Title: Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures

Policy Number: RP-007

Version Number: 2026.07.27

Medicare Advantage:	PA, WV, DE, NY	Version Effective:	July 27, 2026
Commercial:	PA, WV, DE, NY	Originally Effective:	January 1, 2017
Claim Type:	CMS 1500	History Versions:	Click Here → History

Disclosure: *The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan and ensure you are reimbursed based on the codes that correctly describe the health care services provided. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the members' contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations. The policy is applicable to designated markets either entirely, or partially, as indicated within the policy. Policy designation of claim type is based on how the provider is contracted with the Plan.*

Description:

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 (MPPR) 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 MPPR may also apply to professional component (PC) services.

Reimbursement Guidelines:

Application of same provider includes same physician or physician group practice billing under the same National Provider Identifier (NPI).

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 provider, reimbursement 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 provider, reimbursement 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 provider, reimbursement 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 provider, reimbursement for the technical component portion only will be reduced to 50% of the allowance for the technical component. This reduction applies to the 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 provider, the charge for the global procedure codes will be divided into the PC and TC (modifiers 26 and TC). The relative value units (RVU) 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.

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 provider. MPPRs apply independently to cardiovascular and ophthalmology services.

Cardiovascular Services

For cardiovascular services, full reimbursement is made for the TC service with the highest allowance under the MPFS. Reimbursement is made at 75% for subsequent TC services furnished to the same patient on the same day by the same provider. This reduction applies to the technical component only and the technical component of global 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 MPFS. Reimbursement is made at 80% for subsequent TC services furnished by the same provider to the same patient on the same day. This reduction applies to the technical component only

and the technical component of global services. See ***Appendix C*** for applicable ophthalmology imaging procedure codes. Note, the MPPRs do not apply to professional component (PC) for ophthalmology services.

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

70336	70487	70545	71260	72128	72149	72197	73222	73722	74181	75563	76700	77046	0807T
70450	70488	70546	71271	72129	72156	72198	73223	73723	74182	75572	76705	77047	0808T
70460	70490	70547	71275	72130	72157	73200	73225	73725	74183	75573	76770	77048	0865T
70470	70491	70548	71550	72131	72158	73201	73701	74150	74185	75574	76775	77049	0876T
70471	70492	70549	71551	72132	72159	73202	73702	74160	74261	75635	76831	78306	0898T
70473	70496	70551	71552	72141	72191	73206	73706	74170	74262	76016	76856	78802	0944T
70480	70498	70552	71555	72142	72192	73218	73718	74174	74712	76017	76857	78803	0946T
70481	70542	70553	72125	72146	72193	73219	73719	74176	75557	76018	76870	0689T	0947T
70482	70543	70554	72126	72147	72194	73220	73720	74177	75559	76019	76978	0697T	0972T
70486	70544	71250	72127	72148	72196	73221	73721	74178	75561	76391	76981	0721T	1039T
										76604	76982	0723T	1043T

APPENDIX B – Applicable Cardiovascular Procedure Codes

75600	75736	75831	75891	78458	93005	93226	93270	93287	93312	93880	93926	93985	0902T
75605	75741	75833	75893	78466	93015	93229	93271	93288	93314	93882	93930	93986	0903T
75625	75743	75840	78428	78468	93017	93241	93278	93289	93318	93886	93931	93990	0904T
75630	75746	75860	78445	78469	93024	93242	93279	93290	93350	93888	93970	0605T	0926T
75705	75756	75870	78451	78472	93025	93243	93280	93291	93351	93892	93971	0683T	0927T
75710	75809	75872	78452	78473	93040	93245	93281	93292	93701	93893	93975	0684T	0938T
75716	75820	75880	78453	78481	93041	93246	93282	93303	93702	93895	93976	0685T	0939T
75726	75822	75885	78454	78483	93050	93247	93283	93304	93724	93922	93978	0716T	0962T
75731	75825	75887	78456	78494	93224	93260	93284	93306	93784	93923	93979	0804T	1036T
75733	75827	75889	78457	93000	93225	93261	93285	93307	93786	93924	93980	0826T	1052T
						93268	93286	93308	93788	93925	93981	0897T	1053T

APPENDIX C – Applicable Ophthalmology Procedure Codes

76510	76512	76514	76519	92060	92082	92132	92136	92228	92240	92265	92274	92285	0507T
76511	76513	76516	92025	92081	92083	92133	92137	92229	92242	92270	92283	92286	0509T
						92134	92145	92235	92250	92273	92284	0506T	1010T

Coding:

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

Definitions:

N/A

References:

- Centers for Medicaid and Medicare Services; Medicare Claims Processing Manual, Chapter 13
- Centers for Medicaid and Medicare Services; MLM Matters, MM7747/CR7747, SE0665

Related Plan Policies:

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines

Policy Update History:

7 / 2024	Added 0876T, 0897T and 0898T
1 / 2025	Added 76016-76019, 0944T, 0946T, 0947T, 0902T-0904T, 0926T, 0927T, 0938T, 0939T, 92137 and removed 0398T, 93890
7 / 2025	Added 0962T and 0972T
1 / 2026	Added 70471, 70473, 1010T, 0605T and removed 75842
7 / 2026	Added 1039T, 1043T, 1036T, 1052T, and 1053T.

Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

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, 2026	**Revised Date:**	January 2026
Date Reviewed:	December 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.

HISTORY

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 the 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 the 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 the technical component only and the technical component of global services.

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

HISTORY

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	71260	72141	72197	73706	74181	76016	76981	0865T
70450	70498	71271	72142	72198	73718	74182	76017	76982	0876T
70460	70542	71275	72146	73200	73719	74183	76018	77046	0898T
70470	70543	71550	72147	73201	73720	74185	76019	77047	0944T
70471	70544	71551	72148	73202	73721	74261	76391	77048	0946T
70473	70545	71552	72149	73206	73722	74262	76604	77049	0947T
70480	70546	71555	72156	73218	73723	74712	76700	78306	0972T
70481	70547	72125	72157	73219	73725	75557	76705	78802	
70482	70548	72126	72158	73220	74150	75559	76770	78803	
70486	70549	72127	72159	73221	74160	75561	76775	0689T	
70487	70551	72128	72191	73222	74170	75563	76831	0697T	
70488	70552	72129	72192	73223	74174	75572	76856	0721T	
70490	70553	72130	72193	73225	74176	75573	76857	0723T	
70491	70554	72131	72194	73701	74177	75574	76870	0807T	
70492	71250	72132	72196	73702	74178	75635	76978	0808T	

APPENDIX B – Applicable Cardiovascular Procedure Codes

75600	75809	75891	78473	93226	93280	93306	93882	93975	0826T
75605	75820	75893	78481	93229	93281	93307	93886	93976	0897T
75625	75822	78428	78483	93241	93282	93308	93888	93978	0902T
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75705	75827	78451	93000	93243	93284	93314	93893	93980	0904T
75710	75831	78452	93005	93245	93285	93318	93895	93981	0926T
75716	75833	78453	93015	93246	93286	93350	93922	93985	0927T
75726	75840	78454	93017	93247	93287	93351	93923	93986	0938T
75731	75860	78456	93024	93260	93288	93701	93924	93990	0939T
75733	75870	78457	93025	93261	93289	93702	93925	0605T	0962T
75736	75872	78458	93040	93268	93290	93724	93926	0683T	
75741	75880	78466	93041	93270	93291	93784	93930	0684T	
75743	75885	78468	93050	93271	93292	93786	93931	0685T	
75746	75887	78469	93224	93278	93303	93788	93970	0716T	
75756	75889	78472	93225	93279	93304	93880	93971	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

HISTORY

76512	76519	92082	92134	92228	92242	92273	92284	0506T	1010T
76513	92025	92083	92136	92229	92250				

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
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
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
1 / 2026	Added 70471, 70473, 1010T, 0605T and removed 75842

HISTORY

IMPORTANT INFORMATION

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the member's contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations.

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.

HISTORY

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.

HISTORY

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
70470	70544	71550	72146	72198	73706	74178	75574	76857	0721T
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
70487	70549	72126	72157	73218	73722	74261	76019	77046	0876T
70488	70551	72127	72158	73219	73723	74262	76391	77047	0898T
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
75625	75822	75893	78481	93229	93281	93307	93886	93976	0902T
75630	75825	78428	78483	93241	93282	93308	93888	93978	0903T
75705	75827	78445	78494	93242	93283	93312	93892	93979	0904T
75710	75831	78451	93000	93243	93284	93314	93893	93980	0926T
75716	75833	78452	93005	93245	93285	93318	93895	93981	0927T
75726	75840	78453	93015	93246	93286	93350	93922	93985	0938T
75731	75842	78454	93017	93247	93287	93351	93923	93986	0939T
75733	75860	78456	93024	93260	93288	93701	93924	93990	0962T
75736	75870	78457	93025	93261	93289	93702	93925	0683T	
75741	75872	78458	93040	93268	93290	93724	93926	0684T	
75743	75880	78466	93041	93270	93291	93784	93930	0685T	
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

HISTORY

76512	76519	92082	92134	92228	92242	92273	92284	0506T
76513	92025	92083	92136	92229	92250			

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
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

HISTORY

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, 2025	**Revised Date:**	January 2025
Date Reviewed:	December 2024		
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.

HISTORY

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.

HISTORY

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	70540	71270	72133	72195	73700	74175	75571	76776	0648T
70450	70542	71271	72141	72196	73701	74176	75572	76831	0689T
70460	70543	71275	72142	72197	73702	74177	75573	76856	0697T
70470	70544	71550	72146	72198	73706	74178	75574	76857	0721T
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
70487	70549	72126	72157	73218	73722	74261	76019	77046	0876T
70488	70551	72127	72158	73219	73723	74262	76391	77047	0898T
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	
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
75625	75822	75893	78481	93229	93281	93307	93886	93976	0902T
75630	75825	78428	78483	93241	93282	93308	93888	93978	0903T
75705	75827	78445	78494	93242	93283	93312	93892	93979	0904T
75710	75831	78451	93000	93243	93284	93314	93893	93980	0926T
75716	75833	78452	93005	93245	93285	93318	93895	93981	0927T
75726	75840	78453	93015	93246	93286	93350	93922	93985	0938T
75731	75842	78454	93017	93247	93287	93351	93923	93986	0939T
75733	75860	78456	93024	93260	93288	93701	93924	93990	
75736	75870	78457	93025	93261	93289	93702	93925	0683T	
75741	75872	78458	93040	93268	93290	93724	93926	0684T	
75743	75880	78466	93041	93270	93291	93784	93930	0685T	
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
76513	92025	92083	92136	92229	92250			

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:

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HISTORY

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, 2024	**Revised Date:**	July 2024
Date Reviewed:	June 2024		
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.

HISTORY

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

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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.

HISTORY

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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APPENDIX B – Applicable Cardiovascular Procedure Codes

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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

HISTORY

76511	76514	92025	92082	92133	92145	92235	92265	92283	0506T
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