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

☒ Tufts Health Plan Senior Care Options (SCO) products

Applies to the following Tufts Health Public Plans products:

☒ Tufts Health Direct – Health Connector

☒ Tufts Health Together – Includes MassHealth Plan and Accountable Care Partnership Plans

☒ Tufts Health RITogether – A RI Medicaid Plan

☒ Tufts Health Unify – OneCare Plan

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 applies multiple surgical procedures reductions when two or more surgical procedures, including procedures performed bilaterally, are performed on the same member within the same operative session.

DEFINITIONS

A **bilateral procedure** is a procedure typically performed on both sides of the body (mirror image) during the same operative session. Modifier 50 identifies the performance of a bilateral procedure.

Multiple surgical procedures are procedures performed on the same patient by a surgeon, co-surgeon, surgical team, or assistant-at-surgery in the same group practice during the same operative session or on the same day. Modifier 51 identifies the performance of multiple surgical procedures.

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 Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

AUTHORIZATION REQUIREMENTS

While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization for services has been obtained when applicable.

BILLING INSTRUCTIONS

Tufts Health Plan follows AMA CPT/HCPCS coding guidelines. Refer to current industry standard coding guidelines for a complete list of procedure codes, modifiers and their usage. For more information refer to the Professional Services and Facilities Payment Policy.

Tufts Health Plan requires the use of modifier 50 to report bilateral procedures and 51 to report multiple procedures. Providers may not use modifier 51 to identify intra-operative procedures or procedures that are components of or incidental to a primary procedure.

Tufts Health Plan Commercial and Tufts Health Public Plans
Providers should append modifier 50 to the appropriate unilateral, five-digit billing code as a one-line entry on the claim form.

Tufts Health Plan requires providers to report multiple procedures by appending modifier 51 to the secondary or additional procedure as a **one-line entry** on the claim form, using the appropriate five-digit CPT billing code.

Tufts Medicare Preferred HMO and Tufts Health Plan SCO
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.

Note: For Tufts Health Plan Commercial products, 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.

Bilateral Surgical Procedures

Bilateral surgical procedures billed with modifier 50 are compensated at 150 percent of the contractual/allowed amount.

Tufts Health Plan does not routinely compensate modifiers LT (left side) or RT (right side) when billed on the same line with modifier 50 (bilateral procedure). Providers may bill for bilateral procedures (modifier 50) in conjunction with modifier 51.

Note: For Tufts Health Plan Commercial products, refer to the Bilateral Procedures List for a list of procedure codes that are eligible for bilateral adjustment.

Multiple and Bilateral Surgical Procedures

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 is applied first. The surgical procedure code(s) with the highest allowable compensation will be compensated at 100 percent after the bilateral adjustment. Other surgical procedure code(s) that are subject to reduction logic are compensated at 50 percent of the allowed amount, after bilateral adjustment, as appropriate.

TUFTS MEDICARE PREFERRED HMO

Multiple Procedure Reductions

Certain clinical activities and supplies are not duplicated when multiple diagnostic services are performed. 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 the following percentages:

- Ophthalmology services: 80 percent
- Cardiovascular services: 75 percent

Multiple Endoscopy Policy

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.

TUFTS HEALTH PLAN SENIOR CARE OPTIONS (SCO) AND TUFTS HEALTH UNIFY

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.

ADDITIONAL RESOURCES

- Chapter 12 – Physicians/Nonphysicians Practitioners of Medicare Claims Processing Manual (Rev. 2159, 02-15-11), Section 40.6 (CMS)

DOCUMENT HISTORY

- February 2019: Combined policy created

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 a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/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.