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 Community Plan reimbursement policies uses 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 Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.*

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, 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 Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan 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 UnitedHealthcare Community Plan Medicaid Product.

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 Community Plan policy is based on the Centers for Medicare and Medicaid Services (CMS) Multiple Procedure Payment Reduction (MPPR) Policy. UnitedHealthcare Community Plan 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 Community Plan 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 6 - Diagnostic Cardiovascular Procedures
- Multiple Procedure Indicator 7 - Diagnostic Ophthalmology Procedures

The edits administered by this policy may be found in the following link using the appropriate year and quarter referencing the “MULT PROC” column:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

Aligning with CMS, UnitedHealthcare Community Plan 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 Community Plan 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 Community Plan utilizes the CMS NPFS MPI 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.

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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 Community Plan 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) and codes that represent the TC of Global Test Only Codes (PC/TC Indicator 4).

The edits administered by this policy may be found in the following link using the appropriate year and quarter referencing the "PCTC IND" column:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

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 Community Plan's Maximum Frequency Per Day Policy.

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.

Multiple Diagnostic Ophthalmology Reductions (MDOR)

UnitedHealthcare Community Plan 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 Community Plan 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.

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 Community Plan's Maximum Frequency Per Day Policy.

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.

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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 Community Plan's standard Professional/Technical percentage splits. Refer to UnitedHealthcare Community Plan's 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 Parent Child Table

Global Procedure	First TC Procedure	First 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

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 Community Plan 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.

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State Exceptions	
Arizona	This policy only applies to participating providers for Arizona Medicaid
Indiana	Indiana is exempt from Multiple Procedure Payment Reduction for Diagnostic Cardiovascular and Ophthalmology Procedures
Kansas	Kansas is exempt from Multiple Procedure Payment Reduction for Diagnostic Cardiovascular and Ophthalmology Procedures
Wisconsin	Wisconsin is exempt from Multiple Procedure Payment Reduction for Diagnostic Cardiovascular and Ophthalmology Procedures

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 Allowable Amounts, 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 List(s) 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 *The Essential RBRVS* 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 Components 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

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	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	**Q:** Does UnitedHealthcare Community Plan apply a multiple diagnostic cardiovascular reduction or multiple diagnostic ophthalmology reduction based on the place of service in which services are rendered? **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 Community Plan's Professional/Technical Component Policy which does not allow reimbursement for the TC portion in a facility setting.
2	**Q:** How will the Same Group Physician and/or Other Health Care Professionals, 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 the reduction? **A:** The charges for the Global Procedure Code(s) will be divided into the PC and TC portions using UnitedHealthcare Community Plan 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.
3	**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? **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. **Example:** Note: The RVUs in this example are intended for illustrative purposes only

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

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Global Test Only Code 93268				5.73		$700.00		
1st TC Line		93270	.26+4.76 = **5.02**		.26/5.73 = 5%	5% of $700.00=	$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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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.

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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 Community Plan 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	3.50	N/A	3.50	**2**
75600	N/A	5.67	**4.98**	**1**
75726	N/A	4.23	2.65	**3**
93225	.75	N/A	.75	**4**

Resources

Individual state Medicaid regulations, manuals & fee schedules

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

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

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Optum "*The Essential RBRVS*" 1st Quarter Update

History	
1/1/2024	Policy Version Change Annual Version Update
8/29/2022	Policy Version Change State Exception Section: Verbiage update for Wisconsin
7/28/2022	Policy Version Change State Exception Section: Wisconsin added
1/1/2022	Policy Version Change History Section: Entries prior to 1/01/2020 archived
7/19/2021	Policy Version Change State exceptions section: Indiana exemption added
5/27/2021	Policy Version Change Attachments Section: Removed attachment(s) and converted to table(s) and direct links History Section: Entries prior to 8/12/2019 archived
3/28/2021	Policy Version Change Policy List Changes: Updated Ophthalmology Procedures (Indicator 1) list
1/17/2021	Policy Version Change Policy List Changes: Updated Cardiovascular Procedures (Indicator 1, 3 and 4) list and Ophthalmology Procedures (Indicator 1) list
1/1/2021	Policy Version Change Policy List Changes: Updated Cardiovascular Procedures (Indicator 1, 3 and 4) and Ophthalmology Procedures (Indicator 1) History Section: Entries prior to 1/1/2019 archived
3/23/2020	Policy Version Change State exceptions section: Removed reference to Louisiana Removed all files and references to Louisiana contained in the body of the policy, information has been moved to the "Louisiana Only" policy
1/12/2020	Policy Version Change Policy List Changes: Updated Cardiovascular Procedures (Indicator 1) list and Ophthalmology Procedures (Indicator 1) list
1/1/2020	Annual Anniversary Date and Version Change Policy List Changes: Updated Cardiovascular Procedures (Indicator 1, 3 and 4) and Ophthalmology Procedures (Indicator 1) History Section: Entries prior to 1/1/2018 archived
08/25/2015	Policy implemented by UnitedHealthcare Community Plan
12/12/2012	Policy approved by the National Reimbursement Forum now known as Payment Policy Oversight Committee

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