

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash –

NEW products from the Medicare Learning Network® (MLN)

- [“Medicare Claim Submission Guidelines,”](#) Fact Sheet, ICN 906764, Downloadable

MLN Matters® Number: MM7442 Revised

Related Change Request (CR) #: 7442

Related CR Release Date: November 4, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R9950TN

Implementation Date: January 3, 2012

Multiple Procedure Payment Reduction (MPPR) on Certain Diagnostic Imaging Procedures

Note: This article was updated on August 27, 2012, to reflect current Web addresses. It was previously revised on April 24, 2012, to add language at the end of the third paragraph on page 2 to clarify the impact of the MPPR on physicians in group practices. All other information remains the same.

Provider Types Affected

This article is for physicians, clinical diagnostic laboratories, and other providers who bill Medicare contractors (carriers or Medicare Administrative Contractors (A/B MACs)) for providing diagnostic imaging services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 7442, from which this article is taken, announces that Medicare is expanding the Multiple Procedure Payment Reduction (MPPR) to the Professional Component (PC) in addition to the Technical Component (TC) of certain diagnostic imaging procedures. You should make sure that your billing staffs are aware of these changes.

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Background

Section 3134 of the Affordable Care Act (ACA) added Section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary of the Department of Health and Human Services must identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a further step in implementing this provision, Medicare is making a change to the MPPR on the certain diagnostic imaging procedures. Specifically, the Centers for Medicare & Medicaid Services (CMS) is applying the MPPR to the PC services as well as to TC services.

The MPPR on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day. Currently, the MPPR on diagnostic imaging services applies only the TC services. It applies to both TC-only services and to the TC portion of global services. Full payment is made for the service with the highest TC payment. Payment is made at 50 percent for the TC of subsequent services furnished by the same physician to the same patient in the same session on the same day.

CMS is expanding the MPPR by applying it to PC services. Full payment is made for each PC and TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day. **Due to operational considerations, at this time, CMS is not applying the imaging MPPR to group practices when different physicians in a group see the same patient on the same day. However, if the same physician within a group practice sees the same patient in the same session on the same day, the imaging MPPR will apply as of January 1, 2012.**

The complete list of codes subject to the MPPR on diagnostic imaging is in Attachment 1 of CR7442, which is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R995OTN.pdf> on the CMS website. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction.

The current and proposed payments are summarized in the following table:

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	Procedure 1	Procedure 2	Current Total Payment	Current Payment Calculation	Proposed Total Payment	Proposed Payment Calculation
PC	\$68	\$102	\$170	No Reduction	\$153	$\$102 + (.75 \times \$68)$
TC	\$476	\$340	\$646	$\$476 + (.50 \times \$340)$	\$646	$\$476 + (.50 \times \$340)$
Global	\$544	\$442	\$816	$\$170 + \$476 + (.50 \times \$340)$	\$799	$\$102 + (.75 \times \$68) + \$476 + (.50 \times \$340)$

When applying the reduction, Medicare contractors will use modifier 51 to identify reduced PC services and reduced global services as they do today for TC services. In addition, they will append Claim Adjustment Reason Code 59 (Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia) Note: Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF), if present.) They will also assign Group Code CO (contractual obligation).

Additional Information

You will find the complete list of codes subject to the MPPR on diagnostic imaging and an example of how payments are calculated in CR7442, which is the official instruction issued to your carrier or A/B MAC on this issue. CR7442 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R995OTN.pdf> on the CMS website.

Also, see the MLN Matters® article MM7703 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7703.pdf> for related information.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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