LifeWise Health Plan of Washington	**Payment Policy**

cmi_161152

Title	**Multiple Endoscopy Procedure Reductions**		
Number	**CP.PP.387.v1.5**		
Last Approval Date	04/11/24	**Original Effective Date**	07/13/14
Replaces			
Cross Reference	• *Multiple Surgical Reductions* • *Modifiers XE, XS, XP, and XU – Separate Encounter, Separate Structure, Separate Practitioner and Unusual Overlapping Service* • *Modifier 59 – Distinct Procedural Services* • *Modifier 51 – Multiple Procedures*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define how the Plan identifies applicable Endoscopic procedures that are subject to multiple Endoscopic procedure reductions and how the Plan applies the reduction that are submitted on a CMS-1500 paper claim form or an 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products. Medicare Advantage products are not subject to this policy.
Definitions	**Base Code, Base Procedure, or EndoBase Code:** A procedure code whose services and allowance is included in the allowance for the other related Endoscopic procedures within that procedure group. **Endoscopic procedure**: A surgical procedure that inspects a body organ or cavity by using an endoscope, a device consisting of a tube and optical system for observing the inside of a hollow organ or cavity. The procedure may be done through a natural body opening or a small incision. **Family or Groupings of codes**: In the CPT Codebook, this is designated by a non-indented code followed by a group or series of indented codes that all share a common service.
Policy	Multiple endoscopy services, which are subject to a multiple endoscopy procedure reductions are identified by the Multiple Procedure flag of 3 on the most current version of the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value Guide (LINK): **Multiple Procedure Flag 3** = Special rules for multiple endoscopic procedures apply if the procedure is billed with another endoscopy in the same family. Each of these Families of codes is also identified by a code in the "ENDOBASE" column of the same NPFS file.

	Code families share a “Base Code” whose allowance and services are always included in the allowance and procedures for other related Endoscopic procedures within the same Family Grouping of codes. Payment rules for certain applicable multiple endoscopy procedures performed for the same patient on the same day during the same session, will be applied to the secondary and subsequent procedure(s). The **primary procedure** is the procedure with the highest per procedure allowance which is either 100% of the procedure fee schedule allowance or 100% of the procedure billed charge, whichever is less, per provider contract. The primary procedure is reported without modifier 51 – *Multiple procedures*. The **secondary procedure and any subsequent procedure(s)** will be allowed either at the procedure allowed fee schedule amount or 100% of the procedure billed charge, whichever is less, per provider contract, **minus the allowed amount for the “Base Code” for the Family Grouping** (i.e. the difference between the allowed amount for the applicable Endoscopic procedure and the allowed amount for the associated Base Procedure in that Family of codes). Applicable secondary and subsequent procedures may be reported with modifier 51 when performed by the same surgeon, on the same member on the same date of service. If multiple endoscopies are reported on the same day as other non-endoscopic surgical procedures, the multiple endoscopy rules are applied first and then the multiple surgical reduction rules are applied to the endoscopic Family based on the total allowed amount and the non-endoscopic procedure’s allowed amount. If an endoscopic procedure is reported in conjunction with its Base Procedure code, no separate payment for the base endoscopy procedure code will be made. Subtracting the “Base Code” allowed amount for the Family group from the allowed amount of the “Base Code” will result in an allowed amount of zero. Some examples of multiple endoscopy reductions include, but not limited to, the following: **A. <u>Multiple endoscopies in the same group/Family:</u>** a. The primary procedure is determined and allowed at 100% of contract allowed amount; b. The secondary applicable endoscopic procedures in the same Family are determined and the allowed amount for the “Base Code” for the Family is subtracted from the allowed amount for each secondary procedure to create the reduced endoscopic allowed amount (the difference between the “Base Code” allowed amount and the allowed amount for each second and subsequent Endoscopic procedure) **B. <u>Multiple Endoscopic procedures in different/multiple groups/Families:</u>** a. For the first Family group: i. The primary procedure is determined and allowed at 100% of contract allowed amount ii. The secondary applicable Endoscopic procedures in the same Family are determined and the allowed amount for the “Base

	Code" for the Family is subtracted from the allowed amount for each secondary procedure to create the reduced endoscopic allowed amount (the difference between the "Base Code" allowed amount and the allowed amount for each second and subsequent Endoscopic procedure) b. For the other Family groups: i. Follow the same method in B.a.i-ii above c. Apply multiple surgical procedure reduction: i. Compare the total allowed amounts for each Family group. Normal multiple surgical reduction discounting will then be applied. **C. <u>Multiple endoscopies in one Family group reported with one endoscopy from a different Family group or with non-endoscopic procedure</u>** (s) a. For the Family group: i. The primary procedure is determined and allowed at 100% of contract allowed amount ii. The secondary applicable Endoscopic procedures in the same Family are determined and the allowed amount for the "Base Code" for the Family is subtracted from the allowed amount for each secondary procedure to create the reduced endoscopic allowed amount (the difference between the "Base Code" allowed amount and the allowed amount for each second and subsequent Endoscopic procedure) b. For the <u>single</u> endoscopy procedure in a different Family group or the non-endoscopic procedure(s), multiple surgical reduction discounts are then considered in the following manner i. The primary procedure is identified by comparing the <u>total</u> allowable for the family grouping to the allowable for the single endoscopy procedure in a different Family Group or the non-endoscopic procedure(s) ii. The service with the higher allowable amount will be considered the primary procedure and normal multiple surgical reduction discounting will be applied to the remaining procedure(s) **D. <u>One endoscopic procedure from one Family group reported with one endoscopic procedure from a different Family group:</u>** a. Normal multiple surgical reduction discounting will be applied; no reductions for multiple endoscopies are applied **E. <u>Multiple endoscopic procedures in one Family group and one of those codes is that Family group's "Base Code" reported with multiple endoscopic procedures in a different Family group</u>** a. For the first Family group: i. The primary procedure is determined and allowed at 100% of contract allowed amount

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	ii. The secondary applicable endoscopic procedures in the same Family are determined and the allowed amount for the "Base Code" for the Family is subtracted from the allowed amount for each secondary procedure to create the reduced endoscopic allowed amount (the difference between the "Base Code" allowed amount and the allowed amount for each second and subsequent endoscopic procedure) b. For the other Family groups: i. Follow the same method in E.a.i-ii above c. For the Family group that includes the "Base Code": i. Subtracting the "Base Code" allowed amount from the "Base Code" will result in the allowed amount of zero (0) because the allowance for the "Base Code" is already included in the allowance for the primary procedure d. Sum the total allowed amounts for each of the Family groups e. Normal multiple surgical reduction discounting will then be applied to the total allowed amounts for each Family group of applicable codes. Modifier 51-*Multiple Procedures* does not affect which procedures are subject to the multiple endoscopic reductions policy criteria Modifiers XE, XS, XP, XU– *Separate Encounter, Separate Structure, Separate Practitioner and Unusual Overlapping Service* and Modifier 59– *Distinct Procedural Services* do not prevent multiple endoscopies, multiple surgical or multiple diagnostic imaging reductions from being applied.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined at the Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	This policy does not apply to any provider reimbursed using an ASC APC payment methodology.
Laws, Regulations & Standards	None
References	• American Medical Association's Current Procedural Terminology, Professional Edition (AMA/CPT) codebook • Center for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS)

Policy Owner Review	Payment Integrity Oversight Committee
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.
Annual Review Dates	04/11/24; 05/19/23; 08/18/22; 09/22/21; 10/06/20; 10/30/19; 11/02/18; 12/04/17; 12/12/16; 01/08/16; 01/11/15; 06/29/14

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Version History	11/02/18	Annual review; no changes
	10/30/19	Added references to the use of modifier 51 on the second and subsequent applicable codes
	10/06/20	Clarified in the Purpose statement that the policy applies to professional services billed on a CMS-1500 or 837P claim form. Added in the Exception section that the policy does not apply to any provider reimbursed under the ASC APC payment methodology
	09/22/21	Annual Review; no changes
	08/18/22	Annual review; no changes
	05/19/23	Annual review; no changes
	04/11/24	Annual review; no changes

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