Reimbursement Policy	
Title: Multiple Procedure Reduction	
Policy Number: RP-F-255X	**Application:** All Medica Members
Last Reviewed: 11/15/2021	**Effective Date:** 04/01/1999
Related Policies: Anesthesia, Assistant Surgeon, Co-Surgeon/Team Surgeon, Discontinued Procedures, Bilateral Procedures, CCI Editing, Maximum Units of Service, Professional/Technical Components Policy, Unlisted Procedure Code	

Disclaimer: *This reimbursement policy is intended to provide general guidance regarding Medica's policy for the services described, and does not constitute a guarantee of payment. You are responsible for submitting accurate claims. Factors affecting claims reimbursement may include, but are not limited to, state and federal laws, regulations and accreditation requirements, along with administrative services agreements, provider contracts, and benefit coverage documents. Coding methodology and industry standards are also considered in developing reimbursement policy.*

Medica routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later, and you are responsible for the information contained in the most recent online version. Medica communicates policy updates to providers via Medica's monthly e-newsletter, Medica Connections®, as well as through Medica Provider Alerts.

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Summary:

Multiple procedures performed by the same individual physician or other qualified health care professional reporting the same Federal Tax Identification number, on the same date of service during the same patient encounter, may be subject to multiple procedure reduction for secondary and subsequent procedures.

Policy Statement:

Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedural and post-procedural work. Full reimbursement for secondary and subsequent procedures would represent duplicative payment for overlapping components of pre-procedural and post-procedural work. Therefore secondary and subsequent procedures are eligible for multiple procedure reduction.

Medica utilizes the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File to determine which procedures are eligible for multiple procedure reduction, and the ranking of procedures. Medica considers procedure codes with the following CMS multiple procedure indicators eligible for reduction within this reimbursement policy:

CMS NPFS Multiple Procedure Indicators	
2	Standard payment adjustment rules for multiple procedures apply. Apply the appropriate reduction to this code (100%, 50%, 50%).
3	Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure).

Services that CMS indicates in the NPFS Relative Value File as carrier priced, or those for which CMS does not develop relative value units (RVUs), are assigned gap fill RVU's.

CMS Special Endoscopic Reduction Procedure:
CMS applies special adjustment rules when multiple endoscopic procedures from the same family (same Endoscopic Base Code) are reported on the same day. Endoscopic codes eligible for a reduction are identified with a multiple procedure indicator of 3 on the NPFS. CMS allows the full allowable amount for the highest valued endoscopy code in the family. Secondary and subsequent endoscopy codes in the same family are allowed at a reduced amount based on the value of the NPFS designated Endoscopic Base Code.

To further align with CMS, effective with dates of service 3/1/2016, Medica will apply CMS multiple Endoscopic Adjustment Rules when related endoscopic procedures (within the same family) are performed on the same day. If billed on the same day as other procedures that are subject to multiple procedure reduction, endoscopy codes may be subject to both the endoscopic and multiple procedure reductions.

Miscellaneous Services:
Multiple procedure reduction applies and additional reimbursement will not be allowed for the following:

- Moving a patient from one surgical suite to another surgical suite to perform an additional procedure.
- Repositioning patient.
- Re-draping a patient.
- Separate incisions or operative sites.

These services are included in the procedure being performed and are not separately reimbursable.

Exclusions/Exemptions:
• **Modifier 78:** Per Current Procedural Terminology (CPT®), it may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it should be reported by adding modifier 78 to the related procedure. In accordance with CMS guidelines, procedures reported with a modifier 78 that have a 10 or 90 day global period are not subject to the multiple procedure guidelines. Refer to the Global Days Policy for details regarding modifier 78 reductions.

Code Lists:
Multiple Procedure Reduction Eligible Code List Multiple Procedure Reduction Gap Fill Code List Multiple Procedure Reduction Endoscopy Codes with Endobase Code List

Modifiers:	
50	Bilateral procedures
51	Multiple procedures Note: This modifier is for informational use only and does not impact processing of codes eligible for multiple procedure reduction.
78	Unplanned return to the operating/procedure room by the same physician or other qualified health professional following initial procedure for a related procedure during the post-operative period

Definitions
• **Multiple Procedures:** distinct surgical procedures performed by the same individual physician or other qualified health care professional on the same patient during the same operative session. • **Gap Fill Codes:** Procedure codes for which CMS does not develop RVUs. These services are assigned gap fill RVUs from data published by CMS carriers. If CMS carrier-priced RVUs are not available, RVUs are assigned to the code. • **Same Individual Physician or Other Qualified Health Care Professional:** Physician or Other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification number.

Q & A:
Q) How does Medica determine which eligible code/procedure is the primary or highest valued procedure? **A)** Medica uses the CMS National Physician Fee Schedule and the assigned RVU's to identify a primary procedure. The code with the highest valued RVU is ranked as the primary procedure.

Q) How does Medica rank one procedure performed multiple times at the same encounter/session?

A) For encounters that include one procedure performed multiple times, one unit will be reimbursed at 100% of the allowed amount and each subsequent procedure will be reimbursed at 50% of the allowed amount.

Resources:
Centers for Medicare and Medicaid Services (CMS)
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
National Physician Fee Schedule (NPFS)

Effective Date:	04/01/1999

Revision Updates:	
2/20/2023	Code List Update
11/21/2022	Annual Policy Review
07/08/2022	Code List Update
01/01/2022	Code List Update
11/15/2021	Annual policy review
08/01/2021	Same Provider definition updated