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Multiple Diagnostic Ophthalmology Procedure Reduction

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DESCRIPTION:

This policy describes the reimbursement when multiple diagnostic ophthalmology procedures are reported on the same date of service for the same patient.

As defined by the Centers for Medicare and Medicaid Services (CMS), some elements that comprise these services are duplicated when multiple procedures are performed on a single day. CMS has said:

Under the resource-based practice expense (PE) methodology, specific PE inputs of clinical labor, supplies, and equipment are used to calculate PE relative value units for each individual service. When multiple diagnostic tests are performed to the same patient on the same day, most of the clinical labor activities and some supplies are not furnished twice.

Duplicate components cited by CMS include preparing the room equipment and supplies, greeting the patient, educating, instructing and counseling the patient, gaining consent, completing diagnostic forms, preparing charges, taking history and vitals, monitoring the patient, providing post-treatment patient assistance, cleaning the room and equipment, quality assurance documentation, and duplicated supply items. CMS implemented its reduction policy for diagnostic ophthalmology procedures in January 2013 based upon instructions in the Affordable Care Act that required CMS to identify potentially mis-valued codes by examining multiple codes that are frequently billed together. This multiple procedure reduction policy seeks to align with CMS' findings and appropriately account for this duplication of value when multiple services are performed on the same day.

This reduction is similar to those Truli for Health applies to multiple surgical procedures, multiple radiologic imaging procedures, multiple therapy procedures and multiple evaluation and management services. This policy applies to billing for ophthalmology services on a CMS-1500 or equivalent claim

form. Same provider for the purposes of this policy includes all physicians and/or other health care professionals reporting under the same Federal Tax Identification number.

REIMBURSEMENT INFORMATION:

Diagnostic ophthalmology codes subject to the reduction policy are defined by the CMS Medicare Physician Fee Schedule (MPFS). The procedure codes with a MULT PROC value of “7” will be considered under this policy.

When multiple diagnostic ophthalmology procedures are performed, the primary procedure is allowed at 100 percent. However, allowances for secondary and all subsequent procedures performed on the same date of service are reduced by **20 percent of the technical component (TC)**.

The primary procedure is identified as the one with the highest total Relative Value Unit (RVU) as published by CMS.

The following is an example of how the multiple procedure reduction is applied:

Procedure Code	Relative Value	Global Allowance	Technical Allowance (TC)
92235	3.09	\$132	\$91
92250	1.11	\$37	\$16

Payment Calculation:

92235 = **\$132** – Primary procedure – no reduction

92250 = \$37 – (\$16 x 20%) = \$37 - \$3.20 = **\$33.80**

TOTAL ALLOWANCE = **\$165.80**

Truli for Health considers a single session to be one encounter where a patient could receive one or more ophthalmologic studies. If more than one of the services is provided to the patient during one encounter, then this would constitute a single session and the lower valued procedure(s) would be reduced.

On the other hand, if a patient has a separate encounter on the same day for a medically necessary reason and receives a second ophthalmology service, Truli for Health considers these multiple studies on the same day to be provided in separate sessions. These exceptions will require documentation of the medically necessary reason in the patient’s medical record and will be considered by Truli for Health upon appeal.

The professional component (PC) will not be affected. The reduction applies only to the technical component (TC) of the ophthalmology code.

BILLING AND CODING:

CPT®/HCPCS codes subject to Multiple Diagnostic Ophthalmology Procedure Reduction are identified in the Medicare Physician Fee Schedule (MPFS) Relative Value File with a value of “7” in the MULT PROC field. The file can be located in the References section below.

DEFINITIONS:

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.

Technical Component is the performance (technician/equipment/facility) of the procedure. In appropriate circumstances, it is identified by appending modifier TC to the designated procedure code or by reporting a standalone code that describes the technical component only of a selected diagnostic test.

Global service includes both professional and technical components. When a physician or other healthcare professional bills a global service, he or she is submitting for both the professional and technical components of that code. Submission of a global service asserts that the same individual physician or 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.

REFERENCES:

1. American Medical Association, *Current Procedural Terminology (CPT®), Professional Edition*
2. CMS, Medicare Physician Fee Schedule Relative Value File: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html>
3. CMS, *MLN Matters MM7848: Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures*, November 6, 2012: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals-Items/R1149OTN?DLPage=1&DLEntries=100&DLSort=1&DLSortDir=descending>
4. CMS, *Final Rule with Comment Period, Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2013*, November 16, 2012. <http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf>

GUIDELINE UPDATE INFORMATION:

02/11/21	Annual Review- Removed "For service dates beginning with August 1, 2014" from the Reimbursement Information section of the policy.
08/12/21	Annual Review – RVUs for the Multiple Diagnostic Ophthalmology Procedure Reduction example revised to reflect 2021 RVUs for procedure codes 92235 and 92250.
08/11/22	Annual Review – RVUs for the Multiple Diagnostic Ophthalmology Procedure Reduction example revised to reflect 2022 RVUs for procedure codes.
08/10/23	Annual Review – RVUs for example updated to reflect 2023 values. References reviewed and updated.

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