Clover

Clover Health Multiple Surgery Reduction Reimbursement Policy

Policy # RP-011

Policy Title	Multiple Surgery Reduction (MSR) Reimbursement Policy
Policy Department	Payment Strategy and Operations
Effective Date	1/1/2022
Revision Date(s)	1/1/2022
Next Review Date	

Disclaimer:

Clover Health applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

- **Multiple Surgery Reduction Reimbursement**
  - Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.
  - Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.
  - Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. Multiple surgical reductions may also apply.

Definitions:

- **Relative Value Unit (RVU)** - The assigned unit value of a particular CPT or HCPCS code. The associated RVU is either from the CMS NPFS Non-Facility Total value or Facility Total value
- **Same Individual Physician or Other Qualified Health Care Professional** - The same individual rendering health care services reporting the same Federal Tax Identification number.

Policy:

Multiple and/or bilateral surgical services rendered by the same professional provider or two providers in the same physician group with the same specialty, in the same setting, and on the same date of service will be reviewed subject to auditing criteria. Allowance for the primary procedure is 100%. Allowance for each secondary procedure will be 50 percent of the fee schedule amount for the second through the fifth highest valued procedures.

The codes with the following CMS multiple procedure indicators are addressed within this reimbursement policy:

- Multiple Procedure Indicator 2 - Standard payment adjustment rules for multiple procedures apply
- Multiple Procedure Indicator 3 - Special rules for multiple endoscopic procedures apply if the procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure).

Note: If more than five procedures with an indicator of "2" are billed, pay for the first five according to the rules listed below and suspend the sixth and subsequent procedures for manual review and payment, if appropriate, "by report." Payment determined on a "by report" basis for these codes should never be lower than 50 percent of the full payment amount. Pay by the unit for services that are already reduced (e.g., 17003). Pay for 17340 only once per session, regardless of how many lesions were destroyed.

Surgeries subject to the multiple surgery rules have an indicator of "2" in the Physician Fee Schedule look-up tool. The multiple procedure Payment Reduction will be applied based on the National Physician Fee Schedule (NPFS) Relative Value Unit (RVU) and not on the submitted amount from the providers. The major surgery may or may not be the one with the larger submitted amount. Multiple surgeries are distinguished from procedures that are components of or incidental to a Primary Procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.

If a code is billed that has an indicator of "3," and multiple endoscopies are billed, the special

rules for multiple endoscopic procedures apply. Clover will pay the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy.

Claim Codes (if applicable)	**Medicare Physician Fee Schedule Database (MPFSDB)** Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service. **0** = No payment adjustment rules for multiple procedures apply. If a procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure. **1** = If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 25%, 25%, 25%, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. **2** = Standard payment adjustment rules for multiple procedures apply. If a procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50%, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. **3** = Special rules for multiple endoscopic procedures apply if the procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the

	base procedure. Payment for the base procedure is included in the payment for the other endoscopy. **4** = Subject to 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017 and after). **5** = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for 1 Pic (x)1 FIELD # & ITEM LENGTH & PIC services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after). **6** = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after). **7** = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after). **9** = Concept does not apply.

References
CMS Transmittal https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3693CP.pdf
CMS Claim processing manual - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

CMS Physician Fact Sheet https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule
NCCI Coding Guidelines https://www.cms.gov/files/document/chapter1generalcorrectcodingpoliciesfinal11.pdf