CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 694	**Date: May 7, 2010**
	Change Request 6965

SUBJECT: Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Certain Diagnostic Imaging Procedures

I. SUMMARY OF CHANGES: Reduction on the TC of certain multiple imaging procedures is increased from 25 percent to 50 percent.

EFFECTIVE DATE: *July 1, 2010
IMPLEMENTATION DATE: July 6, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 694	Date: May 7, 2010	Change Request: 6965

SUBJECT: Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Certain Diagnostic Imaging Procedures

EFFECTIVE DATE: July 1, 2010

IMPLEMENTATION DATE: July 6, 2010

I. GENERAL INFORMATION

A. Background: Medicare currently applies a multiple procedure payment reduction (MPPR) of 25 percent to the technical component (TC) of certain diagnostic imaging procedures. The reduction applies to TC only services, and the TC portion of global services, for the procedures with a multiple surgery value of '4' in the Medicare Fee Schedule database. The MPPR does not apply to the professional component (PC) or to the PC portion of global services. The 11 families of imaging codes to which this policy applies are established according to modality (computed tomography (CT), magnetic resonance imaging (MRI), and ultrasound) and body area. The reduction applies only to more than one procedure performed in a single imaging session on contiguous body parts, i.e., within a family of codes, not across families. For example, the reduction would not apply to an MRI of the brain (CPT 70552) in code family 5 (MRI/MRA Head/Brain/Neck), when performed during the same session, on the same day, as an MRI of the neck and spine (CPT 72142) in code family 6 (MRI/MRA Spine).

Field 33E contains the Diagnostic Imaging Family Indicator. This character field identifies the applicable diagnostic service family for those HCPCS codes with a multiple surgery indicator of '4'. For the global and TC portions of the HCPCS codes subject to this policy, this field contains values of '01' through '11', which corresponds with the established family definitions For those services not subject to this policy, including the PC portion of the applicable HCPCS codes, the value is '99'.

B. Policy: We currently make full payment for the TC of the highest priced procedure and payment at 75 percent for the TC of each additional procedure, when performed during the same session on the same day.

Section 3135(b) of the Patient Protection and Affordable Care Act of 2009 (PPACA) reduces payment for TC of the second and subsequent procedures from 75 percent to 50 percent of the physician fee schedule amount.

The current payment and payment as of July 1, 2010 are summarized below in the following example:

	Procedure 1	Procedure 2	Current Total Payment	Revised Total Payment
PC	$100	$80	$180 (no reduction)	$180 (no reduction)
TC	$500	$400	$800 (($500 + (.75 x $400))	$700 (($500 + (.5 x $400))
Global	$600	$480	$980 (($600 + $480-$400) + (.75 x $400))	$880 (($600 + ($480-$400) + (.5 x $400))

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6965.1	For services furnished on or after dates of service July 1, 2010, contractors shall pay 50 percent of the fee schedule amount for the TC of each additional procedure in the SAME family when performed during the same session on the same day.	X			X						
6965.2	Contractors shall change the reduction value to 50 percent for multiple procedure indicator 4 in field 21 of the MPFSDB and apply the 50 percent reduction to the TC of services performed on or after July 1, 2010.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6965.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
NA	

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Kenneth Marsalek for payment policy issues on 410-786- 4502, Kenneth.Marsalek@cms.hhs.gov. Yvette Cousar for Part B claims processing issues, on 410-786-2160, yvette.cousar@cms.hhs.gov. Anne Stevenson for MPFDB issues on 410-786-1818 , MaryAnne.Stevenson@cms.hhs.gov.

Post-Implementation Contact(s): Kenneth Marsalek 410-786-4502

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:*

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