Multiple Procedure Payment Policy

Policy Overview

This policy documents Neighborhood Health Plan of Rhode Island's (Neighborhood's) coverage and payment requirements for multiple procedure reductions.

Multiple procedures are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed.

Scope

This policy applies to**:**

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001for additional details.

Reimbursement Guidelines

Multiple Surgical Reductions (MSR) and National Correct Coding Initiative (NCCI) guidelines apply to multiple procedures performed by the same physician or physician group, on the same day.

Apply modifiers that affect payment in the first modifier field, followed by informational modifiers.

Modifier 50 (bilateral procedures)-

- Report bilateral surgical procedures on a single claim line with a unit of 1 and modifier -50
- CPT or HCPCS codes with 'bilateral' or 'unilateral or bilateral' written in the description should not be billed with modifier -50.

Modifier 51 (multiple surgical services)-

- Report surgical procedure with the highest allowed amount without the multiple procedures modifier -51.
- Report additional surgical procedures performed by the surgeon on the same day with modifier-51.

Modifier 59 (significant, separately identifiable service)- The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

CMS has established the following HCPC modifiers to define specific subsets of modifier 59:

- XE Separate Encounter- A service that is distinct because it occurred during a separate encounter
- XP Separate Practitioner- A service that is distinct because it was performed by a different practitioner
- XS Separate Structure- A service that is distinct because it was performed on a separate organ/structure
- XU Unusual Non-Overlapping Service- The use of a service that is distinct because it does not overlap usual components of the main service.

Medicaid and **Commercial** Lines of Business

Ambulatory Surgery Centers (ASC's):

Neighborhood reimburses multiple procedure claims as follows:

- The procedure with the highest allowed amount at 100% of the contracted rate
- The procedures with the second, third, fourth, and fifth highest allowed amounts at 50% of the contracted rate

- The sixth and any additional procedures are considered global and will not be separately reimbursed.

Non-ASC Surgical Services and Radiology Services:
Neighborhood reimburses multiple procedure claims as follows:

- The procedure with the highest allowed amount at 100% of the contracted rate
- The procedure with the second highest allowed amount at 50% of the contracted rate
- The procedures with the third, fourth, and fifth highest allowed amounts at 25% of the contracted rate
- The sixth and any additional procedures are considered global and will not be separately reimbursed

INTERGRITY Line of Business**Ambulatory Surgery Centers (ASC's), Non-ASC Surgical Services, and Radiology Services:**

- Neighborhood reimburses multiple procedure claims according to Medicare reduction rules.

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Adjustments, corrections, and reconsiderations must include the required forms. All submissions must be in compliance with National Claims Standards.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

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