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PAYMENT POLICY ID NUMBER: 10-026

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Multiple Surgical Procedure Reduction (Including Multiple Endoscopic Procedure Reduction)

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DESCRIPTION:

This policy describes the reimbursement when multiple surgical procedures are reported by the same physician on the same date of service for the same patient.

When the relative value units (RVUs) are determined for each CPT® code, the assumption is services are performed as a stand-alone procedure. However, when two services are performed during the same encounter, there are duplicated elements in the reimbursement of the other code. The elements may include pre-procedure and post-procedure work as well as services integral to the standard surgical service. Payment at 100% for subsequent procedures would represent reimbursement for duplicative components of the primary procedure. Therefore, when multiple procedures are performed on the same day, by the same physician or other healthcare professional, reduction in reimbursement for the subsequent procedures will occur. This is consistent with longstanding Centers for Medicare & Medicaid Services (CMS) policy and industry practice to avoid duplicate payments for portions of physician work and practice expenses that are incurred only once when two or more surgical services are furnished together by the same physician on the same date of service.

Bilateral surgeries are identical surgical procedures performed on both sides of the body, on the same day, by the same physician, during the same or different operative settings. These procedures are also subject to multiple surgery guidelines. See Bilateral Procedure Payment Policy 10-005.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. Intraoperative services, incidental surgeries or components of surgeries will not be separately reimbursed.

This policy applies to billing for surgical procedures on a CMS-1500 or equivalent claim form. Same provider for the purposes of this policy includes all physicians and/or other health care professionals reporting under the same Federal Tax Identification number.

REIMBURSEMENT INFORMATION:

Multiple surgical procedures, multiple endoscopic procedures and bilateral surgical procedures are subject to multiple procedure payment reduction and may be eligible for coverage when performed by the same physician if the procedures:

- add significant time or complexity to patient care
- deserve a separate allowance for each procedure
- are clearly identified and defined
- are performed on the same date of service

Non-endoscopic codes subject to multiple procedure reduction will be reimbursed at **100%** of the allowed amount for the most clinically intensive procedure (the "primary" procedure), then at **50%** for each additional procedure allowed on the same day. The procedure RVU (facility or non-facility based on the location of service) determines clinically intensity.

Procedure codes identified as "add-on" and "modifier 51 exempt" codes are not subject to multiple surgical procedure reductions. A listing of these codes can be found in the current CPT® code book under Appendix D (add-on) and Appendix E (modifier 51 exempt).

Incidental Procedures will not be reimbursed separately.

Multiple Endoscopic Procedures – Florida Blue uses the endoscopic groups defined by CMS to reimburse for multiple endoscopic procedures performed for the same patient on the same day. These are identified with a MULT PROC value of "3" on the Medicare Physician Fee Schedule (MPFS). Each grouping of related endoscopic procedures shares the same base code. A base code is a procedure whose allowance is included in the allowance for the other related endoscopic procedure codes within that particular grouping. For endoscopic procedures identified within the same grouping, the primary procedure will be determined by the highest facility or non-facility relative value and will be paid at 100% of the allowance. For subsequent endoscopic procedures, the allowance will be reduced as outlined below.

Payment Calculation Steps Effective 01/01/2025 (prior to 01/01/2025 see the archived version) When two or more endoscopic procedures identified within the same grouping are reported, the primary procedure will be the procedure with the highest RVU. The primary endoscopic procedure will be eligible for 100% of the allowance for that procedure.

Secondary and subsequent endoscopic procedures within the same grouping will be reduced as follows:

- An adjusted RVU will be determined by subtracting the lesser valued endoscopy code(s) RVU from the endoscopic base code RVU.
- The adjusted RVU value is then divided by the lesser valued endoscopy code(s) RVU and multiplied by 100 to determine what percent of the value is to be applied to the secondary and subsequent endoscopic procedures within the same grouping.
- The fee schedule allowance of the lesser valued endoscopy code(s) is then multiplied by this new percentage value (rounded to the nearest tenth) to determine the allowance for the endoscopic procedure.
- If the non-facility adjusted RVU for second and subsequent endoscopies is equal to or less than zero, the facility RVU will be used to determine the adjusted RVU for second and subsequent endoscopic procedures within the same grouping.

If one endoscopic procedure is billed with other procedures that are not endoscopies, the standard multiple surgery rules apply.

If two unrelated endoscopies are performed on the same day, the standard multiple surgery rules apply.

If two sets of unrelated endoscopies are performed on the same day, the secondary and subsequent endoscopic procedures within the same grouping rules will be applied and then the multiple surgery rules will be applied. Consider the total RVUs for each set of endoscopies as one service.

If two related endoscopies and a third unrelated procedure are performed on the same day, the endoscopic rules will be applied to the related endoscopic procedures and then the multiple surgery rules will be applied. Consider the total RVUS for the related endoscopies as one service and the unrelated procedure as another service.

BILLING/CODING INFORMATION:

Surgical procedures are reported using CPT® code range 10004-69990. CPT® Category III codes and Healthcare Common Procedures Coding System (HCPCS) codes in the G code range may also be subject to multiple surgery reduction depending on the definition of the code. There may be other codes outside of the surgical range that are subject to multiple procedure reduction as indicated by the MPFS indicator '2'.

Each surgical procedure is reported separately. The most significant procedure should be listed on the claim first, followed by the second or subsequent procedure(s), which can be reported with the modifier 51. While modifier 51 may be reported, the multiple surgery reduction will be applied based on the method described above and is not dependent upon reporting this modifier.

In the case of bilateral procedures, a modifier should be appended to the CPT® procedure codes to denote it as a bilateral procedure unless specified as unilateral or bilateral in the description (i.e., 50, RT, LT).

CPT®/HCPCS codes subject to the Multiple Endoscopic Procedures Reduction and their corresponding RVU and payment percentage value are identified in the link below.

Multiple Endoscopic Procedures Reduction

CPT® Coding/Modifiers:

50	**Bilateral Procedures**: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate five-digit procedure.
51	**Multiple Procedures:** When multiple procedures are performed, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** modifier-51 should not be appended to designated "add-on" codes (see Appendix D of CPT®).

RELATED PAYMENT POLICIES:

Bilateral Procedure Payment Policy 10-005

REFERENCES:

1. American Medical Association, Current Procedural Terminology (CPT®), Professional Edition
2. Centers for Medicare and Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 12, Section 40.6, Claims for Multiple Surgeries https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf
3. CMS, Medicare Physician Fee Schedule Relative Value File http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
4. CMS, Final Rule with Comment Period, Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, November 29, 2010 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS1240932.html
5. United States Government Accountability Office, "Medicare Physician Payments: "Fees Could Better Reflect Efficiencies When Services Are Provided Together" http://www.gao.gov/assets/300/293552.pdf

GUIDELINE UPDATE INFORMATION:

11/15/2008	New Payment Policy
10/29/2010	Revision to include multiple endoscopic procedure reduction rules effective 09/01/2010
07/01/2012	Revised to use RVU based on location of service to determine primary procedure for non-endoscopic procedures
09/01/2015	Revised the number of endoscopic groups from 31 to 33, as indicated by the National Physician Fee Schedule
11/10/2016	Annual Review
08/17/2017	Annual Review – minor verbiage changes under Description
08/16/2018	Annual Review – minor verbiage revisions, revised the number of endoscopic groups from 33 to 34, as indicated by the National Physician Fee Schedule
08/15/2019	Annual Review
08/13/2020	Annual Review
08/12/2021	Annual Review – no changes
08/11/2022	Annual Review – no changes
08/10/2023	Annual Review – References reviewed and updated.
08/08/2024	Annual Review – Clarifying language added to indicate this policy applies to billing for surgical procedures on a CMS-1500 or equivalent claim form. References reviewed and updated.
02/13/2025	Revised – Policy was revised to include the new method of calculating the endoscopic procedure reduction based on a percentage value of the RVU. A link to the Multiple Endoscopic Procedure Reduction list and the corresponding RVU and payment percentage values was added.

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