

Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 Medicare Advantage reimbursement policies 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 (CMS 1450). 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 resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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*** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.*

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 Medicare Advantage policy is based on the Centers for Medicare and Medicaid Services (CMS) Multiple Procedure Payment Reduction (MPPR) Policy for those diagnostic imaging procedures where CMS assigns a

Multiple Procedure Indicator (MPI) of 4 on the CMS National Physician Fee Schedule (NPFS).

UnitedHealthcare Medicare Advantage has adopted CMS guidelines that when multiple diagnostic imaging procedures are performed in a single session, most of the clinical labor activities and most supplies, with the exception of film, are not performed or furnished twice. Equipment time and indirect costs are allocated based on clinical labor time; therefore, these inputs should be reduced accordingly. Specifically, UnitedHealthcare Medicare Advantage 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 diagnostic imaging procedure(s) would represent reimbursement for duplicative components of the primary procedure.

Reimbursement Guidelines

Multiple Diagnostic Imaging Reductions (MDIR)

Diagnostic Imaging services subject to the multiple procedure rules are assigned a MPI of “4” on the NPFS. The Multiple Procedure Payment Reduction will be applied by payment amount. The service with the highest payment amount will be allowed at 100%. Payment for subsequent procedures will be based on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage as set forth.

UnitedHealthcare Medicare Advantage utilizes the CMS NPFS MPI of 4 and the Allowable Amount to determine which diagnostic imaging procedures are eligible for MDIR. Different MDIR percentages apply to the Professional Component (PC) and Technical Component (TC) portion of Global Services.

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.
- 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 Allowable Amount 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 Lists in the attachment section below.

Multiple Diagnostic Imaging Reduction Percentages

When the TC for two or more imaging procedures subject to MDIR are performed on the same patient by the Same Group Physician and/or Other Health Care Professional during the Same Session, UnitedHealthcare Medicare Advantage will reduce the Allowable Amount for the TC of the second and each subsequent procedure by 50%. UnitedHealthcare Medicare Advantage will regard the TC portion of the procedure(s) with the lower TC Allowable Amount, as subject to MDIR.

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 Health Care Professional at the Same Session, UnitedHealthcare Medicare Advantage will reduce the Allowable Amount for the PC of the second and each subsequent procedure by 25% for dates of service 1/1/2012 through 12/31/2016. Effective for dates of service on or after 1/1/2017, a 5% reduction is applied to the Allowable Amount for the PC component of the second and subsequent procedures. UnitedHealthcare Medicare Advantage will regard the PC portion of the procedure(s) with the lower PC Allowable Amount, as subject to MDIR.

Multiple Diagnostic Imaging Procedures Billed Globally

- Full payment is made for each PC and TC service with the highest payment under the NPFS.
- Effective with claims date of service (DOS) on or after January 1, 2012 payment is made at 75 percent for subsequent PC services. Effective with claims with DOS on or after January 1, 2017 payment is made at 95 percent for subsequent PC service. These percentages apply for services furnished by the Same Group Physician and/or Other Health Care Professional to the same patient in the Same Session on the same day.
- Payment is made at 50 percent for subsequent TC services furnished by the Same Group Physician and/or Other Health Care Professional to the same patient in the Same Session on the same day.
- The individual PC and TC services with the highest payments under the NPFS of globally billed services must be determined in order to calculate the reduction.

As an example, the proposed payments are summarized in the following table:

	Procedure	Procedure	1/1/2012 through 12/31/2016	Effective DOS January 1, 2017
	1	2	Total Payment	Total Payment
PC	\$100.00	\$80.00	\$160 (\$100 + (.75 x \$80))	\$176 (\$100 + (.95 x \$80))
TC	\$500.00	\$400.00	\$700 (\$500 + (.50 x \$400))	\$700 (\$500 + (.50 x \$400))
Global	\$600.00	\$480.00	\$860 (\$600 + (.75 x \$80) + (.50 x \$400))	\$876 (\$600 + (.95 x \$80) + (.50 x \$400))

Definitions

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.
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.
Payment Reduction	Indicates the percentage decrease in reimbursement calculated from the allowable amount on the claim.
Professional Component (PC)	The Professional Component represents the physician or other qualified 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 Health Care Professional	All physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number.
Same Session	A single patient encounter that encompasses all of the services performed by the same physician or other health care professional.
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.

Questions and Answers

1	<p>Q: Does UnitedHealthcare Medicare Advantage apply a MDIR based on the place of service in which services are rendered?</p> <p>A: This policy applies to all claims reported on the CMS-1500 claim or its electronic equivalent (837P), regardless of place of service.</p>
2	<p>Q: Does the MPPR for Diagnostic Imaging services apply to facilities?</p> <p>A: The Payment Reduction methodology described in this policy applies to multiple diagnostic imaging services furnished by the same physician, or by the Same Group Physician and/or Other Health Care Professional, to the same patient in the Same Session on the same day.</p>
3	<p>Q: If the Same Group Physician and/or Other Health Care Professional performs a complete ultrasound exam of the abdomen during a single session and reports code 76700, and it becomes necessary to then perform a repeat service later on the same day during a separate session which is reported with code 76700-76, will a multiple imaging reduction be applied to the repeated service reported as 76700-76?</p> <p>A: Yes, multiple imaging reductions will apply as the use of modifier 76 does not indicate that the imaging procedure was done at a separate session. The repeat procedure code 76700 should be appended with either Modifier 59 or XE (but not both) to indicate a distinct service was performed during a different session. Multiple imaging reductions will not apply to services appropriately billed with Modifier 59 or XE.</p>
4	<p>Q: A patient comes in for multiple chest studies, first an ultrasound (CPT code 76604) is completed, and the patient is then moved to a different room for a CT angiography (CPT code 71275). Would this be considered a separate session?</p> <p>A: No, the need to move a patient to a different room does not constitute a separate session; it is a continuation of the same encounter.</p>

Codes

[National Physician Fee Schedule Relative Value File](#)

Modifier code section

TC	Technical Component
XE	Separate Encounter
26	Professional Component
59	Distinct Procedural Service

Resources

www.cms.gov

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History

5/3/2019	Annual Anniversary Date and Version Change <ul style="list-style-type: none"> • Policy template updated; Template header and title change to add the word “Professional”. • Reimbursement Guidelines section: Update verbiage; PC/TC table- changed from “Current” to “1/1/2012-12/31/2016”. • Definition section: Added “PC” after Professional Component; added “TC” after Technical Component; omitted modifiers XE and 59 from list and updated verbiage. • Code section: Updated modifier verbiage. • History Section: Entries prior to 5/3/2017 archived
8/31/2018	Policy number changed from 2018R0085A (new version) Added the word ‘Professional’ to the policy title
7/11/2018	Annual Policy Review New Version Updated Overview Added definitions Added sections: Multiple Diagnostic Imaging Reductions (MDIR), Multiple Diagnostic Imaging Reduction Percentages, Multiple Diagnostic Imaging Procedures Billed Globally History Section: Entries prior to 1/1/2017 archived
7/12/2017	Annual Policy Review Version Change
2/11/2015	Annual Review