

Coding Policy

Multiple Procedure Reductions

CODING POLICY NUMBER: 6.0

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SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”). **The full Company portfolio of current coding policies is available online and can be [accessed here](#).**

POLICY APPLICATION

- Providence Health Plan Participating Providers Non-Participating Practitioners
 Commercial Medicaid/Oregon Health Plan Medicare

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY STATEMENT

- I. When procedures eligible for multiple procedure payment reduction (MPPR) are performed on the same patient at the same operative session or on the same day for which separate payment is allowed, reimbursement is reduced for the second and subsequent procedures.

- II. CPT and HCPCS codes listed as “add-on codes” or “modifier -51 exempt” are exempt from multiple procedure reductions.
- III. Company will only reimburse professional charges for procedures performed by multiple surgeons as either co-surgery, team surgery, or as surgeon-assistant. See Coding Policy 16.0 (Co-Surgeons) and Coding Policy 03.0 (Assistant for Surgical Procedures) for additional information. MPPR still applies when applicable.
- IV. Only codes with an APC payment status indicator of “S” are exempt from the multiple procedure reduction for facility charges.
 - A. Certain codes do not have APC status indicators because they are not paid by CMS in an outpatient setting; however, Company may allow some of these procedures to be performed in an outpatient setting. For codes paid by Company in an outpatient setting that do not have APC status indicators, MPPR is applied unless the code is listed as an “add-on code” or “modifier -51 exempt” in the CPT book.
- V. The multiple procedure reduction applies to Ambulatory Procedure Centers (ASC) unless noted otherwise in the contract. For facilities subject to Reimbursement Policy 3 (Ambulatory Surgery Center Payment Structure) only codes with indicator “N” under “Subject To Multiple Procedure Discounting” in the CMS Final ASC Covered Surgical Procedures schedule are exempt from the multiple procedure reduction for ASC charges.

PROCEDURE

GENERAL

The National Correct Coding Initiative (NCCI) policy states: "Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures and or surgeries are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. The payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work."

When multiple procedures are performed on the same patient in the same session, Company will apply a multiple procedure payment reduction (MPPR) to the second and all subsequent procedures which qualify.

Services subject to multiple procedure guidelines can be identified by the multiple procedure status indicator assigned to the procedure code on the Medicare Physician Fee Schedule (MPFS).

Multiple Procedure Status Indicator Definitions:

- 0 = No payment adjustment rules for multiple procedures apply.

- 2 = Standard payment adjustment rules for multiple procedures apply.
- 3 = Special rules for multiple endoscopic procedures apply.
- 4 = Diagnostic imaging services subject to MPPR methodology.
- 5 = Selected therapy services subject to MPPR methodology.
- 6 = Diagnostic cardiovascular services subject to MPPR methodology.
- 7 = Diagnostic ophthalmology services subject to MPPR methodology.
- 9 = Multiple surgery concept does not apply.

Company will assume all services provided on the same date were furnished in the same session, unless the appropriate modifier is submitted indicating otherwise (i.e. XE – separate encounter).

Services which are subject to multiple procedure reduction should be billed on separate lines rather than billed on a single line with multiple units.

STANDARD MULTIPLE PROCEDURE PAYMENT REDUCTION (MPPR)

The reimbursement for multiple surgical procedures is based on a 100/50/50 methodology. The procedure with the highest allowed amount is reimbursed at 100% and all secondary procedures are reimbursed at 50% of the allowed amount.

This payment methodology is applicable to procedures subject to standard multiple procedure guidelines (e.g. multiple procedure status indicators 2 or 3, APC payment status Indicators other than “S”, ASC codes with multiple procedure discounting indicators other than “N”).

Services qualifying for Company’s standard multiple procedure payment reduction will receive reductions according to the reimbursement scale below:

- Reimbursement Scale
 - Primary Procedure- 100%
 - All Subsequent Procedures - 50%

MULTIPLE ENDOSCOPY CODES

All endoscopy codes with multiple procedure indicator of “3” on the Medicare Physician Fee Schedule (MPFS) are subject to the multiple endoscopy payment reduction. See Coding Policy 06.1 (Multiple Endoscopy Procedures) for details.

DIAGNOSTIC IMAGING, CARDIOVASCULAR, or OPHTHALMOLOGY SERVICES

Codes with multiple procedure indicators of “4”, “6”, or “7” on the Medicare Physician Fee Schedule (MPFS) are subject to payment reductions. See Coding Policy 06.2 (Multiple Diagnostic Service Reductions) for details.

THERAPY PRACTICE EXPENSES (PE)

Multiple therapy reductions are applied to procedure codes with a multiple procedure indicator of “5” on the Medicare Physician Fee Schedule (MPFS).

The Centers for Medicare and Medicaid Services (CMS) maintains a list of “always” and “sometimes” codes for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP). In general, “always therapy” codes may only be billed when the service is included in the patient’s plan of care. The PE portion covers the costs of providing the service, such as equipment, supplies, and staff time.

If a physical therapist provides two or more “always therapy” services during a single session, the first service is allowed at 100%, and the allowable for the subsequent service(s) will be reduced by 25% to account for the overlapping PE components.

- Reimbursement Scale
 - Primary “always therapy” service - 100%
 - All Subsequent “always therapy” services - 75%

CROSS REFERENCES

- Coding Policy 16.0 (Co-Surgeons)
- Coding Policy 03.0 (Assistant for Surgical Procedures)
- Reimbursement Policy 3 (Ambulatory Surgery Center Payment Structure)
- Coding Policy 06.1 (Multiple Endoscopy Procedures)
- Coding Policy 06.2 (Multiple Diagnostic Service Reductions)

REFERENCES

1. CMS/Medicare Rules and Regulations
2. Current Procedural Terminology (CPT)

POLICY REVISION HISTORY

Date	Revision Summary
1/2023	Annual review (converted to new template 5/2023). Original policy effective date: 9/1991
1/2024	Annual review. No changes.
8/2024	Added section II to “Policy Statement” to clarify that this policy does not apply to CPT codes 99202-99499 (Evaluation and Management), CPT codes 00100-01999 (Anesthesia), CPT codes 70010-79999 (Imaging), CPT codes 80000-89999 (Pathology and Laboratory), or codes for proprietary laboratory analyses.
1/2025	Annual review. Added codes 98000-98016 to the list of E/M codes not addressed by this policy.

8/2025

Interim Update. Align with CMS application of MPPR status indicators. Transferred multiple surgeon details to CP 16. Referenced CP 6.2. Added therapy PE information.

12/2025

Interim Update. Updated Therapy PE Reduction methodology to 25% reduction of total allowable instead of 50% of the PE component.