Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Radiology and Diagnostic Imaging

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Point32Health reimburses contracted providers for radiology and diagnostic imaging services, including but not limited to ultrasounds, x-rays, CT, MRI, PET and nuclear cardiology. Professional services must be furnished within the scope of practice in the state in which the physician or non-physician practitioner is licensed to practice.

Prerequisites

Applicable Point32Health referral, notification, and authorization policies may apply. Refer to the appropriate sections within the Provider Manuals or the Prior Authorization page for more information.

General Benefit Information

Services are pursuant to the member's benefit plan documents and are subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible). Member eligibility and benefit specifics should be verified prior to initiating services.

Use of non-contracted labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Point32Health may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Point32Health Reimburses

- Consultation on an x-ray made elsewhere when accompanied by a written report
- Diagnostic angiography
- Dual energy x-ray absorptiometry (DEXA)
- Facilities providing both the technical and professional components of a radiological service according to contracted rates
  - If the professional component is billed by an independent radiologist, the facility is reimbursed for the technical component only
- Nuclear medicine scans, including radionuclide
- Photodensitometry and dual photodensitometry
- Screening and diagnostic mammography
- Stress weight bearing films
- The physician who interprets an x-ray and provides the written 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 may be included in the global inpatient and/or the 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

Point32Health Does *Not* Reimburse

- 3D rendering with interpretation and reporting (Harvard Pilgrim Health Care Commercial and, effective for DOS beginning Nov. 1, 2026, Tufts Health Direct)
- Global radiology services to a physician when performed in a hospital or outpatient location
- High osmolar contrast media for CT scans that specify “with contrast” is included in the technical component
- Multiple interpretations of the same x-ray
- Multiple physicians for interpretation and report of an x-ray
- The professional component of radiology or diagnostic imaging services when performed in the home, assisted living facility, nursing facility or skilled nursing facility unless the transportation of portable x-ray equipment (R0070 or R0075) is also submitted
- Thermography
- Total body scan screening
- Transabdominal ultrasound when performed during the same session as a transvaginal ultrasound as it is considered a redundant service

Tufts Health Plan

Tufts Health Plan does not reimburse procedure codes 93880-93882 (duplex scan of extracranial arteries) when the only diagnosis is syncope and collapse

Urodynamics

Tufts Health Plan does not reimburse ultrasound, pelvic (nonobstetric), limited or follow-up when billed on the same date of service as simple or complex cystometrogram (CMG), simple uroflowmetry or complex uroflowmetry.

Senior Products

Tufts Health Plan does not reimburse the following procedure codes when the only diagnosis on the claim is migraine or syncope and collapse:

- 70450-70471 (CT, head or brain)
- 70496 (CTA, head)
- 70551-70553 (MRI, brain
- 70544-70546 (MRA, head)
- 76380 (CT follow-up); applies to diagnosis of migraine only

Provider Billing Guidelines and Documentation

Providers are reimbursed according to the applicable contracted rates and fee schedules.

Multiple Imaging Procedures Reductions

When services are split billed, a payment adjustment will not be considered if the payment reduction was applied to the procedure with the highest allowable amount.

Harvard Pilgrim Health Care Commercial and Tufts Health Public Plans

Multiple procedure payment reduction will be applied when two or more payable codes are rendered by the same provider or facility on the same date of service. This includes physicians or other health care providers within the same group, same specialty and the same Federal Tax Identification Number. Payment reduction applies to the lower allowable radiological service, including bilateral services.

Multiple Imaging Procedures Code List

Tufts Health Senior Products
Multiple procedure payment reduction will be applied to claims submitted for the technical or global component of a radiology or imaging service when certain procedure code combinations are billed for a single member within the same visit. The service with the highest allowable amount will be reimbursed at 100% of the contracted rate and/or fee schedule and subsequent procedure(s) will be reimbursed at 50% of the contracted rate and/or fee schedule.

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

Other information

- Submit global services on one line with no modifier
- Submit professional and technical only services with the appropriate modifier(s)
- Submit the date of service for the date of interpretation of the diagnostic test as the date of service of the diagnostic test
- When the same service is performed multiple times at different sessions, the service should be reported with the total count on one claim and/or line

Related Policies and Resources

Payment Policies

- Anesthesia
- General Coding and Claims Editing
- Modifiers
- Non-Covered Services
- Obstetrics/Gynecology
- Outpatient Facility
- Unlisted Procedure Codes

Clinical Policies

- Noncovered Investigational Services
- Outpatient Diagnostic Imaging/Advanced Imaging (Evolent)

Publication History

10/01/2026: Policy moved to new template; includes all lines of business; removed language related to correct coding

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. 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.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and 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, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.