Payment Policy: Multiple Procedure Payment Reduction (MPPR) for Diagnostic Cardiovascular Procedures

Reference Number: CC.PP.065
Last Review Date: 02/2025

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, in the same session and on the same day. When this occurs, the primary procedure is reimbursed at 100% of the allowable fee schedule 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 diagnostic cardiovascular procedure reimbursement reduction to procedures assigned a multiple procedure indicator (MPI) of 6 on the CMS National Physician Fee Schedule (NPFS). When this occurs, only the highest-valued procedure is reimbursed at the full payment allowance (100%) and payment for subsequent procedures/units is reimbursed at 75% of the allowance.

Application

MPPR for Diagnostic Cardiovascular Procedures Applies When:

- The same physician (or by multiple physicians in the same group practice, i.e., same group national provider identifier (NPI)), performs multiple diagnostic cardiovascular procedures with an MPI of 6 to the same patient, in the same session, on the same day.
- A single diagnostic cardiovascular procedure with an MPI of 6 is submitted with multiple units by the same group physician and/or other health care professional.
- Multiple procedures performed.
- Institutional providers
- Non-institutional providers

MPPR for Diagnostic Cardiovascular Procedures Will Not Apply When:

- Procedure codes with an MPI of 6 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 policy does not apply to these services.
- Codes Reviewed by NIA

NIA PROCEDURE CODES EXCLUDED FROM POLICY

CPT/HCPCS Code	Descriptor
78428	Cardiac shunt detection
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique
78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing

78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification
78481	Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78483	Cardiac blood pool imaging (planar), first pass technique; multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
93318	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular

	stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report
93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional

- The procedure is not included on the Diagnostic Cardiovascular Procedure CMS NPFS list.

Reimbursement
The Plan uses the CMS NPFS MPI of 6 to determine which diagnostic cardiovascular procedures are eligible for the MPPR for Diagnostic Cardiovascular Procedure Reduction that are eligible for reduction of the technical component of the procedure.

When multiple (two or more) diagnostic cardiovascular procedures with an MPI of 6 are performed by the same provider, on the same patient, on the same day, and during the same session, the Plan will allow 100% of the maximum allowance for the first diagnostic procedure with the **highest cost per unit** and 75% of the allowance for each subsequent diagnostic cardiovascular procedure and unit(s).

Furthermore, a single diagnostic cardiovascular procedure billed in multiple units is also subject to the MPPR for Diagnostic Cardiovascular Procedures. The first unit will be reimbursed at 100% of the maximum allowance and subsequent units will be reimbursed at 75% of the maximum allowance. The units allowed are also subject to the Plan's Maximum Units policy. The claim paid amount is divided by units. The highest unit is paid at 100% while all others are paid at 75%.

Example Cardiovascular Payment Reduction: Single Unit				
CPT Code	Units	Billed Amt	Paid Amt	Final Paid
93925	1	$764	$117	$87.75 (75% of $117)
93922	1	$419	$54	$40.50 (75% of $54)
93306	**1**	**$2,342**	**$227**	**$227 Highest unit paid amount =$227 no reduction**
93880	1	$1,108	$102	$76.50 (75% of $102)

Example Cardiovascular Payment Reduction: Multiple Units				
CPT Code	Units	Billed Amt	Paid Amt	Final Paid
93925	3	$2,292	$352	$264 (75% of $352)
93922	2	$838	$110	$82.50 (75% of $110)
93306	**1**	**$2,342**	**$227**	**$227 - Highest unit paid amount = $227 @ 100%; no reduction**
93880	1	$1,108	$102	$76.50 (75% of $102)

Sample Cardiovascular Payment Reduction Single Procedure Code Billed with Multiple Units with Modifier -26 appended					
CPT Code	Modifier	Units	Billed Amount	Paid Amount	Final Paid Amount
93925	**26**	**3**	**$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
75600-93990	**https://www.cms.gov/index.php/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/2020**
75600	Aortography, thoracic, without serialography, radiological supervision and interpretation
75605	Aortography, thoracic, by serialography, radiological supervision and interpretation
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation
75705	Angiography, spinal, selective, radiological supervision and interpretation
75710	Angiography, extremity, unilateral, radiological supervision and interpretation
75716	Angiography, extremity, bilateral, radiological supervision and interpretation

75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation
75731	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation
75733	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation
75736	Angiography, pelvic, selective or supraselective, radiological supervision and interpretation
75741	Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation
75743	Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation
75746	Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation
75756	Angiography, internal mammary, radiological supervision and interpretation
75809	Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation
75820	Venography, extremity, unilateral, radiological supervision and interpretation
75822	Venography, extremity, bilateral, radiological supervision and interpretation
75825	Venography, caval, inferior, with serialography, radiological supervision and interpretation
75827	Venography, caval, superior, with serialography, radiological supervision and interpretation
75831	Venography, renal, unilateral, selective, radiological supervision and interpretation
75833	Venography, renal, bilateral, selective, radiological supervision and interpretation
75840	Venography, adrenal, unilateral, selective, radiological supervision and interpretation
75842	Venography, adrenal, bilateral, selective, radiological supervision and interpretation
75860	Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation
75870	Venography, superior sagittal sinus, radiological supervision and interpretation

75872	Venography, epidural, radiological supervision and interpretation
75880	Venography, orbital, radiological supervision and interpretation
75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation
75887	Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation
75889	Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation
75891	Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation
75893	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation
78445	Non-cardiac vascular flow imaging (ie, angiography, venography)
78456	Acute venous thrombosis imaging, peptide
78457	Venous thrombosis imaging, venogram; unilateral
78458	Venous thrombosis imaging, venogram; bilateral
93024	Ergonovine provocation test
93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias
93050	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive
93260	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system
93278	Signal-averaged electrocardiography (SAECG), with or without ECG
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber

93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter;

	single, dual, or multiple lead pacemaker system, or leadless pacemaker system
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements
93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis
93292	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system
93724	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	Duplex scan of extracranial arteries; unilateral or limited study
93886	Transcranial Doppler study of the intracranial arteries; complete study
93888	Transcranial Doppler study of the intracranial arteries; limited study
93890	Transcranial Doppler study of the intracranial arteries; vasoreactivity study
93892	Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection
93893	Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection
93895	Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral

93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study

93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study
93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study
93981	Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study
93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study
93986	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

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.

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.

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	
01/24/2020	Initial Policy Draft
02/06/2020	Final Medical Affairs and Payment Integrity Review, Policy Approved and Watermarks Removed
08/22/2020	Title Correction per Superior Health Plan Review, added “same session” to definition of MPPR for Diagnostic Cardiovascular Procedures; added procedure codes included and excluded per NIA process. Added institutional and non-institutional providers.
09/28/2020	Added four procedure codes to the NIA exclusion list 78451, 78452, 78453 and 78454
02/06/2021	Conducted annual review, updated review date and copyright dates
02/09/2022	Conducted annual review, removed product type, updated dates
02/28/2023	Conducted annual review, updated dates
02/26/2025	Conducted annual review, updated 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.

 Providers, patients and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, patients and their representatives agree to be bound by such terms and conditions by providing services to patients and/or submitting claims for payment for such services.

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.