Anthem Blue Cross

PROFESSIONAL REIMBURSEMENT POLICIES (continued)

MUTIPLE SURGERY*

Multiple surgeries are distinct surgical procedures performed by a provider on the same patient during the same operative session. These secondary surgical procedures are eligible for reimbursement, but at a lower allowance, and can be distinguished from other procedures that might be components of, or incidental to, the primary service performed.

Standard multiple surgery reimbursement:

Standard multiple surgery reimbursement is 100% of the maximum allowance for the procedure with the highest RVU, and 50% of the maximum allowance for the second and each subsequent procedure. (Exception: Some members will continue to apply 100%, 50%, 25% for MSR for all surgeries including multi-Endoscopy until member contract is modified). Currently, MSR ranking is based on highest units and reimbursed at 100%, 50%, 25%.

Multiple endoscopic surgical procedure reimbursement:

Endoscopic surgical procedures in the same base family will be reimbursed at 100% for the primary procedure and at a lower percentage for each subsequent procedure when performed at the same operative session. (Exception: Some other members will continue to apply 100%, 50%, 25% for MSR for all surgeries including multi-Endoscopy until member contract is modified). Currently, standard MSR (100%, 50%, 25%) is applied. The code ranges and percentages are as follows:

Base Family	Codes	Percentages
Shoulder arthroscopy	29805 – 29828	100% primary; 30% subsequent
Elbow arthroscopy	29830 – 29838	100% primary; 25% subsequent
Wrist arthroscopy	29840 – 29847	100% primary; 25% subsequent
Hip arthroscopy	29860 – 29863	100% primary; 25% subsequent
Knee arthroscopy	29870 – 29887	100% primary; 35% subsequent
Bronchoscopy	31622 - 31631, 31635 - 31636, 31638, 31640 - 31641, 31645	100% primary; 25% subsequent
Upper GI endoscopy	43231, 43232, 43235 – 43259	100% primary; 25% subsequent
Retrograde Cholangiopancreatography (ECRP)	43260 – 43265, 43267 – 43269, 43271 - 43272	100% primary; 25% subsequent
Colonoscopy	45378 – 45392	100% primary; 25% subsequent

***Some member plans will apply the current payment policy until such time as the applicable Member Benefits Agreements are revised to reflect the new policy.**

25% – Fifth procedure

Exception –
Effective 1/1/95, multiple surgeries in the medical range of 93501-93581 performed on the same day (even if billed with one other surgery in the medical range), are all reimbursed at full unit value. The multiple surgery reduction applies to surgeries in the 10040-69979 range (see exceptions in "Major and Minor Surgeries") when billed on the same day with procedures in the 93501-93581 range. Anthem Blue Cross reimburses the following ranges 11140X, 1160X, 1727X, 1728X of dermatological procedures at 100%, 50%, 50%, and 50% etc. If any of these procedures are billed with one, and up to four other unrelated CPT codes, the calculation, excluding the primary procedure, will at the 50% level. The unrelated CPT codes will be processed at the 25% level if the surgery represents the third, fourth, or fifth procedure.

Physical Therapy

Physical medicine is the art and science of physical/ corrective rehabilitation or treatment designed to improve or restore maximum functional ability, relieve pain, and prevent minimize disability following disease, injury or loss of a body part. Physical and/or occupational therapy treatments may include and/or occupational therapy treatments may include functional activities, mobility training, manipulations, physical modalities, assessment, instruction, special tests and/or therapeutic exercises. Physical medicine codes are divided into and/or therapeutic exercises four types of service:

1. **Special Procedures** – (97530-97546) are more complex procedures. The price of these procedures is always calculated using the full unit value. Additional procedures (97110-97150) for the same date of service are treated as subsequent procedures. (Price using 30% of the unit value). Additional modalities (97010-97039) for the same date of service are treated as subsequent modalities (Price using 10% of the unit value).
2. **Procedures** – (97110-97150) are more involved and are performed while the Provider is in attendance the entire time. The price of the initial procedure (most expensive) is calculated using the full unit value of the procedure (unless billed on the same date of service as a "Special Procedure") same date of service as a "Special Procedure"). The price of each subsequent "procedure" performed during the same session is calculated using 30% of the unit value of the procedure.
3. **Modalities** – (97010-97039) require less time and skill by the provider. The price of the initial (most expensive) modality is calculated using the full unit value of the modality (unless billed on the same date of service as a "Special Procedure"). The price of each subsequent "modality" performed during the same session is calculated using 10% of the unit value of the modality.
4. **Tests and Measurements** – (97750-97755) are evaluations and/or assessments. When calculating the price for these codes, the full unit value is always used. Tests and measurements are not considered "procedures" or "modalities," and therefore do not affect the price of any other services performed.