HEALTH PLANS
UNIVERSITY OF UTAH

Coding/Reimbursement Policy

Multiple Procedure Guidelines for Ambulatory Surgical Centers

Policy REIMB-031

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Current Effective Date: 03/27/2024

Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, CHIP and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

Description:

Many medical and surgical services include pre-procedure, post-procedure and other services integral to the standard medical/surgical service. When multiple surgeries or procedures are performed on the same patient at the same operative session, reduction in reimbursement for secondary and subsequent procedures may occur.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. In some cases, these intra-operative services, incidental surgeries or components of more major surgeries are not separately billable.

Bilateral surgeries are performed on both sides of the body during the same operative session or on the same day. Multiple surgical reductions may also apply.

Guidelines in this policy refer to ambulatory surgical centers (ASCs).

Policy Statement and Criteria

1. Commercial Plans/CHIP

U of U Health Plans reimburses for multiple procedures consistent with multiple procedure reduction logic followed by CMS, unless superseded by contract language.

Specific actions include the following:

A. Allowance for the primary procedure is 100%. Allowance for each secondary procedure will be 50%. There is no cap on the number of procedures that may be reduced unless specified otherwise in the provider contract or non-adherent to correct coding rules.

   i. Procedures billed with modifier -51 will be reduced systematically.

   ii. When no modifier is billed, determination of the primary procedure will be based on the CPT with the highest allowable amount. To determine which procedures are eligible for multiple procedure reductions U of U Health Plans uses the multiple procedure indicators 2 and 3 in the current CMS NPFS Relative Value File and any additional codes that are identified as subject to multiple procedure reduction from the CMS ASC payment file.

   iii. Procedure codes identified as "add-on" and "modifier -51 exempt" are not subject to multiple surgical procedure reductions.

   iv. Multiple procedure reductions may apply when a single code is submitted with multiple units.

   v. The endoscopy base is not considered in multiple procedure reduction amounts.

   vi. Multiple procedure reduction is not applied on rehab therapy codes.

B. Procedures performed in conjunction with the primary surgical procedure considered by U of U Health Plans to be incidental, integral or mutually exclusive to that primary procedure will not receive additional reimbursement.

C. Each secondary procedure will be eligible for reimbursement at 50% of the allowance, if the following criteria are met:

   i. The secondary procedure is to correct a separate pathological condition that requires intervention, AND

   ii. The degree of difficulty, operative time and risk were significantly increased by the secondary procedure.

U of U Health Plans periodically audits claims with multiple procedures and bilateral surgical procedures based on standard audit criteria.

2. Medicaid Plans

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies

and coverage, please visit their website at: https://medicaid.utah.gov/utah-medicaid-official-publications/ or the Utah Medicaid code Look-Up tool

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

Clinical Rationale

When more than a single (non-evaluation and management) procedure during a single encounter is performed, payers typically will reimburse only the highest-valued procedure at full fee schedule value, and will reduce payment for the second and subsequent procedures. This occurs because payers reason that many of the component services that comprise the physician's work (such as surgical approach and closure) should be paid only one time, per session. Chapter 1 of the National Correct Coding Initiative (NCCI) Policy Manual explains:

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.

This is the basis for the "multiple procedure rule," under which Medicare pays a reduced amount for the second and subsequent procedures performed during the same session.

Applicable Coding

CPT Codes

Too numerous to list.

HCPCS Codes

N/A

References:

1. Current Procedural Terminology (CPT®), American Medical Association
2. Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners, 40.6 - Claims for Multiple Surgeries (Rev. 1, 10-01-03) B3-4826, B3-15038, B3-15056