Reimbursement Policy:

Multiple Procedure Payment Reduction Cardiology/Ophthalmology (Commercial, Medicare, and Medicaid)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20230039	8/01/2020	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

This policy is based on the Centers for Medicare and Medicaid Services (CMS) Multiple Procedure Payment Reduction (MPPR) Policy.

EmblemHealth/ConnectiCare have adopted CMS guidelines that when multiple Diagnostic Cardiovascular Procedures or Diagnostic Ophthalmology Procedures are performed on the same day, most of the clinical labor activities are not performed or furnished twice.

Specifically, EmblemHealth/ConnectiCare consider 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.

Payment at 100% for secondary and subsequent procedures would represent reimbursement for duplicative components of the primary procedure.

CMS assigns Multiple Procedure Indicators (MPI) on the National Physician Fee Schedule (NPFS) to procedures that are subject to the MPPR Policy.

The codes with the following CMS multiple procedure indicators are addressed within this reimbursement policy:

- Multiple Procedure Indicator (MPI) 6 - Diagnostic Cardiovascular Procedures
- Multiple Procedure Indicator (MPI) 7 - Diagnostic Ophthalmology Procedures

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Multiple Diagnostic Cardiovascular Reductions (MDCR)

Except for those Global Test Only Codes, EmblemHealth/ConnectiCare utilize the CMS NPFS MPI of 6 and Non-Facility Total Relative Value Units (RVUs) to determine which Diagnostic Cardiovascular Procedures are eligible for MDCR to the TC portion of the procedure.

When the TC for two or more Diagnostic Cardiovascular Procedures are performed on the same patient by the Same Group Physician and/or Other Health Care Professional on the same day, EmblemHealth/ConnectiCare will apply a MDCR to reduce the Allowable Amount for the TC of the second and each subsequent procedure by 25%. No reduction is taken on the TC with the highest TC Non-Facility Total RVU according to the NPFS.

The MDCR applies to the Technical Component Only codes (PC/TC Indicator 3), and to the TC portion of Global Procedure Codes (PC/TC Indicator 1).

The MDCR <u>will</u> apply when:

- Multiple Diagnostic Cardiovascular Procedures with an MPI of 6 are performed on the same patient by the Same Group Physician and/or Other Health Care Professional on the same day.
- A single Diagnostic Cardiovascular Procedure subject to the MDCR is submitted with multiple units. For example, code 78445 is submitted with 2 units. A MDCR would apply to the TC of the second unit.

The MDCR <u>will not</u> apply when:

- Multiple Diagnostic Cardiovascular Procedures are billed, appended with modifier 26 for the Professional Component (PC) only. MDCRs will not be applied to the PC.
- The procedure does not have an MPI of 6.

Multiple Diagnostic Ophthalmology Reductions (MDOR)

EmblemHealth/ConnectiCare utilize the CMS NPFS MPI of 7 and Non-Facility Total RVUs to determine which Diagnostic Ophthalmology Procedures are eligible for MDOR to the TC portion of the procedure.

When the TC for two or more Diagnostic Ophthalmology Procedures are performed on the same patient by the Same Group Physician and/or Other Health Care Professional on the same day, EmblemHealth/ConnectiCare will apply a MDOR to reduce the Allowable Amount for the TC of the second and each subsequent procedure by 20%. No reduction is taken on the TC with the highest TC Non-Facility Total RVU according to the NPFS.

The MDOR applies to TC only services and the TC portion of Global Procedure Codes.

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The MDOR will apply when:

- Multiple Diagnostic Ophthalmology Procedures with an MPI of 7 are performed on the same patient by the Same Group Physician and/or Other Health Care Professional on the same day.
- A single Diagnostic Ophthalmology Procedure subject to MDOR is submitted with multiple units. For example, code 92060 is submitted with 2 units. A MDOR would apply to the TC of the second unit.

The MDOR will not apply when:

- Multiple Diagnostic Ophthalmology Procedures are billed, appended with modifier 26 for the PC only. MDORs will not be applied to the PC.
- The procedure does not have an MPI of 7.

Multiple Diagnostic Cardiovascular and Ophthalmology Procedures Billed Globally

When the Same Group Physician and/or Other Health Care Professional bills multiple Diagnostic Cardiovascular Procedure Global Procedure Codes (PC/TC indicator 1) or multiple Diagnostic Ophthalmology Procedure Global Procedure Codes (PC/TC indicator 1) the procedures will be ranked to determine which procedure(s) are considered secondary or subsequent as indicated below:

For Diagnostic Cardiovascular or Diagnostic Ophthalmology Global Procedure Codes (assigned PC/TC indicator 1):

- When a provider bills globally for two or more procedures subject to multiple diagnostic cardiovascular or ophthalmology reduction, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC) using CMS standard Professional/Technical percentage splits. Ranking is based on the TC Non-Facility Total RVU and a reduction of 25% will be applied for MDCR and 20% will be applied for MDOR.

For Diagnostic Cardiovascular Procedures Global Test Only Codes (PC/TC indicator 4):

- When a provider bills for two or more Diagnostic Cardiovascular Procedures represented by a Global Test Only code, a reduction of 25% will be applied to the corresponding Technical Component Only Code(s) (PC/TC Indicator 3). No reduction will apply to the corresponding Professional Component Only Code(s). Refer to Q&A #3 for an example of how the MDCR reduction is applied.

Diagnostic Cardiovascular Parent Child Table

Global Procedure	First TC Procedure	Second PC Procedure	Second TC Procedure	Second PC Procedure	Effective Date	Expiration Date
93000	93005	93010			20180601	29991231
93015	93017	93016		93018	20180601	29991231
93040	93041	93042			20180601	29991231
93224	93225	93227	93226		20180601	29991231
93268	93270	93272	93271		20180601	29991231
93784	93786	93790	93788		20180601	29991231

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Example # 1:

A provider bills Global Test Only Codes 93040 and 93268 (which are PC/TC Indicator 4). The example below explains how the TC portion is obtained in order to rank and apply MDCR to these Diagnostic Cardiovascular Procedures.

In order to obtain the TC portion of a Global Test Only Code, first refer to the Cardiovascular Parent Child Table which lists the TC and PC codes associated with each Global Test Only Code. Next, refer to the NPFS for the values of each TC code. If a Global Test Only Code has multiple TC codes, all TC code values would be added together for ranking purposes as shown in the example below.

Note: RVU values and dollar amounts in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Codes Billed	Recoded to PC Only Codes(s)	Recoded to TC Only Code(s)	TC Only Code(s)	Global Test Only Code	TC Only Total RVU / Global Test Only Total RVU	Total Charge	Technical Component Charge	Rank
Global Test Only Code 93268				5.73		$700.00		
1st TC Line		93270	.26+4.76= **5.02**		.26/5.73 = 5%	5% of $700=	$35.00	**1**
2nd TC Line		93271	4.76+.26= **5.02**		4.76/5.73 = 83%	83% of $700 =	$581.00	**1**
PC Line	93272						$84.00	**No Rank**
Global Test Only Code 93040				2.12		$600.00		
TC Line		93041	**1.09**		1.09/2.12 = 51%	51% of $600 =	$306.00	**2**
PC Line	93042						$294.00	**No Rank**

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Example # 2:

A provider bills Global Procedure Codes 75600 and 75726 and Technical Component Only Codes 93225 and 93702. The example below explains how the TC portion is obtained in order to rank and apply MDCR to these Diagnostic Cardiovascular Procedures.

When a provider bills globally for two or more procedures subject to MDCR, the charge for the Global Procedure Code will be divided into the PC and TC (indicated by modifiers 26 and TC). Ranking is based on the TC Non-Facility Total RVU of each code.

Note: RVU values and dollar amounts in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Code	TC Only Code(s) RVU	Global Code(s) RVU	TC Non-Facility Total RVU	Ranking
93702	3.05	N/A	3.05	2
75600	N/A	5.57	**4.88**	1
75726	N/A	4.23	2.65	3
93225	.75	N/A	.75	4

Diagnostic Cardiovascular and Ophthalmology Procedures with No Assigned CMS RVU

Services that CMS indicates may be carrier-priced, or those for which CMS does not develop RVUs are considered Gap Fill Codes and are addressed as follows:

0.00 RVU Codes: Some codes cannot be assigned a gap value or remain without an RVU due to the nature of the service (example: unlisted codes). Codes assigned an RVU value of 0.00 will not be included in the Diagnostic Cardiovascular Procedures or Diagnostic Ophthalmology Procedures Subject to CMS MPPR Policy lists below and therefore, will be excluded from ranking.

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References:

- Centers for Medicare and Medicaid Services (CMS) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7848.pdf
- American Medical Association, Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- Centers for Medicare and Medicaid Services, National Physician Fee Schedule (NPFS)

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	4/10/2024	• Updated policy with addition of Examples # 1 & 2 under Multiple Diagnostic Cardiovascular and Ophthalmology Procedures Billed Globally section
EmblemHealth ConnectiCare	9/13/2023	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number