Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid Product.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Policy, Professional policy is based on the Centers for Medicare and Medicaid Services (CMS) MPPR Policy for those diagnostic imaging procedures where CMS assigns a Multiple Procedure Indicator (MPI) of 4 on the National Physician Fee Schedule (NPFS).

Under the CMS guidelines, when multiple diagnostic imaging procedures are performed in a single session, most of the clinical labor activities and most supplies, with the exception of film, are not performed or furnished twice.

Therefore, CMS applies a reduction in reimbursement for secondary and subsequent procedures because payment at 100% for secondary and subsequent procedures would result I duplicative reimbursement for clinical labor activities only performed once.

Examples of clinical labor activities, not furnished twice, include but are not limited to:

Greeting the patient
Positioning and escorting the patient
Providing education and obtaining consent
Retrieving prior exams
Setting up the IV
Preparing and cleaning the room

Payment at 100% for secondary and subsequent diagnostic imaging procedure(s) would represent reimbursement for duplicative components of the primary procedure.

In accordance with CMS, UnitedHealthcare Community Plan has considered multiple diagnostic imaging procedures assigned a MPI of 4, subject to a reduction for the Technical Component (TC) of imaging procedures ranked as secondary and subsequent as described below in the Multiple Diagnostic Imaging Reductions section.

Additionally, UnitedHealthcare Community Plan will follow CMS and apply reductions to the secondary and subsequent Professional Component (PC) of multiple diagnostic imaging procedures assigned a MPI of 4. Reductions will be applied as described below in the Multiple Diagnostic Imaging Reductions section.

The codes to which this policy applies may be found in the following link (the PFS Relative Value Link) using the appropriate year and quarter referencing the “non-Facility Total or Facility Total” column:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

Reimbursement Guidelines

Multiple Diagnostic Imaging Reductions (MDIR)

UnitedHealthcare Community Plan uses the CMS NPFS MPI of 4 and Non-Facility Total Relative Value Units (RVUs) to determine which radiology procedures are eligible for MDIR. Different MDIR percentages apply to the PC and TC of global services.

MDIR applies when:

- Multiple diagnostic imaging procedures with a MPI of 4 are performed on the same patient by the Same Group Physician and/or Other Health Care Professional during the Same Session.
- A single imaging procedure subject to MDIR is submitted with multiple units. For example, code 73702 is submitted with 2 units. MDIR would apply to the second unit. The units are also subject to UnitedHealthcare Community Plan's Maximum Frequency Per Day Policy.

MDIR will not apply when:

- The diagnostic imaging procedure is the primary procedure as ranked based on the RVU assigned to the code (and modifier, when applicable), compared to other diagnostic imaging procedures billed during the Same Session.
- Multiple diagnostic imaging procedures are billed, appended with Modifier 59 or Modifier XE to indicate the procedure was performed on the same day but not during the Same Session.
- Multiple diagnostic imaging procedures are billed for the same patient on the same day but not by the Same Group Physician and/or Other Health Care Professional during the Same Session.
- The imaging service does not have an MPI of 4. See the Diagnostic Imaging Procedures Subject to Multiple Imaging Reduction Lists in the attachment section below.

Multiple Diagnostic Imaging Reduction Percentages

When the TC for two or more imaging procedures subject to MDIR are performed on the same patient by the Same Group Physician and/or Other Health Care Professional during the Same Session, UnitedHealthcare Community Plan will reduce the Allowed Amount for the TC of the second and each subsequent procedure by 50%. UnitedHealthcare Community Plan will regard the TC portion of the procedure(s) with the lower TC total (RVUs) as subject to MDIR.

In addition, when the PC for two or more imaging procedures subject to MDIR are performed on the same patient by the Same Group Physician and/or Other Health Care Professional at the Same Session, UnitedHealthcare Community Plan will reduce the Allowed Amount for the PC of the second and each subsequent procedure by 5%. UnitedHealthcare Community Plan will regard the PC portion of the procedure(s) with the lower PC total RVUs, as subject to MDIR.

Multiple Diagnostic Imaging Procedures Billed Globally

When the Same Group Physician and/or Other health Care Professional bills globally for two or more procedures subject to MDIR, for a patient at the Same Session, the charge for the Global Procedure Codes will be divided into the PC and TC (indicated by modifiers 26 and TC) using UnitedHealthcare Community Plan's standard Professional/Technical percentage splits. The RVUs assigned to each component (26 or TC) will determine which code will be ranked as primary, with no reduction applied, and those that will be ranked as secondary or subsequent, with reductions applied in accordance with this policy. The components (26 or TC) will be ranked independently of each other utilizing the CMS Non-Facility Total RVUs.

State Exceptions	
Arizona	This policy only applies to Non-Participating providers for Arizona Medicaid
Indiana	Indiana is exempt from Multiple Diagnostic Imaging Reductions
Kansas	Kansas is exempt from Multiple Diagnostic Imaging Reductions
Washington	Per state regulations, Washington Medicaid does not apply MDIR to the professional component (PC) of diagnostic imaging services
Wisconsin	Wisconsin is exempt from Multiple Diagnostic Imaging Reductions

Definitions	
Allowable Amount	Defined as the dollar amount eligible for reimbursement to the physician or health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of Allowable Amounts. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
Global Service	A Global Service includes both a Professional Component and a Technical Component. When a physician or other health care professional bills a Global Service, he or she is submitting for both the Professional Component and the Technical Component of that code. Submission of a Global Service asserts that the Same Individual Physician or Other Health Care Professional provided the supervision, interpretation, and report of the professional services as well as the technician, equipment, and the facility needed to perform the procedure. In appropriate circumstances, the Global Service is identified by reporting the appropriate professional/technical split eligible procedure code with no modifier attached or by reporting a standalone code for global test only services
Modifier 59	Distinct Procedural Service. Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances.
Modifier XE	Separate Encounter, A Service That Is Distinct Because It Occurred During a Separate Encounter
Professional Component	The Professional Component represents the physician or other health care professional work portion (physician work/practice overhead/malpractice expense) of the procedure. The Professional Component is the physician or other health care professional supervision and interpretation of a procedure that is personally furnished to an individual patient, results in a written narrative report to be included in the patient's medical record,

	and directly contributes to the patient's diagnosis and/or treatment. In appropriate circumstances, it is identified by appending modifier 26 to the designated procedure code or by reporting a standalone code that describes the Professional Component only of a selected diagnostic test.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification number.
Same Session	A single patient encounter that encompasses all of the services performed by the same physician or other health care professional.
Technical Component	The Technical Component is the performance (technician/equipment/facility) of the procedure. In appropriate circumstances, it is identified by appending modifier TC to the designated procedure code or by reporting a standalone code that describes the Technical Component only of a selected diagnostic test.

Questions and Answers

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Q: Which procedure would be primary when code 76604 (Ultrasound) and code 76831 (Sonohysterography) are billed together by the Same Group Physician and/or Other Health Care Professional, and how would the multiple imaging reduction be applied?

A: First, the PC/TC percentage splits would be applied to each code reported globally using UnitedHealthcare Community Plan's standard Professional/Technical percentage splits. Then the PC and TC portions with the lesser RVU(s) will be considered reducible as shown in the table below.

- 76831-TC has the higher TC total RVU of 2.47; therefore, it would be primary and would be reimbursed at 100% of the Allowable Amount for the TC
- 76604-TC with the lower TC total RVU of 1.73 would be secondary and reimbursed by applying a 50% reduction to the Allowable Amount for the TC
- 76831-26 has the higher PC total RVU of 1.03; therefore, it would be primary and would be reimbursed at 100% of the Allowable Amount for the PC
- 76604-26 with the lower PC total RVU of .78 would be secondary and reimbursed by applying a 5% reduction to the Allowable Amount for the PC with a date of service on or after 1/1/2017; for dates of service prior to 1/1/2017, a 25% reduction is applied to the Allowable Amount

Note: RVU values in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Code	Modifier	PC Non-Facility Total RVU	TC Non-Facility Total RVU	RVU used for Ranking	Multiple Diagnostic Imaging Ranking
76604	26	.78	Not applicable	.78	**2 - Secondary**
76604	TC	Not applicable	1.73	1.73	**2 - Secondary**
76831	26	1.03	Not applicable	1.03	**1 - Primary**
76831	TC	Not applicable	2.47	2.47	**1 - Primary**

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Q: Does UnitedHealthcare Community Plan apply a multiple imaging reduction based on the place of service in which services are rendered?

A: This policy will apply to all claims reported on a CMS-1500 claim form, regardless of place of service. However, it should be noted that procedures reported for the TC portion are additionally subject to UnitedHealthcare Community Plan's Professional/Technical Component Policy which does not allow reimbursement for the TC portion in a facility setting.

3	**Q:** If the Same Group Physician and/or Other Healthcare Professional performs a complete ultrasound exam of the abdomen during a single session and reports code 76700, and it becomes necessary to then perform a repeat service later on the same day during a separate session which is reported with code 76700-76, will a multiple imaging reduction be applied to the repeated service reported as 76700-76? **A:** Yes, multiple imaging reductions will apply as the use of modifier 76 does not indicate that the imaging procedure was done at a separate session. The repeat procedure code 76700 should be appended with either Modifier 59 or XE (but not both) to indicate a distinct service was performed during a different session. Multiple imaging reductions will not apply to services appropriately billed with Modifier 59 or XE.
4	**Q:** How will the Same Group Physician and/or Other Health Care Professional, contracted at percent of charge rates, be reimbursed when reporting the Global Procedure Code for multiple imaging procedures which are subject to the MDIR during the Same Session? **A:** The charges for the Global Procedure Code(s) will be divided into the PC and TC portions using UnitedHealthcare Community Plan's standard Professional/Technical splits, with MDIR applied to the Allowed Amount for the PC and TC portion of the second and each subsequent procedure.
5	**Q:** When the Same Group Physician and/or Other Health Care Professional bills globally for two or more procedures which are subject to MDIR for a patient at the Same Session, and is also contracted with a specific rate for modifier TC, how is the Technical Component to be reduced determined? **A:** The charge for the Global Procedure Codes will be divided into the Professional and Technical Components using UnitedHealthcare Community Plan's standard Professional/Technical percentage splits. Then the Technical Component(s) with the lesser RVU(s) will be considered reducible. The Allowable Amount is then determined based on the lesser of the charges assigned for modifier TC using UnitedHealthcare Community Plan's standard Professional/Technical percentage splits or the contracted rate, with an imaging reduction applied.
6	**Q:** A patient comes in for multiple chest studies, first an ultrasound (CPT code 76604) is completed, and the patient is then moved to a different room for a CT angiography (CPT code 71275), would this be considered a separate session? **A:** No, the need to move a patient to a different room does not constitute a separate session; it is a continuation of the same encounter.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History

5/18/2025	Policy Version Change State Exceptions Section: Verbiage update for Arizona History Section: Entries prior to 5/18/2023 archived
1/1/2024	Policy Version Change Logo Updated History Section: Entries prior to 1/1/2022 archived
6/19/2006	Policy implemented by UnitedHealthcare Employer & Individual
11/15/2005	Policy approved by the Payment Policy Oversight Committee