BlueCross BlueShield of North Carolina

Commercial Reimbursement Policy

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MULTIPLE AND BILATERAL SURGERY

File Name: multiple_and_bilateral_surgery
Origination: 1/2000
Last Review: 3/2024

Description

Multiple Surgeries are the performance of a primary surgery and additional surgeries on the same day and same member by a single provider or providers in the same group practice. Multiple surgeries are distinguished from procedures that are components of or integral to a primary procedure and not separately reimbursable.

Bilateral Procedures are a single surgical procedure performed on both sides of the body on the same day and same member by a single provider or providers in the same group practice.

Incidental services are carried out at the same time as a more complex primary procedure. These procedures require little additional provider resources and/or are integral to the performance of the primary procedure.

Same group practice is a provider of the same group and same specialty with the same Federal Tax ID number.

Policy

Blue Cross NC allows professional reimbursement for multiple and bilateral procedures performed on the same day by the same provider or provider group, according to the criteria outlined in this policy.

Reimbursement Guidelines

Blue Cross NC will utilize editing software to identify the primary and secondary procedures and appropriate modifier usage.

<u>Multiple Surgery</u>

Reimbursement will be based on the following:

- Primary procedure, indicated by the highest Relative Value Unit (RVU) – 100% of the Blue Cross NC allowance
- Secondary procedure(s) – 50% of the Blue Cross NC allowance

Modifier 51 should be used for secondary surgical procedures.

Surgical procedures performed more than once (i.e., billed with multiple units) are subject to the multiple surgery reduction. Additionally, maximum unit rules may apply. Please see reimbursement policy “Maximum Units of Service” for more information.

Add-on services or Modifier 51-exempt” services are not subject to the multiple surgery reduction. Additionally, incidental services and duplicate services are not subject to this policy, as they are not eligible for separate or additional reimbursement.

Bilateral Procedures

For procedures performed bilaterally, reimbursement will based on 150% of the Blue Cross NC allowance. Modifier 50 should be used to indicate a bilateral procedure. Modifier 50 is not appropriate for use with services defined as “bilateral” or “unilateral”; they are reimbursable only once per date of service and are not eligible for additional reimbursement.

Note: Blue Cross NC reserves the right to edit “S” codes for multiple and/or bilateral surgery procedures.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com .

Appropriate use of modifiers will facilitate claims processing. Refer to reimbursement policy titled, “Modifier Guidelines”.

Modifier -51 should be used for secondary procedures in accordance with CPT guidelines. If a procedure is performed more than once, indicate number in the units field.

Modifier -50 should be used for bilateral procedures. Bilateral procedures should be listed on the claim as a single line item, with modifier -50 and “one” in the units field.

CPT® Code / Modifier	Description
Modifier 50	Bilateral Procedure
Modifier 51	Multiple Procedures

Related policy

Bundling Guidelines

Co-Surgeon, Assistant Surgeon, Team Surgeon and Assistant-at-Surgery Guidelines

Maximum Units of Service

Modifier Guidelines

References

Medical Policy Advisory Group - 10/2003

Medical Policy Advisory Group - 03/10/2005

Medical Policy Advisory Group - 03/24/2006

Medical Director Review – 6/21/2010

Medical Director Review – 9/2013

Medical Director Review – 1/2014

History

1/00	Implementation
3/00	Removed Blue Edge references.
1/01	Changed title from "Multiple Procedure Guidelines" to "Multiple Surgical Procedure Guidelines." Added guidelines for other BCBSNC products. Added definitions.
9/01	Medical Policy Advisory Group review. No change in policy.
4/02	Policy reformatted for clarity. Code 28292 changed to 28290 in example in the Policy Guidelines section.
8/02	The following statement added to the Policy Application section of the policy, "Some provider, facility, member, or group contracts may limit the number of services that can be billed on the same date of service.'
11/02	The following statement added to the Description of Procedure or Service section of the policy, For bilateral surgical procedures refer to medical policy entitled "Bilateral Surgical Procedure Guidelines."
11/03	Medical Policy Advisory Group review. Information added concerning adding code to claim when unilateral code is used, and bilateral procedure was performed. Reformatted. Policy statement and criteria reaffirmed.
5/13/04	Changed the title from "Multiple Surgical Procedure Guidelines" to "Multiple Surgical Procedure Guidelines for Professional Providers", for clarity. Added the word "professional" to further clarify what type of provider to the following sections: "Description of Procedure or Service" and "Policy" of the policy. Removed the following statement from the "Benefits Application" section: "Some provider, facility, member, or group contracts may limit the number of services that can be billed on the same date of service. Revision to the reference made to "Bilateral Surgical Procedure Guidelines" to "Bilateral Surgical Procedure Guidelines for Professional Providers".
8/26/04	Under section I titled, "When Multiple Surgical Procedures are covered for Blue Care, Blue Choice, Blue Options, and Classic Blue added the following statement: Effective for claims received on or after August 1, 2004, the primary procedure will be based on the most appropriate CPT code as defined by the version of Claim Check utilized by BCBSNC at the time of receipt of the claim. The definition of CPT was added to the Medical Terms Definitions section. Medpoint no longer applies to this policy.
11/11/04	Under section I titled, "When Multiple Surgical Procedures are covered for Blue Care, Blue Choice, Blue Options, and Classic Blue updated this section to indicate "the secondary procedure is to correct a separate pathological condition that requires intervention. Removed any references to PCP as it no longer applicable.
4/7/05	Medical Policy Advisory Group reviewed policy on 03/10/2005. No changes required to the policy.
5/08/06	Medical Policy Advisory Group review 3/24/06. No change to policy criteria. Policy number added to the Key Words Section.

9/18/06	Revised the wording in "Section II - When Multiple Surgical Procedures are covered for Preferred Care, Preferred Care Select, CMM," to remove "according to the allowed amount". Added the statement to indicate, "The primary procedure will be considered the service with the highest charge." (btw)
3/26/07	Under the section, "Description of Procedure or Service" added "Blue Advantage". Under "Section I" added "Blue Advantage". Medical Policy reviewed by Senior Medical Director of Network Support.
12/3/07	"Those procedures as designated by CPT as modifier 51 exempt or as add-on code are not subject to the multiple surgical reduction." added to the "Policy" statement. (dpe)
05/05/08	Policy reviewed 4/4/2008 by Vice President and Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy. No changes to policy criteria.
6/16/08	In the Policy section, revised the wording from "Multiple surgical services rendered by the same professional provider, in the same setting, and on the same date of service will be reviewed subject to auditing criteria." to "Multiple and or bilateral surgical services rendered by the same professional provider, in the same setting, and on the same date of service will be reviewed subject to auditing criteria." In the Billing/Coding/Physician Documentation Information section, revised the wording from" Modifier -50 should be used for bilateral procedures. Bilateral procedures should be listed on the claim as a single line item, with modifier -50 and a two in the units field." to Modifier -50 should be used for bilateral procedures. Bilateral procedures should be listed on the claim as a single line item, with modifier -50." Under the "Description of Procedure or Service" section, removed the statement, "For bilateral surgical procedures refer to medical policy entitled "Bilateral Surgical Procedure Guidelines for Professional Providers." because the policy titled "Bilateral Surgical Procedure Guidelines for Professional Providers" is being archived.
6/22/10	Policy Number(s) removed (amw)
7/6/10	In the Billing/Coding/Physician Documentation Information section, revised the wording from" Modifier -50 should be used for bilateral procedures. Bilateral procedures should be listed on the claim as a single line item, with modifier -50." to "Modifier -50 should be used for bilateral procedures. Bilateral procedures should be listed on the claim as a single line item, with modifier -50 and two in the units field." Reviewed with Senior Medical Director 6/21/2010 (btw)
10/15/13	Description section revised for clarity. Previous version of this policy contained guidelines for Section 1 (Blue Advantage, Blue Care, Blue Choice, Blue Options and Classic Blue) and Section II (Preferred Care, Preferred Select, CMM). These were combined into one section titled, "Guidelines for Reimbursement of Multiple Surgical Procedures." Determination of the primary procedure will be based on the most appropriate CPT code as defined by the editing software utilized by BCBSNC at the time of receipt of the claim. The primary procedure will be considered the service with the highest charge. Reimbursement for the primary procedure will be based on 100% of the BCBSNC allowance. Procedures performed in conjunction with the primary surgical procedure considered by BCBSNC to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures are defined as procedures requiring little additional provider resources and/or are clinically integral to the performance of the primary procedure. No additional benefits will be provided for procedures which are considered to be incidental, integral or mutually exclusive to the covered primary or secondary procedure.

	Procedure codes identified as “add-on” and “modifier -51 exempt” codes are not subject to multiple surgical procedure reductions. Multiple procedure reductions may apply when a single code is submitted with multiple units. (adn)
1/28/14	Determination of the primary procedure, as stated in the section “Guidelines for Reimbursement of Multiple Surgical Procedures” was changed from the procedure with the highest charge to procedure with the higher RVU. Statement now reads: “Typically the primary procedure is the one with the higher RVU (relative value units).” (adn)
5/13/14	Policy category changed from “Corporate Medical Policy” to “Corporate Reimbursement Policy”. No changes to policy content. (adn)
10/30/15	Routine policy review. No change to current policy. (adn)
12/30/16	Routine policy review. Removed the hallux valgus example from the Policy Guidelines section. (an)
12/29/17	Routine policy review. No change to current policy. (an)
12/31/18	Routine policy review. No change to current policy. (an)
1/14/20	Routine policy review. Senior Medical Director approved 12/2019. No changes to policy statement. (an)
4/20/21	Policy format update. No changes to policy statement. (eel)
12/30/21	Clarification added in Reimbursement Guidelines section specific to “S” codes. Routine policy review. Medical Director approved. (eel)
12/31/2022	Routine policy review. Minor revisions only. (ckb)
6/12/2024	Policy name change from Multiple Surgical Procedure Guidelines for Professional Providers to Multiple and Bilateral Surgery. Modifier 50 unit quantity updated to “one”. RPOC approved. **Notification on 03/01/2024 for effective date 06/12/2024.** (ss)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.

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