Professional Pricing Policy

Subject: **Multiple and Bilateral Surgery Processing**	
Policy Number: HLSP-0001	Policy Section: **Surgery**
Last Approval Date: October 4, 2022	Effective Date: December 12, 2022

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. 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. 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. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

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

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

Standard Multiple Surgery:

For standard multiple surgery HealthLink allows 100% of the allowance for the procedure with the highest Relative Value Unit (RVU) or allowance for the place of service and date of service and 50% of the allowance for each subsequent procedure eligible for separate allowance when performed during the same operative session by the same physician or other qualified health care provider. Standard multiple surgery allowance will also apply when a single procedure code is reported with multiple units on a single line.

Bilateral surgical procedure:

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 allowance equal to 150% of the amount applicable to the unilateral code on the date of service.

When a bilateral surgery that uses a unilateral code is reported with other surgical procedures, we will increase the RVU for the applicable unilateral code by 150%. We will then apply our multiple surgical rules as described above in Section 1—Standard multiple surgery. If bilateral surgery using a unilateral code is not reported on a single line with modifier 50 and one unit, HealthLink will treat the following coding scenarios as bilateral:

- A single line, no modifier 50, quantity = 2— we will apply the policy described above related to bilateral surgeries that use a unilateral code.
- When two claim lines are reported with the same procedure code and one line is reported with modifier 50 and the second line is unmodified, we will and apply the policy described above related to bilateral surgeries that use a unilateral code and apply the pricing to the line with modifier 50.

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.

When standard multiple surgery is NOT applicable:

- Add-on codes as defined by CPT Appendix D, and HCPCS code G0289
- Modifier 51 exempt codes as defined by CPT Appendix E
- Procedures listed in the Surgery section of CPT (10000-60000 series) that HealthLink does not consider to be a surgical procedure (e.g., 36415-36416; 36593; 59425-59426)
- When two physicians or other qualified health care providers work separately on each side of the patient (e.g., major joint replacement such as left knee and right knee).

Multiple arthroscopic and endoscopic surgical procedure pricing:

Pricing for multiple arthroscopic and endoscopic surgical procedures is determined by the base family as defined by Centers for Medicare & Medicaid Services (CMS). When services provided by the same physician or qualified health care provider, during the same operative session reimbursement guidelines are:

- With the same base family
    - 100% of the allowance for the procedure with the highest RVU or maximum allowance for the place of service and date of service.
    - Each subsequent procedure priced as identified in the Related Coding section below.
- Not within the same base family
    - Subject to the standard multiple surgery pricing calculation as outlined above.
- Procedures listed in the Surgery section of CPT (10000-60000 series) that HealthLink does not consider to be a surgical procedure (e.g., 36415-36416; 36593; 59425-59426)
- When two physicians or other qualified health care providers work separately on each side of the patient (e.g., major joint replacement such as left knee and right knee).

Related Coding

Code	Description	Comments
29805 – 29825, 29827 – 29828	Shoulder arthroscopy	100% primary; 30% subsequent
29830 – 29838	Elbow arthroscopy	100% primary; 25% subsequent
29840 – 29847	Wrist arthroscopy	100% primary; 25% subsequent
29860 – 29863, 29914 - 29916	Hip arthroscopy	100% primary; 25% subsequent
29870 – 29887	Knee arthroscopy	100% primary; 25% subsequent
31622 – 31625, 31628 – 31631, 31634 – 31636, 31638, 31640, 31641, 31645, 31647, 31648, 31660, 31661	Bronchoscopy	100% primary; 25% subsequent
43210, 43233, 43235 – 43259, 43266, 43270	Esophagogastroduodenoscopy (EGD)	100% primary; 25% subsequent
45378 – 45398	Colonoscopy	100% primary; 25% subsequent

43260 – 43265, 43274 – 43278	Endoscopic Retrograde Cholangiopancreatography (ERCP)	100% primary; 25% subsequent
G0289	Knee arthroscopy	Multiple Surgery pricing is not applicable

Exemptions

Policy History

10/04/2022	Added Multiple arthroscopic and endoscopic surgical procedure pricing and related codes.
05/17/2022	Biennial review approved and effective; minor administrative changes made to the policy body.

Definitions

Bilateral	Bilateral procedures are procedures performed on both sides of the body during the same operative session.
Modifier 50	**Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5-digit code. **Note:** This modifier should not be appended to designated 'add-on' codes.
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). **Note:** This modifier should not be appended to designated 'add-on' codes.
Modifier LT	Left side (used to identify procedures performed on the left side of the body)
Modifier RT	Right side (used to identify procedures performed on the right side of the body)
Multiple surgeries	Distinct surgical procedures performed by a provider on the same patient during the same operative session.
Unilateral	Unilateral procedures are procedures performed on one side of the body.
General Professional Pricing Policy Definitions	

Related Policies and Materials

Modifier Rules

References and Research Materials

This policy has been developed through consideration of the following

- CMS
- American Medical Association (AMA) Current Procedural Terminology (CPT) 2020

Use of Pricing 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. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.