# Reimbursement Policy:

## Multiple Diagnostic Imaging Payment Reduction

## (Commercial)

| POLICY NUMBER | EFFECTIVE DATE: | APPROVED BY |
|---|---|---|
| RPC20210002 | 8/01/2020 | **RPC (Reimbursement Policy Committee)** |



## Overview:

EmblemHealth/ConnectiCare apply multiple procedure reduction when more than one diagnostic imaging procedure is performed in a single session to the same patient on the same day by providers who report under the same federal tax identification number (TIN).

Certain components of these services include most of the clinical labor activities and most supplies, with the exception of film, these are not performed or furnished twice. Equipment time and indirect costs are allocated based on clinical labor time, so these efforts should be reduced accordingly. Therefore, payment at 100% for secondary and subsequent diagnostic imaging procedure(s) would represent reimbursement for duplicative components of the primary procedure.

***Note: This policy does not apply to eviCore contracted providers***

## Policy Statement:

This policy aligns with the Centers for Medicare and Medicaid Services (CMS). EmblemHealth/ConnectiCare will consider codes in the National Physician Fee Schedule (NPFS) with Multiple Procedure Indicator (MPI) of 4 performed in a single session as eligible for Multiple Procedure Payment Reductions (MPPR) for Diagnostic Imaging.

EmblemHealth/ConnectiCare consider the primary diagnostic imaging procedure code allowable amount at 100%. The primary code is determined by the highest relative value unit (RVU).

EmblemHealth/ConnectiCare only reorders the primary procedure. Second and subsequent procedures subject to reduction are reduced and reimbursed based on the order in which they are billed.

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## MDIR applies when:

- Multiple diagnostic 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 (regardless of place of service).
- A single imaging procedure subject to MDIR is submitted with multiple units. For example, code 73702 is submitted with 2 units. MDIR would apply to the second unit.

## MDIR will *not* apply when:

- The diagnostic imaging procedure is the primary procedure as ranked based on the highest RVU assigned to the code (and modifier, when applicable), compared to other diagnostic imaging procedures billed during the Same Session.
- Multiple diagnostic imaging procedures are billed, appended with Modifier 59 or Modifier XE to indicate the procedure was performed on the same day but not during the Same Session.
- Multiple diagnostic imaging procedures are billed for the same patient on the same day but not by the Same Group Physician and/or Other Health Care Professional during the Same Session.
- The imaging service does not have an MPI of 4. *See the Diagnostic Imaging Procedures Subject to Multiple Imaging Reduction*

## Ordering MD Requirements:

- EmblemHealth/ConnectiCare may pend or deny your claim if you do not list the ordering provider. Diagnostic claims such as labs and/or radiology must include the ordering physician's name and NPI as well as TIN.

## Multiple Diagnostic Imaging Reduction (MDIR) Percentages:

| Multiple Diagnostic Imaging Reduction (MDIR) Percentages: | |
|---|---|
| **Professional Component** | In addition, when the PC for two or more imaging procedures subject to MDIR are performed on the same patient by the Same Group Physician and/or Other Qualified Health Care Professional at the Same Session, EmblemHealth/ConnectiCare will reduce the Allowed Amount for the PC of the second and each subsequent procedure by 5%.<br><br>The reduction is applied to the Allowed Amount for the PC component of the second and subsequent procedures.<br><br>EmblemHealth/ConnectiCare will regard the PC portion of the procedure(s) with the lower PC total RVUs, as subject to MDIR. |

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| **Technical Component** | When the technical component for two or more imaging procedures subject to MPPR for Diagnostic Imaging are performed on the same patient by the same physician during the same session, the allowed amount for the procedure with the highest RVU will be paid at 100% of the allowable amount; the second and subsequent procedure(s) will be paid at 50% of the allowable amount |
| **Multiple Diagnostic Imaging Procedures Billed Globally** | When a provider bills globally for two or more procedures subject to MDIR that are performed on the same patient by the same physician during the same session, the charge for the global procedure(s) will be reduced by the TC (indicated by modifiers 26 and TC) using EmblemHealth's/ConnectiCare's Professional/Technical percentage splits.<br><br>The highest RVU assigned to each component (26 and TC) will determine which code will be ranked as primary, with no reduction applied. Those that will be ranked as secondary or subsequent will have reductions applied. The TC will be reduced by 50%. |

**Example:** *Note: RVU values in the example below may not accurately reflect the current NPFS and are intended for illustrative purposes only.*

Code 76604 (Ultrasound Exam Chest) and code 76831 (Sonohysterography) are billed together by the Same Group Physician and/or Other Health Care Professional

- First, the PC/TC percentage splits would be applied to each code reported globally using EmblemHealth's/ConnectiCare's standard Professional/Technical percentage splits.
- Then the PC and TC portions with the lesser RVU(s) will be considered reducible as shown in the table below:

| Code | Modifier | PC Non-facility RVU | TC Non-facility RVU | RVU used for Ranking | MDIP Ranking |
|---|---|---|---|---|---|
| 76604 | 26 | .78 | N/A | .78 | Secondary (2) |
| 76604 | TC | N/A | 1.73 | 1.73 | Secondary (2) |
| 76831 | 26 | 1.03 | N/A | 1.03 | Primary (1) |
| 76831 | TC | N/A | 2.47 | 2.47 | Primary (1) |

- 76831-TC has the higher TC total RVU of 2.47; therefore, it would be primary and would be reimbursed at 100% of the Allowable Amount for the TC
- 76604-26 with the lower PC total RVU of .78 would be secondary and reimbursed by applying a 50% reduction to the Allowable Amount for the PC

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## Definitions:

| Term | Definition |
|---|---|
| **Allowable Amount** | Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount. |
| **CMS Multiple Procedure Indicator (MPI): 4** | CMS multiple radiology procedure reductions apply |
| **Modifier 59** | Distinct Procedural Service. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25. This modifier is allowable for radiology services. It may also be used with surgical or medical codes in appropriate circumstances. |
| **Modifier XE** | Separate encounter, a service that is distinct because it occurred during a separate encounter. |
| **Modifier 50** | Bilateral Procedure. Modifier applies to surgical procedures (CPT codes 10040-69990) and to radiology procedures performed bilaterally. Used to report bilateral procedures performed in the same session. |
| **Professional Component** | 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. |

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| **Relative Value Unit (RVU)** | RVUs are the basic component of the Resource-Based Relative Value Scale (RBRVS), which is a methodology used by the Centers for Medicare & Medicaid Services (CMS) and private payers to determine physician payment.<br><br>RVUs define the value of a service or procedure relative to all services and procedures. This measure of value is based on the extent of physician work, clinical and nonclinical resources, and expertise required to deliver the healthcare service to patients. In other words, the RVUs assigned to a procedure or service compares its value relative to other procedures or services. A service with 6 total RVUs means the resources consumed in delivering that service are 6 times greater than those consumed by a procedure with 1 RVU.<br><br>RVUs ultimately determine physician compensation when the conversion factor (CF) for a particular year, dollars per RVU, is applied to the total RVU. |
| **Same Group Physician and/or Other Healthcare Provider** | All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification Number (TIN) |
| **Same Session** | A single patient encounter that includes all of the services performed by the same physician or other health care professional |
| **Technical Component** | Portion of a health care service that identifies the provision of the equipment, supplies, technical personnel and costs associated to the performance of the procedure other than the professional services.<br><br>The technical component 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. |

## References:


1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services. CPT® is a registered trademark of the American Medical Association
2. Centers for Medicare & Medicaid Services, CMS Manual System and other CMS publications and services including but not limited to 2017 guidelines.
3. 2017 Guidelines: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9647.pdf
4. Centers for Medicare and Medicaid Services (CMS), Physician Fee Schedule (PFS) Relative Value Files. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

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## Revision History

| Company(ies) | DATE | REVISION |
|---|---|---|
| **EmblemHealth ConnectiCare** | 3/30/2022 | • Added CMS Multiple Procedure Indicator (MPI) “4” to definitions<br>• Added Relative Value Units (RVU) to definitions<br>• Added example of primary procedure determination using RVUs |
| **EmblemHealth ConnectiCare** | 2/08/2022 | • Updated policy to clarify that primary procedure is determined by highest RVU |
| **EmblemHealth ConnectiCare** | 7/2021 | • Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number |
| **ConnectiCare** | 6/2020 | • Updated policy to include professional component<br>• Updated policy to include Ordering MD Claim Requirement |