UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
Policy Number 2020R9021B

Multiple Procedure Payment Reduction (MPPR) for Medical and Surgical Services Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 Medicare Advantage reimbursement policies use 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 (CMS 1450). 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 resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

Application

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 surgeries are separate procedures performed by a single physician on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same patient on the same day.

The codes with the following CMS multiple procedure indicators are addressed within this reimbursement policy:

- Multiple Procedure Indicator 2 - Standard payment adjustment rules for multiple procedures apply
- Multiple Procedure Indicator 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).

Surgeries subject to the multiple surgery rules have an indicator of "2" in the Physician Fee Schedule look-up tool. The multiple procedure Payment Reduction will be applied based on the National Physician Fee Schedule (NPFS) Relative Value Unit (RVU) and not on the submitted amount from the providers. The major surgery may or may not be the one with the larger submitted amount. Multiple surgeries are distinguished from procedures that are components of or incidental to a Primary Procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.

Reimbursement Guidelines

Multiple procedure reductions apply when:

There are two or more procedure codes subject to reductions. If two codes are billed but only one is subject to reduction, no reduction will be taken for either procedure; both codes are reimbursable at 100% of the allowable amount.

A single code subject to the multiple procedure concepts when submitted with multiple units.

For example, CPT code 11300 is submitted with 3 units. Multiple procedure reductions would apply to the second and third unit. The units are also subject to UnitedHealthcare Medicare Advantage Medically Unlikely Edits Reimbursement Policy. The billing of more than one separately payable surgical procedure, by the same physician, performed on the same patient, on the same day, whether on different lines or with a number greater than 1 in the units column on the claim form or inappropriately billed with modifier "-78" (i.e., after the global period has expired) are subject to multiple payment procedure reductions. Multiple procedures subject to the multiple procedure concept as defined above performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service are ranked to determine applicable reductions.

Multiple Procedure Ranking:

UnitedHealthcare Medicare Advantage uses the CMS Facility Total RVUs to determine the ranking of primary, Secondary and Subsequent Procedures when those services are performed in a facility setting (Place of Service [POS] 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56 and 61). Procedures performed in a place of service other than the facility POS setting will be ranked by the CMS Non-Facility RVUs.

Multiple Procedure Reduction Codes with Assigned RVUs Reported with Modifiers 26, 53, TC:

For certain codes that are subject to multiple procedure reductions CMS has assigned separate RVU values when reported with modifiers 26, 53, and TC. When these modified services are billed with other services subject to the multiple procedure concept, the CMS RVUs associated with the reported modifier 26, 53, or TC are used in determining which services should be reduced according to the multiple procedure concept.

Reduction Codes with no assigned CMS RVU:

Services that CMS indicates may be carrier-priced, or those for which CMS does not develop RVUs are considered Gap Fill Codes and are addressed as follows:
0.00 RVU Codes: Some codes cannot be assigned a gap value or remain without an RVU due to the nature of the service

(example: unlisted codes). Codes assigned an RVU value of 0.00 will not be excluded from ranking.

Example: Note: RVU values in this example may not accurately reflect the current National Physician Fee Schedule (NPFS) and are intended for illustrative purposes only.

Procedure	RVU	Procedure Ranking
Reduction Procedure 1	22.83	2 – Secondary
Reduction Procedure 2	173.29	**1 – Primary**

Postoperative Guidelines

If the patient returns to the operating room after the initial operative session on the same day as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not apply. When a 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 concept.

Bilateral Procedures

Selected bilateral eligible services may also be subject to multiple procedure reductions when billed alone or with other multiple procedure reduction codes.

Multiple Procedures for Assistant Surgeon Services Reported with Modifiers 80, 81, 82, AS

When services are reported by more than one assistant surgeon using modifiers 80, 81, 82 or AS those services will be ranked collectively if reported by the Same Individual Physician and/or Other Health Care Professional. Assistant surgeon services will be ranked separately from the services reported by the primary surgeon.

Refer to the Questions and Answers section, Q&A #3 for an example of multiple procedure ranking on an assistant surgeon claim.

Multiple Procedures for Co-Surgeon/Team Surgeon Services Reported with Modifiers 62, 66

Multiple procedures performed by a co-surgeon (modifier 62) or team surgeon (modifier 66) are subject to the multiple procedure concept as defined above when performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service. Co-surgeon and team surgeon services are ranked separately and independently of any other co-surgeon or team surgeon services.

Refer to the Questions and Answers section, Q&A #4 for an example of multiple procedure ranking on a co-surgeon claim.

Endoscopic Procedures

When related endoscopic procedures (within the same family) are performed on the same day by the Same Individual Physician or Other Qualified Health Care Professional, the lower ranking endoscopy codes will receive an adjustment under the Endoscopic Adjustment Rule to reduce the Allowed Amount based on the amount of the Endoscopic Base Code. No reimbursement will be made for the Endoscopic Base Code.

Multiple endoscopies in the same family performed on the same day as other procedures subject to multiple procedure reduction will be ranked accordingly and may be subject to endoscopic and multiple procedure reductions.

If two or more endoscopic procedures are performed on the same day but are from different families, the multiple procedure reduction will be applied to the endoscopic codes with the lower RVU values.

Refer to the Questions and Answers section, Q&A #6, #7 and #8 for examples of how the Endoscopic Adjustment Rule will be applied.

Anesthesia Management Service

Multiple procedure reductions do not apply to time-based anesthesia management services.

Definitions	
Relative Value Unit (RVU)	The assigned unit value of a particular CPT or HCPCS code. The associated RVU is either from the CMS NPFS Non-Facility Total value or Facility Total value
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number

Questions and Answers

1

Q: Which procedure would be primary when CPT code 58150 (total abdominal hysterectomy) and CPT code 57270 (repair of enterocele) are performed in a facility and reported by two different specialty physicians within the same group practice?

A: Multiple procedure ranking is based on the facility RVUs. CPT code 58150 is the Primary Procedure with the higher CMS RVU value of 29.55 and CPT code 57270 is the secondary procedure with the lower CMS RVU of 23.74. CPT code 58150 would be reimbursed at 100% of the Allowable Amount, and CPT code 57270 would be reimbursed at 50% of the Allowable Amount.

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

Two Different Specialty Physicians/Same Group	Code	Non-Facility RVU	Facility RVU	RVU used for ranking	Multiple Procedure Ranking
Dr. A	57270	29.22	23.74	23.74 – facility	2 - Secondary
Dr. B	58150	34.01	29.55	29.55 – facility	1 - Primary

2

Q: Are multiple procedure reductions applied when the same individual surgeon reports multiple procedure reduction codes while acting as both surgeon and assistant surgeon during the same operative session?

A: Yes, however the surgeon is acting in two different capacities, as surgeon and assistant surgeon. This means all multiple procedure reduction codes reported by the surgeon (with no assistant surgeon modifier) are ranked as one group and all multiple procedure reduction codes reported with an assistant surgeon modifier are ranked as a second group, independent of each other.

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Q: Are multiple procedure reductions applied when two different physicians within the same group practice each report assistant surgeon services, Dr. A reports 19307-80 and Dr. B reports 19367-81?

A: Yes. A multiple procedure reduction would be applied to CPT code 19307-80 (the secondary code). In addition, both 19307-80 and 19367-81 would be subject to reduction based on the assistant surgeon modifiers (e.g. 80, 81).

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

Two Different Physicians/Same Group	Code	Non-Facility RVU	Facility RVU	RVU used for ranking	Multiple Procedure Ranking	Applicable Reductions
Dr. A	19307-80	34.16	34.16	34.16	2 - Secondary	50% of the Allowable Amount for multiple

							procedure subject to modifier 80 assistant surgeon reduction.
	Dr. B	19367-81	53.54	53.54	53.54	1 - Primary	100% of the Allowable Amount for multiple procedure subject to modifier 81 assistant surgeon reduction.

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Q: How is multiple procedure ranking applied when two different physicians in the same group practice each report multiple co-surgeon services eligible for multiple procedure reductions on the same day?

A: Each co-surgeon's services are ranked separately and independently of the other regardless of whether they are in the same group practice. In addition, each co-surgeon's services are subject to reduction based on the co-surgeon modifier (62) reported.

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

Services reported by Dr. A - CPT 19361-62, RVU = 29, CPT 19340-62, RVU = 20

Services reported by Dr. B - CPT 19361-62, RVU = 29, CPT 19340-62, RVU = 20

Dr. A	Code	Charge	Multiple Procedure Ranking	Applicable Reductions
1	19361-62	$4000.00	1 – Primary	100% of the Allowable Amount for multiple procedure subject to modifier 62 co-surgeon reduction
2	19340-62	$1600.00	2 – Secondary	50% of the Allowable Amount for multiple procedure subject to modifier 62 co-surgeon reduction

Dr. B	Code	Charge	Multiple Procedure Ranking	Applicable Reductions
1	19361-62	$4000.00	1 – Primary	100% of the Allowable Amount for multiple procedure subject to modifier 62 co-surgeon reduction
2	19340-62	$1600.00	2 – Secondary	50% of the Allowable Amount for multiple procedure subject to modifier 62 co-surgeon reduction

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Q: Are there any modifiers that will override the multiple procedure policy?

A: No, other than those services which are appropriately reported with modifier 78 as described in the section of this policy titled 'Multiple Procedures Reported with Modifier 78'.

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Q: How will the Endoscopic Adjustment Rule be applied to multiple endoscopy codes within the same family (same Endoscopic Base Code) billed on the same day by the Same Group Physician and/or Other Qualified Health Care Professional

A: Below is an example of how the Endoscopic Adjustment Rule will be applied:

In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), the Endoscopic Adjustment Rule will pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the Endoscopic Base Code (45378).

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

Code:	Description:	Facility RVU:	Allowable:	Endoscopic Ranking:	Adjusted Allowable:
45380	Colonoscopy, flexible; with biopsy, single or multiple	**7.73**	**$285.98**	**2 (lower RVU)**	**$45.76 ($331.74 - $285.98)**
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	**9.17**	**$374.56**	**1 (Highest RVU)**	**$374.56**
45378 Base Code	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure	**6.48**	**$331.74**	**Base Code Not Allowed**	**$0.00**

Based on the above RVUs for these codes if the procedures were performed in a facility: 45378 (6.48), 45380 (7.73) and 45385 (9.17), procedure code 45385 would be reimbursed at 100% of the allowable $374.56 as the higher ranked service. Procedure Code 45380 would be reimbursed at the adjusted allowable $45.76 as lower ranked service. The Endoscopic Base Code (45378) is not reimbursed.

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Q: How will the Endoscopic Adjustment Rule be applied to multiple endoscopy codes within the same family and another procedure that is not related?

A: Below is an example of how the Endoscopic Adjustment Rule and multiple procedure reduction will be applied when the physician bills for codes 45380 and 45381 (same endoscopic family) and 45562 (unrelated procedure).

a. First determine the Total Adjusted RVU for each endoscopic family. Each "family" of endoscopic codes is considered as a single procedure (RVUs combined) for ranking.
b. Rank the Family Adjusted RVUs against other reducible procedures RVUs from highest to lowest.
c. Apply the Multiple Procedure Reduction (Example: Standard reduction of 100-50-50).

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

Code:	Facility RVU:	Allowable:	Endo Ranking:	Family Adjusted RVU:	Multiple Procedure Ranking:	Adjusted Allowable:
45380	7.73	$285.98	1	*7.34 – 6.48 = 0.86* 7.73 + 0.86 = 8.56	2 (50%)	*($331.74 - $233.57) + $285.98 = $384.15 * 50%* $192.08
45381	7.34	$233.57	2			
45378 Base Code	6.48	$331.74	N/A Base Code Not allowed	N/A	N/A	
45562	33.19	$643.53	N/A Unrelated Procedure	N/A	1 (100%)	$643.53

Based on the above RVUs for these codes if the procedures were performed in a facility: 45378 (6.48), 45380 (7.73), 45381 (7.34) and 45562 (33.19), first calculate the Total Adjusted RVUs based on the Endoscopic Adjustment Rule by subtracting the difference between the Endoscopic Base Code and the lower valued endoscopy code (.86) and then adding that calculation to the higher valued endoscopy code (7.73), which equals (8.56). Compare the Family Adjusted RVUs (8.56) to the RVUs of the unrelated procedure (33.19) to determine Multiple Procedure Ranking.

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Q: How will the Endoscopic Adjustment Rule be applied to multiple endoscopy codes that are not within the same family (same Endoscopic Base Code) billed on the same day by the Same Group Physician and/or Other Qualified Health Care Professional?

A: If two or more endoscopic procedures are performed on the same day but are from different families, the multiple procedure reduction will be applied to the endoscopic codes with the lower RVU values.

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

Code:	Allowable:	Facility RVU:	Endoscopic Ranking:	Multiple Procedure Ranking:	Adjusted Allowable:
29838 29830 Base Code	$342.96	16.93	N/A Different Base Codes	1 (100%)	$342.96
29847 29840 Base Code	$297.83	15.67		2 (50%)	$148.92

Based on the above scenario, the procedure codes billed are not within the same family (same Endoscopic Base Code) therefore Endoscopic Adjustment Rule is not applicable, standard multiple procedure reduction rules apply.

Codes	
CPT code section	
National Physician Fee Schedule Relative Value File	
Modifier code section	
22	Increased Procedural Services
26	Professional Component
53	Discontinued Procedure
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
66	Surgical Team
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
AS	PA, nurse practitioner, or clinical nurse specialist services for assistant at surgery
TC	Technical component

Resources
https://www.cms.gov/ CMS Claims Processing Manual CMS Medicare Physician Fee Schedule Payment System Fact Sheet Series

History	
04/02/2020	Annual Policy Review • Policy number changed from 2019R9021B to 2020R9021B • Reimbursement Guidelines Section: ▪ Updated ranking section with Facility POS (Place of Service) ▪ Added Multiple Procedure Reduction codes with Assigned RVU's Reported with Modifiers 26, 53, TC ▪ Updated endoscopic Procedure Section ▪ Added questions 6,7 and 8 to Q&A Section for endoscopic billing scenarios
4/5/2019	Annual Anniversary Date and Version Change Title section: Removed Annual Approval information & moved policy # to the header Remove Q&A 6 Updated Overview, Reimbursement Guideline, and Definition Section History Section: Entries prior to 1/1/2017 archived
1/1/2019	Policy Anniversary Version Change o Updated question #5 o Remove references to other policies
10/1//2018	Policy Version Change Policy Title Changed from Multiple Procedure Payment Reduction (MPPR) for Surgical Procedures Policy, Professional to 'Multiple Procedure Payment Reduction (MPPR) for Medical and Surgical Services Policy, Professional'.
9/4/2018	Policy Version Change Policy number changed from 2018R0034A to 2018R9021A Added the word 'Professional' to the policy title
7/11/2018	Annual Policy Review Version Change Policy Name Change Policy Verbiage Changes: Updated language in the Overview and Reimbursement Guidelines Section Added Q&A Updated definition section History Section: Entries prior to 2/10/2016 archived
7/12/2017	Annual Policy Review Version Change
4/1/2008	Policy Approved

