

## Chapter 6

### Policies and Procedures

#### Unit 5: Outpatient Radiology and Other Diagnostic Services

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## 6.5 Radiology Management Program Overview

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**Overview** Highmark's Radiology Management Program is designed to improve the quality and appropriateness of services delivered to our members.

Highmark retains the services of an imaging management firm, National Imaging Associates, Inc. (NIA), to assist with the program. NIA is certified in Pennsylvania and compliant with all Department of Health regulations applicable to their services.

The Highmark Radiology Management Program's goal is to ensure that *outpatient* diagnostic imaging providers demonstrate competency in administration of these services, thus improving quality and safety to our members. The initiative will also ensure that selected outpatient advanced imaging services such as MRIs, CT Scans and PET Scans are used only when they are clinically appropriate and that these services are being performed by quality providers.

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**Program Applies To All Network Products** This program applies to all of Highmark's products, except indemnity products.

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**Multiple Phases Of Implementation** The Highmark Radiology Management Program was implemented in three phases:

- Privileging,
- Prior Notification, and
- Prior Authorization

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## 6.5 Privileging for Radiology Services

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**Definition** Privileging is a process that addresses the quality of imaging services performed at an imaging center or in a physician’s office. All professional providers who perform imaging services must be privileged. Non-privileged providers are not eligible for reimbursement of imaging services.

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**Requirements For Privileging** Requirements intended to promote reasonable and consistent quality and safety standards for the provision of imaging services have been developed and can be found on the *Highmark Radiology Management Program* link in the Provider Resource Center via NaviNet or Highmark’s Web Site.

Highmark will not reimburse providers for imaging services performed for Highmark members if they do not satisfy the privileging requirements. Any denied services will not be billable to the member.

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**How To Become A Privileged Provider** Eligible network practitioners who wish to provide imaging services should first consult the Privileging Requirements, and then submit an application. Applications can be completed online by visiting [www.RadMD.com](http://www.RadMD.com). They are also available on the *Highmark Radiology Management Program* link in the Provider Resource Center via NaviNet or Highmark’s Web Site or by calling NIA at 1-888-972-9642.

An application must be submitted for each physical location where imaging services are rendered.

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**Request For Expansion, Additional Services Or Additional Sites** Providers must complete an application for each addition or expansion of services, or when adding additional sites. Practitioners will not be reimbursed for services provided on transferred or new equipment without being privileged.

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## 6.5 Prior Authorization Phase - Radiology

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### Overview

Prior Authorization is intended to ensure quality and proper use of diagnostic imaging consistent with clinical guidelines. This requires physicians to use NaviNet to request authorizations through NIA prior to ordering any of the selected CT scans, selected MRI and MRA scans and PET scans.

Providers who are not NaviNet-enabled should call the NIA Call Center:

In the Central Region Only:  
1-866-731-8080, Option 2, then Option 4.

[What Region Am I?](#)

In the Western Region Only:  
1-800-547-3627, Option 4

NIA will issue authorization numbers, which will be required for reimbursement. Denials may be issued based on medical necessity and/or appropriateness determinations.

Physicians are advised to recommend Highmark-privileged imaging providers to members who have been approved to receive the selected non-emergency advanced imaging services; a current list is available on our online Provider Resource Center under *Radiology Management Program*.

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### Authorization Is Not A Guarantee Of Payment

When an authorization number is provided, it serves as a statement about medical necessity and appropriateness; it is not a guarantee of payment. Payment is dependent upon the member's having coverage at the time the service is rendered and the type of coverage available under the member's benefit plan. Some benefit plans may also impose deductibles, coinsurance, co-payments and/or maximums that may impact the payment. Providers may consult NaviNet, InfoFax or OASIS to obtain benefit information.

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### Services Affected

The prior authorization process applies only to certain outpatient, *non-emergency* advanced imaging services. The prior authorization process does not apply to outpatient *emergency* imaging services, inpatient imaging services or observation stays. Please review member benefits accordingly through NaviNet. If you are not NaviNet enabled you may contact Customer Service.

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## 6.5 Prior Authorization Phase - Radiology, Continued

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### Procedures That Require Prior Authorization

The prior authorization process applies to the following imaging procedures. Refer to the *Radiology Management Program* link on the online Provider Resource Center for a complete list of procedure codes (CPT) and descriptions.

- Select CT scans
- Select MRI scans
- Select MRA scans
- PET scans\*

\* Not all PET scans are included in this program, as some are not covered due to Highmark's medical policy. Please check medical policy if your PET scan is not include in the procedure code list.

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### Process Overview

The ordering physician's office staff uses NaviNet to contact NIA for prior authorization before scheduling the test. NIA staff will use nationally accepted clinical standards, or indicators, to determine the medical necessity/appropriateness.

For more detailed information on the prior authorization process, please refer to the *Prior Authorization Reference Guide* available on the Provider Resource Center under the Radiology Management Program link via NaviNet or Highmark's Web Site.

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## 6.5 Reporting Methods

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### **Inpatient Versus Outpatient**

When you submit claims to Highmark Blue Shield for diagnostic or therapeutic radiology services or diagnostic medical services provided to hospital inpatients or outpatients, you must report the place of service as inpatient hospital or outpatient hospital, as appropriate. In these cases, you will be reimbursed only the professional component of the service.

- **Inpatient** – a patient who is an inpatient of a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed. When an inpatient is taken outside the hospital setting, such as to a physician’s office, and is then returned to the hospital, the physician must report services according to the patient’s status, in this case, inpatient. Therefore, you must report only “inpatient” as the place of service, rather than the place, such as “office” or “outpatient hospital”, where the service actually was performed.
- **Outpatient** – a patient, other than an inpatient, who is treated in a hospital, on hospital grounds or in a hospital-owned or controlled satellite, when it has been determined that the satellite is an outpatient department of the hospital. This definition does not apply when a treating physician’s sole practice is located in a hospital or hospital owned building, if the practice is not affiliated or controlled, in any way, by the hospital or a related entity; or, if the practice has been approved by Provider Data Analysis to be recognized as an office practice.

For example, if a mobile ultrasound, MRI or CT unit locates on hospital grounds one day each week, all services provided to patients on that day must be reported with inpatient or outpatient, but not office, as the place of service.

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## 6.5 Cost Sharing on Outpatient Diagnostic Services

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**Overview** Effective January 1, 2006, Highmark began offering optional benefit designs that include cost sharing provisions specific to outpatient diagnostic services.

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**Services Affected** Cost sharing on outpatient diagnostic services will be applied to:

- routine/preventive diagnostic services (with the exception of all mammograms and the annual routine PAP test) and
- non-routine diagnostic services including preadmission testing

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**Impacted Products** Products that may have a cost sharing benefit design include:

- PPOBlue<sup>®</sup>
- DirectBlue<sup>®</sup>
- EPOBlue<sup>SM</sup>
- FreedomBlue<sup>SM</sup>

NOTE: Cost sharing provisions will not be noted on Member ID cards. Please review member benefits accordingly through NaviNet or by contacting Customer Service if you are not a NaviNet-enabled provider.

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**Five Categories Of Outpatient Diagnostic Services**

**Advanced Imaging Services:**

1. **Advanced Imaging Services** – include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

**Basic Diagnostic Services:**

2. **Standard Imaging Services** – procedures such as skeletal x-rays, ultrasound and fluoroscopy.

3. **Diagnostic Medical Services** – procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology tests.

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## 6.5 Cost Sharing on Outpatient Diagnostic Services, Continued

**Five Categories of Outpatient Diagnostic Services, continued**

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4. **Laboratory and Pathology Services** – procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures.
  5. **Allergy Testing Services** – allergy testing procedures such as percutaneous tests, intracutaneous tests and patch tests.
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**How Coinsurance Is Applied**

If a member has coinsurance, it is applied to all line items identified as outpatient diagnostic services either on Advanced Imaging only or also on the four categories of Basic Diagnostic Services depending on the benefit design selected.

The coinsurance amount (e.g., 80%) for the four categories of Basic Diagnostic Services is the same.

Coinsurance for outpatient diagnostic services is applicable to the total component, technical component and/or professional component only.

The member may be responsible for both a copayment and coinsurance when a service, such as an office visit or therapy service, and an outpatient diagnostic service are performed on the same date of service.

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**How Copayments Are Applied**

If a member has copayments on outpatient diagnostic services, they are applied per date of service and per type of diagnostic service. If services fall in more than one of the five diagnostic service categories (see above), multiple copayments can be applied. Please review the member's benefit program to determine if a copayment is owed on multiple services. Please note: For FreedomBlue, copayments are applied per date of service, per type of diagnostic service and also per provider.

Copayments may be applicable to only the advanced imaging services or also to all four categories of basic diagnostic services. The copayment amount for the advanced imaging services would usually be a higher amount (e.g., \$100). The copayment amount for the four categories of basic diagnostic services is the same (e.g., \$25 for each type of service).

Copayments are applied to the total component or technical component claims for outpatient diagnostic services. Copayments are not applied to professional component (26 modifier) only claims.

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## 6.5 Cost Sharing on Outpatient Diagnostic Services, Continued

### Examples of Multiple Copayments And/Or Coinsurance

1. If a PPOBlue member sees his cardiologist and receives an EKG during the visit, he would be responsible for two copayments: an office visit copayment and an outpatient diagnostic service copayment for the EKG (diagnostic medical service).
2. If a PPOBlue member receives an MRI (advanced imaging service), then has a spinal X-ray (standard imaging service) and lab work (laboratory/pathology service) on the same day – all as outpatient services – she would be responsible for three outpatient diagnostic copayments.
3. If an EPOBlue member sees his cardiologist and receives a stress test (diagnostic medical service) while there, he would pay an office visit copayment, and then would be responsible for any applicable coinsurance when the stress test claim is processed.
4. If a FreedomBlue member sees his cardiologist and receives an EKG (diagnostic medical service) while there and on the same day goes to another physician and receives a stress test (also a diagnostic medical service), he would be responsible for two copayments, one for each provider.

### Cost Sharing Exception

- All mammograms (routine and medically necessary) and the annual routine PAP tests are generally unaffected by the cost sharing benefit designs.
- Diagnostic services performed in conjunction with an Emergency Room visit would not be impacted in most cases.
- Especially for self-insured employer groups, there may be situations where cost sharing may apply in the above situations. Please be sure to review each service on a case-by-case basis.

### Determining If Members Have Cost Sharing

More information on outpatient radiology and other diagnostic services cost sharing can be easily accessed through NaviNet<sup>sm</sup> or by contacting Customer Service if you are not a NaviNet-enabled provider.

Log on to NaviNet and follow these steps:

1. Select *Eligibility and Benefits Inquiry* for a specific patient, then
2. Select *Outpatient Diagnostic Services*.
3. Scroll to the bottom of the benefits page to find any applicable copayment and coinsurance information.

## 6.5 Outpatient Laboratory Overview

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**Prescription Necessary**      PCPs and specialists need only give their members a prescription for the necessary lab tests and direct them to a network-participating lab.

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**Communication Between The PCP And Specialist**      Specialty practitioners should communicate with a member's PCP after a consultation visit so that laboratory services can be appropriately coordinated.

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**Designated Outpatient Lab Providers**      Network-participating hospitals provide outpatient lab services. In addition, there are several freestanding labs and specialty labs that are designated outpatient lab providers.

*NaviNet is the fastest method for accessing real-time lists of network participating providers.*

<i>Step</i>	<i>Action</i>
<i>1</i>	<i>Log In to NaviNet by accessing <a href="https://navinet.navimedix.com">https://navinet.navimedix.com</a></i>
<i>2</i>	<i>From Plan Central, select Network Facility Inquiry</i>
<i>3</i>	<i>Use the descriptive fields to narrow your search requirements by network, facility number, specialty description, etc.</i>  <i>NOTE: Laboratories can be found selecting Laboratory Medicine in the specialty description field.</i>
<i>4</i>	<i>Click Search to return requested information.</i>

*NaviNet is the preferred Highmark tool for inquiring about participating providers, however, if you are not NaviNet-enabled, please click the links below for a list of designated outpatient lab providers. Please select the appropriate region-specific link below:*

[Western Region Outpatient Lab Providers](#)

[What Region Am I?](#)

[Central Region Outpatient Lab Providers](#)

*If you are a provider who participates with Highmark and are interested or want more information about NaviNet, call your Highmark Provider Relations representative.*

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## 6.5 Outpatient Laboratory Overview, Continued

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**Note For  
Western Region  
Medicare  
Advantage  
HMO**

Laboratory services for members of Western Region Medicare Advantage HMO products may be provided by the appropriate network-participating hospital. In addition, members may also use other network laboratories at their convenience.

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