Multiple Procedures

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Important Note About This Policy

Oscar's reimbursement policies serve as a guide to assist providers with accurate claims submission and outline the basis for reimbursement if the service is a covered benefit. Coverage does not guarantee reimbursement; services must meet authorization and medical necessity guidelines for the procedure, diagnosis, and member's state of residence.

Our policies provide general reference for described services and do not cover every aspect of reimbursement. Other factors may supplement, modify, or supersede this policy, including legislative mandates, provider contracts, member benefit documents, and/or other reimbursement, medical, or drug policies. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

Providers are responsible for submission of accurate documentation of services performed. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Oscar routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later. Oscar communicates policy updates to providers via update notifications.

Description

Centers for Medicare and Medicaid Services (CMS) created the Multiple Procedure Payment Reduction (MPPR) policy to address scenarios where multiple procedures are performed on the same day by the same physician. Per the National Correct Coding Initiative (NCCI) Policy Manual: Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work. Therefore, the MPPR defines how the services are to be reimbursed.

Policy

When multiple procedures are performed on the same day, by the same group, physician, or other healthcare professional, reduction in reimbursement for secondary and subsequent procedures will occur. Oscar follows multiple procedure CMS standards, such as the National Physician Fee Schedule (NPFS) Relative Value File, Ambulatory Surgical Center (ASC) Fee Schedule, and Hospital Outpatient Prospective Payment System (OPPS) for reduction of payment. The use of modifier 51 appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions.

Reimbursement Guidelines

When two or more services are performed during the same encounter, there are often duplicated elements in the reimbursement, including pre-procedure and post-procedure work as well as services integral to the service. Therefore, when multiple procedures are

performed on the same day, by the same physician or other healthcare professional, reduction in reimbursement for the subsequent procedure(s) will occur.

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 other Oscar reimbursement policies, such as Medically Unlikely Units.

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 as defined within Oscar's Bilateral Procedures reimbursement policy.

Determining the Primary Procedure Code:

- When multiple procedure rules apply, the NPFS relative value units (RVUs) are used to rank procedure codes and determine the primary and secondary procedures on all professional claims.
- For facility claims with Ambulatory Payment Classification (APC) contracts, a Medicare pricing tool is used to rank the multiple procedure reductions.
- The procedure code with the highest RVU is determined to be the primary procedure:
    - Regardless of the order in which the procedure codes are billed on the claim.
    - Regardless of which procedure code has the highest billed charges.

<u>Professional Claims</u>

MPPR reductions are applied to professional claims based on the status indicators within the NPFS Relative Value File as follows:

- **Surgical / Endoscopic Procedures (Status Indicators 2 & 3)**

If a procedure is reported on the same day as another procedure with an indicator of 2 or 3, the procedures with the greatest reimbursable amount will be paid at 100% followed by 50% for all subsequent procedures.

    - Special rules for multiple endoscopic procedures apply if an endoscopic procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of the CMS NPFS Relative Value File. The multiple endoscopy rules are applied to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately payable. Payment for the base procedure is included in the payment for the other endoscopy.

- **Radiology Procedures (Status Indicator = 4)**

  The multiple procedure payment reduction on diagnostic imaging applies when multiple services are furnished by the same physician or physicians in the same group practice, to the same patient, in the same session, on the same day (CPT/HCPCS code where the CMS NPFS Status Indicator is equal to 4). The allowance for the technical component of the primary procedure is 100%. The allowance for the technical component of the second and each subsequent imaging procedure is 50%. The allowance for the professional component of the primary procedure is 100%. The allowance for the professional component of the second and each subsequent imaging procedure is 95%.

- **Therapy Services (Status Indicator = 5)**

For therapy services, full payment is made for the service with the highest payment. Payment is reduced by 50 percent of the practice expense component for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the practice expense component, the other components are paid at 100% for all procedures.

- **Cardiovascular Services (Status Indicator = 6)**

For cardiovascular services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the technical component, the professional component is paid at 100% for all procedures.

- **Ophthalmology Services (Status Indicator = 7)**
  For ophthalmology services, full payment is made for the service with the highest payment. Payment is made at 80 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the technical component, the professional component is paid at 100% for all procedures.

Ambulatory Surgery Center Claims

MPPR reductions are applied to ambulatory surgery center claims based on the ASC addendum AA. This file defines which procedures are subject to multiple procedure discounting using yes/no indicators. Services defined as "yes" within this file are reimbursed based on a 100%-50%-50% method as follows:

- 100% of the Allowable Amount for the primary/major procedure
- 50% of the Allowable Amount for the secondary procedure
- 50% of the Allowable Amount for all subsequent procedures

Outpatient Facility Claims

MPPR reductions are applied to outpatient facility claims based on status indicators defined in the OPPS. Procedures are subject to multiple procedure discounting when priced via APC methodology, as follows:

A Medicare pricing tool is used to rank the multiple procedure reductions in alignment with status indicators in addendum B of the OPPS fee schedule

Related Policies

Bilateral Procedures
Medically Unlikely Units
Modifier Guidelines
Radiology

References

1. CMS Transmittal 995 (11/04/2011): https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R995OTN.pdf
2. CMS Internet Only Manual 100-04
3. NCCI Policy Manual, Chapter 1
4. CMS Physician Fee Schedule
5. CMS Hospital Outpatient Prospective Payment System
6. CMS Ambulatory Surgical Center Fee Schedule

Publication History

Date	Action/Description
09/01/2015	Original Documentation
10/01/2015	Initial Policy Approval
07/20/2017	Policy Updated
08/19/2019	Policy Updated
01/30/2025	Annual Review; Template updated; Description Section added; Related Policies section added Sources section renamed to References; Global/Case Rate Adjustment policy statement removed. No change to policy intent.

10/12/2026	Annual Review. Added standard disclaimer; Updated Policy section; Added introduction to Reimbursement Guidelines section that discusses multiple procedures, when reductions apply, and how the primary procedure is determined; Added new subsection heading of Professional Claims and transitioned Surgical / Endoscopic Procedures, Therapy Services, Cardiovascular Services, and Ophthalmology Services to bullet points in this subsection; Added Radiology Services bullet point to Professional Claims based on information already present in Oscar's Radiology reimbursement policy; Added Ambulatory Surgery Center Claims and Facility Claims subsections to discuss multiple procedures in those locations; Added more policies to the Related Policies section; Added additional references to the References section