Payment Policy: Multiple Procedure Reduction: Ophthalmology

Reference Number: CC.PP.069
Last Review Date: 11/2024

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

When multiple procedures are 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)), the majority of clinical labor activities are not performed or furnished twice. Some examples of clinical labor activities include 1) greeting the patient; 2) gowning the patient, 3) positioning and escorting the patient, 4) providing education and obtaining consent, 5) retrieving prior exams, 6) setting up an IV, and 7) preparing and cleaning the room. Therefore, payment at 100% for the secondary and subsequent procedures represent duplicative components of the primary procedure.

The Centers for Medicare and Medicaid Services (CMS) establishes reimbursement guidelines for multiple procedure payment reduction (MPPR) when the same provider performs multiple procedures to the same patient on the same day. When this occurs, the primary procedure is reimbursed at 100% of the allowable and subsequent procedures are reduced by an established percent based upon the multiple procedure reduction rules for those services.

This policy is based on CMS reimbursement methodologies for MPPR and applies a multiple procedure reimbursement reduction to diagnostic ophthalmology procedures assigned a **Multiple procedure indicator (MPI) of 7** on the CMS National Physician Fee Schedule (NPFS). When this occurs, only the highest-valued procedure is reimbursed at the full paid amount allowance (100%) and payment for subsequent procedures/units is reimbursed at 80% of the paid amount allowance.

Application

Multiple Procedure Reduction applies when:

- The same physician (or by multiple physicians in the same group practice, i.e., same group national provider identifier (NPI)), performs multiple (2 or more) diagnostic ophthalmology procedures with an MPI of 7 to the same patient, on the same day.
- A single diagnostic ophthalmology procedure with an MPI of 7 is submitted with multiple units by the same group physician and/or other health care professional.
- Multiple (2 or more) procedures performed on the same day regardless if performed at the same or separate sessions.
- This applies to diagnostic ophthalmology procedures billed within the same claim and across claims

Multiple Procedure Reduction will not apply when:

- Procedure codes with an MPI of 7 are billed with the modifier -26 for the professional component (PC). The modifier -26 represents the professional (interpretation and report)

component of a procedure and not the technical component. Consequently, the multiple procedure reduction does not apply.
- The procedure is not included on the Diagnostic Ophthalmology Procedure CMS NPFS list.

Reimbursement
The Plan uses the **CMS NPFS MPI 7** to determine which diagnostic ophthalmology procedures are eligible for the multiple diagnostic ophthalmology procedure reduction that are eligible for reduction of the technical component of the procedure.

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, the Plan 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%.

Example Ophthalmology Payment Reduction: Single Unit					
CPT Code	**Units**	**Billed Amt**	**Paid Amt**	**Calculation**	**Final Paid**
92083	1	$90	$33.68	(80% of 33.68) for secondary procedure	$26.94
92550-TC	**1**	**$120**	**$50.88**	**(100% of highest paid valued unit billed of $50.88)**	**$50.88**

Example Ophthalmology Payment Reduction: Multiple Units Final Paid					
CPT Code	**Units**	**Billed Amt**	**Paid Amt**	**Calculation**	**Final Paid**
76519	**2**	**$358**	**$221.65**	**100% of highest paid valued unit billed of $110.83 and 80% of secondary unit of $110.83**	**$199.49**

Sample Ophthalmology Payment Reduction Single Procedure Code Billed with Multiple Units with Modifier -26 appended					
CPT Code	**Modifier**	**Units**	**Billed Amount**	**Paid Amount**	**Final Paid Amount**
92083	**26**	**2**	**$2,292**	**$352**	**$352=no reduction; policy does not apply.**

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report
0507T	Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, with interpretation and report
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)
76513	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
76516	Ophthalmic biometry by ultrasound echography, A-scan
76519	Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report
92060	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)

92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral
92250	Fundus photography with interpretation and report
92265	Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report
92270	Electro-oculography with interpretation and report
92273	Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)
92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG)
92283	Color vision examination, extended, eg, anomaloscope or equivalent

92284	Diagnostic dark adaptation examination with interpretation and report
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)
92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis

Modifier	Descriptor
26	Modifier -26 is used to report the **provider (professional versus facility) component of a procedure. Modifier -26** represents the physician's interpretation of the diagnostic test/study performed. The interpretation of the diagnostic test/study is a patient-specific service that is separate, distinct, written, and signed. The report must be available if requested by the payer.
TC	Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'TC' the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier tc; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles

ICD-10 Codes	Descriptor
NA	NA

Definitions:

Professional Component (PC): The Professional Component represents the physician or other health care professional work portion (physician work/practice overhead/malpractice expense) of the procedure. The Professional Component is the physician or other health care professional supervision and interpretation of a procedure that is personally furnished to an individual patient, results in a written narrative report to be included in the patient's medical record, and directly contributes to the patient's diagnosis and/or treatment. In appropriate circumstances, it is identified by appending modifier 26 to the designated procedure code or by reporting a standalone code that describes the Professional Component only of a selected diagnostic test.

Other Health Care Professional provided the supervision, interpretation and report of the professional services as well as the technician, equipment, and the facility needed to perform the procedure. In appropriate circumstances, the Global Service is identified by reporting the appropriate professional/technical split eligible procedure code with no modifier attached or by reporting a standalone code for global test only services.

Same Group Physician and/or Other Health Care Professional: All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification number.

Technical Component
The technical component of a service includes the provision of all equipment, supplies, personnel and costs relate to the performance of the exam.

References
1. *Current Procedural Terminology (CPT®)*, 2024
2. *Centers for Medicare and Medicaid Services,* CMS Manual System and other CMS publications and services. **https://www.cms.gov/index.php/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/2020**

Revision History	
08/18/2020	Initial Policy Draft
08/23/2020	Revised from "maximum fee schedule allowance" to "paid amount"
08/23/2021	Review policy, updated dates, removed product type
08/23/2022	Conducted annual review, updated CPT code descriptions and policy dates
08/22/2023	Conducted annual review, verified CPT code descriptions, and updated policy dates
11/15/2024	Conducted annual review, removed deleted code 0508T, updated policy dates

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of patients. This payment policy is not intended to recommend treatment for patients. Patients should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid patients, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare patients, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.