Reimbursement Policy

Subject: Multiple Radiology Payment Reduction

Effective Date: **04/20/18**	Committee Approval Obtained: **04/20/18**	Section: **Radiology**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://mediproviders.anthem.com/nv**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem). 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 CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating 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.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Anthem reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Anthem allows professional and facility reimbursement for multiple diagnostic imaging procedures unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Multiple diagnostic imaging procedures will be subject to a multiple procedure payment reduction when services are performed by the same provider or provider group on the same date of service during the same patient encounter. The global, professional component and technical component of diagnostic imaging procedures will reimburse at 100% of the

Anthem Blue Cross and Blue Shield Healthcare Solutions is the trade name of Community Care Health Plan of Nevada, Inc., an independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
ANV-RP-0113-19 May 2019

	contracted/negotiated rate for each professional component and technical component service with the highest payment. Reimbursement of subsequent services is based on: • 95% of the professional component. • 50% of the technical component. A reduced allowance for the second and subsequent procedures will not apply when multiple imaging procedures are billed appended with Modifier 59 or X{EPSU} to indicate the procedure was done on the same day but not during the same session. A single imaging procedure is subject to the multiple imaging reductions when submitted with multiple units. Note: The PC modifier is defined as wrong surgery on a patient. It should not be used to represent the professional component of a service. Claims that incorrectly use this modifier may be denied. Claims with this modifier used incorrectly must be resubmitted as a corrected claim and indicate the appropriate coding for the service(s) rendered.
History	• Biennial review approved and effective **04/20/18:** Professional and facility reimbursement language added • Review approved **12/15/17**: Provider group and X{EPSU} modifiers language added • Review approved **09/28/17**: Policy template updated • Review approved **07/19/17** and effective **03/15/18**: Professional component reduction language added • Biennial review approved **03/08/17**: "Certain" language removed • Review approved **07/14/16:** Policy template updated • Initial approval and effective date: **04/09/12**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU) • Modifier Usage
Related Materials	• None