PREMERA BLUE CROSS
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Payment Policy

cmi_051737

Title	**Multiple Surgical Reductions**		
Number	**CP.PP.086.v3.3**		
Last Approval Date	02/04/25	**Original Effective Date**	06/20/00
Cross Reference	• *Add-On Codes* • *Modifier 51 – Multiple Procedures*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define how Multiple Surgical Reductions are identified and reimbursed when two or more applicable surgical procedures are performed for the same patient on the same date of service by the same provider during the same surgical session that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Policy	The Plan primarily determines codes eligible for multiple surgical reduction rules based on the "Multiple Procedure Flag" indicator in the current CMS National Physician Fee Schedule (NPFS) Relative Value Guide (LINK) as follows: • **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 if procedure is billed with another endoscopy in the same family • **9** = Concept does not apply Codes identified in the NPFS with a flag indicator of *9-Concept does not apply* may utilize other professional resources within the company and outside of the company such as the American Medical Association (AMA) Current Procedural Terminology (CPT) codebook or professional societies and colleges to make exceptions. When it has been determined that two or more surgical procedures which are subject to multiple procedure reduction, were performed for the same patient on the same date of service by the same provider, the following adjustments will be applied: **Surgical Procedures** The surgical procedure with the highest per procedure allowance will be allowed at either 100% of the procedure fee schedule allowance or 100% of the procedure billed charge, whichever is less. All other applicable lesser allowed procedures will be allowed at either 50% of the procedure fee schedule allowance or the per procedure billed charge, whichever is less. Modifier 51-*Multiple procedures* appended to a code does not determine which codes are subject to multiple procedure reductions.

	Add-on Surgical Procedures An add-on code is not subject to multiple surgical reduction rules since it describes work performed **in addition to** the primary procedure. The add-on surgical code must be billed with an appropriate primary procedure in order to be reimbursed. If the primary procedure code is denied reimbursement, then the add-on code will be denied as well. Refer to the AMA's current edition of the CPT Professional Edition codebook, **Appendix D** for examples of add-on codes that are exempt from multiple surgical reductions. **Modifier 51-Exempt Procedures** Codes that are exempt from the use of modifier 51 can be separately reimbursed without reduction. Refer to the AMA's current edition of the CPT Professional Edition codebook **Appendix E** for examples of codes exempt from multiple surgical reductions. Modifiers XE, XS, XP, XU– Separate Encounter, Separate Structure, Separate Practitioner, and Unusual Overlapping Service and Modifier 59– Distinct Procedural Services do not prevent multiple surgical reductions from being applied.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined at the Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	This policy does not apply to any provider reimbursed using an ASC APC payment methodology. The following codes are exempt from multiple surgical procedure reductions: • 17380 – Electrolysis epilation, each 30 minutes • 17999 – Unlisted procedure, skin, mucous membrane, and subcutaneous tissue
Laws, Regulations & Standards	
References	• American Medical Association's Current Procedural Terminology, Professional Edition (AMA/CPT) codebook o Appendix D – Summary of CPT Add-on Codes o Appendix E – Summary of CPT Codes Exempt from Modifier 51 • Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File (NPFS)
Policy Owner Review	Payment Integrity Oversight Committee
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.
Annual Review Dates	02/04/25; 03/04/24; 04/06/23; 06/06/22; 08/02/21; 08/17/20; 10/30/19; 11/02/18; 12/04/17; 12/12/16; 01/08/16; 01/11/15; 06/29/14; 12/01/13; 01/13/13; 01/26/12; 01/27/11; 02/12/10; 03/05/09; 06/16/08; 05/13/07; 05/05/06; 01/12/06; 08/29/05; 06/06/05; 04/19/05; 11/01/04; 10/08/04; 09/21/04; 04/14/04; 05/16/03; 6/20/00

This policy was published on February 8, 2025

Version History	11/02/18	Annual review; no changes
	10/30/19	• Added references to the use of modifier 51 in the Surgical Procedures section and the Exempt Procedures section. • Added a reference to the Add-On Surgical Procedures section that add-on codes must be billed with an appropriate primary code in order to be reimbursed
	08/17/20	• Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms. • In the Policy section, added a link to the CMS National Physician Fee Schedule • In the Exceptions sections, indicated that the policy does not apply to providers reimbursed using an ASC-APC payment method and the policy does not apply to the codes noted
	08/02/21	Annual review; no changes
	06/06/22	Additional clarification added to paragraph three indicating only those applicable codes will be subject to multiple procedure reduction.
	04/06/23	In the Add-On Surgical Procedure section, added the last sentence indicating that if the primary code is denied, the add-on code will also be denied.
	03/04/24	Annual review; no changes
	02/04/25	Annual review: Removed statement “or 50% of the per procedure billed charge, whichever is less, per provider contract” from the surgical procedure details in the policy statement. Added statement “Modifiers XE, XS, XP, XU– Separate Encounter, Separate Structure, Separate Practitioner, and Unusual Overlapping Service and Modifier 59– Distinct Procedural Services do not prevent multiple surgical reductions from being applied.” to the end of the policy section.