Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-007		
Subject:	Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures		
Effective Date:	January 1, 2017	**End Date:**	
Issue Date:	July 1, 2025	**Revised Date:**	July 2025
Date Reviewed:	June 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

The Centers for Medicare and Medicaid Services (CMS) has established a reimbursement methodology for certain multiple diagnostic imaging procedures performed for the same patient on the same day during the same imaging session.

The Multiple Procedure Payment Reduction for the Technical Component of Certain Diagnostic Imaging Procedures is defined as physicians, group practice and suppliers billing for diagnostic imaging supplies and services. The technical component (TC) represents practice expense (PE) and includes clinical staff, supplies, and equipment. The multiple procedure payment reduction (MPPR) is now expanded to also apply to professional component (PC) services.

REIMBURSEMENT GUIDELINES:

Professional Component

When the professional component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the professional component of the imaging procedure with the highest allowance. For the additional imaging services performed for the same patient during the same imaging session on the same date of service, by the same physician or physician/Group practice, payment for the professional component portion only will be reduced to 95% of the allowance for the professional component. This reduction applies to the professional component only and the professional component of global services.

Technical Component

When the technical component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the imaging procedure with the highest allowance. For additional imaging services performed on contiguous anatomic areas during the same imaging session for the same patient, on the same date of service by the same physician or physician/Group practice, payment for the technical component portion only will be reduced to 50% of the allowance for the technical component. This reduction applies to technical component only and the technical component of global services.

Global Services

When a provider bills globally for two or more services subject to this policy, for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC). The RVUs assigned to each component (26 or TC) on the Medicare Physician Fee Schedule (MPFS) will determine which code will be ranked as primary (paid at 100%), and those that will be ranked as secondary or subsequent (paid with reductions applied in accordance with this policy).

See ***Appendix A*** for diagnostic imaging procedure codes that are applicable to the PC and TC reduction.

The Multiple Procedure Payment Reductions (MPPRs) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient, on the same date of service by the same physician or physician/Group practice. The MPPRs apply independently to cardiovascular and ophthalmology services.

Cardiovascular Services

For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix B*** for applicable cardiovascular imaging procedure codes.

Ophthalmology Services

For ophthalmology services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 80% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix C*** for applicable ophthalmology imaging procedure codes.

When multiple imaging services within the same family are performed on the same day for the same patient, but at different imaging sessions, modifier -59 must be reported for the subsequent session(s).

APPENDIX A – Procedure Codes Applicable To Professional And Technical Component Reduction

70336	70336	70336	70336	70336	70336	70336	70336	70336	70336
70450	70542	71271	72141	72196	73701	74176	75572	76831	0689T
70460	70543	71275	72142	72197	73702	74177	75573	76856	0697T
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70480	70545	71551	72147	73200	73718	74181	75635	76870	0723T
70481	70546	71552	72148	73201	73719	74182	76016	76978	0807T
70482	70547	71555	72149	73202	73720	74183	76017	76981	0808T
70486	70548	72125	72156	73206	73721	74185	76018	76982	0865T
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70490	70552	72128	72159	73220	73725	74712	76604	77048	0944T
70491	70553	72129	72191	73221	74150	75557	76700	77049	0946T
70492	70554	72130	72192	73222	74160	75559	76705	78306	0947T
70496	71250	72131	72193	73223	74170	75561	76770	78802	0972T
70498	71260	72132	72194	73225	74174	75563	76775	78803	

APPENDIX B – Applicable Cardiovascular Procedure Codes

75600	75809	75889	78472	93225	93279	93304	93880	93971	0826T
75605	75820	75891	78473	93226	93280	93306	93882	93975	0897T
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75746	75885	78468	93050	93271	93292	93786	93931	0716T	
75756	75887	78469	93224	93278	93303	93788	93970	0804T	

APPENDIX C – Applicable Ophthalmology Procedure Codes

76510	76514	92060	92132	92137	92235	92265	92274	92285	0507T
76511	76516	92081	92133	92145	92240	92270	92283	92286	0509T

76512	76519	92082	92134	92228	92242	92273	92284	0506T
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REFERENCES, ADDITIONAL BILLING INFORMATION AND GUIDELINES:

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POLICY UPDATE HISTORY INFORMATION:

8 / 2017	Implementation
1 / 2018	Removed procedure code 75658
12 / 2018	Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, 77049 0506T, 0507T, 0508T, 0509T, 92273 and 92274. Removed 77058, 77059 and 92275
5 / 2019	Updated reimbursement guidelines for global services
1 / 2021	Added 71271, 74712, 76978, 93050, 93241-93247, 93260, 93261, 93702, 93895, 93985, 93986 and 92229. Removed 36901-36906 and 93965.
7 / 2021	Removed code 0508T
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1 / 2024	Added 0826T and 0865T
7 / 2024	Added 0876T, 0897T and 0898T
1 / 2025	Added 76016-76019, 0944T, 0946T, 0947T, 0902T-0904T, 0926T, 0927T, 0938T, 0939T, and 92137. Removed 0398T and 93890
7 / 2025	Added 0962T and 0972T

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Date Reviewed:	December 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
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REIMBURSEMENT GUIDELINES:

Professional Component

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Global Services

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See ***Appendix A*** for diagnostic imaging procedure codes that are applicable to the PC and TC reduction.

The Multiple Procedure Payment Reductions (MPPRs) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient, on the same date of service by the same physician or physician/Group practice. The MPPRs apply independently to cardiovascular and ophthalmology services.

Cardiovascular Services

For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix B*** for applicable cardiovascular imaging procedure codes.

Ophthalmology Services

For ophthalmology services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 80% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

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See ***Appendix C*** for applicable ophthalmology imaging procedure codes.

When multiple imaging services within the same family are performed on the same day for the same patient, but at different imaging sessions, modifier -59 must be reported for the subsequent session(s).

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See ***Appendix B*** for applicable cardiovascular imaging procedure codes.

Ophthalmology Services

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75741	75870	78456	93017	93246	93285	93314	93890	93976	0897T
75743	75872	78457	93024	93247	93286	93318	93892	93978	
75746	75880	78458	93025	93260	93287	93350	93893	93979	

APPENDIX C – Applicable Ophthalmology Procedure Codes

76510	76513	76519	92081	92132	92136	92229	92250	92274	92286

76511	76514	92025	92082	92133	92145	92235	92265	92283	0506T
76512	76516	92060	92083	92134	92228	92240	92270	92284	0507T
						92242	92273	92285	0509T

REFERENCES, ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Centers for Medicaid and Medicare Services; Medicare Claims Processing Manual. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf
- Centers for Medicaid and Medicare Services; MLM Matters, MM7747/CR7747 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7747.pdf
- Centers for Medicaid and Medicare Services; MLM Matters, SE0665. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0665.pdf

POLICY UPDATE HISTORY INFORMATION:

8 / 2017	Implementation
1 / 2018	Removed procedure code 75658
12 / 2018	Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, 77049 0506T, 0507T, 0508T, 0509T, 92273 and 92274. Removed 77058, 77059 and 92275
5 / 2019	Updated reimbursement guidelines for global services
1 / 2021	Added 71271, 74712, 76978, 93050, 93241-93247, 93260, 93261, 93702, 93895, 93985, 93986 and 92229. Removed 36901-36906 and 93965.
7 / 2021	Removed code 0508T
10 / 2021	Added code 0648T
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy. Added 0683T, 0684T, 0685T, 0689T, 0697T
7 / 2022	Added 0716T, 0721T, 0723T, 0398T
7 / 2023	Added 0804T, 0807T, 0808T
10 / 2023	Removed G0297, added 78306, 78802, 78803
1 / 2024	Added 0826T and 0865T
7 / 2024	Added 0876T, 0897T and 0898T

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-007		
Subject:	Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures		
Effective Date:	January 1, 2017	**End Date:**	
Issue Date:	January 1, 2024	**Revised Date:**	January 2024
Date Reviewed:	December 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

The Centers for Medicare and Medicaid Services (CMS) has established a reimbursement methodology for certain multiple diagnostic imaging procedures performed for the same patient on the same day during the same imaging session.

The Multiple Procedure Payment Reduction for the Technical Component of Certain Diagnostic Imaging Procedures is defined as physicians, group practice and suppliers billing for diagnostic imaging supplies and services. The technical component (TC) represents practice expense (PE) and includes clinical staff, supplies, and equipment. The multiple procedure payment reduction (MPPR) is now expanded to also apply to professional component (PC) services.

REIMBURSEMENT GUIDELINES:

Professional Component

When the professional component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the professional component of the imaging procedure with the highest allowance. For the additional imaging services performed for the same patient during the same imaging session on the same date of service, by the same physician or physician/Group practice, payment for the professional component portion only will be reduced to 95% of the allowance for the professional component. This reduction applies to the professional component only and the professional component of global services.

Technical Component

When the technical component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the imaging procedure with the highest allowance. For additional imaging services performed on contiguous anatomic areas during the same imaging session for the same patient, on the same date of service by the same physician or physician/Group practice, payment for the technical component portion only will be reduced to 50% of the allowance for the technical component. This reduction applies to technical component only and the technical component of global services.

Global Services

When a provider bills globally for two or more services subject to this policy, for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC). The RVUs assigned to each component (26 or TC) on the Medicare Physician Fee Schedule (MPFS) will determine which code will be ranked as primary (paid at 100%), and those that will be ranked as secondary or subsequent (paid with reductions applied in accordance with this policy).

See ***Appendix A*** for diagnostic imaging procedure codes that are applicable to the PC and TC reduction.

The Multiple Procedure Payment Reductions (MPPRs) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient, on the same date of service by the same physician or physician/Group practice. The MPPRs apply independently to cardiovascular and ophthalmology services.

Cardiovascular Services

For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix B*** for applicable cardiovascular imaging procedure codes.

Ophthalmology Services

For ophthalmology services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 80% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix C*** for applicable ophthalmology imaging procedure codes.

When multiple imaging services within the same family are performed on the same day for the same patient, but at different imaging sessions, modifier -59 must be reported for the subsequent session(s).

APPENDIX A – Procedure Codes Applicable To Professional And Technical Component Reduction

70336	70498	71250	72130	72191	73220	73723	74261	76700	77048
70450	70540	71260	72131	72192	73221	73725	74262	76705	77049
70460	70542	71270	72132	72193	73222	74150	74712	76770	78306
70470	70543	71271	72133	72194	73223	74160	75557	76775	78802
70480	70544	71275	72141	72195	73225	74170	75559	76776	78803
70481	70545	71550	72142	72196	73700	74174	75561	76831	0398T
70482	70546	71551	72146	72197	73701	74175	75563	76856	0648T
70486	70547	71552	72147	72198	73702	74176	75571	76857	0689T
70487	70548	71555	72148	73200	73706	74177	75572	76870	0697T
70488	70549	72125	72149	73201	73718	74178	75573	76978	0721T
70490	70551	72126	72156	73202	73719	74181	75574	76981	0723T
70491	70552	72127	72157	73206	73720	74182	75635	76982	0807T
70492	70553	72128	72158	73218	73721	74183	76391	77046	0808T
70496	70554	72129	72159	73219	73722	74185	76604	77047	0865T

APPENDIX B – Applicable Cardiovascular Procedure Codes

75600	75746	75872	78456	93015	93245	93284	93312	93888	93975
75605	75756	75880	78457	93017	93246	93285	93314	93890	93976
75625	75809	75885	78458	93024	93247	93286	93318	93892	93978
75630	75820	75887	78466	93025	93260	93287	93350	93893	93979
75705	75822	75889	78468	93040	93261	93288	93351	93895	93980
75710	75825	75891	78469	93041	93268	93289	93701	93922	93981
75716	75827	75893	78472	93050	93270	93290	93702	93923	93985
75726	75831	78428	78473	93224	93271	93291	93724	93924	93986
75731	75833	78445	78481	93225	93278	93292	93784	93925	93990
75733	75840	78451	78483	93226	93279	93303	93786	93926	0683T
75736	75842	78452	78494	93229	93280	93304	93788	93930	0684T
75741	75860	78453	93000	93241	93281	93306	93880	93931	0685T
75743	75870	78454	93005	93242	93282	93307	93882	93970	0716T
				93243	93283	93308	93886	93971	0804T

APPENDIX C – Applicable Ophthalmology Procedure Codes

76510	76513	76519	92081	92132	92136	92229	92250	92274	92286
76511	76514	92025	92082	92133	92145	92235	92265	92283	0506T
76512	76516	92060	92083	92134	92228	92240	92270	92284	0507T
						92242	92273	92285	0509T

REFERENCES, ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Centers for Medicaid and Medicare Services; Medicare Claims Processing Manual. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf

- Centers for Medicaid and Medicare Services; MLM Matters, MM7747/CR7747 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7747.pdf

- Centers for Medicaid and Medicare Services; MLM Matters, SE0665. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0665.pdf

POLICY UPDATE HISTORY INFORMATION:

8 / 2017	Implementation
1 / 2018	Removed procedure code 75658
12 / 2018	Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, 77049 0506T, 0507T, 0508T, 0509T, 92273 and 92274. Removed 77058, 77059 and 92275
5 / 2019	Updated reimbursement guidelines for global services
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7 / 2021	Removed code 0508T
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1 / 2022	Added Delaware Medicare Advantage applicable to the policy. Added 0683T, 0684T, 0685T, 0689T, 0697T
7 / 2022	Added 0716T, 0721T, 0723T, 0398T
7 / 2023	Added 0804T, 0807T, 0808T
10 / 2023	Removed G0297, added 78306, 78802, 78803
1 / 2024	Added 0826T and 0865T

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-007		
Subject:	Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures		
Effective Date:	January 1, 2017	**End Date:**	
Issue Date:	October 16, 2023	**Revised Date:**	October 2023
Date Reviewed:	September 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

The Centers for Medicare and Medicaid Services (CMS) has established a reimbursement methodology for certain multiple diagnostic imaging procedures performed for the same patient on the same day during the same imaging session.

The Multiple Procedure Payment Reduction for the Technical Component of Certain Diagnostic Imaging Procedures is defined as physicians, group practice and suppliers billing for diagnostic imaging supplies and services. The technical component (TC) represents practice expense (PE) and includes clinical staff, supplies, and equipment. The multiple procedure payment reduction (MPPR) is now expanded to also apply to professional component (PC) services.

REIMBURSEMENT GUIDELINES:

Professional Component

When the professional component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the professional component of the imaging procedure with the highest allowance. For the additional imaging services performed for the same patient during the same imaging session on the same date of service, by the same physician or physician/Group practice, payment for the professional component portion only will be reduced to 95% of the allowance for the professional component. This reduction applies to the professional component only and the professional component of global services.

Technical Component

When the technical component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the imaging procedure with the highest allowance. For additional imaging services performed on contiguous anatomic areas during the same imaging session for the same patient, on the same date of service by the same physician or physician/Group practice, payment for the technical component portion only will be reduced to 50% of the allowance for the technical component. This reduction applies to technical component only and the technical component of global services.

Global Services

When a provider bills globally for two or more services subject to this policy, for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC). The RVUs assigned to each component (26 or TC) on the Medicare Physician Fee Schedule (MPFS) will determine which code will be ranked as primary (paid at 100%), and those that will be ranked as secondary or subsequent (paid with reductions applied in accordance with this policy).

See ***Appendix A*** for diagnostic imaging procedure codes that are applicable to the PC and TC reduction.

The Multiple Procedure Payment Reductions (MPPRs) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient, on the same date of service by the same physician or physician/Group practice. The MPPRs apply independently to cardiovascular and ophthalmology services.

Cardiovascular Services

For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix B*** for applicable cardiovascular imaging procedure codes.

Ophthalmology Services

For ophthalmology services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 80% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix C*** for applicable ophthalmology imaging procedure codes.

When multiple imaging services within the same family are performed on the same day for the same patient, but at different imaging sessions, modifier -59 must be reported for the subsequent session(s).

APPENDIX A – Procedure Codes Applicable To Professional And Technical Component Reduction

70336	70496	70554	72129	72159	73219	73722	74185	76604	77047
70450	70498	71250	72130	72191	73220	73723	74261	76700	77048
70460	70540	71260	72131	72192	73221	73725	74262	76705	77049
70470	70542	71270	72132	72193	73222	74150	74712	76770	78306
70480	70543	71271	72133	72194	73223	74160	75557	76775	78802
70481	70544	71275	72141	72195	73225	74170	75559	76776	78803
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70490	70549	72125	72149	73201	73718	74178	75573	76978	0721T
70491	70551	72126	72156	73202	73719	74181	75574	76981	0723T
70492	70552	72127	72157	73206	73720	74182	75635	76982	0807T
	70553	72128	72158	73218	73721	74183	76391	77046	0808T

APPENDIX B – Applicable Cardiovascular Procedure Codes

75600	75746	75872	78456	93015	93245	93284	93312	93888	93975
75605	75756	75880	78457	93017	93246	93285	93314	93890	93976
75625	75809	75885	78458	93024	93247	93286	93318	93892	93978
75630	75820	75887	78466	93025	93260	93287	93350	93893	93979
75705	75822	75889	78468	93040	93261	93288	93351	93895	93980
75710	75825	75891	78469	93041	93268	93289	93701	93922	93981
75716	75827	75893	78472	93050	93270	93290	93702	93923	93985
75726	75831	78428	78473	93224	93271	93291	93724	93924	93986
75731	75833	78445	78481	93225	93278	93292	93784	93925	93990
75733	75840	78451	78483	93226	93279	93303	93786	93926	0683T
75736	75842	78452	78494	93229	93280	93304	93788	93930	0684T
75741	75860	78453	93000	93241	93281	93306	93880	93931	0685T
75743	75870	78454	93005	93242	93282	93307	93882	93970	0716T
				93243	93283	93308	93886	93971	0804T

APPENDIX C – Applicable Ophthalmology Procedure Codes

76510	76513	76519	92081	92132	92136	92229	92250	92274	92286
76511	76514	92025	92082	92133	92145	92235	92265	92283	0506T
76512	76516	92060	92083	92134	92228	92240	92270	92284	0507T
						92242	92273	92285	0509T

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- Centers for Medicaid and Medicare Services; Medicare Claims Processing Manual. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf
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- Centers for Medicaid and Medicare Services; MLM Matters, SE0665. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0665.pdf

POLICY UPDATE HISTORY INFORMATION:

8 / 2017	Implementation
1 / 2018	Removed procedure code 75658
12 / 2018	Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, 77049 0506T, 0507T, 0508T, 0509T, 92273 and 92274. Removed 77058, 77059 and 92275
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7 / 2021	Removed code 0508T
10 / 2021	Added code 0648T
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy. Added 0683T, 0684T, 0685T, 0689T, 0697T
7 / 2022	Added 0716T, 0721T, 0723T, 0398T
7 / 2023	Added 0804T, 0807T, 0808T
10 / 2023	Removed G0297, added 78306, 78802, 78803

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-007		
Subject:	Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures		
Effective Date:	January 1, 2017	**End Date:**	
Issue Date:	July 3, 2023	**Revised Date:**	July 2023
Date Reviewed:	June 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

The Centers for Medicare and Medicaid Services (CMS) has established a reimbursement methodology for certain multiple diagnostic imaging procedures performed for the same patient on the same day during the same imaging session.

The Multiple Procedure Payment Reduction for the Technical Component of Certain Diagnostic Imaging Procedures is defined as physicians, group practice and suppliers billing for diagnostic imaging supplies and services. The technical component (TC) represents practice expense (PE) and includes clinical staff, supplies, and equipment. The multiple procedure payment reduction (MPPR) is now expanded to also apply to professional component (PC) services.

REIMBURSEMENT GUIDELINES:

Professional Component

When the professional component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the professional component of the imaging procedure with the highest allowance. For the additional imaging services performed for the same patient during the same imaging session on the same date of service, by the same physician or physician/Group practice, payment for the professional component portion only will be reduced to 95% of the allowance for the professional component. This reduction applies to the professional component only and the professional component of global services.

Technical Component

When the technical component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the imaging procedure with the highest allowance. For additional imaging services performed on contiguous anatomic areas during the same imaging session for the same patient, on the same date of service by the same physician or physician/Group practice, payment for the technical component portion only will be reduced to 50% of the allowance for the technical component. This reduction applies to technical component only and the technical component of global services.

Global Services

When a provider bills globally for two or more services subject to this policy, for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC). The RVUs assigned to each component (26 or TC) on the Medicare Physician Fee Schedule (MPFS) will determine which code will be ranked as primary (paid at 100%), and those that will be ranked as secondary or subsequent (paid with reductions applied in accordance with this policy).

See ***Appendix A*** for diagnostic imaging procedure codes that are applicable to the PC and TC reduction.

The Multiple Procedure Payment Reductions (MPPRs) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient, on the same date of service by the same physician or physician/Group practice. The MPPRs apply independently to cardiovascular and ophthalmology services.

Cardiovascular Services

For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix B*** for applicable cardiovascular imaging procedure codes.

Ophthalmology Services

For ophthalmology services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 80% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix C*** for applicable ophthalmology imaging procedure codes.

When multiple imaging services within the same family are performed on the same day for the same patient, but at different imaging sessions, modifier -59 must be reported for the subsequent session(s).

APPENDIX A – Procedure Codes Applicable To Professional And Technical Component Reduction

70336	70496	70553	72127	72157	73206	73720	74182	75635	76982
70450	70498	70554	72128	72158	73218	73721	74183	76391	77046
70460	70540	71250	72129	72159	73219	73722	74185	76604	77047
70470	70542	71260	72130	72191	73220	73723	74261	76700	77048
70480	70543	71270	72131	72192	73221	73725	74262	76705	77049
70481	70544	71271	72132	72193	73222	74150	74712	76770	G0297
70482	70545	71275	72133	72194	73223	74160	75557	76775	0398T
70486	70546	71550	72141	72195	73225	74170	75559	76776	0648T
70487	70547	71551	72142	72196	73700	74174	75561	76831	0689T
70488	70548	71552	72146	72197	73701	74175	75563	76856	0697T
70490	70549	71555	72147	72198	73702	74176	75571	76857	0721T
70491	70551	72125	72148	73200	73706	74177	75572	76870	0723T
70492	70552	72126	72149	73201	73718	74178	75573	76978	0807T
			72156	73202	73719	74181	75574	76981	0808T

APPENDIX B – Applicable Cardiovascular Procedure Codes

75600	75746	75872	78456	93015	93245	93284	93312	93888	93975
75605	75756	75880	78457	93017	93246	93285	93314	93890	93976
75625	75809	75885	78458	93024	93247	93286	93318	93892	93978
75630	75820	75887	78466	93025	93260	93287	93350	93893	93979
75705	75822	75889	78468	93040	93261	93288	93351	93895	93980
75710	75825	75891	78469	93041	93268	93289	93701	93922	93981
75716	75827	75893	78472	93050	93270	93290	93702	93923	93985
75726	75831	78428	78473	93224	93271	93291	93724	93924	93986
75731	75833	78445	78481	93225	93278	93292	93784	93925	93990
75733	75840	78451	78483	93226	93279	93303	93786	93926	0683T
75736	75842	78452	78494	93229	93280	93304	93788	93930	0684T
75741	75860	78453	93000	93241	93281	93306	93880	93931	0685T
75743	75870	78454	93005	93242	93282	93307	93882	93970	0716T
				93243	93283	93308	93886	93971	0804T

APPENDIX C – Applicable Ophthalmology Procedure Codes

76510	76513	76519	92081	92132	92136	92229	92250	92274	92286
76511	76514	92025	92082	92133	92145	92235	92265	92283	0506T
76512	76516	92060	92083	92134	92228	92240	92270	92284	0507T
						92242	92273	92285	0509T

REFERENCES, ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Centers for Medicaid and Medicare Services; Medicare Claims Processing Manual. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf

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POLICY UPDATE HISTORY INFORMATION:

8 / 2017	Implementation
1 / 2018	Removed procedure code 75658
12 / 2018	Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, 77049 0506T, 0507T, 0508T, 0509T, 92273 and 92274. Removed 77058, 77059 and 92275
5 / 2019	Updated reimbursement guidelines for global services
1 / 2021	Added 71271, 74712, 76978, 93050, 93241-93247, 93260, 93261, 93702, 93895, 93985, 93986 and 92229. Removed 36901-36906 and 93965.
7 / 2021	Removed code 0508T
10 / 2021	Added code 0648T
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy. Added 0683T, 0684T, 0685T, 0689T, 0697T
7 / 2022	Added 0716T, 0721T, 0723T, 0398T
7 / 2023	Added 0804T, 0807T, 0808T

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-007		
Subject:	Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures		
Effective Date:	January 1, 2017	**End Date:**	
Issue Date:	July 4, 2022	**Revised Date:**	July 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

➦ A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

The Centers for Medicare and Medicaid Services (CMS) has established a reimbursement methodology for certain multiple diagnostic imaging procedures performed for the same patient on the same day during the same imaging session.

The Multiple Procedure Payment Reduction for the Technical Component of Certain Diagnostic Imaging Procedures is defined as physicians, group practice and suppliers billing for diagnostic imaging supplies and services. The technical component (TC) represents practice expense (PE) and includes clinical staff, supplies, and equipment. The multiple procedure payment reduction (MPPR) is now expanded to also apply to professional component (PC) services.

REIMBURSEMENT GUIDELINES:

Professional Component

When the professional component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the professional component of the imaging procedure with the highest allowance. For the additional imaging services performed for the same patient during the same imaging session on the same date of service, by the same physician or physician/Group practice, payment for the professional component portion only will be reduced to 95% of the allowance for the professional component. This reduction applies to the professional component only and the professional component of global services.

Technical Component

When the technical component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the imaging procedure with the highest allowance. For additional imaging services performed on contiguous anatomic areas during the same imaging session for the same patient, on the same date of service by the same physician or physician/Group practice, payment for the technical component portion only will be reduced to 50% of the allowance for the technical component. This reduction applies to technical component only and the technical component of global services.

Global Services

When a provider bills globally for two or more services subject to this policy, for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC). The RVUs assigned to each component (26 or TC) on the Medicare Physician Fee Schedule (MPFS) will determine which code will be ranked as primary (paid at 100%), and those that will be ranked as secondary or subsequent (paid with reductions applied in accordance with this policy).

See ***Appendix A*** for diagnostic imaging procedure codes that are applicable to the PC and TC reduction.

The Multiple Procedure Payment Reductions (MPPRs) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient, on the same date of service by the same physician or physician/Group practice. The MPPRs apply independently to cardiovascular and ophthalmology services.

Cardiovascular Services

For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix B*** for applicable cardiovascular imaging procedure codes.

Ophthalmology Services

For ophthalmology services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 80% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix C*** for applicable ophthalmology imaging procedure codes.

When multiple imaging services within the same family are performed on the same day for the same patient, but at different imaging sessions, modifier -59 must be reported for the subsequent session(s).

APPENDIX A – Procedure Codes Applicable To Professional And Technical Component Reduction

70336	70496	70553	72127	72156	73201	73718	74178	75573	76978
70450	70498	70554	72128	72157	73202	73719	74181	75574	76981
70460	70540	71250	72129	72158	73206	73720	74182	75635	76982
70470	70542	71260	72130	72159	73218	73721	74183	76391	77046
70480	70543	71270	72131	72191	73219	73722	74185	76604	77047
70481	70544	71271	72132	72192	73220	73723	74261	76700	77048
70482	70545	71275	72133	72193	73221	73725	74262	76705	77049
70486	70546	71550	72141	72194	73222	74150	74712	76770	G0297
70487	70547	71551	72142	72195	73223	74160	75557	76775	0398T
70488	70548	71552	72146	72196	73225	74170	75559	76776	0648T
70490	70549	71555	72147	72197	73700	74174	75561	76831	0689T
70491	70551	72125	72148	72198	73701	74175	75563	76856	0697T
70492	70552	72126	72149	73200	73702	74176	75571	76857	0721T
					73706	74177	75572	76870	0723T

APPENDIX B – Applicable Cardiovascular Procedure Codes

75600	75746	75872	78456	93015	93243	93283	93308	93886	93971
75605	75756	75880	78457	93017	93245	93284	93312	93888	93975
75625	75809	75885	78458	93024	93246	93285	93314	93890	93976
75630	75820	75887	78466	93025	93247	93286	93318	93892	93978
75705	75822	75889	78468	93040	93260	93287	93350	93893	93979
75710	75825	75891	78469	93041	93261	93288	93351	93895	93980
75716	75827	75893	78472	93050	93268	93289	93701	93922	93981
75726	75831	78428	78473	93224	93270	93290	93702	93923	93985
75731	75833	78445	78481	93225	93271	93291	93724	93924	93986
75733	75840	78451	78483	93226	93278	93292	93784	93925	93990
75736	75842	78452	78494	93229	93279	93303	93786	93926	0683T
75741	75860	78453	93000	93241	93280	93304	93788	93930	0684T
75743	75870	78454	93005	93242	93281	93306	93880	93931	0685T
					93282	93307	93882	93970	0716T

APPENDIX C – Applicable Ophthalmology Procedure Codes

76510	76513	76519	92081	92132	92136	92229	92250	92274	92286
76511	76514	92025	92082	92133	92145	92235	92265	92283	0506T
76512	76516	92060	92083	92134	92228	92240	92270	92284	0507T
						92242	92273	92285	0509T

REFERENCES, ADDITIONAL BILLING INFORMATION AND GUIDELINES:

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- Centers for Medicaid and Medicare Services; MLM Matters, SE0665. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0665.pdf

POLICY UPDATE HISTORY INFORMATION:

8 / 2017	Implementation
1 / 2018	Removed procedure code 75658
12 / 2018	Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, 77049 0506T, 0507T, 0508T, 0509T, 92273 and 92274. Removed 77058, 77059 and 92275
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1 / 2021	Added 71271, 74712, 76978, 93050, 93241-93247, 93260, 93261, 93702, 93895, 93985, 93986 and 92229. Removed 36901-36906 and 93965.
7 / 2021	Removed code 0508T
10 / 2021	Added code 0648T
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy. Added 0683T, 0684T, 0685T, 0689T, 0697T
7 / 2022	Added 0716T, 0721T, 0723T, 0398T

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-007		
Subject:	Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures		
Effective Date:	January 1, 2017	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	December 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

The Centers for Medicare and Medicaid Services (CMS) has established a reimbursement methodology for certain multiple diagnostic imaging procedures performed for the same patient on the same day during the same imaging session.

The Multiple Procedure Payment Reduction for the Technical Component of Certain Diagnostic Imaging Procedures is defined as physicians, group practice and suppliers billing for diagnostic imaging supplies and services. The technical component (TC) represents practice expense (PE) and includes clinical staff, supplies, and equipment. The multiple procedure payment reduction (MPPR) is now expanded to also apply to professional component (PC) services.

REIMBURSEMENT GUIDELINES:

Professional Component

When the professional component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the professional component of the imaging procedure with the highest allowance. For the additional imaging services performed for the same patient during the same imaging session on the same date of service, by the same physician or physician/Group practice, payment for the professional component portion only will be reduced to 95% of the allowance for the professional component. This reduction applies to the professional component only and the professional component of global services.

Technical Component

When the technical component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the imaging procedure with the highest allowance. For additional imaging services performed on contiguous anatomic areas during the same imaging session for the same patient, on the same date of service by the same physician or physician/Group practice, payment for the technical component portion only will be reduced to 50% of the allowance for the technical component. This reduction applies to technical component only and the technical component of global services.

Global Services

When a provider bills globally for two or more services subject to this policy, for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC). The RVUs assigned to each component (26 or TC) on the Medicare Physician Fee Schedule (MPFS) will determine which code will be ranked as primary (paid at 100%), and those that will be ranked as secondary or subsequent (paid with reductions applied in accordance with this policy).

See ***Appendix A*** for diagnostic imaging procedure codes that are applicable to the PC and TC reduction.

The Multiple Procedure Payment Reductions (MPPRs) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient, on the same date of service by the same physician or physician/Group practice. The MPPRs apply independently to cardiovascular and ophthalmology services.

Cardiovascular Services

For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix B*** for applicable cardiovascular imaging procedure codes.

Ophthalmology Services

For ophthalmology services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 80% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix C*** for applicable ophthalmology imaging procedure codes.

When multiple imaging services within the same family are performed on the same day for the same patient, but at different imaging sessions, modifier -59 must be reported for the subsequent session(s).

APPENDIX A – Procedure Codes Applicable To Professional And Technical Component Reduction

70336	70496	70553	72127	72156	73201	73706	74176	75563	76856
70450	70498	70554	72128	72157	73202	73718	74177	75571	76857
70460	70540	71250	72129	72158	73206	73719	74178	75572	76870
70470	70542	71260	72130	72159	73218	73720	74181	75573	76978
70480	70543	71270	72131	72191	73219	73721	74182	75574	76981
70481	70544	71271	72132	72192	73220	73722	74183	75635	76982
70482	70545	71275	72133	72193	73221	73723	74185	76391	77046
70486	70546	71550	72141	72194	73222	73725	74261	76604	77047
70487	70547	71551	72142	72195	73223	74150	74262	76700	77048
70488	70548	71552	72146	72196	73225	74160	74712	76705	77049
70490	70549	71555	72147	72197	73700	74170	75557	76770	G0297
70491	70551	72125	72148	72198	73701	74174	75559	76775	0648T
70492	70552	72126	72149	73200	73702	74175	75561	76776	0689T
								76831	0697T

APPENDIX B – Applicable Cardiovascular Procedure Codes

75600	75746	75872	78456	93015	93243	93282	93307	93882	93970
75605	75756	75880	78457	93017	93245	93283	93308	93886	93971
75625	75809	75885	78458	93024	93246	93284	93312	93888	93975
75630	75820	75887	78466	93025	93247	93285	93314	93890	93976
75705	75822	75889	78468	93040	93260	93286	93318	93892	93978
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75716	75827	75893	78472	93050	93268	93288	93351	93895	93980
75726	75831	78428	78473	93224	93270	93289	93701	93922	93981
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75741	75860	78453	93000	93241	93280	93303	93786	93926	0683T
75743	75870	78454	93005	93242	93281	93304	93788	93930	0684T
						93306	93880	93931	0685T

APPENDIX C – Applicable Ophthalmology Procedure Codes

76510	76513	76519	92081	92132	92136	92229	92250	92274	92286
76511	76514	92025	92082	92133	92145	92235	92265	92283	0506T
76512	76516	92060	92083	92134	92228	92240	92270	92284	0507T
						92242	92273	92285	0509T

REFERENCES, ADDITIONAL BILLING INFORMATION AND GUIDELINES:

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POLICY UPDATE HISTORY INFORMATION:

8 / 2017	Implementation
1 / 2018	Removed procedure code 75658
12 / 2018	Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, 77049 0506T, 0507T, 0508T, 0509T, 92273 and 92274. Removed 77058, 77059 and 92275
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7 / 2021	Removed code 0508T
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11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy. Added 0683T, 0684T, 0685T, 0689T, 0697T.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-007		
Subject:	Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures		
Effective Date:	January 1, 2017	**End Date:**	
Issue Date:	October 18, 2021	**Revised Date:**	October 2021
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☐	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

The Centers for Medicare and Medicaid Services (CMS) has established a reimbursement methodology for certain multiple diagnostic imaging procedures performed for the same patient on the same day during the same imaging session.

The Multiple Procedure Payment Reduction for the Technical Component of Certain Diagnostic Imaging Procedures is defined as physicians, group practice and suppliers billing for diagnostic imaging supplies and services. The technical component (TC) represents practice expense (PE) and includes clinical staff, supplies, and equipment. The multiple procedure payment reduction (MPPR) is now expanded to also apply to professional component (PC) services.

REIMBURSEMENT GUIDELINES:

Professional Component

When the professional component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the professional component of the imaging procedure with the highest allowance. For the additional imaging services performed for the same patient during the same imaging session on the same date of service, by the same physician or physician/Group practice, payment for the professional component portion only will be reduced to 95% of the allowance for the professional component. This reduction applies to the professional component only and the professional component of global services.

Technical Component

When the technical component of certain diagnostic imaging services or procedures are performed for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, payment will be made at 100% for the imaging procedure with the highest allowance. For additional imaging services performed on contiguous anatomic areas during the same imaging session for the same patient, on the same date of service by the same physician or physician/Group practice, payment for the technical component portion only will be reduced to 50% of the allowance for the technical component. This reduction applies to technical component only and the technical component of global services.

Global Services

When a provider bills globally for two or more services subject to this policy, for the same patient during the same imaging session on the same date of service by the same physician or physician/Group practice, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC). The RVUs assigned to each component (26 or TC) on the Medicare Physician Fee Schedule (MPFS) will determine which code will be ranked as primary (paid at 100%), and those that will be ranked as secondary or subsequent (paid with reductions applied in accordance with this policy).

See ***Appendix A*** for diagnostic imaging procedure codes that are applicable to the PC and TC reduction.

The Multiple Procedure Payment Reductions (MPPRs) on diagnostic cardiovascular and ophthalmology procedures apply when multiple services are furnished to the same patient, on the same date of service by the same physician or physician/Group practice. The MPPRs apply independently to cardiovascular and ophthalmology services.

Cardiovascular Services

For cardiovascular services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix B*** for applicable cardiovascular imaging procedure codes.

Ophthalmology Services

For ophthalmology services, full payment is made for the TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 80% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. This reduction applies to technical component only and the technical component of global services.

Note: The MPPRs do not apply to professional component (PC) services.

See ***Appendix C*** for applicable ophthalmology imaging procedure codes.

When multiple imaging services within the same family are performed on the same day for the same patient, but at different imaging sessions, modifier -59 must be reported for the subsequent session(s).

APPENDIX A – Procedure Codes Applicable To Professional And Technical Component Reduction

70336	70496	70553	72127	72156	73201	73706	74176	75563	76831
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70460	70540	71250	72129	72158	73206	73719	74178	75572	76857
70470	70542	71260	72130	72159	73218	73720	74181	75573	76870
70480	70543	71270	72131	72191	73219	73721	74182	75574	76978
70481	70544	71271	72132	72192	73220	73722	74183	75635	76981
70482	70545	71275	72133	72193	73221	73723	74185	76391	76982
70486	70546	71550	72141	72194	73222	73725	74261	76604	77046
70487	70547	71551	72142	72195	73223	74150	74262	76700	77047
70488	70548	71552	72146	72196	73225	74160	74712	76705	77048
70490	70549	71555	72147	72197	73700	74170	75557	76770	77049
70491	70551	72125	72148	72198	73701	74174	75559	76775	G0297
70492	70552	72126	72149	73200	73702	74175	75561	76776	0648T

APPENDIX B – Applicable Cardiovascular Procedure Codes

75600	75746	75872	78456	93015	93243	93282	93306	93788	93926
75605	75756	75880	78457	93017	93245	93283	93307	93880	93930
75625	75809	75885	78458	93024	93246	93284	93308	93882	93931
75630	75820	75887	78466	93025	93247	93285	93312	93886	93970
75705	75822	75889	78468	93040	93260	93286	93314	93888	93971
75710	75825	75891	78469	93041	93261	93287	93318	93890	93975
75716	75827	75893	78472	93050	93268	93288	93350	93892	93976
75726	75831	78428	78473	93224	93270	93289	93351	93893	93978
75731	75833	78445	78481	93225	93271	93290	93701	93895	93979
75733	75840	78451	78483	93226	93278	93291	93702	93922	93980
75736	75842	78452	78494	93229	93279	93292	93724	93923	93981
75741	75860	78453	93000	93241	93280	93303	93784	93924	93985
75743	75870	78454	93005	93242	93281	93304	93786	93925	93986
									93990

APPENDIX C – Applicable Ophthalmology Procedure Codes

0506T	76510	76514	92060	92132	92145	92240	92270	92284
0507T	76511	76516	92081	92133	92228	92242	92273	92285
0509T	76512	76519	92082	92134	92229	92250	92274	92286
	76513	92025	92083	92136	92235	92265	92283	

REFERENCES, ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Centers for Medicaid and Medicare Services; Medicare Claims Processing Manual. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf

- Centers for Medicaid and Medicare Services; MLM Matters, MM7747/CR7747 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7747.pdf

- Centers for Medicaid and Medicare Services; MLM Matters, SE0665. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0665.pdf

POLICY UPDATE HISTORY INFORMATION:

8 / 2017	Implementation
1 / 2018	Removed procedure code 75658
12 / 2018	Added 76391, 76978, 76981, 76982, 77046, 77047, 77048, 77049 0506T, 0507T, 0508T, 0509T, 92273 and 92274. Removed 77058, 77059 and 92275
5 / 2019	Updated reimbursement guidelines for global services
1 / 2021	Added 71271, 74712, 76978, 93050, 93241-93247, 93260, 93261, 93702, 93895, 93985, 93986 and 92229. Removed 36901-36906 and 93965.
7 / 2021	Removed code 0508T
10 / 2021	Added code 0648T
11 / 2021	Added NY region applicable to the policy