Priority Health	BILLING POLICY No. 046
ONCE PER LIFETIME	
Date of origin: Oct. 8, 2024	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS policies, NCD and LCD unless otherwise defined below.
- Medicaid follows MDHHS unless otherwise defined below.

DEFINITION

This policy identifies procedures or services that are payable only once per patient's lifetime based on the description associated with the CPT or HCPCS codes and/or anatomy.

POLICY SPECIFIC INFORMATION

Certain CPT or HCPCS codes are reimbursed only once per member's lifetime based on code description or anatomy because the service involves the removal of an organ from the body.

- Service may be defined by a single code or by a code family (group of codes that are similar in description for the same anatomical site). For example, hysterectomy has multiple codes that describe this service. Only one code from the code family is payable per lifetime.
- Services defined as once in a lifetime may be payable on separate claims with separate dates of certain when certain modifiers are appended indicating a special circumstance.
    - Modifier 53 – discontinued procedure
    - Modifier 54, 55, 56 – indicates separate billing for global surgical package
- Services billed related to an anatomical site that has previously been surgically removed will result in a denial (explanation, service on foot when amputation has occurred).
- Services where there is a bilateral anatomy should have appropriate modifier for anatomical site appended. Failure to accurately code will result in a denial.

Documentation requirements

- Documentation must support CPT or HCPCS code reported.
- Procedure or operative report must be authenticated

Modifiers

- Modifier 53 – discontinued procedure
- Modifier 54, 55, 56 – indicates separate billing for global surgical package – see Modifiers 54 and 55, surgical or post-op procedures only; and Modifier 56, pre-operative management only
- Anatomical modifiers

Questions / answers

- What if two separate physicians each bill for same procedure on the same date of service from the Once in a Lifetime Procedures list?
    - The Once in a Lifetime Procedure codes are subject to duplicate billing logic when reported by the same or different providers on the same date of service. If a second claim is received for the same member and date of service that contains a CPT code within a code family, it will be denied.

Related policies

- General coding policy (#022)

Once in a lifetime codes list (includes family of codes)

Note: This may not be an all-inclusive list and is subject to change without notification based on the AMA CPT code changes that occur quarterly or ad hoc as released.

- **Appendectomy**: 44950 44955 44960 44970
- **Cervical Stump Excision**: 57540 57545 57550 57555 57556
- **Cholecystectomy**: 47562 47563 47564 47600 47605 47610 47612 47620
- **Circumcision**: 54150 54160 54161
- **Colectomy**: 44150 44151 44155 44156 44157 44158 44210 44211 44212
- **Cystectomy**: 51570 51575 51580 51585 51590 51595 51596
- **Epididymectomy**: 54861
- **Gastrectomy**: 43620 43621 43622
- **Glossectomy**: 41140 41145
- **Hysterectomy**: 51925 58150 58152 58180 58200 58210 58240 58260 58262 58263 58267 58270 58275 58280 58285 58290 58291 58292 58293 58294 58541 58542 58543 58544 58548 58550 58552 58553 58554 58570 58571 58572 58573 58575 58950 58951 58952 58953 58954 58956
- **Laryngectomy**: 31360 31365
- **Pancreatectomy**: 48155
- **Pelvic Exenteration**: 51597
- **Penile amputation**: 54125 54130 54135
- **Pneumonectomy**: 32440 32442 32445
- **Proctectomy**: 45110 45112 45119 45120 45121 45126 45395 45397
- **Prostate Enucleation**: 52649
- **Prostatectomy**: 55810 55812 55815 55821 55831 55840 55842 55845 55866 55867
- **Rhinectomy**: 30160
- **Splenectomy**: 38100 38102
- **Subtotal Prostatectomy**: 55801
- **Thyroidectomy**: 60240 60252 60254 60270 60271
- **Trachelectomy**: 57530 57531
- **Umbilectomy**: 49250
- **Urethrectomy**: 53210 53215
- **Uvulectomy**: 42140
- **Vaginectomy**: 57110 57111 57112
- **Vulvectomy**: 56625 56633 56634 56637

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to

document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section