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## Reimbursement Policy

# Multiple Radiology Payment Reduction

Policy Number: G-12002

Policy Section: Radiology

Last Approval Date: 12/10/2024

Effective Date: 04/01/2026

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to <https://anthem.com/provider>.

### Policy

The health plan 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 with the CMS National Physician Fee Schedule (NPFs) multiple procedure indicator (MPI) of 4 will be subject to a multiple procedure payment reduction (MPPR) when services are performed by the same care provider or care provider group on the same date of service during the same member encounter.

The global procedure, professional component, or technical component of diagnostic imaging procedures will reimburse at 100% of the contracted/negotiated rate for each

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professional component and technical component service with the highest allowance. Reimbursement of subsequent procedures 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 reported 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 multiple imaging reductions when submitted with multiple units.

### Related Coding

Standard correct coding applies.

### Definitions

General Reimbursement Policy Definitions

### Related Policies and Materials

- Modifier Usage
- Modifiers 26 and TC
- Modifiers 59, XE, XP, XS, XU: Distinct Procedural Services

### References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2024
- State contract

### Policy History

- **12/10/2024** - Review approved 12/10/2024 and effective 04/01/2026; added language of MPI 4 to policy body, removed language 'CT scan services are not subject to a multiple procedure payment reduction'
- **08/15/2022** - Review approved: policy template updated; minor language changes to policy section
- **06/24/2020** - Review approved: minor changes
- **04/20/2018** - Review approved: professional and facility reimbursement language added
- **12/15/2017** - Review approved: provider group and X{EPSU} modifiers language added; repetitive language removed
- **09/28/2017** - Review approved: policy template updated
- **07/19/2017** - Review approved 07/19/2017 and effective 03/15/2018: professional component reduction language added

- 03/08/2017 - Review approved 03/08/2017 and effective 09/15/2017: 'certain' language removed
- 07/14/2016 - Review approved: policy language updated; definition section updated
- 01/01/2015 - Initial approval and effective

## 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 a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural 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, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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, we will publish the most current policy to the website.