Priority Health	BILLING POLICY No. 028
RADIOLOGY PC/TC MULTIPLE SAME-DAY BILLING	
Date of origin: Aug. 2024	**Review dates: 11/2024, 2/2025**

APPLIES TO
All products

DEFINITION
When multiple radiological codes are billed during a single encounter with the same provider, a reduction will be applied to the professional component (PC) and technical component (TC).

POLICY SPECIFIC INFORMATION
Imaging codes billed in a single encounter from the same CMS-defined code family by any provider with the same tax ID will have a reduction applied.

The service with the highest allowed amount will be priced at 100% of the Priority Health fee schedule (login required).

- A **50% reduction** will be applied to each subsequent **technical component**.
- A **5% reduction** will be applied to each subsequent **professional component**.

These reductions will be described as MSD on the remittance advice.

Radiology codes subject to multiple same-day procedure reductions

- 2024 MSD Codes
- 2025 MSD Codes

Modifiers

- **Modifier 26** indicates a **professional component** only is being billed
- **Modifier TC** indicates a **technical component** only is being billed

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity

pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Nov. 26, 2024	Removed 2023 MSD Codes and added 2025 MSD Codes
Feb. 13, 2025	Added "Disclaimer" section