Commercial Reimbursement Policy

Subject: **Multiple Diagnostic Imaging Procedures – Professional**	
Policy Number: **C-11004**	Policy Section: **Radiology**
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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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 follows CMS guidance in applying multiple procedure payment reduction (MPPR) of diagnostic imaging procedures that have a multiple procedure indicator (MPI) of 4 of the CMS National Physician Fee Schedule (NPFS) unless provider, state, or federal contracts and/or mandates indicate otherwise.

Multiple diagnostic-imaging procedures will be subject to a MPPR when services are performed by the same provider or provider group, on the same date of service, and during the same member encounter.

The global procedure, professional component, and technical component of diagnostic imaging procedures will reimburse at 100% of the highest Relative Value Unit (RVU) allowance for each

professional component and technical component service. Reimbursement of the second or subsequent procedures is based on:

- 95% of the professional component
- 50% of the technical component

When two or more imaging procedures with an MPI of 4 are reported as global imaging procedures performed by the same provider on the same patient during the same imaging session, the primary imaging procedure will be the procedure with the highest global RVUs for the date of service. The primary imaging procedure will be eligible for 100% of the allowance for that procedure. For all other imaging procedures with an MPI of 4 rendered on that date of service that are reported globally by the same provider on the same patient during the same imaging session, the technical component RVU and professional component RVU will be identified separately and eligible reimbursement will be calculated as follows:

- The technical component RVU will be reduced by 50%
- The professional component RVU will be reduced by 5%
- These two values are added together to obtain a new RVU value to be used in the calculation
- The new RVU value is then divided by the original total global RVU and multiplied by 100 to determine what percent of the global value is to be applied to the imaging procedures
- The original fee-schedule global allowance is then multiplied by this new percentage value (which is rounded up) to determine the allowance for the imaging procedure with an MPI of 4

Multiple imaging reimbursement rules will also be applied to the eligible imaging codes if modifiers 76 or 77 (repeat procedure) are reported. These modifiers do not indicate to the Health Plan that the repeat procedure was performed as a distinct procedural service at a separate session/encounter.

A single imaging procedure is subject to the multiple diagnostic imaging reductions when submitted with multiple units.

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)	
26 (Professional Component)	Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified	Reimbursement for subsequent procedures is based on 95% of the RVU.

	by adding modifier 26 to the usual procedure number.	
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 RVU.

Policy History

04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: updated Related Coding section to include modifiers; updated Definitions section
11/06/2020	Review approved: added language regarding professional component reimbursement and changed reimbursement for the professional component in the calculation; added language for same provider group; moved section III bilateral language to related coding table and updated definitions; 5% reduction on the professional component effective 01/01/2022
06/01/2019	Policy template updated: added related-coding, exemption, reference, definition, and related-materials sections
08/03/2018	Review approved: moved code descriptions into policy description section, added clarifying language “for TC only,” and removed section C for being redundant
10/04/2016	Review approved: no changes
09/01/2015	Review approved: added language to include “same provider, same patient during the same imaging session”
09/02/2014	Review approved: removed references to modifier 59; modifier 59 does not override the pay percent rule
09/03/2013	Review approved: language changed to provide a specific example of the reduction calculation
09/11/2012	Review approved: language changed to focus on technical component only; language added to indicate rules do not apply to the professional component
09/13/2011	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023

Definitions

Professional Component	The portion of the service involving the interpretation of the collected information by a physician or other practitioner
Technical Component	The portion of the service that involves the collection of information from the patient
General Reimbursement Policy Definitions	

Related Policies and Materials

Modifier 26 and TC: Professional and Technical Component – Professional
Modifier Rules – Professional

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.