Commercial Reimbursement Policy

Subject: **Multiple Surgery – Facility**	
Policy Number: **C-21004**	Policy Section: **Facilities**
Last Approval Date: **04/24/2024**	Effective Date: **01/01/2022**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross and Blue Shield (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan's reimbursement for facility providers is based on the below multiple procedure rules, unless provider, state, or federal contracts and/or requirements indicate otherwise.

Reimbursement is allowed for only the primary, or highest valued, procedure when multiple procedures are performed on the same day or same session, and at the same place of treatment.

Modifier 51 should not be appended to facility claims.

A single surgical procedure is subject to multiple procedure reduction guidelines when submitted with multiple units.

Related Coding

Standard correct coding applies

Exemptions

Maine	This market is not subject to this policy.
New Hampshire	This market is not subject to this policy.
Wisconsin	Anthem Blue Cross and Blue Shield (Anthem) reimburses surgeries at 100/50/50. Reimbursement is the total of 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure, 50% for the secondary through 5th procedures, and 50% for the 6th and additional procedures.

Policy History

04/24/2024	Review approved 04/24/2024 and effective 10/01/2024: updated Wisconsin exemption from (*This market is not subject to this policy)* to reimburses surgeries at 100/50/50
12/29/2023	Review approved: no changes
04/13/2023	Revision: added Maine exemption
11/23/2022	Revision approved: removed all bilateral language from policy; updated policy name to Multiple Surgery - Facility from Multiple Bilateral Surgery Processing- Facility
06/01/2022	Review approved and effective: Georgia and Kentucky
04/14/2021	Initial approval 04/14/2021 and effective 01/01/2022: New Hampshire and Wisconsin are exempt from this policy. Georgia and Kentucky effective TBD due to delayed implementation.

References and Research Materials

This policy has been developed through consideration of the following: • CMS • Optum EncoderPro 2023

Definitions

Modifier 51	Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg. vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). This modifier is only appropriate for professional claims. Note: This modifier should not be appended to designated 'add-on' codes (see Appendix F).
Multiple surgeries	Distinct surgical procedures performed by a provider on the same patient during the same operative session.
General Reimbursement Policy Definitions	

Related Policies and Materials

Distinct Procedural Services - Modifier 59 and XE, XP, XS, and XU - Professional
Global Surgery - Facility
Modifier Usage - Professional
Scope of License - Professional

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.