Amerigroup An Anthem Company	**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 the 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://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicare. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 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 participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Amerigroup Medicare Advantage 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage 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	Amerigroup Medicare Advantage 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. CT scan services are not subject to a multiple procedure payment reduction. The global, Professional Component, and Technical Component of diagnostic imaging procedures will reimburse at 100 percent of the contracted/negotiated rate for each Professional Component and Technical Component service with the highest payment. Reimbursement of subsequent services is based on: • 95 percent of the Professional Component • 50 percent 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; repetitive language removed • 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 and effective 09/15/17: "Certain" language removed • Review approved 07/14/16: Policy language updated; Definition section updated • Initial review approved and effective 01/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contract

Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU) • Modifier Usage
Related Materials	• None