

Reimbursement Policy: Multiple & Bilateral Surgical Procedures (Commercial, Medicare and Medicaid)

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

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member’s benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

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 current year 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.

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

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

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 current year 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 # 1:

The following is an example of how the Endoscopic Adjustment Rule will be applied to multiple endoscopy codes within the same family (same Endoscopic Base Code) billed on the same day by the Same Group Physician and/or Other Qualified Health Care Professional.

While 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), the Endoscopic Adjustment Rule will pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the Endoscopic Base Code (45378).

Note: RVU values and dollar amounts in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Code	Description	Facility RVU	Allowable	Endoscopic Ranking	Adjusted Allowable
45380	Colonoscopy, flexible; with biopsy, single or multiple	5.86	\$206.52	2 (Lower RVU)	\$15.56 (\$206.52-\$190.96)
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	7.45	\$260.68	1 (Highest RVU)	\$260.68
45378 Base Code	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.4	\$190.96	Base Code Not Allowed	\$0.00

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Based on the above RVUs for these codes if the procedures were performed in a facility: 45378 (5.4), 45380 (5.86) and 45385 (7.45), procedure code 45385 would be reimbursed at 100% of the allowable \$260.68 as the higher ranked service. Procedure Code 45380 would be reimbursed at the adjusted allowable \$15.56 as lower ranked service. The Endoscopic Base Code (45378) is not reimbursed.

Example # 2:

Below is an example of how the Endoscopic Adjustment Rule and multiple procedure reduction will be applied when the physician bills for codes 45380 and 45381 (same endoscopic family) and 45562 (unrelated procedure).

- First determine the Total Adjusted RVU for each endoscopic family. Each “family” of endoscopic codes is considered as a single procedure (RVUs combined) for ranking.
- Rank the Family Adjusted RVUs against other reducible procedures RVUs from highest to lowest.
- Apply the Multiple Procedure Reduction (Example: Standard reduction of 100-50-50).

Note: RVU values and dollar amounts in this example may not accurately reflect the current NPFS and are intended for illustrative purposes only.

Code	Facility RVU	Allowable	Endo Ranking	Family Adjusted RVU	Multiple Procedure Ranking	Adjusted Allowable
45380	5.86	\$206.52	1	$5.86 - 5.40 = 0.46$	2 (50%)	[[(\$206.52-\$190.96) + \$206.52] *50% = \$111.04
45381	5.86	\$206.52	2	$5.86 + 0.46 = 6.32$		
45378 Base Code	5.40	\$190.96	N/A Base Code Not allowed	N/A	N/A	
45562	33.92	\$1,192.64	N/A Unrelated Procedure	N/A	1 (100%)	\$1,192.64

Based on the above RVUs for these codes if the procedures were performed in a facility: 45378 (5.40), 45380 (5.86), 45381 (5.86) and 45562 (33.92), first calculate the Total Adjusted RVUs based on the Endoscopic Adjustment Rule by subtracting the difference between the Endoscopic Base Code and the lower valued endoscopy code (0.46) and then adding that calculation to the higher valued endoscopy code (5.86), which equals (6.32). Compare the Family Adjusted RVUs (6.32) to the RVUs of the unrelated procedure (33.92) to determine Multiple Procedure Ranking.

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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 current year 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.

Multiple Procedures with No Assigned CMS RVU

Services that CMS indicates may be carrier-priced, or those for which CMS does not develop RVUs are considered Gap Fill Codes and are addressed as follows:

Gap Fill Codes: When data is available for Gap Fill Codes, EmblemHealth/ConnectiCare uses the relative values published in the first quarter update of the Optum The Essential RBRVS publication for the current calendar year.

0.00 RVU Codes: Some codes cannot be assigned a gap value or remain without an RVU due to the nature of the service (example: unlisted codes). Codes assigned an RVU value of 0.00 on the Multiple Procedure Reduction Codes list and will be ranked as secondary or subsequent procedures when reported with other procedures that are subject to the multiple procedure concept described above.

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.

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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

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	8/21/2024	<ul style="list-style-type: none"> Updated policy with clarification regarding Gap Fill Codes/ codes with no CMS assigned RVUs

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Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	4/2024	<ul style="list-style-type: none"> Updated with Examples 1 & 2 in “Multiple Endoscopic Surgical Reimbursement” section Updated to clarify that EmblemHealth/ConnectiCare reimburses “100% of the allowable amount for the procedure with the highest current year CMS National Physician Fee Schedule RVU”
EmblemHealth ConnectiCare	6/2022	<ul style="list-style-type: none"> 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%)
EmblemHealth ConnectiCare	12/2021	<ul style="list-style-type: none"> Updated Multiple Endoscopic Surgical Reimbursement calculation to align with CMS. <i>See also previously communicated EmblemHealth/ConnectiCare Coding Edits Reimbursement Policy update – effective 9/01/2021</i>
EmblemHealth ConnectiCare	7/2021	<ul style="list-style-type: none"> Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number
EmblemHealth ConnectiCare	1/2019	<ul style="list-style-type: none"> Updated Bilateral Multiple Surgical Reimbursement calculation to align with CMS
EmblemHealth ConnectiCare	1/2019	<ul style="list-style-type: none"> Updated Bilateral Multiple Surgical Reimbursement calculation to align with CMS