Payment Policy: Multiple Diagnostic Cardiovascular Procedure Payment Reduction (MDCR)

Reference Number: CC.PP.065
Product Types: ALL
Last Review Date: 2-6-2020

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

When multiple procedures are performed on the same day, for the same patient, and by the same physician (or by multiple physicians in the same group practice, i.e., same group national provider identifier (NPI)), the majority of clinical labor activities are not performed or furnished twice. Some examples of clinical labor activities include; 1) greeting the patient; 2) gowning the patient, 3) positioning and escorting the patient, 4) providing education and obtaining consent, 5) retrieving prior exams, 6) setting up an IV, and 7) preparing and cleaning the room. Therefore, payment at 100% for the secondary and subsequent procedures represent duplicative components of the primary procedure.

The Centers for Medicare and Medicaid Services (CMS) establishes reimbursement guidelines for multiple procedure payment reduction (MPPR) when the same provider performs multiple procedures to the same patient on the same day. When this occurs, the primary procedure is reimbursed at 100% of the allowable and subsequent procedures are reduced by an established percent based upon the multiple procedure reduction rules for those services.

This policy is based on CMS reimbursement methodologies for MPPR and applies a multiple diagnostic cardiovascular procedure reimbursement reduction (MDCR) to procedures assigned a multiple procedure indicator (MPI) of 6 on the CMS National Physician Fee Schedule (NPFS). When this occurs, only the highest-valued procedure is reimbursed at the full payment allowance (100%) and payment for subsequent procedures/units is reimbursed at 75% of the allowance.

Application

MDCR applies when:

- The same physician (or by multiple physicians in the same group practice, i.e., same group national provider identifier (NPI)), performs multiple diagnostic cardiovascular procedures with an MPI of 6 to the same patient, on the same day.
- A single diagnostic cardiovascular procedure with an MPI of 6 is submitted with multiple units by the same group physician and/or other health care professional.
- Multiple procedures performed on the same day regardless if performed at the same or separate sessions.

MCDR will not apply when:

- Procedure codes with an MPI of 6 are billed with the modifier -26 for the professional component (PC). The modifier -26 represents the professional (interpretation and report) component of a procedure and not the technical component. Consequently, the MDCR does not apply.

- The procedure is not included on the Diagnostic Cardiovascular Procedure CMS NPFS list.

Reimbursement
The Plan uses the CMS NPFS MPI 6 to determine which diagnostic cardiovascular procedures are eligible for the multiple diagnostic cardiovascular procedure reduction that are eligible for reduction of the technical component of the procedure.

When multiple (two or more) diagnostic cardiovascular procedures with an MPI of 6 are performed by the same provider, on the same patient, on the same day, the Plan will allow 100% of the maximum allowance for the first diagnostic procedure with the **highest cost per unit** and 75% of the allowance for each subsequent diagnostic cardiovascular procedure.

Furthermore, a single diagnostic cardiovascular procedure billed in multiple units is also subject to the MDCR. The first unit will be reimbursed at 100% of the maximum allowance and subsequent units will be reimbursed at 75% of the maximum allowance. The units allowed are also subject to the Plan's Maximum Units policy. The claim paid amount is divided by units. The highest unit is paid at 100% while all others are paid at 75%.

Example Cardiovascular Payment Reduction: Single Unit				
CPT Code	Units	Billed Amt	Paid Amt	Final Paid
93925	1	$764	$117	$87.75 (75% of $117)
93922	1	$419	$54	$40.50 (75% of $54)
93306	**1**	**$2,342**	**$227**	**$227 Highest unit paid amount =$227 no reduction**
93880	1	$1,108	$102	$76.50 (75% of $102)

Example Cardiovascular Payment Reduction: Multiple Units				
CPT Code	Units	Billed Amt	Paid Amt	Final Paid
93925	3	$2,292	$352	$264 (75% of $352)
93922	2	$838	$110	$82.50 (75% of $110)
93306	**1**	**$2,342**	**$227**	**$227 - Highest unit paid amount = $227 @ 100%; no reduction**
93880	1	$1,108	$102	$76.50 (75% of $102)

Sample Cardiovascular Payment Reduction Single Procedure Code Billed with Multiple Units with Modifier -26 appended					
CPT Code	Modifier	Units	Billed Amount	Paid Amount	Final Paid Amount
93925	**26**	**3**	**$2,292**	**$352**	**$352=no reduction; policy does not apply.**

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
75600-93990	https://www.cms.gov/index.php/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/2020

Modifier	Descriptor
26	Modifier -26 is used to report the provider (professional versus facility) component of a procedure. Modifier -26 represents the physician's interpretation of the diagnostic test/study performed. The interpretation of the diagnostic test/study is a patient-specific service that is separate, distinct, written, and signed. The report must be available if requested by the payer.

ICD-10 Codes	Descriptor
NA	NA

Definitions:

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.

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.

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.

References

1. *Current Procedural Terminology (CPT®)*, 2019
2. *Centers for Medicare and Medicaid Services,* CMS Manual System and other CMS publications and services. **https://www.cms.gov/index.php/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/2020**

Revision History	
01/24/2020	Initial Policy Draft
02/06/2020	Final Medical Affairs and Payment Integrity Review, Policy Approved and Watermarks Removed

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of patients. This payment policy is not intended to recommend treatment for patients. Patients should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, patients and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, patients and their representatives agree to be bound by such terms and conditions by providing services to patients and/or submitting claims for payment for such services.

Note: For Medicaid patients, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare patients, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.