RADIOLOGY SERVICES REIMBURSEMENT POLICY

File Name: radiology_services_reimbursement_policy
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Description

Many diagnostic services are composed of a technical and a professional component.

The **technical component** refers to the equipment and technician performing the test. It is identified by adding Modifier TC to the procedure code.

The **professional component** refers to the interpretation of the results of the test. When the professional component is reported separately the service may be identified by adding Modifier 26 to the procedure code. Interpretation of a diagnostic procedure includes a written report.

When multiple diagnostic imaging services are performed during a single session, most of the clinical labor activities and most supplies are not performed or furnished twice. The following clinical labor activities are performed once during the session and are duplicated for subsequent procedures, creating an overlap in the services comprising the separately billed technical components:

- Greeting the patient
- Positioning and escorting the patient
- Providing education and obtaining consent
- Retrieving prior exams
- Setting up the IV
- Preparing and cleaning the room

In addition, the supplies used are not duplicated for subsequent procedures.

Policy

The multiple procedure payment reduction on diagnostic imaging applies when multiple services are furnished by the same physician or physicians in the same group practice, to the same patient, in the same session, on the same day. The allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 50%. The allowance for the professional component of the primary procedure is 100%. The allowance for the professional component of the second and each subsequent imaging procedure is 95%.

Reimbursement Guidelines

Reimbursement will be determined based on 100% of the allowed amount for the primary procedure. The primary procedure is considered the service with the higher RVU of current year NC Medicare rates.

Services provided on an inpatient basis are not subject to the reduced allowance for the overlapping technical components.

When multiple procedures are obtained on the same patient in the same setting and billed on a global basis (technical and professional fees billed on one claim line), reduced allowance applies to the professional and technical components.

This policy applies to the following imaging procedures:

- Ultrasound
- MRI/MRA
- CT/CTA

High tech imaging services (CT, MRI, PET) in an outpatient setting may require prior review.

When the reduced allowance for technical components of multiple radiology services will be applicable:

The multiple procedure reduction applies to individual providers who furnish multiple services to the same patient in the same session on the same day as well as to providers in the same group practice who furnish multiple services to the same patient in the same session on the same day.

When the reduced allowance for technical components of multiple radiology services will not be applicable:

The reduced allowance for the second and subsequent procedures will not apply when:

- Multiple procedures are billed, appended with an appropriate modifier to indicate the procedure was done on the same day but not during the same session.
- If a global fee is charged by one provider, an additional component fee from another provider will not be reimbursed. (Global fees include both a professional and technical component.)

Rationale

In accordance with CMS, Blue Cross Blue Shield North Carolina (Blue Cross NC) will reduce reimbursement for multiple radiology services.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross NC web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Please reference the CMS Physician Fee Schedule Relative Value Files using the appropriate year and quarter for applicable codes.

Related policy

Bundling Guidelines

Modifier Guidelines

Multiple Surgical Procedure Guidelines for Professional Providers

Multiple Procedure Payment Reduction on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures

PRICING AND ADJUDICATION PRINCIPLES

References

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c13.pdf

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

History

11/21/12	Notification for policy effective date 1/21/2013. Note: this article is revised from the original version and replaces any other versions released. This medical policy was previously issued and later retracted pending an administrative hearing with the North Carolina Department of Insurance (NCDOI). The hearing process is now complete, and this policy is being reissued consistent with the hearing decision. You can view the NCDOI's final decision granting summary judgment in favor of BCBSNC on our website or at www.ncdoi.com.
5/26/17	Minor changes to Description section for clarity. Policy statement revised to read: **The multiple procedure payment reduction on diagnostic imaging applies when multiple services are furnished by the same physician or physicians in the same group practice, to the same patient, in the same session, on the same day. The allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 50%.** The "when reductions are applied" section revised to read: The multiple procedure reduction applies to individual providers who furnish multiple services to the same patient in the same session on the same day as well as to providers in the same group practice who furnish multiple services to the same patient in the same session on the same day. The following statement was added to the "when reductions are not applied" section: Multiple procedure payment reductions do not apply to professional component services. The following were added to the list of applicable codes: 70336, 70554, 72159, 73225, 74174, 75557, 75559, 75571, 75572, 75573, 75574, 76776, 76870. Code 76778 was deleted. **Notification 5/26/2017 for policy effective date 8/1/2017.** (an)
11/16/17	Policy statement revised with the addition of the following statement: The allowance for the professional component of the primary procedure is 100%. The allowance for the professional component of the second and each subsequent imaging procedure is 95%. The following statement was **removed** from the "Not Applicable" section: Multiple procedure payment reductions do not apply to professional component services. **Notification 11/16/2017 for policy effective date 1/15/2018.** (an)
12/31/18	Routine review. No change to policy. (an)
1/14/20	Routine policy review. Senior medical director approved 12/2019. No changes to policy statement. (an)

12/31/20	Routine policy review. Coding section updated with new code 71271. Added codes 74712, 76391, 76978, 76981, 76982, 77046, 77047, 77048, 77049. Removed codes 77058 and 77059. Medical director approved 12/2020. No changes to policy statement. **Policy notification given 12/31/2020 for effective date 3/9/2021. (eel)**
6/9/21	Policy format update. No changes to policy statement. (eel)
7/1/21	Coding section updated with new code 0648T. (eel)
12/30/21	Routine policy review. Grammatical corrections. Medical Director approved. (eel)
12/31/2022	Routine policy review. Minor revisions only. (ckb)
6/30/23	Updated coding section with instruction to reference CMS Physician Fee Schedule and removed coding grid. No change to policy intent. (eel)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.