If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Multiple Surgical Procedures-Professional Provider Services

Policy Number: CPCP015

Version: 1.0

Clinical Payment and Coding Policy Committee Approval Date: July 7, 2020

Effective Date: July 7, 2020

This Clinical Payment and Coding Policy is intended to serve as a general reference guide for professional health care providers submitting reimbursement for the code(s) that correctly describe health care services rendered for multiple procedures. Health care Providers (i.e. facilities, physicians and other qualified health care professionals) are expected to exercise independent medical judgement in providing care to patients. This policy is not intended to impact care decisions or medical practice. This policy does not address all situations that may occur and in certain circumstances these situations may override the criteria within this policy. **This policy applies to in-network and out of network professional surgery and medical services.**

Description:

To be considered for multiple surgical procedure reductions, these services must be performed:

- On the same date of service;
- Within the same Operative Session;
- By the same provider; and
- At the same place of treatment.

Multiple surgical procedure reductions apply to all claim processing; exceptions may exist, so it is important to check with the Plan. Modifier 51 may be appropriately appended in these cases, but it is not required.

Reimbursement Information:

When two or more surgical procedures are performed on the same date of service by the same professional provider, the following pricing methodology is used:

- **Primary Procedure:** Eligible at 100% of the fee schedule, or billed amount whichever is less. [1]
- **Secondary and Subsequent Procedures:** Eligible at 50% of the fee schedule, or billed amount whichever is less.

[1] The primary procedure is the service line with the highest total allowable.

All services rendered by the same performing provider for the same patient and date of service should be submitted as one claim.

Surgical procedures should be submitted with one (1) unit. If the same surgical service was performed more than once and the procedure is not eligible for modifier 50 then the procedure code should be billed on a separate line on the claim with (1) unit. Modifier 50 should only be reported with one line with one unit of service.

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

Eligible reimbursement for services should reflect codes that best represent the services provided. Providers should submit claims in accordance with the Plan's billing policies and guidelines to ensure that correct claim pricing methodology is applied when billing multiple surgical procedures.

Multiple Surgical Pricing Exclusions

The following services are excluded from multiple surgical pricing reductions:

- Add on codes.
- Modifier 51 exempt codes are excluded from multiple surgery reductions but can be considered the primary procedure when the service line has the highest allowable.

For more information on filing claims properly, refer to the Plan's Provider Website.

References:

Centers for Medicare and Medicaid Services (CMS). Physician Fee Schedule Relative Value Files. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.html

Clinical Payment and Coding Policy: CPCP023 Modifier Reference Guideline

Policy Update History:

Approval Date	Description
02/28/2018	New Policy
07/07/2020	Annual Review, Disclaimer Update, Verbiage Update