Bilateral and Multiple Surgical Procedures Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)
☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)
☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers and facilities who render services in an inpatient, outpatient or office setting.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary surgical services, as described below. Tufts Health Plan applies multiple surgical procedures reductions when the same provider performs two or more surgical procedures, including procedures performed bilaterally, on the same member within the same operative session.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or by contacting Commercial Provider Services or Senior Products Provider Relations.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

BILLING INSTRUCTIONS

Submit bilateral surgical procedure code(s) on one or two claim lines/service lines for Tufts Medicare Preferred HMO and Tufts Health Plan SCO members.

For more information on the use of bilateral and multiple procedure modifiers, refer to the Modifier Payment Policy.

COMPENSATION/REIMBURSEMENT INFORMATION

Tufts Health Plan closely aligns with CMS guidelines in determining which procedure codes are subject to bilateral adjustment and/or multiple procedure reduction. Refer to the CMS website for specifics on procedures eligible for bilateral and multiple surgical procedures.

Multiple Surgical Procedures

Tufts Health Plan compensates multiple surgical procedure code(s) by paying the surgical procedure code with the Tufts Health Plan highest allowable compensation at 100% of the allowed amount. Subsequent surgical procedure code(s) that are subject to reduction logic are compensated at 50% of the allowed amount. Refer to the Multiple Surgical Procedures Reduction List for Professionals and Multiple Surgical Procedures Reduction List for Facilities for the surgical procedure code(s) that are subject to multiple surgical procedures reduction.

Multiple and Bilateral Surgical Procedures Performed in the Same Operative Session

When a bilateral procedure code and surgical procedure code(s) are submitted together and both the bilateral and surgical procedure code(s) are eligible for multiple procedure reduction, the bilateral adjustment will be applied first.

The surgical procedure code(s) with the highest allowable compensation, after the bilateral adjustment, will be compensated at 100 percent. Other surgical procedure code(s) subject to

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1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
reduction logic are compensated at 50 percent of the allowed amount, after bilateral adjustment, as appropriate.

**Bilateral Surgical Procedures**

Bilateral surgical procedures billed with modifier 50 are compensated at 150 percent of the contractual/allowed amount. Refer to the [Bilateral Procedures List](#) for a list of procedure codes that are eligible for bilateral adjustment.

**Multiple Radiology Services**

Refer to the [Imaging Services Professional Payment Policy](#) for information on how multiple radiology services are compensated.

**Tufts Medicare Preferred HMO only:**

The following policies are based on CMS policy:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
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<tbody>
<tr>
<td>Multiple endoscopy policy</td>
<td>Compensation for procedures subject to multiple endoscopy guidelines is based on a percentage methodology, whereby the endoscopy with the highest allowed amount is determined and secondary endoscopies are reduced by the percentage that is representative of the value of the base endoscopy.</td>
</tr>
<tr>
<td>Multiple procedure reduction for ophthalmology services</td>
<td>Certain clinical activities and supplies are not duplicated when multiple diagnostic ophthalmology services are performed. Therefore, CMS has instituted a reduction in compensation for the technical component of secondary services or studies. The service or study with the highest technical component is compensated at 100% and all other subsequent technical components are reduced to 80%.</td>
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<tr>
<td>Multiple procedure reduction for cardiovascular services</td>
<td>Certain clinical activities and supplies are not duplicated when multiple diagnostic cardiovascular services are performed. Therefore, CMS has instituted a reduction in compensation for the technical component of the secondary services or studies. The service or study with the highest technical component is compensated at 100% and all other subsequent technical components are reduced to 75%.</td>
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**OPPS Technical Cap Policy**

When a procedure that is subject to the OPPS technical cap amount is billed, the procedure’s compensation will be adjusted to equal the OPPS technical cap amount.

**DOCUMENT HISTORY**

- June 2018: Template updates
- January 2017: Policy reviewed; template updates; combined Bilateral and Multiple Surgical Procedures policies for Commercial, Tufts Medicare Preferred HMO and Tufts Health Plan SCO
- September 2015: Template conversion
- January 2015: Added Revenue Codes 0681-0684, 0689, 1000-1002 accepted when submitted electronically without a corresponding CPT and/or HCPCS procedure code; template updates
- September 2013: Template conversion
- August 2013: Added policy changes for Tufts Medicare Preferred HMO effective for dates of service on or after October 1, 2013; template updates
- March 2013: Policy reviewed; added link to Multiple Imaging procedures List; template updates
- February 2013: Policy reviewed; added information regarding Tufts Health Plan SCO
- January 2013: Template updates
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- October 2011: Template updates; added information regarding paper and electronic SOAs effective January 1, 2012
- February 2011: Reviewed policy; template updates
- January 2010: Removed references to the Tufts Medicare Preferred PPO product
- December 2009: Added links to multiple and bilateral procedures lists and information about multiple and bilateral surgical procedures performed in the same operative session, effective January 10, 2010
- October 2009: Changes effective November 15, 2009 have been delayed: Multiple and Bilateral Surgical Procedures Performed in the Same Operative Session
- July 2009: Added links to multiple and bilateral procedures lists and information about multiple and bilateral surgical procedures performed in the same operative session
- September 2008: Removed: Append modifier 51 to all surgical procedures that are billed in addition to the primary surgical procedure
- March 2009: Moved Tufts Medicare Preferred information to its own document
- April 2008: Removed information on submitting bilateral surgical procedure code(s) on two claim lines/service lines, effective April 1, 2008
- February 2008: Added effective April 1, 2008, information for submitting bilateral surgical procedure code(s) on one or two claim line/service lines
- August 2007: Added Tufts Medical Preferred HMO information

AUDIT AND DISCLAIMER INFORMATION
Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.