In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy 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.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the 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), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Multiple Surgical Procedures

Policy Number: CPCP015

Version: 6.0

Clinical Payment and Coding Policy Committee Approval Date: 02/22/2019

Effective Date: June 22, 2019 (Blue Cross and Blue Shield of Texas)

This policy was created to serve as a general reference guide for coding and payment for multiple procedures. Health care providers (i.e., facilities, physicians and other 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 professional surgery and medical services.

Modifications to this policy may be made at any time. Any updates to this policy will result in an updated publication of this policy.

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.

Description, cont'd:

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.
- Secondary and Subsequent Procedures: Eligible at 50% of the fee schedule, or billed amount whichever is less.

Multiple procedures should be submitted on one (1) claim.

References:

American Dental Association. Current Dental Terminology (CDT).
http://www.ada.org/en/publications/cdt

American Medical Association. Current Procedural Terminology (CPT).
https://www.ama-assn.org/practice-management/cpt

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

Policy Update History:

HCSC Approval Date	BCBSTX Approval Date	Description
02/28/2018	06/22/2019	New Policy
02/22/2019	06/22/2019	Annual Review