

MULTIPLE PROCEDURE PAYMENT REDUCTION (MPPR) FOR DIAGNOSTIC IMAGING POLICY

Policy Number: DIAGNOSTIC 053.2 TO

Effective Date: January 1, 2019

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Related Policies

- [Maximum Frequency Per Day](#)

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

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, 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.

OVERVIEW

The Oxford 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 National Physician Fee Schedule (NPFSS).

Oxford 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, Oxford 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.

In accordance with CMS, Oxford has considered multiple diagnostic imaging procedures assigned a MPI of 4, subject to a reduction for the Technical Component (TC) of imaging procedures ranked as secondary and subsequent as described below in the Multiple Diagnostic Imaging Reductions section.

In accordance with CMS, Oxford will apply reductions to the secondary and subsequent Professional Component (PC) of multiple diagnostic imaging procedures assigned a MPI of 4. Reductions will be applied as described below in the Multiple Diagnostic Imaging Reductions section.

REIMBURSEMENT GUIDELINES

Multiple Diagnostic Imaging Reductions (MDIR)

Oxford utilizes the CMS NPFS MPI of 4 and Non-Facility Total Relative Value Units (RVUs) to determine which radiology procedures are eligible for MDIR. Different MDIR percentages apply to the PC and 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. The units are also subject to Oxford's [Maximum Frequency Per Day](#) Policy.

MDIR will not apply when:

- The diagnostic imaging procedure is the primary procedure as ranked based on the 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 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, Oxford will reduce the Allowed Amount for the TC of the second and each subsequent procedure by 50%. Oxford will regard the TC portion of the procedure(s) with the lower TC total RVUs, 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, Oxford will reduce the Allowed Amount for the PC of the second and each subsequent procedure by 5%. The reduction is applied to the Allowed Amount for the PC component of the second and subsequent procedures. Oxford will regard the PC portion of the procedure(s) with the lower PC total RVUs, as subject to MDIR.

Multiple Diagnostic Imaging Procedures Billed Globally

When a provider bills globally for two or more procedures subject to MDIR, for a patient at the Same Session, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC) using Oxford's standard Professional/Technical percentage splits. The RVUs assigned to each component (26 or TC) will determine which code will be ranked as primary, with no reduction applied, and those that will be ranked as secondary or subsequent, with reductions applied in accordance with this policy. The components (26 or TC) will be ranked independently of each other utilizing the CMS Non-Facility Total RVUs.

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. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.

Global Procedure Code: A Global Procedure Code includes both Professional and Technical Components. When a physician or other health care professional bills a Global Procedure Code, he or she is submitting for both the Professional and Technical Components of that code. Submission of a Global Procedure Code asserts that the physician or other health care professional provided the supervision and interpretation as well as the technician, equipment, and the facility needed to perform the procedure. The global procedure is identified by reporting the appropriate Professional Technical eligible procedure code with no modifier attached.

Modifier 59: Distinct Procedural Service. Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.

Modifier XE: Separate Encounter. A service that is distinct because it occurred during a separate encounter.

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.

Same Group Physician and/or Other Health Care Professional: All physicians and/or other 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: 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	Q:	Which procedure would be primary when code 76604 (Ultrasound, chest) and code 76831 (Saline infusion sonohysterography) are billed together by the Same Group Physician and/or Other Health Care Professional, and how would the multiple imaging reduction be applied?																							
	A:	<p>First, the PC/TC percentage splits would be applied to each code reported globally using Oxford'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.</p> <ul style="list-style-type: none"> • 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-TC with the lower TC total RVU of 1.73 would be secondary and reimbursed by applying a 50% reduction to the Allowable Amount for the TC • 76831-26 has the higher PC total RVU of 1.03; therefore, it would be primary and would be reimbursed at 100% of the Allowable Amount for the PC • 76604-26 with the lower PC total RVU of .78 would be secondary and reimbursed by applying a 5% reduction to the Allowable Amount for the PC <p>Note: RVU values in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #e67e22; color: white;">Code</th> <th style="background-color: #e67e22; color: white;">Modifier</th> <th style="background-color: #e67e22; color: white;">PC Non-Facility Total RVU</th> <th style="background-color: #e67e22; color: white;">TC Non-Facility Total RVU</th> <th style="background-color: #e67e22; color: white;">RVU used for Ranking</th> <th style="background-color: #e67e22; color: white;">Multiple Diagnostic Imaging Ranking</th> </tr> </thead> <tbody> <tr> <td>76604</td> <td>26</td> <td>.78</td> <td>Not applicable</td> <td>.78</td> <td>2 - Secondary</td> </tr> <tr> <td>76604</td> <td>TC</td> <td>Not applicable</td> <td>1.73</td> <td>1.73</td> <td>2 - Secondary</td> </tr> <tr> <td>76831</td> <td>26</td> <td>1.03</td> <td>Not applicable</td> <td>1.03</td> <td>1 - Primary</td> </tr> </tbody> </table>	Code	Modifier	PC Non-Facility Total RVU	TC Non-Facility Total RVU	RVU used for Ranking	Multiple Diagnostic Imaging Ranking	76604	26	.78	Not applicable	.78	2 - Secondary	76604	TC	Not applicable	1.73	1.73	2 - Secondary	76831	26	1.03	Not applicable	1.03
Code	Modifier	PC Non-Facility Total RVU	TC Non-Facility Total RVU	RVU used for Ranking	Multiple Diagnostic Imaging Ranking																				
76604	26	.78	Not applicable	.78	2 - Secondary																				
76604	TC	Not applicable	1.73	1.73	2 - Secondary																				
76831	26	1.03	Not applicable	1.03	1 - Primary																				

		76831	TC	Not applicable	2.47	2.47	1 - Primary
2	Q:	Does Oxford apply a multiple imaging 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 Oxford's Professional/Technical Component Policy which does not allow reimbursement for the TC portion in a facility setting.					
3	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?					
	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.					
4	Q:	How will the Same Group Physician and/or Other Health Care Professional, who is contracted at percent of charge rates, be reimbursed when reporting the Global Procedure Code for multiple imaging procedures which are subject to the MDIR during the Same Session?					
	A:	The charges for the Global Procedure Code(s) will be divided into the PC and TC portions using Oxford's standard Professional/Technical splits, with MDIR applied to the Allowed Amount for the PC and TC portion of the second and each subsequent procedure.					
5	Q:	When the Same Group Physician and/or Other Health Care Professional bills globally for two or more procedures which are subject to MDIR for a patient at the Same Session, and is also contracted with a specific rate for modifier TC, how is the Technical Component to be reduced determined?					
	A:	The charge for the Global Procedure Codes will be divided into the Professional and Technical Components using Oxford's standard Professional/Technical percentage splits. Then the Technical Component(s) with the lesser RVU(s) will be considered reducible. The Allowable Amount is determined based on the lesser of the charges assigned for modifier TC using Oxford's standard Professional/Technical percentage splits or the contracted rate, with an imaging reduction applied.					
6	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?					
	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.					

ATTACHMENTS

Diagnostic Imaging Procedures Subject to Multiple Diagnostic Imaging Reduction Technical Component List

A list identifying codes that are subject to MDIR of the Technical Component and their TC Non-Facility Total RVUs, as published in the CMS NPFS



Diagnostic Imaging
Procedures Subject to

Diagnostic Imaging Procedures Subject to Multiple Diagnostic Imaging Reduction Professional Component List

A list identifying codes that are subject to MDIR of the Professional Component and their PC Non-Facility Total RVUs, as published in the CMS NPFS



Diagnostic Imaging
Procedures Subject to

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [2017R0085C]

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

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
01/10/2019	<ul style="list-style-type: none"> Corrected formatting error in attachment files; removed <i>Effective Date</i> and <i>Expiration Date</i> fields (not applicable to Oxford plan membership)
01/01/2019	<ul style="list-style-type: none"> Updated <i>Diagnostic Imaging Procedures Subject to Multiple Diagnostic Imaging Reduction Technical Component List</i> (CPT/HCPCS codes that are subject to MDIR of the Technical Component and their TC Non-Facility Total RVUs) to reflect annual code edits: <ul style="list-style-type: none"> Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, and 77049 Removed 77058 and 77059 Revised RVU value for 70336, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 71250, 71260, 71270, 71275, 71550, 71551, 71552, 71555, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74181, 74182, 74183, 74185, 74261, 74262, 74712, 75557, 75559, 75561, 75563, 75572, 75573, 75574, 75635, 76604, 76700, 76705, 76770, 76776, 76831, 76856, 76870, and G0297 Updated <i>Diagnostic Imaging Procedures Subject to Multiple Diagnostic Imaging Reduction Professional Component List</i> (CPT/HCPCS codes that are subject to MDIR of the Professional Component and their PC Non-Facility Total RVUs) to reflect annual code edits: <ul style="list-style-type: none"> Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, and 77049 Removed 77058 and 77059 Revised RVU value for 70490, 70492, 70547, 70551, 70554, 71550, 71555, 72130, 72158, 72159, 72194, 73220, 73225, 73706, 73718, 73725, 74170, 74712, 75559, 75563, 75573, 76705, and 76831 Archived previous policy version DIAGNOSTIC 053.1 T0