Clover

Clover Health Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Reimbursement Policy

Policy # RP-054

Policy Title	Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Reimbursement Policy
Policy Department	Payment Strategy Operations
Effective Date	4/1/2022
Revision Date(s)	
Next Review Date	

Disclaimer:

Clover Health applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

Clover Health has developed this policy to define reimbursement for multiple diagnostic imaging procedures. This policy applies to both Clover Health contracted and non-contracted providers.

Definitions:

- Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging
  - MPPR for diagnostic imaging defines the payment rules for imaging procedures performed on the same day by the same provider for a single patient.
- Global Service
  - Services that are billed for both the professional and technical components of a procedure.
- Professional Component
  - Professional supervision and interpretation of a procedure.
- Technical Component
  - The equipment, supplies, and other associated costs related to a procedure.

Policy:

Clover Health follows Medicare methodology for multiple procedure reductions related to diagnostic imaging. This methodology applies a reduction in payment to subsequent procedures based on the lower of the actual charge or the fee schedule amount. Imagining procedures subject to MPPR reductions are identified by having an MPPR indicator of “4” on the National Physician Fee Schedule (NPFS). Examples of these procedures are MRIs, CT scans, and ultrasounds.

Professional Component (PC)Only:
The first unit with the highest fee schedule rate will have an allowable amount of 100% of the PC rate. All additional imaging procedure units will be paid at 95% of the PC rate.

Technical Component (TC) Only:
The first unit with the highest fee schedule rate will have an allowable amount of 100% of the TC rate. All additional imaging procedure units will be paid at 50% of the TC rate.

Global services:
Global services are billed when both the professional and technical components are performed by the same provider. The procedure with the highest payment rate will have an allowable amount of 100% of the Medicare rate for the first unit. All subsequent diagnostic imaging services provided for that same member on the same date will have an allowable equal to 95% of the PC rate plus 50% of the TC rate.

In certain circumstances (when appropriate) providers may add a modifier to indicate additional imaging procedures should be considered as the primary procedure.
Valid Modifier usage for Exceptions:
59: Distinct procedural service
78: Unplanned return to the operating room
XE: Separate encounter
XP: Separate practitioner
XS: Separate structure
XU: Unusual non-overlapping service

Claim Codes (if applicable)	• Modifier 59
	  ○ Distinct procedural service
	• Modifier 78
	  ○ Unplanned return to the operating room
	• Modifier XE
	  ○ Separate encounter
	• Modifier XP
	  ○ Separate practitioner
	• Modifier XS
	  ○ Separate structure
	• Modifier XU
	  ○ Unusual non-overlapping service

References
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3578CP.pdf
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm9647.pdf