Bilateral and Multiple Surgical Procedures Payment Policy

Applies to the following Tufts Health Plan products:

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

Applies to the following Tufts Health Public Plans products:

☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
☒ Tufts Health Unify (OneCare Plan; 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 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 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 portal 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.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial

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1 Commercial products include HMO, POS, PPO, and CareLink® when Tufts Health Plan is the primary administrator.
2 Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.
exhibits of their provider agreements and applicable fee schedules. 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.

**Senior Products**

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**

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

**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 lists for professionals and 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% 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 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: Enterprise policy created
- 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

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 CareLinkSM 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.