PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_171650

Title	**Modifier 51 – Multiple Procedures**		
Number	**CP.PP.411.v1.1**		
Last Approval Date	06/11/24	**Original Effective Date**	01/01/19
Replaces			
Cross Reference	• *Multiple Diagnostic Cardiovascular Services Reduction* • *Multiple Diagnostic Imaging Reduction* • *Multiple Diagnostic Ophthalmology Services Reduction* • *Multiple Endoscopy Procedure Reductions* • *Multiple Surgical Reductions*		

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/ Application	To identify how the Plan recognizes Modifier 51 when appended on a procedure code 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.
Definitions	**Primary Procedure Code** – the billed code with the highest maximum allowed amount compared to all of the other procedure codes billed on the same claim, same date of service by the same provider that are eligible for multiple procedure reduction.
Policy	When multiple procedures, other than Evaluation and Management (E&M), Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines) are performed at the same session by the same provider, the primary procedure or service should be reported as listed. The additional procedures or services may be identified by appending modifier 51 to each procedure. The Plan does not use modifier 51 to determine multiple procedure reductions. Multiple procedure reductions are primarily determined based on the multiple procedure indicator flag in the current CMS National Physician Fee Schedule (NPFS) Relative Value Guide as follows (LINK): • **0** = No payment adjustment rules for multiple procedure apply • **1 =** Standard payment adjustment rules apply • **2** = Standard payment adjustment rules for multiple procedures apply • **3** = Special rules for multiple endoscopic procedure apply if procedure is billed with another endoscopy procedure in the same family • **4** = Special rules for the technical component (TC) of diagnostic imaging procedures apply • **6** = Special rules apply to the second highest and subsequent procedure to the technical component (TC) of diagnostic cardiovascular services • **7** = Special rules apply to the second highest and subsequent procedures technical component (TC) of diagnostic ophthalmology services • **9** = Concept does not apply

	Codes that are identified in the NPFS with the flag indicator of *9-Concept does not apply* may utilize other resources such as the AMA CPT Codebook or professional societies and colleges to make exceptions. Modifier 51 should not be appended to the following categories of codes: • Designated "add-on" codes as found in the CPT Codebook with either the plus symbol (+) or listed in Appendix D, or • Procedure codes that are exempt from modifier 51 as listed in Appendix E in the CPT Codebook No reimbursement adjustment is applied to Modifier 51. Codes which are appended with modifier 51 will be reimbursed consistent with the current criteria as contained in the Payment Policies noted in the "Cross Reference" section at the beginning of this policy.
Codes and Coding Guidelines	
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	• Add on codes (CPT Codebook – Appendix D) • Modifier 51 exempt codes (CPT Codebook - Appendix E)
Laws, Regulations & Standards	
References and Resources	• CMS National Physician Fee Schedule (NPFS) Relative Value Guide • AMA Current Procedural Terminology (CPT) codebook

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	06/11/24; 09/06/23; 10/13/22; 11/01/21; 11/04/20; 12/04/19; 12/06/18	
Version History	12/06/18	Creation of New Policy
	12/04/19	Annual review; no changes
	11/04/20	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms, Added a link to the National Physician Fee Schedule Relative Value file. Clarified the location of Appendix E of Modifier 51 exempt procedure codes as being in the CPT Codebook
	11/01/21	Annual review; no changes
	10/13/22	Annual review; no changes
	09/06/23	Annual review; no changes
	06/11/24	Annual review; no changes

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