PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_171625

Title	**Multiple Diagnostic Cardiovascular Services Reductions**		
Number	**CP.PP.401.v1.4**		
Last Approval Date	**10/03/24**	**Original Effective Date**	**11/01/16**
Replaces			
Cross Reference	• *Modifiers XE, XS, XP and XU Separate Encounter, Separate Structure, Separate Practitioner and Unusual Overlapping Service* • *Modifier 59 - Distinct Procedural Services* • *Modifier TC – Technical Component*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define how the Plan identifies applicable diagnostic cardiovascular procedures that are subject to multiple procedure reduction and applies the reduction that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Policy	Diagnostic cardiovascular services, which are subject to a multiple diagnostic cardiovascular reduction of the technical component, are identified by the Multiple Procedure flag of 6 on the current Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value Guide (LINK): **Multiple Procedure flag 6** = Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic cardiovascular services When two or more diagnostic cardiovascular procedures, subject to the multiple cardiovascular reduction concept, are performed on the same patient by the same physician or other qualified healthcare professional at the same session, the following steps will occur to determine allowed amounts: • For the technical component, the allowed amount of the second and each subsequent procedure will be reduced by 25% on any diagnostic cardiovascular procedure that is subject to the multiple cardiovascular reduction concepts. • For the professional component, no reductions will be applied on any diagnostic cardiovascular procedure that is subject to the multiple cardiovascular reduction concepts. • For global submissions of diagnostic cardiovascular services that are subject to the multiple cardiovascular reduction concepts, the allowed amount for the code will be separated into its technical and professional components, based on RVU percentages. The technical component of the second and subsequent global codes will be reduced by 25% and then combined back with the professional component to create the reduced global allowed amount.

	<u>Multiple Procedures Rendered During the Same Session</u> When diagnostic cardiovascular procedures which are subject to multiple diagnostic cardiovascular reductions, are rendered to a member during the **same session**, on the same date of service by the same provider but billed on separate claims, the services billed will be combined onto a single claim during claims processing. These combined services will then be subject to multiple diagnostic cardiovascular reductions for the technical component of the applicable diagnostic cardiovascular procedures. **<u>Multiple Procedures Rendered During Multiple "Separate and Distinct" Sessions or Encounters</u>** When diagnostic cardiovascular procedures which are subject to the multiple diagnostic cardiovascular reduction are rendered to the same member, on the same date of service, by the same provider **but** provided at **multiple separate and distinct sessions/encounters,** (e.g., Services rendered in the morning and then again later in the day), these services will need to be billed on two separate claims. These services rendered during the separate and distinct session/encounter on the same date of service will need to be billed with the appropriate distinct procedural services modifier, ***XE – Separate Encounter***, in order to identify the services as "separate and distinct" sessions/encounters rendered on the same date of service. The use of this modifier will indicate that multiple cardiovascular reduction should not apply. Documentation in the member's medical record/chart should reflect the multiple separate sessions/encounters in order to support the use of modifier XE.	
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.	
Exceptions		
Laws, Regulations & Standards		
References	• American Medical Association's Current Procedural Terminology (AMA/CPT) Codebook • Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File	
Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	10/03/24; 01/16/24; 02/08/23; 03/04/22; 03/23/21; 04/01/20; 05/03/19; 06/05/18; 08/11/17; 09/14/16; 06/26/16	
Version History	06/05/18	Annual review; no changes
	05/03/19	Annual review; no changes
	04/01/20	Annual review; no changes

	03/23/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms. Added link to the CMS National Physician Fee Schedule.
	03/04/22	Annual review; no changes
	02/08/23	Annual review; no changes
	01/16/24	Annual review; no changes
	10/03/24	Removed the following statement from the Exceptions section: "Claims history for Blue Card Home and Host claims and Federal Employee Program (FEP) claims will not subject to this policy."

This policy was published on November 27, 2024