If a conflict arises 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. If a conflict arises between a CPCP 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. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Texas may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Multiple Surgical Procedures-Professional Provider

Policy Number: CPCP015

Version: 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: April 16, 2025

Effective Date: April 23, 2025

Description

This policy applies to professional health care providers when submitting reimbursement for the code(s) that correctly describe health care services rendered for multiple surgical procedures. Health care Providers (i.e., facilities, physicians, and other qualified health care professionals- QHP) are expected to exercise independent medical judgement in providing care to members. 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.

Multiple Surgical Procedure Reduction is a reduction in payment rate applied when more than one surgical procedure, assistant surgical procedure, or bi-lateral surgical procedure is performed during the same patient encounter and by the same provider.

To be considered for MSPR, 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.

Multiple surgical procedure reductions apply to all claim processing. Providers should check with the Plan for exceptions that may exist.

Reimbursement Information

The plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

Eligible reimbursement for services should reflect codes that best represent the services provided. Providers should submit claims in accordance with the Plan's billing policies and/or guidelines to ensure that correct claim pricing methodology is applied when billing multiple surgical procedures.

All surgical services (multiple and/or bilateral) rendered by the same performing provider for the same member and date of service in the same setting should be submitted on one claim.

Multiple Surgeries

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. [1]
- **Secondary and Subsequent Procedures:** Eligible at 50% of the fee schedule, or billed amount whichever is less.

[1] The primary procedure is the service line with the highest total allowable.

Modifier 51 may be appended to procedure codes to reflect multiple procedures were performed during the same surgical session on the same day by the same provider, however it is not required to be added.

Bilateral Surgery

Bilateral surgical procedures are performed on both sides of the body during the same surgical session or on the same day. Multiple surgical pricing reductions may apply.

Surgical procedures should be submitted with one (1) unit of service. If the same surgical service was performed more than once and the procedure is not eligible for **modifier 50,** then the procedure code should be billed on a separate line on the claim with (1) unit of service. **Modifier 50** should only be reported with one line and with one unit of service.

Multiple Surgical Pricing Exclusions

The following services are excluded from multiple surgical pricing reductions:

- Add-on codes
- Codes that are exempt from **Modifier 51** are excluded from multiple surgery reductions but can be considered the primary procedure when the service line has the highest allowable.

Additional Resources

Clinical Payment and Coding Policy

CPCP010 Anesthesia Information

CPCP023 Modifier Reference Policy

References

Policy Update History

Approval Date	Description
02/22/2019	New Policy
07/07/2020	Annual Review, Disclaimer Update, Verbiage Update
08/24/2021	Annual Review
06/24/2022	Annual Review
09/05/2023	Annual Review
01/12/2024	Annual Review
04/16/2025	Annual Review; Grammatical updates; Updated References.