

Multiple Procedure Payment Reduction (MPPR) for Diagnostic Cardiovascular and Ophthalmology Procedures Policy, Professional

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 reimbursement policies may use 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's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare 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 enrollees. 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, 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 due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare 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.

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Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent

of charge contract physicians and other qualified health care professionals.

Policy

Overview

The UnitedHealthcare Policy is based on the Centers for Medicare and Medicaid Services (CMS) Multiple Procedure Payment Reduction (MPPR) Policy. UnitedHealthcare has 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, UnitedHealthcare 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.

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

[CMS Physician Fee Schedule Relative Value Files](#)

Aligning with CMS, UnitedHealthcare independently ranks and applies reductions to the secondary and subsequent Technical Component(s) (TC) of multiple **Diagnostic Ophthalmology Procedures** as described in the Reimbursement Guidelines section below.

Also aligning with CMS, UnitedHealthcare independently ranks and applies reductions to the secondary and subsequent Technical Component(s) (TC) of multiple **Diagnostic Cardiovascular Procedures** as described in the Reimbursement Guidelines section below.

Reimbursement Guidelines

Multiple Diagnostic Cardiovascular Reductions (MDCR)

UnitedHealthcare utilizes 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, UnitedHealthcare 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), the TC portion of Global Procedure Codes (PC/TC Indicator 1) and codes that represent the TC of Global Test Only Codes (PC/TC Indicator 4).

The MDCR will 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 units allowed are also subject to UnitedHealthcare's Maximum Frequency Per Day Policy.

The MDCR will not 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 and is not included on the Diagnostic Cardiovascular Procedures Subject to MPPR lists in the Attachment section below.

Refer to the Attachment section for a listing of PC/TC Indicator 1, 3 and 4 codes.

Multiple Diagnostic Ophthalmology Reductions (MDOR)

UnitedHealthcare utilizes 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, UnitedHealthcare 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.

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 units allowed are also subject to UnitedHealthcare's Maximum Frequency Per Day Policy.

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 and is not included on the Diagnostic Ophthalmology Procedures Subject to MPPR list in the Attachment section below.

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) and/or Global Test Only Codes (PC/TC indicator 4); 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 UnitedHealthcare's standard Professional/Technical percentage splits. Refer to the UnitedHealthcare Employer & Individual Professional/Technical Component Policy for applicable PC/TC 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 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:

- Gap Fill Codes:** When data is available for Gap Fill Codes, UnitedHealthcare uses the RVUs published in the first quarter update of the Optum *The Essential RBRVS* publication for the current calendar year. A Diagnostic Cardiovascular Procedure or Diagnostic Ophthalmology Procedure assigned a gap value, will be denoted with an asterisk (*) next to the code in the applicable list below.
- 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 MPPR Policy Lists below and therefore, will be excluded from ranking.

Definitions	
Allowable Amount	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 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.
Diagnostic Cardiovascular Procedures	Those procedures listed in the Diagnostic Cardiovascular Procedures Subject to MPPR Policy Lists set forth in this policy.
Diagnostic Ophthalmology Procedures	Those procedures listed in the Diagnostic Ophthalmology Procedures Subject to MPPR Policy List set forth in this policy.
Gap Fill Codes	Codes for which CMS does not develop RVUs. Relative values are therefore assigned based on the first quarter update of Optum <i>The Essential RBRVS</i> publication for the current calendar year.
Global Service	A Global Service includes both a Professional Component and a Technical Component. When a physician or other qualified health care professional bills a Global Service, he or she is submitting for both the Professional Component and the Technical Component of that code. Submission of a Global Service asserts that the Same Individual Physician or Other Health Care Professional provided the supervision, interpretation and report of the professional services as well as the technician, equipment, and the facility needed to perform the procedure. In appropriate circumstances, the Global Service is identified by reporting the appropriate professional/technical split eligible procedure code with no modifier attached or by reporting a standalone code for global test only services.
Global Test Only Code	A Global Test Only Code is designated by a PC/TC indicator of 4 on the CMS NPFs. This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are separate but associated codes that describe the Professional Component of the test only code, and the Technical Component of the test only code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs

	for Global Test Only Codes equals the sum of the total RVUs for the Professional and Technical Component Only Codes combined.
Professional Component (PC)	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.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number.
Technical Component (TC)	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.
Technical Component Only Code	A Technical Component Only Code is designated by a PC/TC indicator of 3 on the CMS NPFS. This indicator identifies stand- alone codes that describe the Technical Component of selected diagnostic tests for which there is a separate but associated code that describes the Professional Component of the diagnostic test only. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for Technical Component Only Codes include values for practice expense and malpractice expense only.

Questions and Answers	
1	<p>Q: Does UnitedHealthcare apply a multiple diagnostic cardiovascular reduction or multiple diagnostic ophthalmology reduction based on the place of service in which services are rendered?</p> <p>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's Professional/Technical Component Policy which does not allow reimbursement for the TC portion in a facility setting.</p>
2	<p>Q: How will the Same Group Physician and/or Other Health Care Professional, who are contracted at percent of charge rates, be reimbursed when reporting the Global Procedure Code for multiple diagnostic cardiovascular or ophthalmology procedures which are subject to reduction?</p> <p>A: The charges for the Global Procedure Code(s) will be divided into the PC and TC portions using UnitedHealthcare's standard Professional/Technical splits. The MDCR or MDOR is applied to the Allowable Amount for the TC portion of the second and each subsequent procedure within the respective category of Diagnostic Cardiovascular Procedures or Diagnostic Ophthalmology Procedures.</p>
3	<p>Q: If the provider bills Global Test Only Codes 93040 and 93268 (which are PC/TC Indicator 4), how is the TC portion obtained in order to rank and apply MDCR to these Diagnostic Cardiovascular Procedures?</p> <p>A: 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.</p> <p>Example: Note: The RVUs in this example are intended for illustrative purposes only</p>

Codes Billed	Recoded to PC Only Code(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(s)	Rank
Global Test Only Code 93268				5.73		\$700.00		
1 st TC Line		93270	.26+4.76= 5.02		.26/5.73 = 5%	5% of \$700 =	\$35.00	1
2 nd TC Line		93271	4.76+.26 = 5.02		4.76/5.73 = 83%	83% of \$700 =	\$581.00	1
PC Line	93272						\$84	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	No rank

Q: Are there any modifiers that will override MDCR or MDOR?
A: No, in accordance with CMS MPPR Policy, both MDCR and MDOR apply when multiple procedures are performed on the same day regardless if they were performed at the same or separate sessions.

Q: If the provider bills Global Procedure Codes 75600 and 75726 and Technical Component Only Codes 93225 and 93702, how is the TC portion obtained in order to rank and apply MDCR to these Diagnostic Cardiovascular Procedures?
A: 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) using UnitedHealthcare's standard Professional/Technical percentage splits included in the Professional/Technical Component Policy. Ranking is based on the TC Non-Facility Total RVU of each code and can be found in the Attachments section of the policy.

Example

Note: The RVUs in this example 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

Attachments: Please right-click on the icon to open the file



Diagnostic Cardiovascular

This table identifies codes that are subject to MDCR of the Technical Component and their TC Non-Facility Total RVU, as published in the CMS NPFS. Gap Fill Codes will be denoted with an asterisk (*).

Procedures Subject to MPPR (PC/TC Indicator 1)	
 Diagnostic Cardiovascular Procedures Subject to MPPR (PC/TC Indicator 3)	<p>This table identifies codes that are considered Technical Component Only codes that are subject to MDCR and their Non-Facility Total RVU, as published in the CMS NPFS. Gap Fill Codes will be denoted with an asterisk (*).</p>
 Global Cardiovascular Procedures (PC/TC Indicator 4)	<p>This table identifies Global Test Only Codes that are subject to MDCR using the Non-Facility Total TC RVU of the Technical Component Only Codes (child codes), as published in the CMS NPFS. Gap Fill Codes will be denoted with an asterisk (*).</p>
 Diagnostic Cardiovascular Parent Child Table	<p>This table identifies Global Test Only Codes that are subject to MDCR, known as Parent codes, and their corresponding Technical Component Only Code(s) and Professional Component Only Code(s), known as Child codes.</p>
 Diagnostic Ophthalmology Procedures Subject to MPPR (PC/TC Indicator 1)	<p>This table identifies codes that are subject to MDOR of the Technical Component and their TC Non-Facility Total RVU, as published in the CMS NPFS. Gap Fill Codes will be denoted with an asterisk (*).</p>

Resources
<p>American Medical Association, <i>Current Procedural Terminology (CPT®)</i> and associated publications and services</p> <p>Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files</p> <p>Optum “<i>The Essential RBRVS</i>” 1st Quarter Update</p>

History	
8/12/2019	<p>Policy Version Change</p> <p>Overview: Removed reference to 6/1/2018 implementation date of Global Test Only Codes</p> <p>Reimbursement Guidelines: Updated ‘Multiple Diagnostic Cardiovascular and Ophthalmology Procedures Billed Globally’</p> <p>Q&A section: Updated Q&A #3</p>
1/13/2019	<p>Policy Version Change</p> <p>Policy List Changes: Updated Cardiovascular Procedures (Indicator 1) list</p>
1/1/2019 – 1/12/2019	<p>Policy Version Change</p> <p>Adding ‘Professional’ to the policy title</p> <p>Application section: Removed Community and State and Medicare and Retirement information</p> <p>Policy List Changes: Updated Cardiovascular Procedures (Indicator 1, 3 and 4) and Ophthalmology Procedures (Indicator 1)</p> <p>Definitions: Updated Gap Fill Codes, Same Group Physician, and added Global Service</p> <p>History Section: Entries prior to 1/1/2017 archived</p>
6/1/2018 – 12/31/2018	<p>Policy List Changes: Added Global Cardiovascular Procedures (PC/TC Indicator 4) and Diagnostic Cardiovascular Parent Child Table.</p> <p>Policy Verbiage Change: Added information on Global Test Only Codes being subject to reduction as of 6/1/2018 dates of service.</p>



3/14/2018	Annual Approval Date only (no new version)
1/1/2018 – 5/31/2018	Annual Policy Version Change Policy List Changes: Updated Cardiovascular Procedures (Indicator 1 and 3) and Ophthalmology Procedures (Indicator 1)
10/8/2017	Policy Logo, Preamble and Footer have been updated (no new version)
3/8/2017	Annual Approval Date only (no new version)
1/8/2017 – 12/31/2017	Policy List Change: Updated Cardiovascular Procedures (PC/TC Indicator 1) list with 2017 gap value for CPT 93318
1/1/2017 – 1/7/2017	Annual Policy Version Change Policy List Changes: Updated Cardiovascular Procedures (Indicator 1 and 3) and Ophthalmology Procedures (Indicator 1)