Coding Policy

Multiple Procedure Reductions

CODING POLICY NUMBER: 6

Effective Date: 1/1/2025

Last Review Date: 1/2025

Next Annual Review: 2026

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

POLICY STATEMENT

Professional Charges

I. When non-incidental multiple procedures are performed on the same patient at the same operative session, reimbursement is reduced for the second and subsequent procedures. Except as noted in Policy Statement II, only CPT and HCPCS codes listed as "add-on codes" or "modifier -51 exempt" are exempt from the multiple procedure reduction for professional charges.

II. This policy does not apply to CPT codes 99202-99499, 98000-98016 (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.

III. Multiple surgeons will be reimbursed using the following methodology:

A. Company will reimburse procedures performed by multiple surgeons as either co-surgery, team surgery, or as surgeon-assistant. See Coding Policy 16.0 *(Co-Surgeons/Team Surgeons)* and Coding Policy 03.0 (Assistants for Surgical Procedures) for additional information.
B. Except for co-surgery or team surgery, only one surgeon may be considered the primary surgeon for all procedures performed in a single surgical session.
C. Components of a procedure, separate procedures, or bilateral procedures may not be billed by more than one single primary surgeon. In these cases, the surgeons may bill as co-surgeons (Coding Policy 16.0), or one surgeon may bill as primary for all procedures and the other surgeon may bill as assistant for all procedures (Coding Policy 03.0). For example:
    1. One surgeon may not bill a column 1 procedure code and another bill a column 2 procedure code of a CCI procedure-to-procedure (PTP) edit.
    2. Two surgeons may not each bill one side of a bilateral surgery as the primary surgeon.
D. Two surgeons of the same specialty may not perform related procedures or bill different CPT codes not billed by the other surgeon and both be reimbursed as primary surgeons. All surgical procedures must be billed by a single surgeon with the second surgeon billing as assistant (Coding Policy 03.0). If it is medically necessary for two surgeons of the same specialty to perform as co-surgeons, and criteria listed on Coding Policy 16.0 are met, the two surgeons may bill as co-surgeons. Payment is subject to medical review.

Facility Charges

IV. Only C-codes with an APC status indicator of "S" are exempt from the multiple procedure reduction for facility charges. All codes with a status indicator of "T" are subject to the multiple procedure reduction for facility charges.

V. 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 even though CMS does not. For codes paid by Company in an outpatient setting that do not have APC status indicators, the multiple procedure reduction is applied unless the code is listed as an "add-on code" or "modifier -51 exempt" in the CPT book.

VI. The multiple procedure reduction applies to Ambulatory Procedure Centers (ASC) unless noted otherwise in the contract. For facilities subject to Coding Policy 74.0 (ASC Payment System), 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

PROFESSIONAL AND FACILITY CHARGES

- All endoscopy codes with multiple surgery indicator of "3" on the Medicare Physician Fee Schedule (MPFS) are subject to the multiple endoscopy payment reduction. See Coding Policy 41.0 (Multiple Endoscopy Procedures) for details.

- For codes other than the ones addressed on Coding Policy 41.0 or listed as "add-on" codes or "modifier -51 exempt" in the CPT book, or C-codes with an APC status indicator of "S," or codes with indicator "N" in the CMS Final ASC Covered Surgical Procedures schedule, Company will pay according to the reimbursement scale below. The usual adjustment for multiple surgeries does not apply to add-on services. Refer to CPT code book for the list of add-on codes and services that are exempt from modifier -51.
    - Reimbursement Scale
        - Primary Procedure- 100%
        - All Subsequent Procedures - 50%

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

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.