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PAYMENT POLICY ID NUMBER: 15-046

Original Effective Date: 08/01/2014

Revised: 08/08/2024

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 on 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 Florida Blue 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:

When multiple diagnostic ophthalmology procedures are reported, the primary procedure will be the procedure with the highest global Relative Value Unit (RVU). The reduction applies to the technical component (TC) of global services and to TC only services. The coding edit will apply a 20% reduction to the TC of second and subsequent procedures.

The primary diagnostic ophthalmology procedure will be eligible for 100% of the allowance for that procedure. Allowances for secondary and all subsequent procedures performed on the same date of service are reduced by **20% of the TC**.

If two or more diagnostic ophthalmology procedures subject to the multiple procedure reduction are performed on the same patient by the same provider during the same session and a technical component only is performed and submitted with modifier TC, the TC only component will be reduced by 20%. If two or more diagnostic ophthalmology procedures are performed and submitted as global procedures, the second or subsequent procedure's TC will be reduced by 20% based on the global RVU ranking of the procedures.

Payment Calculation Steps Effective 05/01/2024 (prior to 05/01/2024 see the archived version)

When two or more diagnostic ophthalmology procedures are reported, the primary procedure will be the procedure with the highest global RVU. The primary diagnostic ophthalmology procedure will be eligible for 100% of the allowance for that procedure.

Secondary and subsequent diagnostic ophthalmology procedures will be reduced as follows:

- The technical component RVU will be reduced by 20%
- This value is added to the PC RVU to obtain a new RVU value.
- 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 the diagnostic ophthalmology procedures.
- The original fee-schedule global allowance is then multiplied by this new percentage value (rounded to the nearest thousandth) to determine the allowance for the diagnostic ophthalmology procedure.

The following is an example of how the multiple diagnostic ophthalmology procedure reduction is applied to global procedures. Note: RVU values in this example may not accurately reflect the current values and are intended for illustrative purposes only.

Procedure Code	Modifier	Relative Value	RVU used for ranking	Global Allowance	Multiple Diagnostic Ophthalmology Ranking
92235		4.87	4.87	\$151.72	Primary
	TC	3.63			
	PC	1.24			
92250		1.11	1.11	\$35.30	Secondary
	TC	0.50			
	PC	0.61			

$$[(TC\ RVU \times 80\%) + PC] / Global\ RVU \times 100 = \text{payment percent of global allowance}$$

Global reduction (Secondary proc 92250)

$$[(0.50 \times 80\%) + 0.61] / 1.11 \times 100 = 90.991\% \text{ of Secondary procedure}$$

$$90.991\% \times \$35.30 = \$32.12$$

Florida Blue 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 allowance for secondary and subsequent 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, Florida Blue may consider 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 Florida Blue 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 the Multiple Diagnostic Ophthalmology Procedure Reduction and their corresponding RVU and payment percentage value are identified in the link below.

[Multiple Diagnostic Ophthalmology Procedure Reduction](#)

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 health care 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/R11490TN?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:

09/10/2015	New Payment Policy
08/04/2016	Annual Review
08/17/2017	Annual Review – examples refreshed
08/16/2018	Annual Review
08/15/2019	Annual Review
08/13/2020	Annual Review- Removed “For service dates beginning with August 1, 2014” from the Reimbursement Information section of the policy.
08/12/2021	Annual Review – RVUs for the Multiple Diagnostic Ophthalmology Procedure Reduction example revised to reflect 2021 RVUs for procedure codes 92235 and 92250.
08/11/2022	Annual Review – RVUs for the Multiple Diagnostic Ophthalmology Procedure Reduction example revised to reflect 2022 RVUs for procedure codes.
08/10/2023	Annual Review – RVUs for example updated to reflect 2023 values. References reviewed and updated.
05/01/2024	Revised – Policy was revised to include the new method of calculating the reduction based on a percentage value of the total global RVU. A link to the Multiple Ophthalmology Procedure Reduction list and the corresponding RVU and payment percentage values was added.
08/08/2024	Annual Review – Effective date 05/01/2024 and clarifying language added to the Reimbursement Information section. References reviewed and updated.

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