Commercial Reimbursement Policy

Subject: **Multiple Diagnostic Imaging – Facility**	
Policy Number: **C-17005**	Policy Section: **Facilities**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, Anthem will publish the most current policy to the website.

Policy

The Health Plan applies multiple imaging reimbursement rules for multiple diagnostic imaging procedures unless provider, state, or federal contracts and/or mandates indicate otherwise.

When two or more diagnostic imaging procedures are performed in the same facility, on the same member, using the same modality, during the same imaging session; reimbursement is 100% of the highest facility allowance for the first imaging procedure for the date of service, and 50% of the facility allowance for each subsequent imaging procedure for the same date of service.

Multiple diagnostic imaging reimbursement rules are applied to the highest facility allowance of the following diagnostic imaging procedures rendered on the same date of service and eligible for reimbursement:

- ultrasound
- computed tomography (CT)
- computed tomographic angiography (CTA)
- magnetic resonance imaging (MRI)
- magnetic resonance angiography (MRA)

Multiple diagnostic imaging reimbursement rules are not limited to contiguous body areas.

This policy applies to all UB-04 submitters billing the Health Plan for reimbursement of Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (Level II HCPCS®) codes for the type of diagnostic imaging procedures identified above.

Related Coding

Modifier	Description	Comments
LT	Left side (used to identify procedures performed on the left side of the body)	If a diagnostic imaging procedure with an MPI of 4 is performed bilaterally, report the service on two lines and include the side-specific modifiers LT and RT.
RT	Right side (used to identify procedures performed on the right side of the body)	
TC (Technical Component)	Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles	Reimbursement for subsequent procedures is based on 50% of the fee allowance.

Policy History

04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: updated Related Coding section to include modifiers; updated Definition section for clarity
11/06/2020	Review approved: added an introductory sentence and removed TC modifier language
06/01/2019	Revised: added related-coding, Exemption, Reference, Definition, and Related Policies and Materials sections
04/06/2018	Revised: “multiple modality” reference updated to “same modality”
08/17/2017	Initial approval 08/17/2017 and effective 05/01/2018

References and Research Materials

This policy has been developed through consideration of the following:

- Business decision
- CMS
- Merriam-Webster Dictionary

Definitions

Contiguous body areas	In actual contact: touching along a boundary or at a point
Modality	(An apparatus for applying) a usually physical therapeutic agency
General Reimbursement Policy Definitions	

Related Policies and Materials

None

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.