up)

Lung Cancer Screening with Low Dose Computed Tomography (LDCT)

CarePartners of Connecticut does not routinely compensate for the following:

- G0296 (counseling visit to discuss need for screening LDCT) or G0297 (LDCT for lung cancer screening) when billed and the member is less than 55 or greater than 80 years of age
- G0297 when billed by any provider more frequently than once within 365 days from the first date of service

Radiological Chest Examinations

CarePartners of Connecticut does not routinely compensate chest x-ray (71010, 71015 or 71020) if billed and the only diagnosis on the claim is a general medical exam, pre-admission, administrative or pre-operative exam.

CarePartners of Connecticut does not routinely compensate chest x-rays (71045 or 71046) if the only diagnosis on the claim is an encounter for screening for respiratory tuberculosis or the only diagnosis on the claim is for lung cancer screening or nicotine use/dependence.

Ultrasound

CarePartners of Connecticut does not routinely compensate for the following:

- 76856 (ultrasound, pelvic [nonobstetric], real time with image documentation; complete) when billed with code 76831 (Saline infusion sonohysterography).
- detailed fetal anatomic ultrasound (76811, 76812) when billed and the only diagnosis on the claim is supervision of normal pregnancy, routine screening for malformations using ultrasonics, fetal anatomic survey, or antenatal screening of mother.
- Initial obstetric ultrasound services when codes 76805 or 76810-76812 have been billed in the past five months.
- 76801 or 76802 (pregnant uterus ultrasound services) when 76801 or 76802 has been billed in the past three months.

Urodynamics

CarePartners of Connecticut does not routinely compensate ultrasound, pelvic (nonobstetric), limited or follow-up when billed on same date of service as simple or complex CMG, simple uroflowmetry, or complex uroflowmetry.

Document History

- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- July 2020: Policy reviewed by committee; clarified existing claim edits for all products
- January 2020: Eliminate referral requirements for in-network providers effective January 1, 2020
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves 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 a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.