

# MULTIPLE PROCEDURES POLICY

**Policy Number:** SURGERY 022.35 T0

**Effective Date:** January 1, 2019

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## Related Policies

- Refer to the [Reimbursement Guidelines](#) and [Questions and Answers](#) sections of the policy

## INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

## APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

## APPLICATION

This policy applies to 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.

### **Exception for Multiple Endoscopy (New York Large and Small Group Plans)**

If the member is enrolled in a New York (NY) Large or Small group product and the services are rendered by a non-network provider, the [Reimbursement Guidelines](#) for multiple endoscopic procedures apply to:

- NY Large Group: For plan years on or after 12/01/2016
- NY Small Group: For plan years on or after 01/01/2017

## OVERVIEW

Many medical and surgical services include pre-procedure and post-procedure work, as well as generic services integral to the standard medical/surgical service. When multiple procedures are performed on the same day, by the Same Group Physician and/or Other Healthcare Professional, reduction in reimbursement for secondary and

subsequent procedures will occur. Payment at 100% for secondary and subsequent procedures would represent reimbursement for duplicative components of the primary procedure.

The Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File identifies procedures that are subject to the multiple procedure reductions. Medical and surgical services which have multiple procedure indicators 2 and 3 are subject to multiple procedure concept and multiple procedure reductions. Oxford aligns with CMS in determining which procedures are subject to multiple procedure reductions and the primary or secondary ranking of these procedures based on the Relative Value Units.

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).

For endoscopy codes CMS applies special adjustment rules when multiple endoscopic procedures from the same family (same Endoscopic Base Code) are reported on the same day. CMS allows the full Allowable Amount for the highest valued endoscopy code in the family and allows any additional endoscopy codes in the same family 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 12/01/16, Oxford 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 the both endoscopic and multiple procedure reductions.

## REIMBURSEMENT GUIDELINES

### **Multiple Procedure Concept**

Multiple procedure reductions apply when:

- There are two or more procedure codes subject to reductions (i.e., two or more codes on the [Multiple Procedure Reduction Codes List](#)). If two codes are billed but only one is subject to reduction, no reduction will be taken on either procedure;
- A single code subject to the multiple procedure concept is 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 may also be subject to Oxford's other policies, such as *Maximum Frequency Per Day Policy*.

Oxford uses the CMS multiple procedure indicators 2 and 3 in the NPFS Relative Value File to determine which procedures are eligible for multiple procedure reductions. The use of modifier 51 appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions.

In addition, Oxford applies the payment indicators for HCPCS codes G0412-G0415 when adjudicating CPT codes 27215-27218 for the purposes of this policy.

The Multiple Procedure Reduction Codes list contains all codes that are subject to the multiple procedure concept as described above.

- [Multiple Procedure Reduction Codes List](#)
- [CMS Physician Fee Schedule Relative Value Files](#)

### **Endoscopic Procedures for Dates of Service Through 11/30/16**

For dates of service 11/30/16 and prior, when multiple endoscopic procedures from the Multiple Procedure Reduction Codes list are performed on the same patient by the Same Group Physician and/or Other Health Care Professional on the same day, Oxford applies multiple procedure reductions to the endoscopic code(s) with the lower RVU values [i.e., the secondary/subsequent procedure(s)].

### **Endoscopic Procedures for Dates of Service Beginning 12/01/16**

For dates of service 12/01/16 and after, when related endoscopic procedures (within the same family) are performed on the same day, 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 reduction. A list of Endoscopy and Endoscopic Base Codes can be found in the [Attachments](#) section of the policy.

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

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

### **Additional Services**

Additional reimbursement will not be allowed for the following services which are considered included in the procedure being performed:

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

### **Multiple Procedure Reductions**

Multiple procedures subject to the multiple procedure concept (as described above) performed by the Same Group Physician and/or Other Health Care Professional on the same date of service are ranked to determine applicable reductions. There are no modifiers that override the multiple procedure concept other than those services which are appropriately reported with modifier 78.

When two or more procedure codes subject to reductions are performed on the same date of service and are subject to the reduction list, only one of the procedure codes will be considered as the primary procedure, and all the remaining procedures will be considered secondary. The procedure with the highest CMS-based Relative Value Unit will be considered the primary procedure. All other procedures performed during the session, and not billed with the multiple procedure modifier (-51) will be adjusted, and an identical new claim line(s) will be added with a -51 modifier appended to the code. The fee for the procedures not considered primary will be reduced.

Oxford providers should bill appropriate -51 modifiers on secondary procedures. If modifiers are not billed or accurately assigned, the primary and secondary procedures are determined based on CMS-based RVU's. Oxford's claims processing system automatically makes the reimbursement reduction calculation to procedures with a -51 modifier.

Reimbursement will be calculated as follows:

1. **Primary procedure:**

Reimbursement of primary procedure will be based on 100% the applicable fee schedule minus any applicable cost share. No modifier or adjustment is necessary.

2. **Secondary procedures:**

Reimbursement of secondary procedures will be based on 50% of the applicable fee. This is accomplished by adding the modifier -51 following the procedure code, which will automatically calculate reimbursement based on 50% of the applicable fee schedule minus any applicable cost share.

**Note:** Multiple procedure reductions and Endoscopic Adjustment Rules are applicable to percent of charge or discount contracts. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.

**Exception for New York Commercial Lines of Business:** Oxford will determine the Primary Procedure based on the code with the highest maximum Allowable Amount for contracted providers. For services supplied by providers who are not contracted with Oxford, Oxford will compare the UCR amounts for each code and use the code with the highest UCR as the primary procedure.

### **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.

### **Multiple Procedure 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:

- **Gap Fill Codes:** When data is available for Gap Fill Codes, Oxford uses the relative values published in the first quarter update of the Optum, *The Essential RBRVS* publication for the current calendar year.

[Multiple Procedure Reduction Codes Assigned Gap Fill RVUs](#)

- **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). These codes are assigned an RVU value of 0.00.

**Multiple Procedures Reported with Modifier 78**

Per 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 concept.

**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 Group Physician and/or Other Health Care Professional. Assistant surgeon services will be ranked separately from the services reported by the primary surgeon.

Refer to Oxford’s *Assistant Surgeon* policy for information on when assistant surgeon services are reimbursable.

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 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 Oxford’s *Co-Surgeons/Team Surgeon* policy for information on when co-surgeon and team surgeon services are reimbursable.

Refer to the Questions and Answers section, [Q&A #5](#) for an example of multiple procedure ranking on a co-surgeon claim.

**Multiple Procedures for Bilateral Surgeries Reported with Modifier 50**

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

Refer to Oxford’s *Bilateral Procedures* policy for information on when bilateral procedures are a reimbursable service.

Refer to the Questions and Answers section, [Q&A #4](#), for an example of multiple procedure ranking on a bilateral procedure.

Modifier	Description
26	Professional component
50	Bilateral procedure
51	Multiple procedures
53	Discontinued procedure
62	Two surgeons
66	Surgical team
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

## 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.

**Endoscopic Adjustment Rule:** Allows the full Allowable Amount for the highest valued endoscopy code and allows any additional endoscopy codes (within the same family) at a reduced amount based on the value of the NPFS designated Endoscopic Base Code.

**Endoscopic Base Code:** The most basic, least complex form of the endoscopic procedure being done.

**Gap Fill Codes:** Codes for which CMS does not develop RVUs. Relative values are therefore assigned based on the first quarter update of Optum The Essential RBRVS publication for the current calendar year.

Note: Under the Multiple Procedures policy, a Gap Fill Code would also be subject to reduction per the CMS NPFS multiple procedure indicator of 2 or 3.

**Relative Value Unit (RVU):** The assigned unit value of a particular CPT or HCPCS code.

**Same Individual Physician or Other Health Care Professional:** The same individual rendering health care services reporting the same Federal Tax Identification number.

**Same Group Physician and/or Other Health Care Professional:** All physicians and/or other health care professionals of the same group 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:	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. <b>Note:</b> RVU values in the Q&A may not accurately reflect the current NPFS and are intended for illustrative purposes only.
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.
3	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 the 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).
4	Q:	How is multiple procedure reductions applied to a bilateral eligible procedure reported with a modifier 50?
	A:	When the bilateral code is split for processing, each side is considered separately for multiple procedure reduction. One side is considered primary and the other side is considered secondary.
5	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.

6	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 Oxford's "Global Days Policy".																																					
7	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 Health Care Professional on or after 12/1/2016 date of service?																																					
	A:	<p>Below is an example of how the Endoscopic Adjustment Rule will be applied:</p> <ul style="list-style-type: none"> <li>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 base endoscopy (45378).</li> <li>Based on the following fee schedule amounts for these codes if the procedures were performed in a facility: 45378 (\$255.40), 45380 (\$285.98), 45385 (\$374.56)</li> <li>Pay the full value of 45385 (\$374.56), plus the difference between 45380 and 45378 (\$30.58), for a total of \$405.14.</li> </ul> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> <th>Facility RVU</th> <th>Fee Schedule</th> <th>Endoscopy Reduction</th> <th>Adjusted Allowable</th> </tr> </thead> <tbody> <tr> <td>45378</td> <td>Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td> <td>6.48</td> <td>255.40</td> <td>Base code = Not allowed</td> <td>0</td> </tr> <tr> <td>45380</td> <td>Colonoscopy, flexible; with biopsy, single or multiple</td> <td>7.73</td> <td>285.98</td> <td>285.98 - 255.40</td> <td>30.58</td> </tr> <tr> <td>45385</td> <td>Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td> <td>9.17</td> <td>374.56</td> <td>Highest RVU - no reduction</td> <td>374.56</td> </tr> </tbody> </table>	Code	Description	Facility RVU	Fee Schedule	Endoscopy Reduction	Adjusted Allowable	45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	6.48	255.40	Base code = Not allowed	0	45380	Colonoscopy, flexible; with biopsy, single or multiple	7.73	285.98	285.98 - 255.40	30.58	45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	9.17	374.56	Highest RVU - no reduction	374.56													
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8	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:	<p>Below is an example of how the Endoscopic Adjustment Rule and multiple procedure reduction will be applied:</p> <ul style="list-style-type: none"> <li>The physician bills for codes 45380 and 45381 (same endoscopic family) and 45562 (unrelated procedure).</li> <li>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 adding this to the higher valued endoscopy code (7.73) which equals (8.56).</li> <li>Compare the total adjusted RVUs (8.56) to the RVUs of the unrelated procedure (33.19) to determine multiple procedure ranking.</li> </ul> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> <th>Facility RVU</th> <th>Fee Schedule</th> <th>Endoscopy Reduction</th> <th>Adjusted Allowable</th> <th>Adjusted RVU</th> <th>Multiple Procedure Ranking</th> </tr> </thead> <tbody> <tr> <td>45378</td> <td>Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</td> <td>6.48</td> <td>235.81</td> <td>Base code = Not allowed</td> <td>0</td> <td>0</td> <td rowspan="3">50%</td> </tr> <tr> <td>45380</td> <td>Colonoscopy, flexible; with biopsy, single or multiple</td> <td>7.73</td> <td>285.98</td> <td>Highest RVU - no reduction</td> <td>285.98</td> <td>7.73</td> </tr> <tr> <td>45381</td> <td>Colonoscopy, flexible; with directed submucosal injection(s), any substance</td> <td>7.34</td> <td>264.11</td> <td>264.11 - 235.81</td> <td>28.30</td> <td>.86</td> </tr> <tr> <td>45562</td> <td>Exploration, repair, and presacral drainage for rectal injury</td> <td>33.19</td> <td>1,017.84</td> <td>N/A</td> <td>1,017.84</td> <td>33.19</td> <td>100%</td> </tr> </tbody> </table>	Code	Description	Facility RVU	Fee Schedule	Endoscopy Reduction	Adjusted Allowable	Adjusted RVU	Multiple Procedure Ranking	45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	6.48	235.81	Base code = Not allowed	0	0	50%	45380	Colonoscopy, flexible; with biopsy, single or multiple	7.73	285.98	Highest RVU - no reduction	285.98	7.73	45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	7.34	264.11	264.11 - 235.81	28.30	.86	45562	Exploration, repair, and presacral drainage for rectal injury	33.19	1,017.84	N/A	1,017.84	33.19
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## ATTACHMENTS

### Multiple Procedure Reduction Codes List

The list identifies codes that are subject to multiple procedure reductions



Multiple Procedure  
Reduction Codes List

### Multiple Procedure Reduction Codes Assigned Gap Fill RVUs

The list identifies codes on the Multiple Procedure Reduction Codes List that have been assigned gap fill RVUs



Mult Proc Reduction  
Assigned Gap Fill RVU

### Endoscopy Code Policy Table

The list identifies Endoscopy and Endoscopic Base Codes that are subject to the Endoscopic Adjustment Rule



Endoscopy Code  
Policy Table

## REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [2017R0034B]

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

Centers for Medicare and Medicaid Services, CMS Manual System and other publications and services.

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

Optum, The Essential RBRVS, 1st Quarter Update.

## POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
01/01/2019	<ul style="list-style-type: none"><li>Updated <i>Multiple Procedure Reduction Codes List</i> (CPT/HCPCS codes that are subject to multiple procedure reductions) to reflect annual code edits:<ul style="list-style-type: none"><li>Added 0510T, 0511T, 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0524T, 0525T, 0526T, 0527T, 0530T, 0531T, 0532T, 10005, 10007, 10009, 10011, 10021, 11102, 11104, 11106, 33274, 33275, 33285, 33286, 33289, 33440, 38531, 43762, 43763, 50436, 50437, and 53854</li><li>Removed 11100, 20005, 27370, 31595, 33282, 33284, 41500, 43760, 46762, 50395, 61332, 61480, 63615, 64508, and 66220</li></ul></li><li>Archived previous policy version SURGERY 022.34 T0</li></ul>