healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Multiple Procedure Reduction		
Policy Number:	PO-RE-172v1		
Effective Date:	07/01/2021	**Last Approval Date:**	07/20/2026

I. Policy Description

Healthfirst applies multiple procedure payment reductions when multiple surgical or procedural services are performed during the same operative session for the same member. This reimbursement methodology aligns with Centers for Medicare & Medicaid Services (CMS) guidelines and is intended to promote consistent, accurate, and standardized reimbursement.

To identify procedures subject to multiple procedure reductions, Healthfirst utilizes the National Medicare Physician Fee Schedule Database (MPFSDB) and applicable CMS reimbursement methodologies. Procedures designated by CMS as subject to multiple procedure payment adjustments may receive reduced reimbursement when reported with other eligible procedures performed on the same date of service.

This policy applies to the Healthfirst lines of business listed below and should be used in conjunction with applicable provider contracts, Healthfirst reimbursement policies, and CMS guidelines.

The information below applies to the following lines of business:

• Child Health Plus (CHP)	• Essential Plan (EP)
• Integrated Benefit Dual Plan (IB-Dual)	• Managed Long Term Care Plan (MLTCP – Senior Health Partners)
• Medicaid Managed Care (MMC)	• Medicaid Advantage Plus/MAP (CompleteCare)
• Medicare Advantage HMO	• Qualified Health Plan (QHP)
• Medicare PPO	• Personal Wellness Plan (HARP)

Policy Scope

This policy applies to:

- Professional claims submitted on the CMS-1500 paper claim form or the 837P electronic claim transaction.

- Institutional/facility claims submitted on the UB-04 (CMS-1450) paper claim form or the 837I electronic claim transaction, including claims reimbursed under applicable Ambulatory Payment Classification (APC) or Ambulatory Patient Group (APG) methodologies, where applicable.
- Surgical and procedural services reported on the same date of service.
- Procedures performed by:
    - Providers
        - Single physician
        - Multiple physicians within the same group practice
        - Physical therapy groups
    - Facilities
        - Hospital outpatient facilities
        - Ambulatory surgery centers (ASCs)
        - Other licensed healthcare facilities

- Services rendered to Healthfirst members where reimbursement is based on the Healthfirst fee schedule, contracted rate, or applicable facility reimbursement methodology.

This policy does not apply to:

- Procedures designated by CMS as add-on codes.
- Procedure codes identified as modifier -51 exempt.
- Procedures are not subject to multiple procedure reductions under CMS guidelines.

Reimbursement Guidelines

A. Identification of Procedures Subject to Reduction

Healthfirst utilizes the CMS Medicare Physician Fee Schedule Database (MPFSDB) to determine whether a procedure is subject to multiple procedure payment adjustment.

Procedures assigned to CMS Multiple Procedure Indicator of "2" or "3" are subject to multiple procedure reduction.

The following services are excluded from multiple procedure reductions:

- CMS-designated add-on codes.
- Modifier 51-exempt procedures.
- Procedures otherwise excluded by CMS reimbursement guidelines

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The presence or absence of Modifier 51 on a claim does not determine whether a multiple procedure reduction applies.

B. Determination of Primary and Secondary Procedures

When two or more procedures subject to multiple procedure reduction are reported for the same member on the same date of service, Healthfirst will:

1. Professional claims: Procedures are ranked in descending order based on Relative Value Units (RVUs) to determine the primary procedure and applicable multiple procedure reduction.
2. Facility claims (UB-04/CMS-1450 or 837I) are ranked in descending order based on the applicable allowed amount or reimbursement methodology, including APC, APG, ASC payment methodologies, or other applicable Healthfirst reimbursement methodologies, as appropriate for the line of business
3. Designate all remaining eligible procedures as secondary procedures.
4. Payment determination is based on the applicable ranking methodology, irrespective of:
    - The order in which procedure codes appear on the claim; or
    - The billed charges submitted by the provider.

C. Reimbursement Methodology

1. Primary Procedure
   The primary procedure will be reimbursed at 100% of the applicable Healthfirst reimbursement amount, as determined by the provider contract or applicable reimbursement methodology.

2. Secondary Procedures
   All additional procedures subject to multiple procedure reduction will be reimbursed at the applicable multiple procedure reduction percentage of the Healthfirst allowed amount, unless otherwise specified by CMS guidelines or the provider's contract.

3. Excluded Procedures
   Add-on codes and Modifier 51-exempt procedures are reimbursed according to the applicable fee schedule or provider contract and are not subject to multiple procedure reduction.

Claim Type and Payment Methodology

Multiple procedure reductions are applied according to the applicable reimbursement methodology for the claim type submitted:

- Professional claims (CMS-1500/HCFA-1500 or 837P) are processed using CMS Physician Fee Schedule multiple procedure reduction methodologies, as applicable.
- Institutional claims (UB-04/CMS-1450 or 837I) are processed using the applicable facility reimbursement methodology, including APCs, APGs, ASC methodologies, or other contracted payment methodologies, as applicable.

Adjudication and Appeal Process

1. Reimbursement for multiple procedure reduction is subject to the provider's contract and applicable Healthfirst reimbursement methodologies.

2. Claims not submitted in accordance with this policy may be denied, rejected, or reimbursed in accordance with applicable reimbursement methodologies.

3. This policy serves as a reimbursement guideline and does not guarantee coverage or payment.

4. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.

5. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

6. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

Please be advised that all services provided are subject to the member's individual benefit coverage

II. Applicable Codes

Code	Description	Comment
Refer to CMS MPFSDB	Multiple Procedure Indicators 2 and 3	Subject to Multiple Procedure Reduction

III. Definitions

Term	Meaning
Add-On Code	A CPT/HCPCS code identified by CMS as an add-on service and not subject to multiple procedure reductions.
Modifier 51 (Multiple Procedures)	Indicates that multiple procedures or surgeries were performed on the same day during the same operative session.
Modifier 51 Exempt Code	A procedure code designated by CMS as exempt from multiple procedure reduction.
Multiple Procedure Indicator	A CMS designation within the Medicare Physician Fee Schedule Database identifying whether a procedure is subject to multiple procedure payment adjustment.
Primary Procedure	The procedure designated for full reimbursement based on the applicable ranking methodology. Professional claims are ranked by Relative Value Units (RVUs). Facility claims are ranked by the applicable Healthfirst allowed amount.
Relative Value Units (RVUs)	A standardized measure of the value assigned to each CPT/HCPCS code based on physician work, practice expense, and malpractice expense components. RVUs are derived from the CMS Medicare Physician Fee Schedule.
Secondary Procedure	Any additional procedure subject to multiple procedure reduction performed during the same operative session.
Same Operative Session	Procedures performed by the same provider (or same provider group, as applicable) for the same member on the same date of service.

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

CMS Medicare Physician Fee Schedule (MPFS)
CMS NCCI Policy Manual
AMA CPT Professional Guidelines
Healthfirst Billing and Reimbursement Manuals
Physical Therapy/Occupational Therapy/Speech Therapy - NGSMEDICARE

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.