

Corporate Reimbursement Policy

Multiple Surgical Procedure Guidelines for Professional Providers

File Name: multiple_surgical_procedure_guidelines_for_professional_providers
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Next Review: 12/2020

Description of Procedure or Service

Many medical and surgical services include pre-procedure, post-procedure and other services integral to the standard medical/surgical service. When multiple surgeries or procedures are performed by a single physician or physicians in the same group practice on the same patient at the same operative session, reduction in reimbursement for secondary and subsequent procedures may occur.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. In some cases, these intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. Multiple surgical reductions may also apply.

Guidelines in this policy refer to professional providers.

See also Corporate Medical/Reimbursement Policies titled:

- Bundling Guidelines
- Co-Surgeon, Assistant Surgeon, Team Surgeon and Assistant-at-Surgery Guidelines
- Maximum Units of Service
- Modifier Guidelines

Policy

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. Allowance for the primary procedure is 100%. Allowance for each secondary procedure will be 50% if specific criteria, as described below, are met.

Benefits Application

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.

Guidelines for Reimbursement of Multiple Surgical Procedures

Benefits are not provided for procedures determined to be Not Medically Necessary.

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. Typically

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the primary procedure is the one with the higher RVU (relative value units). 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.

Each secondary procedure will be eligible for reimbursement at 50% of the allowance, if the following criteria are met:

1. The secondary procedure is to correct a separate pathological condition that requires intervention, AND
2. The degree of difficulty, operative time and risk were significantly increased by the secondary procedure.

No additional benefits will be provided when a procedure is performed in stages or serially.

Procedure codes identified as “add-on” and “modifier -51 exempt” codes are not subject to multiple surgical procedure reductions.

The terminology for some procedure codes includes the terms “bilateral” or “unilateral or bilateral” in the code description. Refer to Policy Guidelines below.

Multiple procedure reductions may apply when a single code is submitted with multiple units. Refer to separate medical policy titled, “Maximum Units of Service Edits.”

Policy Guidelines

Situations involving co-surgeons, assistant surgeons or team surgeons are addressed in a separate medical policy titled, “Co-Surgeon, Assistant Surgeon, Team Surgeon and Assistant-at-Surgery Guidelines.”

Duplicate Procedure

If the description of the duplicate code contains the phrase “bilateral,” payment for the procedure is allowed only once on a single date of service. Any occurrences of that code submitted beyond the first will be denied. Example; 55041, excision of hydrocele; bilateral.

If the description of the duplicate code contains the phrase “unilateral/bilateral”, payment for the procedure is allowed only once on a single date of service. Any occurrences of the code submitted beyond the first will be denied. Example; 58940, oophorectomy, partial or total, unilateral or bilateral.

When the description of the code specifies “unilateral” and there is another procedure code for “bilateral” performance of the same procedure, the bilateral code will be added to the claim when the unilateral code is submitted more than once on the same date of service. Code additions will also be performed when one procedure code specifies a single procedure code and a second procedure code specifies multiple procedures. Example; 54860, epididymectomy; unilateral, would be replaced with 54861, epididymectomy, bilateral.

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Certain procedures may be performed a specified number of times on a single date of service. After that maximum number is reached, all additional occurrences of the procedure code will be denied for payment.

Any procedure code that is billed more than once on the same date of service and is not addressed above will be flagged as a duplicate service and the claim will be reviewed.

Attempted Surgery

In the case of attempted surgery (when the planned surgery could not be completed) coding on the claim should reflect the actual procedure performed.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcsnc.com. They are listed in the Category Search on the Medical Policy search page.

Appropriate use of modifiers will facilitate claims processing. Refer to medical 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 two in the units field.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

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

Policy Implementation/Update Information

1/00 Implementation

3/00 Removed Blue Edge references.

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- 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)

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- 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

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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)

Medical 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 BCBSNC reserves the right to review and revise its medical policies periodically.