IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY
You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee’s benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

UnitedHealthcare Community Plan uses a customized version of the Optum Claims Editing System known as iCES Clearinghouse to process claims in accordance with UnitedHealthcare Community Plan reimbursement policies.

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Policy
Overview

The UnitedHealthcare Community Plan policy is based on the Centers for Medicare and Medicaid Services (CMS) multiple imaging reduction concept.

UnitedHealthcare Community Plan agrees with CMS guidelines that when multiple radiology images are acquired in a single session, most of the clinical labor activities and most supplies are not performed or furnished twice. Specifically, UnitedHealthcare Community Plan considers that the following clinical labor activities, among others, are not duplicated for subsequent procedures:

- 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, UnitedHealthcare Community Plan considers that supplies, with the exception of film, are not duplicated for subsequent procedures. Equipment time and indirect costs are allocated based on clinical labor time; therefore, these inputs should be reduced accordingly.

When multiple imaging procedures are performed during the same patient session by the Same Group Physician and/or Other Health Care Professional, UnitedHealthcare Community Plan will reduce the Technical Component portion of the second and subsequent imaging procedure(s). The CMS National Physician Fee Schedule (NPFS) is utilized to determine which procedures are subject to the multiple imaging reduction concept, and thereby are subject to multiple imaging reductions.

Reimbursement Guidelines

The CMS NPFS Multiple Procedure Indicator (MPI) 4 denotes which procedures are subject to the multiple imaging reduction concept. All imaging procedures with a MPI of 4 on the CMS NPFS are categorized into one Diagnostic Imaging Family. Therefore, the reduction to the Technical Component of the second and any subsequent imaging service(s) will apply to all procedures with this MPI.
**Multiple Imaging Reduction Concept**

UnitedHealthcare Community Plan utilizes the CMS NPFS MPI 4 and relative value units to determine which radiology services are eligible for multiple imaging reductions.

Multiple imaging reductions apply when:

- Multiple imaging procedures with a MPI of 4 are performed on the same patient by the Same Group Physician and/or Other Health Care Professional during the Same Session.
- A single imaging procedure subject to the multiple imaging reduction concepts is submitted with multiple units. For example, code 73702 is submitted with 2 units. A multiple imaging reduction would apply to the second unit. The units are also subject to UnitedHealthcare Community Plan's Maximum Frequency Per Day Policy.

Multiple imaging reductions will not apply when:

- Multiple imaging procedures are billed, appended with modifier 26 for the Professional Component (PC) only. Multiple imaging reductions will not be applied to the Professional Component (PC).
- Multiple imaging procedures are billed, appended with Modifier 59 or Modifier XE to indicate the procedure was done on the same day but not during the Same Session.
- The imaging service does not have a CMS NPFS Multiple Imaging Indicator of 4. See the Diagnostic Imaging Services Subject to Multiple Imaging Reduction List in the attachment section below.

**Multiple Imaging Reductions**

When the Technical Component for two or more imaging procedures, subject to the multiple imaging reduction concept, is performed on the same patient by the Same Group Physician and/or Other Health Care Professional at the Same Session, UnitedHealthcare Community Plan will reduce the allowed amount for the Technical Component of the second and each subsequent procedure by 50%. In determining the reduction for the Technical Component, UnitedHealthcare Community Plan allows the lesser of the billed amount assigned to the Technical Component, or the contracted rate, for the Technical Component with an imaging reduction applied. UnitedHealthcare Community Plan will regard the procedure(s) with the lower total relative value units (RVUs) for the Technical Component as the secondary procedure(s).

When a provider bills globally for two or more procedures, subject to the multiple imaging reduction concept, for a patient at the Same Session, the charge for the Global Procedure Codes will be divided into the Professional and Technical Components using UnitedHealthcare Community Plan's standard Professional/Technical percentage splits.

- To review UnitedHealthcare Community Plan's standard Professional/Technical percentage splits, refer to the "Professional/Technical Component Policy."
- UnitedHealthcare Community Plan will then rank the Technical Components utilizing the CMS Non-Facility Total RVUs.
- The RVUs will determine which Technical Component will be ranked as primary, with no imaging reductions applied, and which Technical Component(s) will be ranked as secondary or subsequent, with imaging reductions applied.
- In determining the reduction for the Technical Component UnitedHealthcare Community Plan allows the lesser of the billed amount assigned to the Technical Component, using UnitedHealthcare Community Plan's standard Professional/Technical percentage splits, or the contracted rate, for the Technical Component with an imaging reduction applied.

**NOTE:** Imaging reductions will apply to percent of charge and discount contracts.

**Multiple Imaging Reduction and Modifier 59 or Modifier XE**

In those situations where the Same Group Physician and/or Other Health Care Professional performs more than one procedure subject to the multiple imaging reduction concept for the same patient on the same day but not during the Same Session, the procedure(s) done at the separate session should be
billed with either Modifier 59 or Modifier XE but not both. The use of one of these modifiers will signify a distinct imaging service was performed during a separate session, and that multiple imaging reductions should not be applied.

### Definitions

<table>
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<th>Term</th>
<th>Description</th>
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<tr>
<td><strong>Allowable Amount</strong></td>
<td>Defined as the dollar amount eligible for reimbursement to the physician or health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of Allowable Amounts. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.</td>
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<tr>
<td><strong>Diagnostic Imaging Families</strong></td>
<td>Radiology procedure codes arranged into a family based on modality and application to contiguous body areas.</td>
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<tr>
<td><strong>Global Procedure Code</strong></td>
<td>A Global Procedure Code includes both Professional and Technical Components. When a physician or other health care professional bills a Global Procedure Code, he or she is submitting for both the Professional and Technical Components of that code. Submission of a Global Procedure Code asserts that the physician or other health care professional provided the supervision and interpretation as well as the technician, equipment, and the facility needed to perform the procedure. The global procedure is identified by reporting the appropriate Professional Technical eligible procedure code with no modifier attached.</td>
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<tr>
<td><strong>Modifier 59</strong></td>
<td>Distinct Procedural Service. Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.</td>
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<tr>
<td><strong>Modifier XE</strong></td>
<td>Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter</td>
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<td><strong>Professional Component</strong></td>
<td>The Professional Component represents the physician or other health care professional work portion (physician work/practice overhead/malpractice expense) of the procedure. The Professional Component is the physician or other health care professional supervision and interpretation of a procedure that is personally furnished to an individual patient, results in a written narrative report to be included in the patient's medical record, and directly contributes to the patient's diagnosis and/or treatment. In appropriate circumstances, it is identified by appending modifier 26 to the designated procedure code or by reporting a standalone code that describes the Professional Component only of a selected diagnostic test.</td>
</tr>
<tr>
<td><strong>Same Group Physician and/or Other Health Care Professional</strong></td>
<td>All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification number.</td>
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<td><strong>Same Session</strong></td>
<td>A single patient encounter that encompasses all of the services performed by the same physician or other health care professional.</td>
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<tr>
<td><strong>Technical Component</strong></td>
<td>The Technical Component is the performance (technician/equipment/facility) of the procedure. In appropriate circumstances, it is identified by appending modifier TC to the designated procedure code or by reporting a standalone code that describes the Technical Component only of a selected diagnostic test.</td>
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Questions and Answers

1. Q: Which procedure would be primary when code 76604 (Ultrasound exam, chest, b-scan) and code 76831 (Echo exam uterus) are billed together by the Same Group Physician and/or Other Health Care Professional, and how would the multiple imaging reduction be applied?
   A: The PC/TC percentage splits would be applied to each code reported globally. 76831-TC has the higher CMS TC total RVU value of 2.33; therefore, it would be primary since 76604-TC has the lower CMS TC total RVU of 1.61. 76831-TC would be reimbursed at 100% of the Allowable Amount for the Technical Component, and 76604-TC would be reimbursed at 50% of the Allowable Amount for the Technical Component. No reductions would be applied to the Professional Components for 76831 or 76604. (The RVUs in this example are based on CMS NPFS RVU09AR)

2. Q: Does UnitedHealthcare Community Plan apply a multiple imaging reduction based on the place of service in which services are rendered?
   A: This policy will apply to all claims reported on a CMS-1500 claim form, regardless of place of service. However, it should be noted that procedures reported for the TC portion are additionally subject to UnitedHealthcare Community Plan’s Professional/Technical Component Policy which does not allow reimbursement for the TC portion in a facility setting.

3. Q: If the Same Group Physician and/or Other Healthcare Professional performs a complete ultrasound exam of the abdomen during a single session and reports code 76700, and it becomes necessary to then perform a repeat service later on the same day during a separate session which is reported with code 76700-76, will a multiple imaging reduction be applied to the repeated service reported as 76700-76?
   A: Yes, multiple imaging reductions will apply as the use of modifier 76 does not indicate that the imaging procedure was done at a separate session. The repeat procedure code 76700 should be appended with Modifier 59 or Modifier XE to indicate a distinct service was performed during a different session. Multiple imaging reductions will not apply to services appended with Modifier 59 or Modifier XE.

4. Q: How will the Same Group Physician and/or Other Health Care Professional, who is contracted at percent of charge rates, be reimbursed when reporting the Global Procedure Code for multiple imaging procedures which are subject to the multiple imaging reduction concept during the Same Session?
   A: The charges for the Global Procedure Code(s) will be divided into the PC and TC portions using UnitedHealthcare Community Plan’s standard Professional/Technical percentage splits, with the multiple imaging reduction applied to the charge(s) for the TC portion of the second and each subsequent procedure(s).

5. Q: When the Same Group Physician and/or Other Health Care Professional bills globally for two or more procedures which are subject to the multiple imaging reduction concept for a patient at the Same Session, and is also contracted with a specific rate for modifier TC, how is the Technical Component to be reduced determined?
   A: The charge for the Global Procedure Codes will be divided into the Professional and Technical Components using UnitedHealthcare Community Plan’s standard Professional/Technical percentage splits. Then the Technical Component(s) with the lesser RVU(s) will be considered reducible. The Allowable Amount is then determined based on the lesser of the charges assigned for modifier TC, using UnitedHealthcare Community Plan’s standard Professional/Technical percentage splits or contracted rate with an imaging reduction applied.

6. Q: A patient comes in for multiple chest studies, first an ultrasound (CPT 76604) is completed, and...
the patient is then moved to a different room for a CT angiography (CPT code 71275), would this be considered a separate session?

A: No, the need to move a patient to a different room does not constitute a separate session; it is a continuation of the same encounter.

Q: Effective January 1, 2011, CMS eliminated the 11 Diagnostic Imaging Families previously utilized to administer the multiple imaging reduction. When did UnitedHealthcare Community Plan eliminate the use of the 11 Diagnostic Imaging Families?

A: UnitedHealthcare Community Plan eliminated the use of the 11 Diagnostic Imaging Families and followed CMS use of a single Diagnostic Imaging Family for determining reductions effective with June 1, 2011 dates of service and after.

Attachments

Diagnostic Imaging Services Subject to Multiple Imaging Reduction List

This table identifies codes that are subject to multiple imaging reductions for the Technical Component and their TC Total RVUs (Non-Facility Total), as published in the CMS National Physician Fee Schedule. This list is effective for claims beginning with dates of service 6/1/2011.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History

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<tr>
<td>7/8/2015</td>
<td>Annual Approval Date Change (no new version)</td>
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<tr>
<td>3/8/2015</td>
<td>Application Section updated: removed reference to location of policy for MS Chip.</td>
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<tr>
<td>1/11/2015</td>
<td>Attachment Section – Updated List</td>
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| 1/1/2015  | Annual Policy Version Change  
Multiple Imaging Reduction Concept Section: Updated  
Multiple Imaging Reduction and Modifier 59 or Modifier XE Section: Updated  
Q&A #3: Updated  
Policy List Change: Diagnostic Imaging Services Subject to Multiple Imaging Reduction  
History Section: Entries prior to 1/1/2013 Archived |
| 9/19/2014 | Application Section: Updated  
Policy Change: Definitions, Q & A, and Resources sections updated (no new version) |
<p>| 8/4/2014  | Application Section: Removed reference to location of policy for Florida Medicaid and Rhode Island Medicaid, added “including, but not limited to” verbiage, and added verbiage stating this policy applies to UnitedHealthcare Community Plan Medicaid and Medicare products. |
| 3/31/2014 | Disclaimer: Revised |</p>
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<tr>
<td>1/27/2014</td>
<td>Annual Renewal of Policy Approved by United HealthCare Community &amp; State Payment Policy Committee</td>
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<tr>
<td>01/01/2014</td>
<td>Annual Version Change&lt;br&gt;Policy List Change: Diagnostic Imaging Services Subject to Multiple Imaging Reduction</td>
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<tr>
<td>11/17/2013</td>
<td>Definitions Section:&lt;br&gt;Same Group Physician and/or Other Health Care Professional added; Primary Procedure, Reductions, Secondary/Subsequent Procedure, Total Relative Value Units for the Technical Component removed;&lt;br&gt;All Policy Sections:&lt;br&gt;Same Individual or Other Health Care Professional replaced by Same Group Provider and/or Other Health Care Professional;&lt;br&gt;Defined terms capitalized</td>
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<tr>
<td>5/8/2013</td>
<td>Annual Renewal of Policy Approved by National Reimbursement Forum</td>
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<td>1/13/2013</td>
<td>Policy List Change: Diagnostic Imaging Services Subject to Multiple Imaging Reduction</td>
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<tr>
<td>1/1/2013</td>
<td>Annual Policy Version Change.&lt;br&gt;Reimbursement Guidelines Section: Updated.&lt;br&gt;Multiple Imaging Reduction Concept For Claims With Dates Of Service Through 5/31/2011 Section: Removed.&lt;br&gt;Multiple Imaging Reduction Concept Section: Updated.&lt;br&gt;Multiple Imaging Reductions Section: Updated.&lt;br&gt;Q&amp;A #3: Removed; Subsequent Q&amp;A entries renumbered.&lt;br&gt;Q&amp;A #8: Updated; renumbered to Q&amp;A #7.&lt;br&gt;Policy List Change: Diagnostic Imaging Services Subject to Multiple Imaging Reduction.&lt;br&gt;History Section: Entries prior to 11/22/2010 Archived.</td>
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