Bilateral and Multiple Surgical Procedures Professional Payment Policy

TUFTS Health Plan
www.tuftshealthplan.com/providers
Provider Services - 888-884-2404

The following payment policy applies to Tufts Health Plan® commercial contracted providers who render professional services in an outpatient or office setting.

This policy applies to commercial[1] products. For information on Tufts Health Plan Medicare Preferred's policies and procedures, click here.

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

Policy

Tufts Health Plan reimburses medically necessary surgical services. Tufts Health Plan applies multiple surgical procedures reduction 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[2]

Services and subsequent payment are based on the member's benefit plan document. Providers and their office staff are required to use self-service channels to verify effective dates and copayments for commercial members prior to initiating services.

Reference the Electronic Services section of our Web site for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our Web site or by contacting Provider Services.

Member Responsibility

Copayments, deductible and/or coinsurance may apply depending upon the member's benefit plan specifics.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider's Statement of Account (SOA) and the Electronic Remittance Advice (ERA) will reflect the member's responsibility amount.

Authorization Requirements

Reference the Authorization Policy for specific referral and authorization requirements.

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Reference the Clinical Resources section of our Web site for a list of procedures, services and items that require prior authorization. Reference the CareLink℠ Prior Authorization List for a list of procedures, services and items requiring prior authorization for CareLink members.

For a complete description of Tufts Health Plan's commercial authorization requirements, reference the Authorization section within the Tufts Health Plan Commercial Provider Manual.

[1] Commercial products include HMO, POS, PPO & CareLink when Tufts Health Plan is Primary Administrator
[2] Eligibility is subject to retroactive reporting of disenrollment by the member's employer group or Medicare.

Billing Information

- Submit the most updated industry-standard codes.
- Append modifier 50 (bilateral procedure) to bilateral surgical procedure code(s) that require the use of a modifier.
- Submit bilateral surgical procedure code(s) on one claim line/service line with one unit.
- Append modifier 51 (multiple procedures) to all surgical procedures that are billed in addition to the primary surgical procedure.

Note: Annually and quarterly, HIPAA medical code sets[3] undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-9 diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

EDI Claim Submitter Information

- Submit claims in HIPAA compliant 837P format for professional services. Claims billed with non-standard codes will reject if billed electronically.

Paper Claim Submitter Information

- Submit claims on a CMS-1500 form for professional services. Claim line(s) billed with non-standard codes will deny.
- Submit the appropriate modifier(s) after the corresponding CPT or HCPCS procedure codes in Box 24d Procedures, Services, or Supplies field.

Reimbursement Information

Providers are reimbursed according to the Tufts Health Plan contracted rate regardless of where the service is rendered. Claims are subject to payment edits that are updated at regular intervals and generally based on CMS, specialty society guidelines, drug manufacturers' package label inserts and National Correct Coding Initiative (CCI).

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

Multiple Surgical Procedures

Tufts Health Plan reimburses multiple surgical procedure code(s) by paying the surgical procedure code with the Tufts Health Plan highest allowable reimbursement at 100%. Subsequent surgical procedure code(s) that are subject to reduction logic are reimbursed at 50% of the allowed amount. Reference the Multiple Surgical Procedures Reduction List for the list of surgical procedure code(s) that are subject to multiple surgical procedures reduction.

Multiple and Bilateral Surgical Procedures Performed in the Same Operative Session

Effective January 10, 2010, 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 reimbursement, after the bilateral adjustment, will be reimbursed at 100%. Other surgical procedure code(s) subject to reduction logic are reimbursed at 50% of the allowed amount, after bilateral adjustment, as appropriate.

Bilateral Surgical Procedures

Bilateral surgical procedures billed with modifier 50 will receive 150% of the allowed amount. Reference the Bilateral Procedures List for a list of procedure codes that are eligible for bilateral adjustment.

[3] HIPAA medical code sets include HCPCS, CPT Procedure and ICD-9 diagnosis codes.

Multiple Radiology Services
Reference the Imaging Professional Payment Policy for information on how multiple radiology services are reimbursed.

Statement of Account (SOA)
The SOA is sent to all providers to provide information on the status of the claim(s) submitted to Tufts Health Plan. The SOA indicates status of claims payments, denials and pending claims.

If the procedure code(s) submitted is not used in processing, the SOA will reflect the actual procedure code(s) utilized by Tufts Health Plan to process the claim.

Electronic Remittance Advice (ERA)
The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

When an industry standard code(s) is submitted and accepted by Tufts Health Plan, the electronic remittance advice will reflect the code(s) submitted and the actual procedure code(s) utilized by Tufts Health Plan for claims processing.

Document History

February 2008: Added that effective April 1, 2008 providers should submit bilateral surgical procedure code(s) on one claim line/service line for commercial members. Revised general benefit information with self-service channels information.

April 2008: Removed information on submitting bilateral surgical procedure code(s) on two claim lines/service lines for commercial members. This has changed effective April 1, 2008. Providers are now required to submit bilateral surgical procedure code(s) on one claim line/service line for commercial members.

July 2009: Added links to multiple and bilateral procedures lists and information about multiple and bilateral surgical procedures performed in the same operative session.

October 2009: The following changes effective November 15, 2009 have been delayed:
Multiple and Bilateral Surgical Procedures Performed in the Same Operative Session
Effective November 15, 2009, 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 multiple and bilateral procedure code lists will not be effective November 15, 2009.

December 2009: Added links to multiple and bilateral procedures lists and information about multiple and bilateral surgical procedures performed in the same operative session.

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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is not a guarantee of payment nor a final prediction 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 guidelines when applicable, adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Health Plan Medicare Preferred, CareLink[SM] when CIGNA HealthCare is primary administrator or Private Health Care Systems (PHCS) network also known as Multiplan members. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink[SM] members.