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Commercial Reimbursement Policy

Subject: **Multiple Procedure Payment Reduction - Professional**	
Policy Number: **C-23003**	Policy Section: **Medicine**
Last Approval Date: **01/01/2026**	Effective Date: **01/01/2025**

Policy

The health plan allows reimbursement for multiple procedures unless provider, state, or federal contracts and/or mandates indicate otherwise. When multiple services are performed on the same date of service, during the same encounter, **and** are performed by the same provider or provider group, the following will be subject to multiple procedure payment reductions (MPPR):

- Cardiovascular procedures
- Ophthalmology procedures

These reductions are based on the CMS National Physician Fee Schedule's (NPFS) multiple procedure indicator (MPI) payment-adjustment rules. MPPR also applies to endoscopic procedures, surgical procedures, and radiology services. For complete reimbursement guidelines, see related policies and materials.

Multiple Diagnostic Cardiovascular Procedures

The technical component (TC) for cardiovascular procedures (with an MPI of 6) will reimburse at the following rates:

- 100% for the first diagnostic cardiovascular procedure with the highest Relative Value Unit (RVU)
- 75% for the TC of subsequent procedures

MPPR does not apply to professional component services.

Multiple Diagnostic Ophthalmology Procedures

The TC for ophthalmology procedures (with an MPI of 7) will reimburse at the following rates:

- 100% for the first diagnostic ophthalmology procedure with the highest RVU
- 80% for the TC of subsequent procedures

MPPR does not apply to professional component services.

MULTI-WP-CM-RP-093417-25-SRS93329 | October 2025

Multiple Global Procedures

When two or more procedures with the same MPI (either 6 or 7) are reported as global procedures, the Health Plan will identify the TC RVU and professional component RVU separately for each procedure and calculate eligible reimbursement as follows:

- The TC RVU will be reduced by the appropriate percentage.
- The professional component RVU will remain at 100%.
- These two values are added together to obtain a new RVU value to be used in the calculation.
- The new RVU value is then divided by the original total-global-RVU and multiplied by 100 to determine what percent of the global value is to be applied to the diagnostic procedures.
- The original fee-schedule global allowance is then multiplied by this new percentage value (which is rounded up) to determine the allowance for cardiovascular procedures with an MPI of 6 or ophthalmology procedures with an MPI of 7.

Modifiers

MPPR will also be applied to the technical component of eligible codes when modifiers 76 or 77 (repeat procedure) are reported. These modifiers do not indicate to the Health Plan that the repeat procedure was performed as a distinct procedural service at a separate session/encounter. Modifiers will not override the MPPRs identified in this policy.

Related Coding		
Code	**Code List**	**Comments**
LT	Left side (used to identify procedures performed on the left side of the body)	If a diagnostic ophthalmology procedure with an MPI of 7 is performed bilaterally and "bilateral" is not included in the code description, report the service on two lines and include the site-specific modifiers.
RT	Right side (used to identify procedures performed on the right side of the body)	
Modifier 26 (Professional Component)	Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.	Reimbursement will remain at 100%.
Modifier TC (Technical Component)	Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical	Reimbursement will reduce at 20% for subsequent diagnostic ophthalmology procedures and 25 percent for subsequent diagnostic cardiovascular procedures.

	component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles	

Exemptions
There are no exemptions to this policy.

Definitions	
Multiple Procedure Indicator (MPI)	Indicates which payment adjustment rule for multiple procedures applies to the service
Professional Component	The portion of the service involving the interpretation of the information collected by a physician or other practitioner
Relative Value Units (RVUs)	Units that account for the relative resources used in furnishing a service
Technical Component	The portion of the service that involves the collection of information from the patient
General Reimbursement Policy Definitions	

Related Policies and Materials
Modifier Usage – Professional
Modifiers 26 and TC: Professional and Technical Component – Professional
Multiple Delivery Services – Professional
Multiple Diagnostic Imaging Procedures – Professional and Facility
Multiple Surgery – Facility

References and Research Materials
This policy has been developed through consideration of the following: • CMS • Optum EncoderPro 2024

Policy History	
01/01/2026	Entered Washington
01/01/2025	Initial approval and effective for Florida, Maryland, and Texas

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet

authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.