BlueCross BlueShield of Alabama

Surgery-Related Claims Filing Updates

Prior to June 1, 2022, Blue Cross and Blue Shield of Alabama required providers to follow set billing guidelines for bilateral procedures, multiple surgeries and split global surgical care.

View the CMS PFS Relative Value Files for more information on payment under the Medicare physician fee schedule for these services.

Changes effective June 1, 2022, are outlined below:

Edit Component	Changes from Current Process
Bilateral Procedures	Processing and filing requirements for bilateral procedures follow CMS guidelines for all procedures with a Bilateral Indicator = 1. All bilateral 1 procedures, including add-on codes, will require submission on a single line with modifier 50 appended and one unit of service. Modifiers RT and LT or multiple line filing will no longer be accepted for the submission of surgical procedures performed bilaterally that have a bilateral indicator 1. These modifiers will still be accepted for procedures performed unilaterally or for procedure codes with a bilateral indicator other than 1.
Multiple Surgeries	The Multiple Procedure Indicator assigned by CMS will be used to determine eligible procedures. This will apply to all provider specialties for procedures with a Multiple Procedure Indicator of 2 or 3 performed by a single physician (or multiple physicians with the same specialty practicing under the same Tax ID). The procedure with the highest fee allowance will be reimbursed at 100% of fee allowance and subsequent procedures will be reimbursed at 50% of the fee allowance.
Split Global Surgical Care	This applies when physicians have agreed on the transfer of care during the global surgery period. Physicians must indicate if care was provided pre-op, post-op or surgical care only by using appropriate modifiers 54, 55 and 56. Modifier 54 represents surgical care only. Modifier 55 represents postoperative care and modifier 56 represents preoperative care. These guides will apply to all provider specialties for procedures having a Global Period of 010 or 090 as identified by CMS. Allowable reimbursement will also be based on the pre-op, intra-op and post-op percentages determined by CMS.

Note: If multiple procedures performed include bilateral procedures and both have the specified indicators, both rules will apply. Refer to the Surgery-Related Claims Calculation example for more information.