Medical Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Medical Procedure Payment Reduction (MPPR) For Medical and Surgical Services

Policy Number: RM011
Last Review: 02/01/2024

GUIDELINES:

- **Reimbursement policies serve as a guide to assist in accurate claims submissions and to outline the basis for reimbursement. This policy is a guideline only and does not constitute a benefit determination, medical advice, guarantee of payment, plan preauthorization, an Explanation of Benefits, or a contract.**
- **Reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.**
- **Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis.**
- **Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes.**
- **Coding methodology, industry-standard reimbursement logic, regulatory requirements, and benefit design are considered in reimbursement policy development.**
- **This policy is not intended to address every claim situation. Whether a procedure is covered shall be determined based on the terms and provisions of a specific member plan or policy.**

SCOPE:
X Professional
_ Facility

DESCRIPTION:
Practitioner reimbursement for many medical and surgical services and procedure codes generally include reimbursement for pre-procedure and post-procedure work, as well as generic services integral to the standard medical/surgical service, i.e., the individual costs, also known as inputs, typically associated with that service. For example, the Centers for Medicare & Medicaid Services (CMS) uses a formula that accounts for the inputs associated with a procedure code to determine Medicare Physician Fee Schedule (MPFS) reimbursement rates for that code. When the same provider renders multiple services, or multiple units of the same service, to the same patient on the same day, the total calculation for the procedure code(s) could account more than once for an input that was only rendered once. Payment at 100% for secondary and subsequent procedures would represent reimbursement for duplicative components of the primary procedure.

CMS' National Physician Fee Schedule Relative Value File identifies procedures that are subject to multiple procedure reductions. Medical and surgical services are subject to the multiple procedure concept and multiple procedure reductions.
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.

POLICY:

Paramount will apply MPPR in accordance with CMS methodologies in determining which procedures are subject to multiple procedure reductions. MPPR will be reimbursed at 100% of the allowed amount for the most clinically intensive procedure (the “primary” procedure), then at 50% for each additional procedure allowed on the same

day. The primary or secondary ranking of these procedures will be based on the highest contracted rate or Relative Value Units of each procedure, establishing the higher reimbursed.

Status Indicator 2 (standard payment adjustment rules for multiple procedure apply) multiple procedure reductions
apply when:

- The same provider performs two or more procedure codes subject to reductions (i.e., two or more codes on the multiple procedure reduction code list) same patient, on the same day, at the same session
- If two codes are billed but only one is subject to reduction, no reduction will be taken on either procedure
- A single code subject to the multiple procedure concept is submitted with multiple units. For example, CPT code 11300 is submitted with three units. Multiple procedure reductions would apply to the second and third unit

If more than one reimbursable procedure is performed during the same session, the primary procedure will be reimbursed at 100% of the allowable rate and all subsequent reimbursable procedures are reimbursed at 50% of the allowable rate

- 100% of the allowable amount for the primary/major procedure
- 50% of the allowable amount for the secondary procedure
- 50% of the allowable amount for all subsequent procedures

Multiple surgeries are distinguished from procedures that are components of, or incidental to a primary procedure. Intraoperative services, incidental surgeries, or component of more major surgeries may not be billed separately.

The use of modifier -51, modifier -59 or modifiers -XE, -XP, -XS, -XU appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions.

Multiple procedures for assistant surgeon services

When services are reported by more than one assistant surgeon using modifiers -80, -81, -82 or –AS, those services will be ranked collectively if reported by the same group physician and/or other qualified healthcare professional. Assistant surgeon services will be ranked separately from the services reported by the primary surgeon.

Multiple procedures for co-surgeon or team surgeon

Multiple procedures performed by a co-surgeon (modifier - 62) or team surgeon (modifier -66) are subject to the multiple procedure concept as defined above when performed by the same individual physician or other qualified healthcare professional on the same date of service. Co-surgeon and team surgeon services are ranked separately and independently of any other co-surgeon or team surgeon services.

Multiple procedures for bilateral surgeries reported with modifier -50

Selected bilateral eligible services may also be subject to multiple procedure reductions when billed alone or with other multiple procedure reduction codes. If a reimbursable surgical procedure is performed bilaterally in a single operative session, Paramount will reimburse the bilateral procedure at 150% of the allowable rate. The payment adjustment rules for bilateral surgeries do not apply to procedures that are inherently bilateral by CPT definition. All bilateral adjustments are made prior to other multiple procedure reduction reimbursement for bilateral services is based on the modifier(s) reported, as well as the CMS bilateral indicator found on the MPFS. The bilateral indicators along with their payment rules are listed as follows:

- Multiple Procedure Indicator 0 – 150% payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or with modifiers RT and LT, Paramount will base payment for the two sides on the lower of:

(a) the total actual charge for both sides or

(b) 100% of the fee schedule amount for a single code. Codes with this identifier are typically unilateral, and modifier -50 is not billable

- Multiple Procedure Indicator 1 – 150% payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with 2 units), Paramount will base payment for these codes when reported as bilateral procedures on the lower of:

(a) the total actual charge for both sides, or
(b) 150% of the fee schedule amount for a single code.

- Multiple Procedure Indicator 2 – 150% payment adjustment for bilateral procedure does not apply. Fees are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the unit's field), Paramount will base payment for both sides on the lower of

(a) the total actual charges by the physician for both sides or
(b) 100% of the fee schedule amount for a single code. Codes with this identifier are typically identified as bilateral in the code description and modifier -50 is not billable.

- Multiple Procedure Indicator 3 - The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with 2 units), Paramount will base payment for each side or organ or site of a paired organ on the lower of:

(a) the actual charge for each side or
(b) 100% of the fee schedule amount for each side. Codes with this identifier are typically radiology procedures or other diagnostic tests not subject to bilateral rules.

- Multiple Procedure Indicator 9 - Codes with this identifier do not apply to the bilateral concept.

Exclusions to multiple procedure rules:

- Procedures deemed to be modifier -51 – exempt (See CPT Manual Appendix E).
- Procedures deemed to be add-on procedures (See CPT Manual Appendix D). Add-on procedures reported without a primary procedure will be denied as non-billable to the member by a participating, preferred, or network provider.
- Services submitted with modifier -78. There are no modifiers that override the multiple procedure concept other than those services that are appropriately reported with modifier -78.
- Per CPT, it may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure).

When this procedure is related to the first procedure and requires the use of an operating/procedure room, it should be reported by adding modifier -78 to the related procedure. In accordance with CMS guidelines, procedures reported with a modifier -78 that have a 10- or 90-day global period are not subject to the multiple procedure concept.

Medicare Advantage Plans:
Effective January 1, 2023, Paramount will expand its multiple procedure reduction claims reimbursement processing beyond the National Physician Fee Schedule Status Indicator 2.
Paramount will align Professional Provider Claims reimbursement processing with the CMS' multiple procedure indicators on the National Physician Fee Schedule (NPFS) Relative Value File to determine which procedures are eligible for multiple procedure reductions. This reimbursement applies to professional providers billing on a CMS-1500 claim form or the equivalent form, 837p. Multiple procedures subject to the multiple procedure concept, 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)) are ranked to determine applicable reductions. The primary procedure is reimbursed at 100% of the allowable fee schedule and subsequent procedures are reduced by an established percent based upon the multiple procedure reduction rules for those services
The identified procedure codes with the assigned CMS multiple procedure indicators, are subject to the multiple procedure reductions as follows:

Multiple Procedure Indicator 2 – standard payment adjustment rules apply for multiple procedures

Multiple Procedure Indicator 3 – Diagnostic Endoscopic Procedures

- Special rules for multiple endoscopic procedure apply. In this code set, the secondary endoscopic procedure = if billed with modifier TC, subject to a 50% reduction of the technical component (TC) portion of the RVU/fee allowance, if billed with modifier 26, subject to a 5% reduction of the professional component (PC) portion of the RVU/fee allowance, if billed as global service (no modifier), subject to a 35% reduction.

Multiple Procedure Indicator 4 – Diagnostic Imaging Procedures

- In this code set, when multiple procedures units are billed, full payment of 100% is paid to the unit or procedure with the highest valued paid amount.
- The secondary imaging procedure; if billed with modifier TC is subject to a 50% reduction of the technical component (TC) portion of the RVU/fee allowance, if billed with modifier 26, subject to a 5% reduction of the professional component (PC) portion of the RVU/fee allowance, if billed as global service (no modifier), subject to a 35% reduction.
    - Furthermore, a single imaging procedure billed in multiple units is also subject to the MPPR for imaging services. Reimbursement for a single procedure billed with multiple units will be reimbursed at 100% of the paid amount allowance. Subsequent units will be reimbursed at multiple procedure payment reduction, percentage of the paid amount allowance as indicated above. The claim paid amount is divided by the units billed.

Multiple Procedure Indicator 5 – Therapy Services (Physical, Occupational, and Speech Therapy)

- In this code set, when multiple procedures units are billed, full payment of 100% is paid to the unit or procedure with the highest valued paid amount. Payment for subsequent procedures/units is reimbursed at 90% of the paid amount allowance
    - This reduction applies to all therapy services furnished on the same day, regardless of whether the services were provided in one therapy discipline or multiple disciplines, such as physical therapy, occupational therapy, or speech-language pathology.
    - When multiple (two or more) therapy procedures with an MPI of 5 are performed by the same provider, or by providers within the same group practice, on the same day, Paramount will allow 100% of the paid amount allowance for the therapeutic procedure with the highest cost per unit and 90% of the paid amount allowance for each subsequent therapeutic procedure and unit(s).
    - Furthermore, a single therapeutic procedure billed in multiple units is also subject to the MPPR for therapeutic services. Reimbursement for a single procedure billed with multiple units will be reimbursed at 100% of the paid amount allowance. Subsequent units will be reimbursed at 90% of the paid amount allowance. The claim paid amount is divided by the units billed.

Multiple Procedure Indicator 6 - Diagnostic Cardiovascular Procedures

- In this code set, the primary procedure is reimbursed at 100% of the allowable fee schedule, the secondary and subsequent diagnostic cardiovascular procedure codes = if billed with modifier TC-subject to a 25% reduction, if billed with modifier 26-processed at full allowable , no reduction, if billed as global (no modifier), subject to a 25% reduction.
    - 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, and during the same session, Paramount 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 and unit(s).
    - Furthermore, a single diagnostic cardiovascular procedure billed in multiple units is also subject to the MPPR for Diagnostic Cardiovascular Procedures. 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%.

Multiple Procedure Indicator 7 - Diagnostic Ophthalmology Procedures

- In this code set, the primary procedure is reimbursed at 100% of the allowable fee schedule, the secondary ophthalmology procedure = if billed with modifier TC-20% reduction, if billed with modifier 26-processed at full allowable, no reduction, if billed as global service (no modifier) subject to a 10% reduction.
    - When multiple (two or more) diagnostic ophthalmology procedures with an MPI of 7 are performed by the same provider, on the same patient, on the same day, Paramount will allow 100% of the maximum paid amount allowance for the first diagnostic procedure with the highest cost per unit and 80% of the maximum paid amount allowance for each subsequent diagnostic ophthalmology procedure and unit(s).

Furthermore, a single diagnostic ophthalmology procedure billed in multiple units is also subject to the multiple procedure reduction. The first unit will be reimbursed at 100% of the maximum paid amount allowance and subsequent units will be reimbursed at 80% of the maximum paid amount allowance. The claim paid amount is divided by units. The highest unit is paid at 100% while all others are paid at 80%.

The Member's specific benefits determine coverage. Claims will be processed following standard Paramount claims logic, including but not limited to the application of CMS National Correct Coding Initiative (NCCI), National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Inclusive Facility Fee Services (i.e., ASCs), Freestanding ASC payment methodology is based on Centers for Medicare & Medicaid Services (CMS) ASC payment system, as well as CMS Outpatient Prospective Payment System (OPPS), Outpatient Hospital payment methodology is based on CMS Outpatient Prospective Payment System (OPPS), Medical Policies, Reimbursement Policies and Administrative Manual, Correct Coding Validation Audits and other vendor algorithms.

RELATED CODING/BILLING INFORMATION

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered

MODIFIERS	DESCRIPTION	COMMENTS
26	Professional component	
50	Bilateral procedure	
51	Multiple procedures	
59	Distinct procedural service	
62	Two surgeons	
66	Surgical team	
78	Unplanned return to the operating/ procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period	
80	Assistant surgeon	
81	Minimum assistant surgeon	
82	Assistant surgeon	When qualified resident surgeon not available
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	
LT	Left Side	Used to identify procedures performed on the left side of the body
RT	Right Side	Used to identify procedures performed on the right side of the body
TC	Technical component	
XE	Separate encounter	A service that is distinct because it occurred during a separate encounter. Only use XE to describe separate encounters on

		the same DOS
XP	**Separate Practitioner**	**A service that is distinct because it was performed by a different practitioner**
XS	**Separate Structure**	**A service that is distinct because it was performed on a separate organ/structure**
XU	**Unusual Non-Overlapping Service**	**The use of a service that is distinct because it does not overlap usual components of the main service**

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE:06/01/2020

Date	Explanation & Changes
06/01/2020	• **Reimbursement Policy created**
07/01/2020	• **Administrative updates**
07/01/2021	• **Reimbursement Policy reviewed and updated** • **Reimbursement Policy title changed from Multiple Procedure Payment Reduction (MPPR) for Medical and Surgical Services, Professional, CMS Status Indicator 2 to Multiple Procedure Payment Reduction (MPPR) for Medical and Surgical Services Policy, Professional Paid at Percent of Charges**
07/01/2022	• **Reimbursement Policy updated with additional MPPR effective 01/01/2023 for Elite/Paramount Medicare Plan**
10/01/2023	• **Reimbursement/Billing Policy updated to new policy template**

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

NCDs https://www.cms.gov/medicare-coverage-database/searchresults.aspx?keyword=&keywordType=starts&areaId=s29&docType=NCD&contractOption=all

LCDs https://www.cms.gov/medicare-coverage-database/searchresults.aspx?keyword=&keywordType=starts&areaId=s29&docType=F,P&contractOption=all

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., Lansdale, PA: Author. Health Technology Assessments. https://www.hayesinc.com/

Industry Standard Review