KAISER PERMANENTE®

PAYMENT POLICY

MULTIPLE DIAGNOSTIC IMAGING

MULTIPLE PROCEDURE PAYMENT REDUCTION (MPPR)

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington

☒ Kaiser Permanente Health Plan of Washington Options, Inc.

☒ Commercial

☐ Medicare

☐ Medicaid

Policy

Original Effective Date: XX/XX/XXXX

When benefits allow, Kaiser Permanente will apply the Multiple Procedure Payment Reduction on Diagnostic Imaging, implemented by CMS in 2012. This policy, unless Other Contractual Agreements supersede, will reimburse the Technical Component (TC) of a qualifying service at 100% for the highest allowed and 50% for any subsequent services performed on the same member, by the same physician/provider, or other qualified healthcare professional, in the same group practice, on the same date of service during the same session. This reduction will apply to the Technical Component of the service. It will apply to TC only services and to the TC portion of a global service.

Kaiser Permanente will assume that all services provided on the same date were furnished in the same session, unless appropriate modifiers are submitted indicating otherwise.

This policy is applicable to claims submitted on a HCFA 1500, without an Inpatient Place of Service.

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

Diagnostic imaging services, which are subject to the multiple diagnostic imaging reduction of the technical component, are identified by the Multiple Procedure Flag of “4” on the current CMS National Physician Fee Schedule Relative Value Files.

Policy Definitions

Same Session – Same session is defined as a single visit that includes all radiology services that have been ordered by a physician and performed on the same date of service, within the same facility. If patient returns to same facility on same date for additional tests, this would not

be considered the same session and would need to be billed with appropriate modifier to designate the separate and distinct encounter.

Same Group Practice – Physicians billing with same National Provider Identifier

Other Contractual Agreements – Reimbursement rates with associated discount vendors.

Prerequisite(s)

Not applicable

References

CMS Manual System Pub 100-20

Physician Fee Schedule CMS-1676-F

Frequently Asked Questions

Q1: Why is Kaiser Permanente reducing payments made on subsequent services performed on the same date?

A1: Kaiser Permanente is following the guidelines set forth by CMS and outlined in the Social Security Act section 1848(c)(2)(K) which allows for examination of multiple codes that are frequently billed in conjunction with a single service.

Q2: If a patient is seen for an MRI and leaves but is asked to return, on the same day, will these services be subject to the Multiple Payment Reduction for Diagnostic Imaging?

A2: Yes. If the claim is not submitted with the appropriate modifier that would indicate a separate encounter, then the services would be considered applicable to the Multiple Payment Reduction for diagnostic services policy.

Q3: How will Kaiser Permanente determine which codes would apply to the Multiple Payment Reduction for diagnostic services policy?

A3: These codes are identified by CMS with a Multiple Procedure flag of 4 on the current CMS National Physician Fee Schedule Relative Value Files.

Q4: If a member goes to a contracted or in-network provider, would they be billed the difference between what the provider expected as payment and what Kaiser Permanente allowed?

A4: No. The member cannot be billed the difference when the member is seeing by one of Kaiser Permanente's in-network providers. The difference between the billed amount and the Kaiser Permanente allowed would be considered a provider write-off.

Q5: How will Kaiser Permanente determine which service to allow at 100% and which service to allow at 50%?

A5: Kaiser Permanente will allow the Technical Component of a service provided with the highest allowable at 100% and will reduce the second and all subsequent qualifying Technical Component services with a lesser allowed amount by 50%.

Revision History

04/20/2022 – Updated to correct hyperlinks and formatting.