Manual: Reimbursement Policy

Policy Title: **Modifier 51 - Multiple Procedure Fee Reductions**

Section: Modifiers

Subsection: None

Date of Origin: 1/1/2000 **Policy Number:** RPM022

Last Updated: 11/15/2018 **Last Reviewed:** 5/12/2020

Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

Reimbursement Guidelines

A. All Provider Types

1. Moda Health requires each provider to submit all procedure codes for the same day/surgical session on the same claim.

2. Moda Health applies multiple procedure fee reductions to secondary procedures even when a billing error occurs and modifier 51 is omitted from a line item when needed.

3. *Please Note # 1:*
   Multiple procedure fee reduction rules do apply to percent of charge or discount contracts. For percent of charge or discount contracts, the applicable fee schedule amount is determined as the billed charge, less the discount. Any multiple procedure fee reduction rules are then applied to that fee schedule amount.

4. Multiple procedure fee reductions are *not waived* when:
   - Modifier SG is appended.
   - Modifiers XE, XS, XP, or XU are appended.
   - Modifier 59 is appended.
   - Modifier 77 is appended.
   - Modifier 78 is appended.
   - Modifier 79 is appended.
   - Maternity surgical procedures are performed during the operative session.

5. Bypassing Clinical Edits
   Modifier 51 does *not* bypass clinical edits, such as subset denials, redundant denials, or other types of clinical edits.

6. Other Pricing Adjustments Affect Final Line Item Allowable

   Please Note # 2: When multiple procedure fee reductions apply, other pricing adjustments may also apply before the final allowable amount for each line item is determined. For example, bilateral adjustments, assistant surgeon adjustments, co-surgery adjustments, related within global adjustments, etc.

7. Valid and invalid procedure code combinations for modifier 51.
   a. Procedure codes with a CMS Physician Fee Schedule (PFS) multiple procedure indicator of "1", "2", "3", "4", "5", "6", and "7" will allow as valid modifier to procedure combinations when billed with modifier 51.

   b. Procedure codes with a CMS PFS multiple procedure indicator of "0" and "9" will deny for invalid modifier to procedure combination when billed with modifier 51.

   c. There is a discrepancy in coding guidelines regarding the use of modifier 51 for medical procedures. Per the AMA, modifier 51 may be appended to medical procedures when medical and surgical procedures are performed in combination during the same session or when multiple medical procedures are performed in the same session. However, the CMS guidelines have indicated that modifier 51 should not be used when the concept of multiple procedure reductions does not apply or when the procedure code is not subject to multiple procedure fee reductions (e.g. add-on surgical codes). Moda Health follows CMS policy for procedure codes with a CMS multiple procedure indicator of "0" and "9."

   d. Chiropractic Services and Modifier 51

      Moda Health does not apply multiple procedure fee reductions to Osteopathic Manipulative Treatment (OMT) procedures or Chiropractic Manipulative Treatment (CMT) procedures. Despite the AMA modifier definition and ChiroCode guidelines indicating to use modifier 51 with chiropractic services, Moda Health follows CMS guidelines as described above. OMT and CMT procedure codes have a multiple procedure indicator of "0" and modifier 51 should not be used in combination with these procedure codes. Moda Health will deny 98925 – 98929 and 98940 - 98943 for invalid modifier to procedure combination when billed with modifier 51.

B. Professional Claims

1. Moda Health applies multiple procedure fee reductions (MPFR) to procedure codes with a multiple procedure indicator of "1" or "2" on the on the National Medicare Physician Fee Schedule Database (MPFSDB).

a. When multiple procedure fee reductions apply, the primary procedure code is processed at 100%, and the secondary procedures are processed at 50% (i.e.: 100 / 50 / 50 / 50 / etc.) unless otherwise specified in an Administrative Services Only (ASO) plan contract.
b. MPFR Cutback Rates for Self-Funded Plans (ASO)
Self-funded employer groups with Administrative Service Only (ASO) plans occasionally elect to specify a non-standard multiple procedure fee reduction structure in the plan benefit language (for example, 100 / 50 / 25 / 25). In those cases, Moda Health administers the MPFR cutback rates specified by the self-funded employer group. The employer plan benefit language takes precedence even over the provider contract language.
c. Determining the Primary Procedure Code
When multiple procedure fee reductions apply, the procedure code with the highest fee schedule amount is considered the primary procedure, regardless of the order in which the procedure codes are billed on the claim and regardless of which procedure code has the highest billed charges.

2. For procedure codes with a multiple procedure indicator or "3":
    a. For Moda Health Advantage claims:
        i. For claims processed before July 1, 2018, CMS Special Multiple Endoscopy Rules apply.
        ii. For Medicare Advantage claims processed on or after July 1, 2018:
            a) Contracted providers, standard multiple fee reductions apply (50%).
            b) For out-of-network providers, secondary endoscopy procedures will be reduced by 24%.
    b. For Commercial claims, procedure codes with an indicator of "3" are subject to standard multiple procedure fee reductions.
3. For claims processed prior to July 1, 2018, Moda Health does not apply the following non-surgical CMS multiple procedure reductions to Moda Health Advantage claims or to Commercial claims:
    a. Multiple radiology procedure reductions (indicator of "4").
    b. Multiple therapy services reductions (indicator of "5").
    c. Multiple diagnostic cardiovascular services reductions (indicator of "6").
    d. Multiple diagnostic ophthalmology services reductions (indicator of "7").

4. For claims processed on or after July 1, 2018 (regardless of the date of service):
    a. For procedure codes with a multiple procedure indicator of "4," CMS diagnostic imaging procedure rules apply. Secondary diagnostic imaging procedures are:

i. If billed with modifier TC, subject to a 50% reduction of the technical component (TC) portion of the RVU/fee allowance.

ii. If billed with modifier 26, subject to a 5% reduction of the professional component (PC) portion of the RVU/fee allowance. (CMS[4])

iii. If billed as global service (no modifier), subject to a 35% reduction.

iv. When Payment Cap Value limits apply under the Commercial and Medicare Advantage provider contract, the above multiple procedure reductions apply before the Payment Cap Value limits. (MLN[6])

b. For procedure codes with a multiple procedure indicator of "5," CMS multiple therapy reduction rules apply. The first unit of the first therapy code is allowed at full fee schedule amount. All secondary units and codes are subject to a 20% reduction.

c. For procedure codes with a multiple procedure indicator of "6," CMS multiple diagnostic cardiovascular reduction rules apply. (CMS[4]) Secondary cardiovascular procedures:

i. If billed with modifier TC, subject to a 25% reduction.

ii. If billed with modifier 26, processed at full allowable, no reduction.

iii. If billed as global service (no modifier), subject to a 20% reduction.

iv. When Payment Cap Value limits apply under the under the Commercial and Medicare Advantage provider contract, the above multiple procedure reductions apply before the Payment Cap Value limits. (MLN[6])

d. For procedure codes with a multiple procedure indicator of "7," CMS diagnostic ophthalmology reduction rules apply. Secondary ophthalmology procedures:

i. If billed with modifier TC, subject to a 20% reduction.

ii. If billed with modifier 26, processed at full allowable, no reduction.

iii. If billed as global service (no modifier), subject to a 10% reduction.

e. For procedure codes with a multiple procedure indicator of "9," the concept of multiple procedure fee reductions does not apply.

C. Ambulatory surgery centers

1. For claims processed on or after July 1, 2018 (regardless of the date of service):
   Multiple procedure fee reductions are applied to ASC claims.

   a. These reductions do apply to any codes with carve-out pricing.

b. If the contract is based upon Medicare payment methodology, CMS multiple procedure fee reduction methodology is used; otherwise Moda multiple procedure reductions of up to 50% will apply.

c. **Note:** Multiple procedure fee reduction rules do apply to percent of charge or discount contracts. For percent of charge or discount contracts, the applicable fee schedule amount is determined as the billed charge, less the discount. Any multiple procedure fee reduction rules are then applied to that fee schedule amount.

2. For claims processed prior to July 1, 2018:

a. Moda Health applies CMS multiple procedure fee reduction methodology to ASC claims for out-of-network ASCs and for contracted ASCs on a 2017 CMS-based ASC fee schedule or newer. These reductions do apply to any codes with carve-out pricing.

b. For contracted ASCs on a 2016 or prior ASC fee schedule:
When multiple procedure fee reductions apply, the primary procedure code is processed at 100%, and the secondary procedures are processed at 50% (i.e.: 100 / 50 / 50 / 50 / etc.) unless otherwise specified in an Administrative Services Only (ASO) plan contract. Moda Health does *not* alter or customize our list of procedure codes subject to multiple procedure fee reductions for facilities. We recognize that the CMS Physician fee schedule, ASC fee schedule, and the OPPS fee schedule each have somewhat different lists of which procedure codes are and are not subject to multiple procedure fee reductions. However, Moda Health uses the CMS physician fee schedule multiple surgery indicator list for all provider types, including facilities.

D. Outpatient hospitals

1. For claims processed on or after July 1, 2018 (regardless of the date of service):

a. Multiple procedure fee reductions are applied to outpatient hospital claims.

i. These reductions do apply to any codes with carve-out pricing.

ii. If the contract is based upon Medicare payment methodology, CMS multiple procedure fee reduction methodology is used; otherwise Moda multiple procedure reductions of up to 50% will apply, as described under the Professional section (B).

a) Facility claim lines with a professional revenue code are treated as though they have a 26 modifier.

b) All other facility revenue codes are treated as though they have a TC modifier.

iii. **Note:** Multiple procedure fee reduction rules do apply to percent of charge or discount contracts. For percent of charge or discount contracts, the applicable fee schedule amount is determined as the billed charge, less the discount. Any

multiple procedure fee reduction rules are then applied to that fee schedule amount.

b. See also E. Outpatient Rehabilitation Services.

2. For claims processed prior to July 1, 2018:

   a. When multiple procedure fee reductions apply, the primary procedure code is processed at 100%, and the secondary procedures are processed at 50% (i.e.: 100 / 50 / 50 / 50 / etc.) unless otherwise specified in an Administrative Services Only (ASO) plan contract.

   b. Moda Health does *not* alter or customize our list of procedure codes subject to multiple procedure fee reductions for facilities. We recognize that the CMS Physician fee schedule, ASC fee schedule, and the OPPS fee schedule each have somewhat different lists of which procedure codes are and are not subject to multiple procedure fee reductions. However, Moda Health uses one list for all provider types, including facilities.

E. Outpatient Rehabilitation Services

Multiple therapy reductions are applied to procedure codes with a multiple procedure indicator of "5" on the National Medicare Physician Fee Schedule Database (MPFSDB).

1. The list of codes eligible for these reductions are defined on the Physician Fee Schedule, but the reductions apply regardless of the type of provider or supplier that furnishes the services. (CMS[5])
2. The first unit of the first therapy code is allowed at the full fee schedule rate. All subsequent units and procedures are subject to a 20% reduction.
3. Note: Multiple procedure fee reduction rules do apply to percent of charge or discount contracts. For percent of charge or discount contracts, the applicable fee schedule amount is determined as the billed charge, less the discount. Any multiple procedure fee reduction rules are then applied to that fee schedule amount.
4. The multiple therapy reductions apply to multiple units of the same code, as well as multiple different therapy codes.
5. The multiple therapy reductions apply to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology. (CMS[5])

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
AMA	=	American Medical Association
ASC	=	Ambulatory Surgery Center
ASO	=	Administrative Services Only
CMS	=	Centers for Medicare and Medicaid Services
CORF	=	Comprehensive Outpatient Rehabilitation Facility

Acronym		Definition
CPT	=	Current Procedural Terminology
EOCCO	=	Eastern Oregon Coordinated Care Organization
HCPCS	=	Healthcare Common Procedure Coding System
MPFR (aka MPPR)	=	Multiple Procedure Fee Reductions (aka Multiple Procedure Payment Reduction)
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MPPR (aka MPFR)	=	Multiple Procedure Payment Reduction (aka Multiple Procedure Fee Reduction)
OPPS	=	Outpatient Prospective Payment System
PFS	=	Physician Fee Schedule (see also MPFSDB)
RVU	=	Relative Value Unit

Modifier Definitions

Modifier	**Modifier Definition**
Modifier 51	**Multiple Procedures:** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation service or provision of supplies (e.g. vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D of CPT book).

Medicare Physician Fee Schedule Database (MPFSDB) Multiple Procedure Indicators

Indicator	Indicator Definition
0 –	No payment adjustment rules for multiple procedures apply. Do not use modifier 51.
1 –	Standard payment adjustment rules for multiple procedures apply If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3.
2 –	Standard payment adjustment rules for multiple procedures apply If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3.

Indicator	Indicator Definition
3 –	Standard payment adjustment rules for multiple procedures apply. Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure).
4 –	CMS multiple radiology procedure reductions apply. Subject to 25% reduction of the TC diagnostic imaging.
5 –	CMS multiple therapy services reductions apply. Subject to 50% reduction of the practice expense component in both institutional and non-institutional settings.
6 –	CMS multiple diagnostic cardiovascular services reductions apply. Subject to 25% reduction of the TC component.
7 –	CMS multiple diagnostic ophthalmology services reductions apply. Subject to 20% reduction of the TC component.
9 –	Multiple procedure reductions concept does not apply. Do not use modifier 51.

Coding Guidelines

Do not append modifier 51 to a procedure to indicate that additional procedures were performed by a different provider in the same session.

Do not use modifier 51 to report an evaluation and management (E/M) service and a procedure performed on the same day.

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 (such as multiple procedure fee reductions) account for the overlap of the pre-procedure and post-procedure work. (CMS[1])

AMA

The AMA guidelines allow modifier 51 to be appended to a wide variety of non-surgical procedure codes. The modifier 51 definition states, "…other than E/M services, Physical Medicine and Rehabilitation service or provision of supplies (e.g. vaccines)…" which encompasses services such as laboratory testing, biofeedback, ophthalmology services, neuromuscular procedures, etc.

Medicare (CMS)

Medicare's policy is described by the multiple procedure indicator on the National Medicare Physician Fee Schedule Database (MPFSDB). Some procedures which the AMA would allow to be combined with modifier 51 are not allowed by CMS.

ChiroCode DeskBook

ChiroCode advises chiropractors to append modifier 51 when both spinal (98940 – 98942) and extraspinal (98943) chiropractic manipulative treatments are performed. (See policy info above.)

Payment Cap Value Limits

"The MPPR rule on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day, and it is applied prior to the application of the OPPS cap." (MLN[6])

Cross References

A. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.

B. "Global Surgery Package for Professional Claims." Moda Health Reimbursement Policy Manual, RPM011.

References & Resources

1. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § C.

2. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. Chicago: AMA Press, 2004, pp. 96-105.

3. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 40.6.C.

4. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layouts, 2018 File Layout, Field 21.

5. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services, § 10.7.

6. MLN. "Interaction of the Multiple Procedure Payment Reduction (MPPR) on Imaging Procedures and the Outpatient Prospective Payment System (OPPS) Cap on the Technical Component (TC) of Imaging Procedures." Medicare Learning Network (MLN) Matters. MM7703. July 1, 2012: November 15, 2018. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7703.pdf .

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.