MULTIPLE PROCEDURE PAYMENT REDUCTION ON THE TECHNICAL COMPONENT (TC) OF DIAGNOSTIC CARDIOVASCULAR AND OPHTHALMOLOGY PROCEDURES

File Name: multiple_procedure_payment_reduction
Origination: 7/2013
Last Review: 6/2023
Next Review: 12/2023

Description

Many diagnostic services are composed of a technical and a professional component. The technical component refers to the equipment and technician utilized during performance of the test. The professional component refers to the interpretation (or reading) of the results of a test.

When multiple diagnostic services are furnished to the same patient on the same day, most of the clinical labor activities and most supplies are not performed or furnished twice. The following clinical labor activities are performed once during the session and are duplicated for subsequent procedures, creating an overlap in the services comprising the separately billed technical components:

- Greeting the patient
- Positioning and escorting the patient
- Providing education and obtaining consent
- Retrieving prior exams
- Setting up the IV
- Preparing and cleaning the room

In addition, the supplies used are not duplicated for subsequent procedures.

The reduced payment for additional procedures is based on the concept that, when services are rendered together, there are efficiencies that occur that would result in duplicate payment of practice expenses and pre- and post-procedure work if all procedures were paid in full.

The multiple procedure payment reduction on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient on the same day during the same session. The multiple procedure payment reductions apply independently to cardiovascular and ophthalmology series. The reductions apply to technical-only services, and to the technical component of global services.

Policy

When multiple diagnostic cardiovascular services are performed during the same outpatient patient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 75%.

When multiple diagnostic ophthalmology services are performed during the same outpatient patient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 80%.

BlueCross BlueShield of North Carolina

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Commercial Reimbursement Policy

Reimbursement Guidelines

Reimbursement will be determined based on 100% of the allowed amount for the primary procedure. The primary procedure is considered the service with the higher RVU of current year NC Medicare rates.

Services provided on an inpatient basis are not subject to the reduced allowance for the overlapping technical components.

When multiple procedures are obtained on the same patient in the same setting and billed on a global basis (technical and professional fees billed on one claim line), reduced allowance applies to the technical component only.

When the reduced allowance is applicable

The reduced allowance for the technical component of the second and subsequent procedures will apply when:

- Multiple procedures are performed on the same patient during the same outpatient session.
- A single procedure is submitted with multiple units.

When the reduced allowance is not applicable

The reduced allowance for the technical component of the second and subsequent procedures will not apply when:

- Multiple procedures are billed, appended with the appropriate modifier to indicate the procedure was done on the same day but not during the same session.
- If a global fee is charged by one provider, an additional component fee from another provider will not be reimbursed. (Global fees include both a professional and technical component.)

Multiple procedure payment reductions do not apply to professional component services.

Rationale

In accordance with CMS, Blue Cross Blue Shield North Carolina (Blue Cross NC) will reduce reimbursement for multiple cardiovascular and ophthalmology services.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see Blue Cross NC web site at www.bcbsnc.com.

Please reference the CMS Physician Fee Schedule Relative Value Files using the appropriate year and quarter for applicable codes.

Related policy

Bundling Guidelines

Modifier Guidelines

Multiple Surgical Procedure Guidelines for Professional Providers

PRICING AND ADJUDICATION PRINCIPLES

Radiology Services Reimbursement Policy

References

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1149OTN.pdf

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

History

5/26/17	New policy developed. When multiple diagnostic cardiovascular services are performed during the same outpatient patient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 75%. When multiple diagnostic ophthalmology services are performed during the same outpatient patient session, the allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 80%. **Notification 5/26/2017 for policy effective date 8/1/2017.** (an)
12/29/17	Routine review. No change to current policy. (an)
12/31/18	Routine review. 2019 code update. Deleted code 75658. Added codes 0509T, 92145, 92242, 92273. 92274, 93050, 93260, 93261, 93702, 93895. No change to policy statement or guidelines. (an)
1/14/20	Routine policy review. Senior medical director approved 12/2019. No changes to policy statement. (AN)
12/31/20	Routine policy review. Medical director approved 12/2020. New codes 92229, 93241, 93242, 93243, 93245, 93246, and 93247 added to coding section. Added codes 0506t, 0507t, 93985, and 93986. Removed code 92275. No changes to policy statement. **Policy notification given 12/31/2020 for effective date 3/9/2021**. (eel)
6/9/21	Policy format update. No changes to policy statement. (eel)
12/30/21	Routine policy review. Medical Director approved. (eel)
12/31/2022	Routine policy review. Minor revisions only. (ckb)
6/30/23	Updated coding section with instruction to reference CMS Physician Fee Schedule and removed coding grid. No change to policy intent. (eel)

Application

BlueCross BlueShield of North Carolina

Commercial Reimbursement Policy

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benef its are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.