Multiple Procedure Payment Reduction (MPPR) for Medical and Surgical Services Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

**CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.*

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Table of Contents

Application
Policy
- Overview
- Multiple Procedure Concept
- Multiple Procedure Reductions
  - Multiple Procedure Ranking
    - Multiple Procedure Reduction Codes with Assigned CMS RVUs Reported with Modifiers 26, 53, TC
  - Multiple Procedure Reduction Codes with No Assigned CMS RVU
    - Multiple Procedure Reduction Methods
- Multiple Procedures Reported with Modifier 78
- Multiple Procedures for Assistant Surgeon Services Reported with Modifiers 80, 81, 82, AS
- Multiple Procedures for Co-Surgeon/Team Surgeon Services Reported with Modifiers 62, 66
- Multiple Procedures for Bilateral Surgeries Reported with Modifier 50
- Anesthesia Management Services

[Definitions](#)
[Questions and Answers](#)
[Codes](#)
[Attachments](#)
[Resources](#)
[History](#)

Policy

Overview

Many medical and surgical services include pre-procedure and post-procedure work, as well as generic services integral to the standard medical/surgical service. When multiple procedures are performed on the same day, by the Same Group Physician and/or Other Qualified Health Care Professional, reduction in reimbursement for secondary and subsequent procedures will occur. Payment at 100% for secondary and subsequent procedures would represent reimbursement for duplicative components of the primary procedure.

The Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File identifies procedures that are subject to multiple procedure reductions. Medical and surgical services which have multiple procedure indicators 2 and 3 are subject to the multiple procedure concept and multiple procedure reductions. UnitedHealthcare aligns with CMS in determining which procedures are subject to multiple procedure reductions and the primary or secondary ranking of these procedures based on Relative Value Units.

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 procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure).

For endoscopy codes CMS applies special adjustment rules when multiple endoscopic procedures from the same family (same Endoscopic Base Code) are reported on the same day. CMS allows the full Allowable Amount for the highest valued endoscopy code in the family and allows any additional endoscopy codes in the same family at a reduced amount based on the value of the NPFS designated Endoscopic Base Code.

To further align with CMS, effective with dates of service 8/1/2016, UnitedHealthcare will apply CMS multiple Endoscopic Adjustment Rules when related endoscopic procedures (within the same family) are performed on the same day. If billed on the same day as other procedures that are subject to multiple procedure reduction, endoscopy codes may be subject to both endoscopic and multiple procedure reductions.

Multiple Procedure Concept

Multiple procedure reductions apply when:

- There are two or more procedure codes subject to reductions (i.e., two or more codes on the Multiple Procedure Reduction Codes list). If two codes are billed but only one is subject to reduction, no reduction will be taken on either procedure;
- A single code subject to the multiple procedure concept is submitted with multiple units. For example, CPT code 11300 is submitted with 3 units. Multiple procedure reductions would apply to the second and third unit. The units may also be subject to UnitedHealthcare Community Plan's other policies, such as the "Maximum Frequency Per Day Policy."

UnitedHealthcare Community Plan uses the CMS multiple procedure indicators 2 and 3 in the NPFS Relative Value File to determine which procedures are eligible for multiple procedure reductions. The use of modifier 51 appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions.

In addition, UnitedHealthcare Community Plan applies the payment indicators for HCPCS codes G0412-G0415 when adjudicating CPT codes 27215-27218 for the purposes of this policy.

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

The Multiple Procedure Reduction Codes list contains all codes that are subject to the multiple procedure concept as described above.

Multiple Procedure Reduction Codes
CMS Physician Fee Schedule Relative Value Files

Endoscopic Procedures for Dates of Service Through 7/31/2016
For dates of service 2/29/2016 and prior, when multiple endoscopic procedures from the Multiple Procedure Reduction Codes list are performed on the same patient by the Same Group Physician and/or Other Qualified Health Care Professional on the same day, UnitedHealthcare applies multiple procedure reductions to the endoscopic code(s) with the lower RVU values [i.e., the secondary/subsequent procedure(s)].

Endoscopic Procedures for Dates of Service Beginning 8/1/2016
For dates of service 3/1/2016 and after, when related endoscopic procedures (within the same family) are performed on the same day, the lower ranking endoscopy codes will receive an adjustment under the Endoscopic Adjustment Rule to reduce the Allowed Amount based on the amount of the Endoscopic Base Code. No reimbursement will be made for the Endoscopic Base Code. Multiple endoscopies in the same family performed on the same day as other procedures subject to multiple procedure reduction will be ranked accordingly and may be subject to endoscopic and multiple procedure reduction. A list of Endoscopy codes and Endoscopic Base codes can be found in the Attachments section of the policy.

Refer to the Questions and Answers section, Q&A #7 and #8 for examples of how the Endoscopic Adjustment Rule will be applied.

If two or more endoscopic procedures are performed on the same day from different families, the multiple procedure reduction will be applied to the endoscopic codes with the lower RVU values.

Additional Services
Additional reimbursement will not be allowed for the following services which are considered included in the procedure being performed:

- Moving a patient from one surgical suite to another surgical suite to perform an additional procedure;
- Repositioning a patient;
- Re-draping a patient;
- Separate incisions or operative sites

Multiple Procedure Reductions

Multiple procedures subject to the multiple procedure concept (as described above) performed by the Same Group Physician and/or Other Qualified Health Care Professional on the same date of service are ranked to determine applicable reductions. There are no modifiers that override the multiple procedure concept other than those services which are appropriately reported with modifier 78.

Multiple Procedure Ranking
UnitedHealthcare Community Plan uses the CMS Facility Total RVUs to determine the ranking of primary, secondary and subsequent procedures when those services are performed in a facility setting (Place of Service [POS] 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56 and 61). Procedures performed in a place of service other than the facility POS setting will be ranked by the CMS Non-Facility RVUs.

Examples:
Note: RVU values in these examples may not accurately reflect the current NPFS and are intended for illustrative purposes only.

POS 11 (Office)

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

Code	Units	Non-Facility Total RVUs	Facility Total RVUs	Multiple Procedure Ranking
11012	1	**18.59**	11.50	**1 - Primary**
14301	1	**18.56**	16.16	2 - Secondary

POS 22 (Outpatient Hospital)

Code	Units	Non-Facility Total RVUs	Facility Total RVUs	Multiple Procedure Ranking
11012	1	18.59	**11.50**	2 - Secondary
14301	1	18.56	**16.16**	**1- Primary**

Multiple Procedure Reduction Codes with Assigned RVUs Reported with Modifiers 26, 53, TC

For certain codes that are subject to multiple procedure reductions CMS has assigned separate RVU values when reported with modifiers 26, 53, and TC. When these modified services are billed with other services subject to the multiple procedure concept, the CMS RVUs associated with the reported modifier 26, 53, or TC are used in determining which services should be reduced according to the multiple procedure concept.

Example:
Note: RVU values in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

522xx was reported with the professional component for 517xx (Modifier 26) in POS 11(office). The global procedure (517xx) is not applicable in this example.

Code	Modifier	Non-Facility RVU	Facility RVU	RVU used for Ranking	Multiple Procedure Ranking
522xx		**8.25**	5.25	**8.25**	**1 – Primary**
517xx		9.00	6.00	Not applicable	Not applicable
517xx	26	**3.15**	1.45	3.15	2 – Secondary

Note: Multiple procedure reduction codes may be reported with modifier 53 that have not been assigned a separate RVU for modifier 53 by CMS. In these situations, the global RVU is used for multiple procedure ranking.

Refer to the Multiple Procedure Reduction Codes list for all codes subject to multiple procedure reductions that have a separate RVU value associated with the 26, 53, or TC modifier.

Multiple Procedure Reduction Codes with No Assigned CMS RVU

Services that CMS indicates may be carrier-priced, or those for which CMS does not develop RVUs are considered Gap Fill Codes and are addressed as follow:

- **Gap Fill Codes:** When data is available for Gap Fill Codes, UnitedHealthcare Community Plan uses the relative values published in the first quarter update of the Optum *The Essential RBRVS* publication for the current calendar year.

Multiple Procedure Reduction Codes Assigned Gap Fill RVUs

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

- **0.00 RVU Codes:** Some codes cannot be assigned a gap value or remain without an RVU due to the nature of the service (example: unlisted codes). These codes are assigned an RVU value of 0.00 on the Multiple Procedure Reduction Codes list and will be excluded from ranking.

Multiple Procedure Reduction Methods

Multiple procedure reductions will be applied using either the Standard or Alternate method as set forth below. The Alternate method is used by Administrative Services Only groups that have not adopted UnitedHealthcare Community Plan's Standard method and by Medicaid programs which require a 100%-50%-25% method of reduction.

- **Standard Method**
  100% of the Allowable Amount for the primary/major procedure.
  50% of the Allowable Amount for the secondary procedure.
  50% of the Allowable Amount for **all** subsequent procedures.

- **Alternate Method**
  100% of the Allowable Amount for the primary/major procedure.
  50% of the Allowable Amount for the secondary procedure.
  25% of the Allowable Amount for **all** subsequent procedures.

NOTE: Multiple procedure reductions are applicable to percent of charge or discount contracts. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.

For additional examples of multiple procedure ranking on claims reported by a surgeon, refer to the Questions and Answers section, Q&A #1.

Multiple Procedures Reported with Modifier 78

Per CPT, it may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating/procedure room, it should be reported by adding modifier 78 to the related procedure. In accordance with CMS guidelines, procedures reported with a modifier 78 that have a 10- or 90-day global period are not subject to the multiple procedure concept.

For additional information, refer to the Questions and Answers section, Q&A #6.

Multiple Procedures for Assistant Surgeon Services Reported with Modifiers 80, 81, 82, AS

When services are reported by more than one assistant surgeon using modifiers 80, 81, 82 or AS those services will be ranked collectively if reported by the Same Group Physician and/or Other Qualified Health Care Professional. Assistant surgeon services will be ranked separately from the services reported by the primary surgeon.

Refer to the Questions and Answers section, Q&A #3 for an example of multiple procedure ranking on an assistant surgeon claim.

Multiple Procedures for Co-Surgeon/Team Surgeon Services Reported with Modifiers 62, 66

Multiple procedures performed by a co-surgeon (modifier 62) or team surgeon (modifier 66) are subject to the multiple procedure concept as defined above when performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service. Co-surgeon and team surgeon services are ranked separately and independently of any other co-surgeon or team surgeon services.

Refer to the Questions and Answers section, Q&A #5 for an example of multiple procedure ranking on a co-surgeon claim.

Multiple Procedures for Bilateral Surgeries Reported with Modifier 50

Selected bilateral eligible services may also be subject to multiple procedure reductions when billed alone or with other multiple procedure reduction codes.

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

Refer to the Questions and Answers section, Q&A #4 for an example of multiple procedure ranking on a bilateral procedure.
Anesthesia Management Services
Multiple procedure reductions do not apply to time-based anesthesia management services, as identified in UnitedHealthcare Community Plan's "Anesthesia Policy."

State Exceptions	
Colorado	Uses the Alternate Reduction Method **100%** of the Allowable Amount for the primary/major procedure. **50%** of the Allowable Amount for the secondary procedure. **25%** of the Allowable Amount for **all** subsequent procedures.
Florida	Uses the Alternate Reduction Method **100**% of the Allowable Amount for the primary/major procedure. **50%** of the Allowable Amount for the secondary procedure. **25%** of the Allowable Amount for **all** subsequent procedures. Per Florida State Requirements, Birthing Centers (POS 25) are reimbursed the facility fee with procedure code 59409 and Provider delivery services in a birthing center with code 59410; therefore, multiple procedure reductions do not apply to this code pair.
Idaho	Uses the Alternate Reduction Method **100**% of the Allowable Amount for the primary/major procedure. **50%** of the Allowable Amount for the secondary procedure. **25%** of the Allowable Amount for **all** subsequent procedures.
Kansas	Uses the Alternate Reduction Method **100**% of the Allowable Amount for the primary/major procedure. **50%** of the Allowable Amount for the secondary procedure. **25%** of the Allowable Amount for **all** subsequent procedures. Kansas Medicaid requires that procedure codes with a multiple surgery indicator of 2 or 3 are reduced using the Alternate Reduction Method of 100%-50%-25% rather than using the CMS endoscopy rules for reduction.
Mississippi	Mississippi Medicaid requires that procedure codes with a multiple surgery indicator of 2 or 3 are reduced using the Standard Reduction Method of 100% - 50% - 50% rather than using the CMS endoscopy rules for reduction.
Missouri	Uses the Alternate Reduction Method 100% of the Allowable Amount for the primary/major procedure. 50% of the Allowable Amount for the secondary procedure. 25% of the Allowable Amount for all subsequent procedures. • No reduction is applied on a subsequent cesarean section after vaginal delivery on the same date. Both deliveries are reimbursed at 100%. • No reduction is applied on a second and/or a subsequent diagnostic endoscopy when performed on the same date with the same or different approach and different instruments. • ONLY the primary/major procedure is reimbursable when more than one (1) diagnostic endoscopy is performed on the same date using the same approach and same instrument.

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

New Mexico	Uses the Alternate Reduction Method **100%** of the Allowable Amount for the primary/major procedure. **50%** of the Allowable Amount for the secondary procedure. **25%** of the Allowable Amount for **all** subsequent procedures.
Ohio	Uses the Alternate Reduction Method 100% of the Allowable Amount for the primary/major procedure. 50% of the Allowable Amount for the secondary procedure. 25% of the Allowable Amount for all subsequent procedures.
Texas	Texas Medicaid does not apply a multiple procedure reduction to tubal ligation CPT code 58605 following a vaginal delivery.
Washington	Washington state regulations allow a specified reimbursement amount for nurse midwives billing 59409 appended with the SU modifier. This code is not subject to a multiple procedure reduction.
Washington DC	Uses the Alternate Reduction Method for all services **100**% of the Allowable Amount for the primary/major procedure. **50%** of the Allowable Amount for the secondary procedure. **25%** of the Allowable Amount for **all** subsequent procedures. Per district requirements, we will reimburse up to 5 surgical procedures, after 5 we will deny.
Wisconsin	Uses the Alternate Reduction Method **100**% of the Allowable Amount for the primary/major procedure. **50%** of the Allowable Amount for the secondary procedure. **25%** of the Allowable Amount for the tertiary procedure. **13%** of the Allowable Amount for **all** subsequent procedures. Wisconsin is exempt from Multiple Diagnostic Endoscopy Reductions

Definitions	
Allowable Amount	Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
Endoscopic Adjustment Rule	Allows the full Allowable Amount for the highest valued endoscopy code and allows any additional endoscopy codes (within the same family) at a reduced amount based on the value of the NPFS designated Endoscopic Base Code.
Endoscopic Base Code	The most basic, least complex form of the endoscopic procedure being done.
Gap Fill Codes	Codes for which CMS does not develop RVUs. Relative values are therefore assigned based on the first quarter update of Optum *The Essential RBRVS* publication for the current calendar year.
Relative Value Units (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.

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number.

Questions and Answers

1

Q: Which procedure would be primary when CPT code 58150 (total abdominal hysterectomy) and CPT code 57270 (repair of enterocele) are performed in a facility and reported by two different specialty physicians within the same group practice?

A: Multiple procedure ranking is based on the facility RVUs. CPT code 58150 is the primary procedure with the higher CMS RVU value of 29.55 and CPT code 57270 is the secondary procedure with the lower CMS RVU of 23.74. CPT code 58150 would be reimbursed at 100% of the Allowable Amount, and CPT code 57270 would be reimbursed at 50% of the Allowable Amount.

Example:

Note: RVU values in this Q&A may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Two Different Specialty Physicians/Same Group	Code	Non-Facility RVU	Facility RVU	RVU used for ranking	Multiple Procedure Ranking
Dr. A	57270	29.22	23.74	23.74 – facility	2 - Secondary
Dr. B	58150	34.01	29.55	29.55 – facility	1 - Primary

2

Q: Are multiple procedure reductions applied when the same individual surgeon reports multiple procedure reduction codes while acting as both surgeon and assistant surgeon during the same operative session?

A: Yes, however the surgeon is acting in two different capacities, as surgeon and assistant surgeon. This means all multiple procedure reduction codes reported by the surgeon (with no assistant surgeon modifier) are ranked as one group and all multiple procedure reduction codes reported with an assistant surgeon modifier are ranked as a second group, independent of each other.

3

Q: Are multiple procedure reductions applied when two different physicians within the same group practice each report assistant surgeon services, Dr. A reports 19307-80 and the Dr. B reports 19367-81?

A: Yes. A multiple procedure reduction would be applied to CPT code 19307-80 (the secondary code). In addition, both 19307-80 and 19367-81 would be subject to reduction based on the assistant surgeon modifiers (e.g. 80, 81).

Example:

Note: RVU values in this Q&A may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Two Different Physicians/Same Group	Code	Non-Facility RVU	Facility RVU	RVU used for ranking	Multiple Procedure Ranking	Applicable Reductions
Dr. A	19307-80	34.16	34.16	34.16	2 – Secondary	50% of the Allowable Amount for multiple procedure subject to modifier 80 assistant surgeon reduction.

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

Dr. B	19367-81	53.54	53.54	53.54	1 - Primary	100% of the Allowable Amount for multiple procedure subject to modifier 81 assistant surgeon reduction.

4

Q: How is multiple procedure ranking applied to a bilateral eligible procedure reported with a modifier 50?

A: When the bilateral code is split for processing, each side is considered separately for ranking when a multiple procedure reduction applies. Side 1 will be ranked primary and side 2 will be ranked secondary.

Example:
Note: RVU values in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Line	Bilateral Code	Charge	Multiple Procedure Ranking	Applicable Reductions
1	19361-50	$2000.00	1 - Primary	100% of the Allowable Amount
2	19361	$2000.00	2 - Secondary	50% of the Allowable Amount

5

Q: How is multiple procedure ranking applied when two different physicians in the same group practice each report multiple co-surgeon services eligible for multiple procedure reductions on the same day?

A: Each co-surgeon's services are ranked separately and independently of the other regardless of whether they are in the same group practice. In addition, each co-surgeon's services are subject to reduction based on the co-surgeon modifier (62) reported.

Example:
Note: RVU values in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Services reported by Dr. A - CPT 19361-62, RVU = 29, CPT 19340-62, RVU = 20

Services reported by Dr. B - CPT 19361-62, RVU = 29, CPT 19340-62, RVU = 20

Dr. A	Code	Charge	Multiple Procedure Ranking	Applicable Reductions
1	19361-62	$4000.00	1 – Primary	100% of the Allowable Amount for multiple procedure subject to modifier 62 co-surgeon reduction
2	19340-62	$1600.00	2 – Secondary	50% of the Allowable Amount for multiple procedure subject to modifier 62 co-surgeon reduction
Dr. B	**Code**	**Charge**	**Multiple Procedure Ranking**	**Applicable Reductions**
1	19361-62	$4000.00	1 – Primary	100% of the Allowable Amount for multiple procedure subject to modifier 62 co-surgeon reduction

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

	2	19340-62	$1600.00	2 – Secondary	50% of the Allowable Amount for multiple procedure subject to modifier 62 co-surgeon reduction

6

Q: Are there any modifiers that will override the multiple procedure policy?

A: No, other than those services which are appropriately reported with modifier 78 as described in the section of this policy titled **'Multiple Procedures Reported with Modifier 78'**.

7

Q: How will the Endoscopic Adjustment Rule be applied to multiple endoscopy codes within the same family (same Endoscopic Base Code) billed on the same day by the Same Group Physician and/or Other Qualified Health Care Professional on or after 3/1/2016 date of service?

A: Below is an example of how the Endoscopic Adjustment Rule will be applied:

In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), the Endoscopic Adjustment Rule will pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the Endoscopic Base Code (45378) or Adjusted Allowable for (45380).

The calculation of the Adjusted Allowable for the lesser valued endoscopy code(s) in the same family is as follows:

a. Determine the Adjusted RVU: Lesser valued endoscopy code(s) RVU minus the Endoscopic Base Code RVU
b. Determine the Percentage to Allow: Adjusted RVU (Step 1a) divided by the lesser valued RVU = ratio (percentage to allow for the lesser valued endoscopy code).
c. Determine the Adjusted Allowable for the lesser code(s): Lesser valued code fee schedule x ratio (Step 1b) = endoscopic adjusted allowable for the lesser valued code.

Based on the following RVUs for these codes if the procedures were performed in a facility: 45378 (6.48), 45380 (7.73) and 45385 (9.17), United HealthCare would reimburse the full value of 45385 ($374.56), plus the Adjusted Allowable for 45380 ($45.76). The Endoscopic Base Code (45378) is not reimbursed.

Note: RVU values and dollar amounts in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Code	Facility RVU	Adjusted RVU	Percentage to Allow	Adjusted Allowable
45378	6.48	Endoscopic Base Code = not allowed	N/A	N/A
45380	7.73	7.73 – 6.48 = 1.25	1.25/7.73 = 16%	285.98 x 16% = $45.76
45385	9.17	Highest RVU – no adjustment	100%	$374.56 – no adjustment

8

Q: How will the Endoscopic Adjustment Rule be applied to multiple endoscopy codes within the same family and another procedure that is not related?

A: Below is an example of how the Endoscopic Adjustment Rule and multiple procedure reduction will be applied when the physician bills for codes 45380 and 45381 (same endoscopic family) and 45562 (unrelated procedure).

a. First determine the Total Adjusted RVU for each endoscopic family. Each "family" of endoscopic codes is considered as a single procedure (RVUs combined) for ranking.

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

b. Rank the Family Adjusted RVUs against other reducible procedures RVUs from highest to lowest.
c. Apply the Multiple Procedure Reduction (Example: Standard reduction of 100-50-50).
d.

Based on the following RVUs for these codes if the procedures were performed in a facility: 45378 (6.48), 45380 (7.73), 45381 (7.34) and 45562 (33.19), first calculate the Total Adjusted RVUs based on the Endoscopic Adjustment Rule by subtracting the difference between the Endoscopic Base Code and the lower valued endoscopy code (.86) and then adding that calculation to the higher valued endoscopy code (7.73), which equals (8.56). Compare the Family Adjusted RVUs (8.56) to the RVUs of the unrelated procedure (33.19) to determine Multiple Procedure Ranking.

Note: RVU values and dollar amounts in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Code	Facility RVU	Total Adjusted RVU	Family Adjusted RVU	Multiple Procedure Ranking	Multiple Procedure Reduction
45378	6.48	Endoscopic Base Code = not allowed	N/A	N/A	N/A
45380	7.73	Highest RVU – no adjustment	7.73 + .86 = 8.56	**2**	50%
45381	7.34	7.34 – 6.48 = .86			
45562	33.19	Unrelated Procedure	N/A	**1**	100%

Codes

Modifier
26, 50, 51, 53, 62, 66, 78, 80, 81, 82, AS, TC

Attachments:

Multiple Procedure Reduction Codes Assigned Gap-Fill RVU	The list identifies codes on the Multiple Procedure Reduction Codes list that have been assigned gap fill RVUs.
Multiple Procedure Reduction Codes	The list identifies codes that are subject to multiple procedure reductions and their associated CMS NPFS Non-Facility RVU value and Facility Total RVU value.
Endoscopy Code Policy Table	The list identifies Endoscopy codes and Endoscopic Base codes that are subject to the Endoscopic Adjustment Rule.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

Optum, "*The Essential RBRVS"* 1st Quarter Update

History	
7/12/2026	Policy Version Change Attachments: Multiple Procedure Reduction Codes updated History Section: Entries prior to 7/12/2024 archived
6/28/2026	Policy Version Change Attachments: Multiple Procedure Reduction Codes updated History Section: Entries prior to 6/28/2024 archived
3/29/2026	Policy Version Change Attachments: Multiple Procedure Reduction Codes Assigned Gap-Fill RVU, Multiple Procedure Reduction Codes and Endoscopy Code Policy Table updated
1/1/2026	Policy Version Change Attachments: Multiple Procedure Reduction Codes and Endoscopy Code Policy Table updated History Section: Entries prior to 1/1/2024 archived
6/29/2025	Policy Version Change Attachments: Multiple Procedure Reduction Codes and Endoscopy Code Policy Table updated
6/1/2025	Policy Version Change State Exceptions: Added Idaho History Section: Entries prior to 6/1/2023 archived
2/16/2025	Policy Version Change Attachments: Multiple Procedure Reduction Codes Assigned Gap-Fill RVU updated History Section: Entries prior to 2/16/2023 archived
1/1/2025	Policy Version Change Attachments: Multiple Procedure Reduction Codes Assigned Gap-Fill RVU, Multiple Procedure Reduction Codes and Endoscopy Code Policy Table updated History Section: Entries prior to 1/1/2023 archived
9/2/2006	Policy implemented by UnitedHealthcare Community & State.

Proprietary information of UnitedHealthcare Community Plan. Copyright 2026 United HealthCare Services, Inc. 2026R0034D