Policy Number: CSCL0034
Manual Name: SMSO Policy Manual
Policy Name: MMPR for Diagnostic Imaging
Approved By: Melissa Rusk
Last Revised: 05/10/2022

SMSO Policy Manual

Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging

Executive Sponsor:	Melissa Rusk, Vice President Operations
Issuing Department:	Claims
Gate Keeper:	Terry Snyder, Director Claims

COMPLIANCE STATEMENT:

Enforcement:	All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.
Review Schedule:	This policy will be reviewed and updated as necessary and no less than every two years.
Monitoring and Auditing:	The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.
Documentation:	Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare
- ☒ Summa Management Service Organization (SMSO)
- ☒ Apex
- ☒ Summa Insurance Company

Line of Business:

- ☒ Commercial Groups
- ☐ Medicare Supplemental
- ☒ Off-Exchange
- ☒ Medicare
- ☒ On-Exchange
- ☒ Self-Funded

1.0 Purpose:

1.1 Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Policy, Professional policy is based on the Centers for Medicare and Medicaid Services (CMS) (MPPR) Policy for those diagnostic imaging procedures where CMS assigns a Multiple Procedure Indicator (MPI) of 4 on the National Physician Fee Schedule (NPFS). Under the CMS guidelines, 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. Therefore, CMS applies a reduction in reimbursement for secondary and subsequent procedures because payment at 100% for secondary and subsequent procedures would result in duplicative reimbursement for clinical labor activities only performed once.

2.0 Policy:

2.1 In accordance with CMS, SummaCare 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. Additionally, SummaCare will follow CMS and apply reductions to the secondary and subsequent Professional Component (PC) of multiple diagnostic imaging procedures assigned a MPI of 4.

3.0 Procedure:

3.1 SummaCare uses 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:

3.1.1 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.

3.1.2 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. SummaCare's maximum per day limits apply.

3.1.3 Services must be medically necessary, and prior authorized where applicable. Benefit plans and/or provider contracts may further limit coverage and reimbursement.

3.2 MDIR will not apply when:

3.2.1 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.

3.2.2 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.

3.2.3 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.

3.2.4 The imaging service does not have an MPI of 4.

3.3 Multiple Diagnostic Imaging Reduction Percentages

3.3.1 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, SummaCare will reduce the Allowed Amount for the TC of the second and each subsequent procedure by 50%. SummaCare will regard the TC portion of the procedure(s) with the lower TC total RVUs, as subject to MDIR.

3.3.2 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 Qualified Health Care Professional at the Same Session, SummaCare will reduce the Allowed Amount for the PC of the second and each subsequent procedure by 5%. SummaCare will regard the PC portion of the procedure(s) with the lower PC total RVUs, as subject to MDIR.

3.4 Multiple Diagnostic Imaging Procedures Billed Globally

3.4.1 When the Same Group Physician and/or Other Health Care Professional 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 SummaCare's standard Professional/Technical percentage.

3.4.2 Who has the authority and responsibility for the activities in this policy or procedure? Director Claims

3.4.3 Who is responsible for monitoring/enforcing the compliance with this policy? Director Claims

4.0 References:

4.1 Source of the policy: Internal Standard

4.2 Are there any references to other documents, regulations, or intranet locations? https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

4.3 Are there other policies that work in conjunction with this policy? None

4.4 Replaces (if applicable): None

5.0 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 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
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 Qualified 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.

5.1 Are there any definitions that may be unclear? None

6.0 Key Words or Aliases (Optional):

6.1 Are there any key words that you may use to find this policy in a search? MPPR, technical component, professional component, diagnostic imaging

ORIGINAL EFFECTIVE DATE: 10/01/2021
REVIEWED: 5/10/2022
REVISED: 5/10/2022