Professional Pricing Policy

Subject: **Multiple Diagnostic Cardiovascular Procedures – Professional**	
Policy Number: HLRP – 0004	Policy Section: Radiology
Last Approval Date: May 17, 2022	Effective Date: July 22, 2022

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

The Multiple Procedure Payment Reduction (MPPR) on diagnostic cardiovascular procedures apply when multiple services are furnished to the same member on the same day. The MPPR applies to the technical component service and to the technical component of global services. Allowable is 100% for the first diagnostic cardiovascular procedure with the highest Relative Value Unit (RVU) and 75% for subsequent technical component procedures furnished by the same provider or provider group to the same member on the same day.

MPPR does not apply to professional component (26) services or to a diagnostic cardiovascular procedure performed during a separate encounter on the same date of service reported with the appropriate modifier.

When two or more diagnostic cardiovascular procedures with an MPI of 6 are reported as global procedures, HealthLink will identify the technical component (TC) RVU and professional component (26) RVU separately for each procedure and calculate eligible pricing as follows:

- The technical component RVU will be reduced by 25%.
- The professional component RVU will remain at 100%.
- These two values are added together to obtain a new RVU value to be used in the calculation.
- The new RVU value is then divided by the original total global RVU and multiplied by 100 to determine what percent of the global value is to be applied to diagnostic procedures.
- The original fee schedule global allowance is then multiplied by this new percentage value (which is rounded up) to determine the allowance for the subsequent cardiovascular procedures with an MPI of 6.

MPPR will also be applied to the technical component of eligible codes when modifiers 76 or 77 (repeat procedure) are reported. These modifiers do not indicate to HealthLink that the repeat procedure was performed as a distinct procedural service at a separate session/encounter.

Related Coding

Modifier	Description	Comments
N/A	N/A	Standard correct coding applies

Exemptions

	There are no exemptions to this policy

Definitions

Global Procedure	Represents both the professional and technical component as a complete procedure or service. Identified by reporting the eligible procedure without modifiers 26 or TC.
Multiple Diagnostic Cardiovascular	Distinct, separate diagnostic services performed by the same provider on the same member during the same session.
Multiple Procedure Allowable Reduction	Applied to the allowance for the technical component (TC) of diagnostic procedures.
Professional Component	Represents the supervision and interpretation portion of a service or procedure and the preparation of a written report.
Technical Component	Represents the technical personnel, equipment, supplies and institutional charges of a service or procedure.
General Pricing Policy Definitions	

Related Policies and Materials

Modifiers Rules

References and Research Materials

This policy has been developed through consideration of the following

- Centers for Medicare & Medicaid Services (CMS)
- American Medical Association (AMA) Coding with Modifiers 5th Edition

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.