How to manage Medical Billing and coding for Multiple Procedures?

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 account for the overlap of the pre-procedure and post-procedure work. When healthcare providers perform multiple procedures during a single patient encounter, Medicare (and many commercial insurers) typically pay "full price" for only the highest-valued procedure.

Under the so-called "multiple procedure rule," Medicare pays less for the second and subsequent procedures performed during the same patient encounter. There are several ways in which reductions may be taken;

- If the code is assigned a "0" in column S, no payment adjustment rules for multiple procedures apply. Per the Centers for Medicare & Medicaid Services (CMS), "If the procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure."

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- If the code is assigned a "1" in column S, payment adjustment rules in effect before January 1, 1995, for multiple procedures apply. In this case, the highest valued procedure will be paid at 100 percent of the fee schedule, the second most-valued procedure will be paid at 50 percent, and all subsequent procedures are paid at 25 percent.

- If the code is assigned a "2" in column S, "standard "payment adjustment rules for multiple procedures apply. The highest valued procedure will be paid at 100 percent of the fee schedule, and all subsequent procedures are paid at 50 percent.

- An indicator of "9" in column S means the multiple procedure reduction concepts does not apply.

Multiple procedure rules do not apply to all CPT codes. No payer (Medicare or otherwise) should reduce payment for:

- Significant, separately identifiable E/M services provided on the same day as other procedures/services and properly appended with modifier 25 Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other services

- Any designated "add-on" CPT code (listed with a "+" next to the descriptor)

- Any procedure designated by CPT as "Modifier 51 exempt," which may be identified in the CPT codebook by a "circle with a slash" next to the code.

- You can find a full list of "add-on" and "modifier 51" exempt procedures in Appendices D and E of the CPT codebook. The relative values assigned to these codes factor in the "additional" nature of the procedure/services; therefore, there is no justification to reduce reimbursement when these codes are reported in addition to other procedures.

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Multiple Procedures and Correct Coding Edits

In some cases, the National Correct Coding Initiative (NCCI) may impose edits that "bundle" codes to one another. If the NCCI lists any two codes as "mutually exclusive," or pairs them as "column 1" and "column 2" codes, the procedures are bundled and normally are not reported together. In such cases, only one procedure (the higher-valued) will be paid if both procedures are reported.

If, however, the two procedures are separate and distinct, you may be able to use a modifier to override the edit and be paid for both procedures. Separate, distinct procedures may include: Different session, Different procedure or surgery, Different site or organ system, Separate incision/excision, Separate lesion, Separate injury (or area of injury in extensive injuries)

Before appending a modifier, you must confirm that unbundling is allowed for the code pair you wish to report. Each CCI code pair edit includes a correct coding modifier indicator of "0" or "1," as indicated by a superscript placed to the right of the column 2 code. A "0" indicator means that you may not unbundle the edit combination, under any circumstances. A "1" indicator means that you may use a modifier to override the edit, assuming the procedures are distinct.

When CCI allows you to override a code combination edit, you will append the appropriate modifier to the "column 2" code. The most frequently-used code to overcome CCI edits is modifier 59-Distinct procedural service, but you should append this modifier with caution. CPT and CMS guidelines agree that modifier 59 should be the "modifier of last resort." CPT Appendix A explains, "Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

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