Reimbursement Policy:

Multiple & Bilateral Surgical Procedures

(Commercial, Medicare and Medicaid)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20210001	9/01/2021	**RPC (Reimbursement Policy Committee)**

Overview:

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. These secondary surgical procedures are eligible for reimbursement at a lower allowance and can be distinguished from other procedures that might be components of, or incidental to, the primary service performed.

EmblemHealth/ConnectiCare follow CMS guidelines in determining which procedures are subject to multiple procedure reductions. Procedure codes identified on the CMS Physician RVU file with status indicators 1,2, or 3 will be subject to EmblemHealth/ConnectiCare Standard Multiple Surgery Reimbursement.

We identify bilateral surgery procedures with bilateral surgery indicator of "1".

Policy Statement:

Standard Multiple Surgery Reimbursement:

EmblemHealth's/ConnectiCare's standard multiple surgery reimbursement is 100% of the allowable amount for the procedure with the highest CMS National Physician Fee Schedule RVU value with Multiple Procedure Indicator "2" for professional services and highest allowable amount for facility services for the place of service and date of service, 50% of the allowable amount for the second procedure and 50% for the third and subsequent procedure eligible for separate reimbursement when performed during the same operative session by the same physician or other qualified health care professional. (100%/50%/50%)*. Standard multiple surgery reimbursement will also apply when a single procedure code is reported with multiple units on a single line.

**Applies to EmblemHealth/ConnectiCare Medicare, EmblemHealth Commercial and Medicaid Plans.*

ConnectiCare Commercial and Exchange Plans reimbursement (100%/50%/25%)

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Multiple Endoscopic Surgical Reimbursement:

We align with CMS in reimbursement of multiple endoscopic surgical procedures; 100% of the allowable amount for the procedure with the highest CMS National Physician Fee Schedule RVU value with Multiple Procedure Indicator of "3" for the same patient, by the same provider, on the same date of service, plus the difference between the next highest and the base endoscopy. In addition to an adjustment based on the multiple endoscopy and multiple surgery guidelines, adjustments may also be made based on the following concepts: Bilateral, Multiple Quantity, and Payment Modifiers.

EXAMPLE: 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), pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).

Assume the following fee schedule amounts for these codes:

45378 - $255.40
45380 - $285.98
45385 - $374.56

Pay the full value of 45385 ($374.56), plus the difference between 45380 and 45378 ($30.58), for a total of $405.14. *NOTE: If an endoscopic procedure with an indicator of "3" is billed with the "-51" modifier with other procedures that are not endoscopies (procedures with an indicator of "1"), the standard multiple surgery rules apply.*

Bilateral Surgical Reimbursement:

A bilateral surgery that uses a unilateral code should be reported on a single line (with modifier 50), using one unit of service. This line item will be considered as one surgery however will be eligible for reimbursement equal to 150% of the allowable amount applicable based on the CMS National Physician Fee Schedule Bilateral Surgery Indicator "1" for a unilateral code for the place of service and the date of service.

When a bilateral surgery that uses a unilateral code is reported (with modifier 50) with other surgical procedures subject to reduction, we will reimburse the applicable unilateral code at 150% of the allowed amount which may or may not include the applicable multiple surgical reductions as described above "Standard Multiple Surgery Reimbursement" depending on whether another procedure is ranked as primary or not based on the highest allowable amount.

When a surgical procedure code contains the terminology "bilateral" or "unilateral or bilateral" or the code is considered inherently bilateral, modifiers LT, RT, or 50 should not be used since the description of the code defines it as a bilateral procedure. Such services should only be reported on one line with one unit.

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Multiple Diagnostic Imaging Payment Reduction (MDIPR): Please follow the links below to view our MDIPR Policy.

www.emblemhealth.com
www.connecticare.com

Note: The use of modifier 51 appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions. Refer to the Medicare Physician Fee Schedule Relative Value Files database to determine when modifier 50, RT or LT is applicable for a procedure code.

Definitions:

Term	Definition
Same Group Physician and/or Other Healthcare Professional	All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification Number (TIN)
Same Session	A single patient encounter that includes all of the services performed by the same physician or other health care professional
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.
Modifier 50	Bilateral Procedure. Modifier applies to surgical procedures (CPT codes 10040-69990) and to radiology procedures performed bilaterally. Used to report bilateral procedures performed in the same session.
Modifier 51	Multiple Procedures. When multiple procedures, other than Evaluation and Management (E/M), Physical Medicine and Rehabilitation services or provisions 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. Multiple procedure rules apply to the secondary procedure or service.

References:

1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications
2. Centers for Medicare and Medicaid Services, CMS Manual System and other publications and services

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Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	1/2019	• Updated Bilateral Multiple Surgical Reimbursement calculation to align with CMS
EmblemHealth ConnectiCare	7/2021	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number
EmblemHealth ConnectiCare	12/2021	• Updated Multiple Endoscopic Surgical Reimbursement calculation to align with CMS. *See also previously communicated EmblemHealth/ConnectiCare Coding Edits Reimbursement Policy update – effective 9/01/2021*
EmblemHealth ConnectiCare	6/2022	• Updated Multiple Surgery Reimbursement section to clarify that EmblemHealth/ConnectiCare Medicare and EmblemHealth Commercial and Medicaid plans reimbursement aligns with CMS standard (100%/50%/50%). ConnectiCare Commercial and Exchange Plans reimbursement (100%/50%25%)