

Medicare Multiple Imaging Procedure Discount FAQ's

1. What is the “multiple imaging procedure discount” regulation and when does it take effect?

The “multiple imaging procedure discount” is part of the final 2006 Medicare Physician Fee Schedule (PFS), and it reduces the technical component payment for multiple imaging services performed on “contiguous body parts” in a single patient session.¹ That is, when a physician performs more than one imaging procedure within a designated family of imaging procedures on a given patient, the technical payment amount will be reduced. CMS (Centers for Medicare and Medicaid Services) has identified 11 families of imaging procedures by modality (CT, MR and Ultrasound) and it is only in situations when multiple imaging procedures involving contiguous body parts in a single session that the reduced payment rates will apply.

CMS will phase-in this change over 2 years. Effective January 1, 2006, when multiple imaging procedures on contiguous body parts in a select family are performed in a single session, Medicare will pay 100% of the highest priced procedure and then pay 75% of payment amount for all additional procedures within the same family. Thus, there would be a 25% payment discount applied to the second and subsequent procedures. Effective January 1, 2007, this will change, and CMS will pay 100% of the highest procedure payment rate and 50% for any additional procedures occurring in a single session with in the same family.

2. Which procedures are impacted by the PFS multiple-imaging procedure discount?

The PFS technical payment reductions only apply to selected families of procedures in CT, MR, and Ultrasound when multiple imaging services are performed in a single patient session on the same imaging modality and on contiguous body parts. The payment reduction applies only to individual procedure services within the same family. Each family has a different number of associated Current Procedural Terminology (CPT) codes. The 11 Families are:

- Family 1 - Ultrasound (Chest/Abdomen/Pelvis – non obstetrical)
- Family 2 – CT and CTA (Chest / Thorax / Abdomen / Pelvis)
- Family 3 – CT and CTA (Head / Brain / Orbit / Maxillofacial / Neck)
- Family 4 – MRI and MRA (Chest / Abdomen / Pelvis)
- Family 5 – MRI and MRA (Head / Brain / Neck)
- Family 6 – MRI and MRA (Spine)

¹ As published in the Federal Register, Volume 70, No. 223, November 21, 2005.

- Family 7 – CT (Spine)
- Family 8 – MRI and MRA (Lower Extremities)
- Family 9 – CT and CTA (Lower Extremities)
- Family 10 – MRI and MRA (Upper Extremities and Joints)
- Family 11 – CT and CTA (Upper Extremities)

3. Which Medicare payment components are affected by the multi-imaging procedure discount?

The “multiple imaging procedure discount” applies only to the technical, or facility, payment component of the imaging service when performed in a freestanding physician clinic or independent diagnostic testing facility (IDTF). It does not apply to the professional payment component in any site of service.

4. Does the “multi-imaging procedure discount” apply to Physician (or Professional) component?

No. The “multiple imaging procedure discount” does not apply to the professional component payment; thus, there is no reduction to the amount the physician will get paid for interpreting multiple images.

5. To which provider sites of care does the “multiple imaging procedure discount” apply?

The “multiple imaging procedure discount” applies only to freestanding physician offices and Freestanding Independent Diagnostic Facilities (IDTF) sites of care which are paid under the Medicare Physician Fee Schedule.

6. Does the “multi-imaging procedure discount” apply to the Hospital Outpatient or Hospital Inpatient sites of care?

No, not at this time. This payment change does not apply to Hospital Outpatient or Hospital Inpatient sites of care.

7. What impact does the “multiple imaging procedure discount” have on non-government or private payers?

Private Payers (e.g. Blue Cross Blue Shield, Aetna, Cigna) set their own reimbursement policies independently of CMS, and these policies are often not publicly available. So, providers should check with their private payers to see if they have similar policies.

8. Are all Diagnostic Imaging modalities impacted by the change?

No, only MR, CT and Ultrasound are impacted.

9. Are all MR, CT, and Ultrasound procedures impacted by this payment change?

No, only procedures that are contained in the 11 Diagnostic Imaging Families set forth by CMS. The specific procedures included in each of these families are provided at <http://new.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/pfs112105fr.pdf> (page 70264-70265). Procedures are only discounted if they are performed on contiguous body parts, in a single patient session and within the same family. Procedures performed in different families in a single session will be fully reimbursed.

10. How does CMS define a single session?

A single session is defined as one encounter where a patient could receive one or more radiological studies. If more than one imaging procedure in a single family is provided to the patient during one encounter the discount would be applied.

If a patient has a separate encounter on the same day for a medically necessary reason and receives a second imaging procedure from the same family, these would be considered multiple studies in multiple sessions. CMS has established that the physician should use modifier –59 to indicate multiple sessions and that the multiple procedure discount does not apply.²

11. What was the CMS rationale for this payment policy change?

CMS believes that when two (2) or more tests in the same family are performed on a Medicare patient during a session, there are duplicate payments being made and that cost savings should be realized for services only performed once in a session (e.g. greeting patient, retrieving prior exams).

² Federal Register / Volume 70, No. 223 / Monday, November 21, 2005, p. 70263