Modifier 51 - Multiple Procedure Fee Reductions

Last Updated: 7/6/2026 **Last Reviewed:** 7/8/2026 **Originally Effective:** 1/1/2000
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No
If yes, Texas Last Update Effective Date: n/a
Policy #: RPM022

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All)
Claim Forms: CMS1500 & CMS1450 (paper and electronic versions)
Provider Contract Status: Any
Claim Dates: All

Reimbursement Guidelines

A. All Provider Types

1. Providers are required to submit all procedure codes for the same day/surgical session on the same claim.
2. Multiple procedure fee reductions are applied to secondary procedures even when a billing error occurs and modifier 51 is omitted from a line item when needed.
3. A maximum of one unit of one procedure code is processed as the primary procedure code.
   a. If multiple units are billed for the primary procedure code, the additional units of that code and any other procedures billed are secondary procedures and are subject to the applicable secondary procedure rules for the multiple procedure indicator assigned to the procedure code.
   b. Primary and secondary code rules do not apply to procedure codes with a multiple procedure indicator of "9."
4. Determining the Primary Procedure Code (Ranking):
   a. When multiple procedure rules apply, the Medicare Physician Fee Schedule (MPFS) RVUs are used to rank procedure codes and determine the primary and secondary procedures on all professional claims.
   b. For facility claims with APC contracts, a Medicare pricer tool is used to rank the multiple procedure reductions. All other facility claims are ranked using the Medicare Physician Fee Schedule (MPFS) RVUs.
   c. The procedure code with the highest RVU is determined to be the primary procedure:
      i. Regardless of the order in which the procedure codes are billed on the claim.
      ii. Regardless of which procedure code has the highest billed charges.
5. For percent of charge or discount fee schedules:
   a. Multiple procedure fee reduction rules do apply. Percent of charge contracts are not excused from these rules.
   b. The RVU ranking process to determine the primary procedure code applies.
   c. When reductions are applied to secondary procedures, the reduction rules are applied to the discounted amount, not the billed charges.
6. Multiple procedure fee reductions are *not waived* when:
   - Modifier SG is appended.
   - Modifiers XE, XS, XP, or XU are appended.
   - Modifier 59 is appended.
   - Modifier 77 is appended.
   - Modifier 78 is appended.

- Modifier 79 is appended.
- Maternity surgical procedures are performed during the operative session.

7. Bypassing Clinical Edits
   Modifier 51 does *not* bypass clinical edits, such as subset denials, redundant denials, or other types of clinical edits

8. Other Pricing Adjustments Affect Final Line Item Allowable
   Please Note: When multiple procedure fee reductions apply, other pricing adjustments may also apply before the final allowable amount for each line item is determined. For example, bilateral adjustments, assistant surgeon adjustments, co-surgery adjustments, related within global adjustments, etc.

9. Valid and invalid procedure code combinations for modifier 51.
   a. Procedure codes with a CMS Physician Fee Schedule (PFS) multiple procedure indicator of "1", "2", "3", "4", "5", "6", and "7" will allow as valid modifier to procedure combinations when billed with modifier 51.
   b. Procedure codes with a CMS PFS multiple procedure indicator of "0" and "9" will deny for invalid modifier to procedure combination when billed with modifier 51.
   c. There is a discrepancy in coding guidelines regarding the use of modifier 51 for medical procedures. Per the AMA, modifier 51 may be appended to medical procedures when medical and surgical procedures are performed in combination during the same session or when multiple medical procedures are performed in the same session. However, the CMS guidelines have indicated that modifier 51 should not be used when the concept of multiple procedure reductions does not apply or when the procedure code is not subject to multiple procedure fee reductions (e.g., add-on surgical codes). Moda Health follows CMS policy for procedure codes with a CMS multiple procedure indicator of "0" and "9."
   d. Chiropractic Services and Modifier 51
      Multiple procedure fee reductions are not applied to Osteopathic Manipulative Treatment (OMT) procedures or Chiropractic Manipulative Treatment (CMT) procedures. Despite the AMA modifier definition and ChiroCode guidelines indicating to use modifier 51 with chiropractic services, Moda Health follows CMS guidelines as described above. OMT and CMT procedure codes have a multiple procedure indicator of "0" and modifier 51 should not be used in combination with these procedure codes. 98925 – 98929 and 98940 – 98943 will be denied for invalid modifier to procedure combination when billed with modifier 51.

B. Professional Claims

1. See how the primary procedure code is determined (ranking).
2. See how multiple procedure reductions apply to percent of charge or discount fee schedules.
3. Multiple procedure fee reductions (MPFR) are applied to procedure codes with a multiple procedure indicator of "1" or "2" on the on the National Medicare Physician Fee Schedule Database (MPFSDB).
   a. When multiple procedure fee reductions apply, the primary procedure code is processed at 100%, and the secondary procedures are processed at 50% (i.e.: 100 / 50 / 50 / 50 / etc.) unless otherwise specified in an Administrative Services Only (ASO) plan contract.
   b. MPFR Cutback Rates for Self-Funded Plans (ASO)
      Self-funded employer groups with Administrative Service Only (ASO) plans occasionally elect to specify a non-standard multiple procedure fee reduction structure in the plan benefit language (for example, 100 / 50 / 25 / 25). In those cases, the MPFR cutback rates specified by the self-funded employer group are applied. The employer plan benefit language takes precedence even over the provider contract language.

4. For procedure codes with a multiple procedure indicator or "3":
   a. For Medicare Advantage claims:
      i. Contracted providers, standard multiple fee reductions apply (50%), as if the multiple procedure indicator is "2."
      ii. For out-of-network providers, secondary endoscopy procedures will be reduced by 24%.
   b. For Commercial and Medicaid claims, procedure codes with an indicator of "3" are subject to standard multiple procedure fee reductions, as if the multiple procedure indicator is "2."

5. Effective July 1, 2018:
   a. For procedure codes with a multiple procedure indicator of "4," CMS diagnostic imaging procedure rules apply. Secondary diagnostic imaging procedures are:
      i. If billed with modifier TC, subject to a 50% reduction of the technical component (TC) portion of the RVU/fee allowance.
      ii. If billed with modifier 26, subject to a 5% reduction of the professional component (PC) portion of the RVU/fee allowance.[4]
      iii. If billed as global service (no modifier), subject to a 35% reduction.
      iv. When Payment Cap Value limits apply under the Commercial and Medicare Advantage provider contract, the above multiple procedure reductions apply before the Payment Cap Value limits.[6]
   b. For procedure codes with a multiple procedure indicator of "5," CMS multiple therapy reduction rules apply. The first unit of the first therapy code is allowed at full fee schedule amount. All secondary units and codes are subject to a 20% reduction.
   c. For procedure codes with a multiple procedure indicator of "6," CMS multiple diagnostic cardiovascular reduction rules apply. (CMS[4]) Secondary cardiovascular procedures:
      i. If billed with modifier TC, subject to a 25% reduction.
      ii. If billed with modifier 26, processed at full allowable, no reduction.
      iii. If billed as global service (no modifier), subject to a 20% reduction.
      iv. When Payment Cap Value limits apply under the under the Commercial and Medicare Advantage provider contract, the above multiple procedure reductions apply before the Payment Cap Value limits.[6]
   d. For procedure codes with a multiple procedure indicator of "7," CMS diagnostic ophthalmology reduction rules apply. Secondary ophthalmology procedures:
      i. If billed with modifier TC, subject to a 20% reduction.
      ii. If billed with modifier 26, processed at full allowable, no reduction.
      iii. If billed as global service (no modifier), subject to a 10% reduction.
   e. For procedure codes with a multiple procedure indicator of "9," the concept of multiple procedure fee reductions does not apply.

C. Ambulatory surgery centers

Effective July 1, 2018, multiple procedure fee reductions are applied to ASC claims.

1. These reductions do apply to procedure codes with carve-out pricing.
2. If the contract is based upon Medicare payment methodology, CMS multiple procedure fee reduction methodology is used; otherwise, Moda multiple procedure reductions of up to 50% will apply.
3. See how the primary procedure code is determined (ranking).
4. See how multiple procedure reductions apply to percent of charge or discount fee schedules.
5. For questions about reimbursement guidelines prior to July 1, 2018, please contact us directly with the affected claim number and date of the explanation of payment.

D. Outpatient hospitals

Effective July 1, 2018, multiple procedure fee reductions are applied to outpatient hospital claims.

1. These reductions do apply to procedure codes with carve-out pricing.
2. If the contract is based upon Medicare payment methodology, CMS multiple procedure fee reduction methodology is used; otherwise, Moda multiple procedure reductions of up to 50% will apply. Procedures codes assigned a status indicator of "T", "J1", "Q1", "Q2" and "Q3" on addendum B of the OPPS fee schedule are eligible for multiple procedure discounting.
   a. Facility claim lines with a professional revenue code are treated as though they have a 26 modifier.
   b. All other facility revenue codes are treated as though they have a TC modifier.
3. See how the primary procedure code is determined (ranking).
4. See how multiple procedure reductions apply to percent of charge or discount fee schedules.
5. See also E. Outpatient Rehabilitation Services.
6. For questions about reimbursement guidelines prior to July 1, 2018, please contact us directly with the affected claim number and date of the explanation of payment.

E. Outpatient Rehabilitation Services

1. Multiple therapy reductions are applied to procedure codes with a multiple procedure indicator of "5" on the National Medicare Physician Fee Schedule Database (MPFSDB).
2. The list of codes eligible for these reductions are defined on the Physician Fee Schedule, but the reductions apply regardless of the type of provider or supplier that furnishes the services.[5]
3. The first unit of the first therapy code is allowed at the full fee schedule rate. All subsequent units and procedures are subject to a 20% reduction.
4. See how the primary procedure code is determined (ranking).
5. See how multiple procedure reductions apply to percent of charge or discount fee schedules.
6. The multiple therapy reductions apply to multiple units of the same code, as well as multiple different therapy codes.
7. The multiple therapy reductions apply to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.[5]

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgery Center
ASO	Administrative Services Only
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")

Acronym	Definition
MPFR (aka MPPR)	Multiple Procedure Fee Reductions (aka Multiple Procedure Payment Reduction)
MPFS MPFSD MPFSDB	(National) Medicare Physician Fee Schedule Database (aka RVU file)
OMT	OMT
OPPS	OPPS
PFS	PFS
RBRVU	RBRVU
RPM	RPM
RVU	RVU
TAC	Texas Administrative Code

Definition of Terms

Term	Definition
Relative Value Units (RVUs)	Resource-based relative value units (RVUs) comprise the core of the Medicare Physician Fee Schedule (MPFS). CMS publishes quarterly updates to the MPFS on the CMS website. Each CPT or HCPCS code on the MPFS has an assigned RVU unit Total Value. Either the Non-Facility Total value or Facility Total value is used for pricing, depending upon the place of service. For more information about RVUs, see items listed in Resources. [7, 8, 9, 10, 11]

Modifier Definitions

Modifier	Modifier Description & Definition
Modifier 51	**Multiple Procedures:** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation service or provision of supplies (e.g. vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D of CPT book).
Modifier 59	**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

Modifier	Modifier Description & Definition
Modifier 77	**Repeat Procedure by Another Physician or Other Qualified Health Care Professional:** It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.
Modifier 78	**Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period:** 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 may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)
Modifier 79	**Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period:** The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)
Modifier SG	Ambulatory surgical center (ASC) facility service
Modifier XE	**Separate encounter,** a service that is distinct because it occurred during a separate encounter
Modifier XP	**Separate practitioner,** a service that is distinct because it was performed by a different practitioner
Modifier XS	**Separate structure,** a service that is distinct because it was performed on a separate organ/structure
Modifier XU	**Unusual nonoverlapping service,** the use of a service that is distinct because it does not overlap usual components of the main service

Medicare Physician Fee Schedule Database (MPFSDB) Multiple Procedure Indicators

Indicator	Indicator Definition
0 –	No payment adjustment rules for multiple procedures apply. Do not use modifier 51.
1 –	Standard payment adjustment rules for multiple procedures apply If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3.
2 –	Standard payment adjustment rules for multiple procedures apply If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3.
3 –	Standard payment adjustment rules for multiple procedures apply. 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).
4 –	CMS multiple radiology procedure reductions apply. Subject to 50% reduction of the TC diagnostic imaging. Subject to 5% reduction of the PC of diagnostic imaging. Both reductions apply to global procedure code. [12]
5 –	CMS multiple therapy services reductions apply. Subject to 50% reduction of the practice expense component in both institutional and non-institutional settings.

Indicator	Indicator Definition
6 –	CMS multiple diagnostic cardiovascular services reductions apply. Subject to 25% reduction of the TC component.
7 –	CMS multiple diagnostic ophthalmology services reductions apply. Subject to 20% reduction of the TC component.
9 –	Multiple procedure reductions concept does not apply. Do not use modifier 51.

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.
C. "Global Surgery Package for Professional Claims." Moda Health Reimbursement Policy Manual, RPM011.

Resources

1. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § C.
2. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. Chicago: AMA Press, 2004, pp. 96-105.
3. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 40.6.C.
4. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layouts, 2018 File Layout, Field 21.
5. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services, § 10.7.
6. MLN. "Interaction of the Multiple Procedure Payment Reduction (MPPR) on Imaging Procedures and the Outpatient Prospective Payment System (OPPS) Cap on the Technical Component (TC) of Imaging Procedures." Medicare Learning Network (MLN) Matters. MM7703. July 1, 2012: November 15, 2018. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7703.pdf .
7. CMS. "Medicare Physicians Fee Schedule (MPFS)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.
8. CMS. "Method for Computing Fee Schedule Amount." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.1.
9. CMS. "Relative Value Units (RVUs)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.2.
10. RAND Corporation. "Overview of the MPFS." Improving Practice Expense Data & Methods Town Hall – June 16, 2021 Read Ahead Materials, pp. 2-3. Last updated June 16, 2021; Last accessed January 26, 2022. Last attempted: 7/6/2026. (This link is no longer active; the document cannot be located at a new URL.) Improving Data and Methods Related to Indirect Practice Expense in the Medicare Physician Fee Schedule: Read-ahead materials for the virtual Town Hall (cms.gov).
11. Burgette, Lane F., et al. "Practice Expense Data Collection and Methodology: Phase II Final Report." Santa Monica, CA: RAND Corporation, 2021. Last accessed October 4, 2022. https://www.rand.org/pubs/research_reports/RRA1181-1.html .
12. CMS. "Physician Fee Schedule Payment Policy Indicator File Record Layout." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, § 50.6.

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
7/8/2026	Updated description for Multiple Procedure Indicator = "4". Acronyms & Resources updated. No policy changes.
5/14/2025	Acronyms, Related Policies updated. Formatting updates. No policy changes.
4/10/2024	Clarified procedure codes eligible for reductions and how reductions are applied for indicator "3." Formatting updates. No policy changes.
11/9/2022	Idaho added to Scope. Clarified ranking method, percent discount calculations. Acronyms & Resources updated. Definition of Terms added. Policy History added; entries prior to 2022 omitted (in archive storage). Minor rephrasing, formatting updates. No policy changes.
4/10/2013	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on ….