COMMERCIAL REIMBURSEMENT POLICY

Multiple Surgical Reduction

Active

Section: Surgery-Interventional
Policy Number: 005
Effective Date: 06/03/24

Description

This policy addresses reimbursement for multiple procedures performed by the same physician or other qualified healthcare professional (QHP) on the same date of service, during the same patient encounter. This policy applies to services submitted on a professional (837P) claim.

Definitions

Multiple Surgical Reduction (MSR): A reduction in payment rate applied when more than one surgical procedure is performed by the same provider during the same patient encounter.

Policy Statement

Blue Cross and Blue Shield of Minnesota (Blue Cross) follows the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File to determine which procedures are eligible for multiple procedure reduction. Blue Cross considers codes with the following indicators to be eligible for reduction.

- 2 = Standard payment adjustment rules for multiple procedures apply.
- 3 = Special rules for multiple endoscopic procedures. Refer to *Commercial Surgery/Interventional Procedure – 008 Multiple Endoscopic Procedures Reimbursement Policy.*

Multiple Surgeries

When more than one surgical procedure is performed during the same patient encounter, by the same provider, all procedures should be billed on the same claim. Modifier 51 may be appended to all secondary procedures; however, it is not necessary to append this modifier as it does not affect payment. Applicable code edits will be applied to services submitted regardless of the modifier.

If the multiple surgery reduction applies, the procedure with the highest allowed amount will be allowed at 100 percent of the allowed amount. The multiple surgery reduction will be applied to the procedure(s) with a lesser allowed amount at 50 percent of the allowed amount.

Assistant-at-Surgery

Assistant-at-Surgery services are indicated by appending one of the following modifiers: -80, -81, -82 and -AS.

When an assistant surgeon is involved in multiple surgical procedures, the same method used for determining reimbursement for the primary surgeon shall be used in determining

reimbursement for the assistant surgeon. Refer to *Commercial Surgery/Interventional Procedure – 001 Assistant-at-Surgery Reimbursement Policy.*

Bilateral Surgery
When a bilateral procedure, appended with modifier 50, is reported with other procedure codes on the same day, the bilateral adjustment of 150 percent will be applied, followed by the multiple surgery reduction of 50 percent if applicable. Refer to *Commercial Surgery/Interventional Procedure – 002 Bilateral Procedure Reimbursement Policy.*

Documentation Submission

Documentation/operative report must identify and describe the procedures performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount, and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	50	51	80	81	82	AS
ICD-10 Diagnosis:	N/A					
ICD-10 Procedure:	N/A					
CPT/HCPCS:	N/A					
Revenue Codes:	N/A					

Policy History

10/29/2014	Initial Committee Approval
11/07/2019	Annual Policy Review
01/26/2021	Annual Policy Review

11/29/2021	Revised
06/27/2023	Annual Policy Review
05/28/2024	Annual Policy Review