PAYMENT AND REIMBURSEMENT POLICY

Title: PRP-16 Bilateral and Multiple Procedures

Category: Compliance

Effective Date: 03/22/2021

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy does not guarantee benefits. Benefits are determined and/or limited by an individual member benefit coverage document (COC, SPD, etc.). Reimbursement is not solely determined on this policy; Health Plan reserves the right to apply coding edits to all medical claims through coding software and accuracy of claim submission per industry billing standards. Prior approval does not exempt adherence to the following billing requirements. This policy applies to all network and non-network physicians and other qualified health care professionals, including but not limited to, percent of charge contract physicians and other qualified health care professionals.

2.0 Description:

Health Plan applies multiple procedure reductions when two or more procedures are performed during the same operative session. This may include procedures performed bilaterally. These payment adjustments may be referred to as Multiple Surgical Reduction, Multiple Procedure Reduction, Multiple Procedure Payment Adjustment or Bilateral Payment Adjustment throughout Health Plan documents.

3.0 Coding and Billing:

Health Plan follows AMA CPT/HCPCS coding guidelines for appropriate code and modifier selection. Health Plan also follows Center for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File payment policy indicators for bilateral and multiple procedures.

Health Plan requires each provider to submit all procedure codes for services they provide for the same patient, same day/surgical session on the same claim.

A. Bilateral Payment Concept

1. Some coding terminology specifically includes the terms “bilateral,” “unilateral,” or “unilateral or bilateral”.

2. When the code terminology specifically states “bilateral,” the procedure is inherently bilateral and should not be reported with modifier -50 as it is already implied and considered in the RVU for the code.

3. When the code terminology specifically states “unilateral,” but the service was performed bilaterally, validate that there isn’t a code for the service provided bilaterally.

4. If a “bilateral” code is not available for the service, bill two separate lines, once with the modifier -LT and once with the modifier -RT.

5. When the code terminology specifically states “unilateral or bilateral”, it is implied that there is no change in RVU when performed either unilaterally or bilaterally, therefore modifier -50 would not be appropriate.

6. If the code description for a procedure does not include any of these specific terms, it may be appropriate to report the procedure with modifier -50 as single line item or as two separate lines, once with modifier -LT and once with modifier -RT to designate the service as bilateral.

7. When bilateral services are billed with two separate lines with the -LT and -RT modifiers, a multiple procedure code payment adjustment may apply instead of a modifier -50 payment adjustment.

8. Since the addition of modifier -50 may affect payment depending on the procedure code, it is also important to review the bilateral payment indicator. The bilateral payment indicator for each procedure can be found on the Medicare Physician Fee Schedule Relative Value File. This file is updated at minimum on a quarterly basis. Based on the assigned indicator a bilateral payment adjustment may be applicable.

9. If the bilateral payment adjustment is applicable, reimbursement of the service will be at 150% of the allowable for the service had it been performed unilaterally.

    a. For example, if the provider contract is fee schedule based, the allowable contracted fee schedule rate for procedure 27331 is $600. If it is billed bilaterally as 27331-50 with $1200 in charges, the allowable amount for the bilateral procedure would be $900.

       $600*150%=$900

    b. If the provider contract is percent of charge based and the contracted rate for 27331 is 60% of charges, and it is billed bilaterally as 27331-50 with $2000 in charges, the allowable amount for the bilateral procedure would be $900.

       $2000/2=$1000--considered charges for the procedure done unilaterally
       $1000*60% of charges=$600
       $600*150%=$900

    c. In both cases, it is assumed that the provider doubles the charges when the service is performed bilaterally, and the 150% payment adjustment is applied to the unilateral rate for the service.

B. Bilateral Payment Indicators when:.

1. 0 = 150 percent, payment adjustment for bilateral procedures does not apply.

    a. The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

    b. If these procedures are billed with modifier 50, they may be denied as an invalid procedure code/modifier combination.

2. 1 = 150 percent, payment adjustment for bilateral procedures applies.

    a. A code may be billed with the bilateral modifier or reported twice on the same day by any other means (such as with RT and LT modifiers).

    b. When services appropriately reported with modifier 50, the code is considered for reimbursement at 150 percent of the provider's applicable contracted rate.

3. 2 = 150 percent, payment adjustment for bilateral procedure does not apply.

a. RVUs are already based on the procedure being performed as a bilateral procedure. If a procedure is reported with modifier 50, procedure may be denied as an invalid procedure code/modifier combination.

b. If the procedure is reported twice on the same day by another means (such as with RT and LT modifiers), the second line or unit may be denied as the bilateral reimbursement allowance has already been applied to the other line or unit of service.

4. 3 = the usual payment, adjustment for bilateral procedures does not apply.

a. It is appropriate to report modifier 50 with these services however the reimbursement is 100 percent for each procedure.

b. A procedure code with an indicator of 3 will be considered for reimbursement at 200 percent of the provider's applicable contracted rate.

c. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

5. 9 = the status indicator, the concept of applying modifier -50 does not apply.

a. Procedures with an indicator of 9 should not be reported with modifier 50. If these procedures are billed with modifier 50 they may be denied as invalid procedure code/modifier combination.

C. Multiple Procedure Concept.

1. Most medical and surgical procedures include pre-procedure, post-procedure work and the general services integral to the medical surgical service.

2. When multiple services are performed during the same patient encounter by the same group physician and/or another qualified health care professional there is an inherent duplication of these components of service. Therefore, allowing full reimbursement on secondary and subsequent procedures would reflect duplicate payment for the overlapping components of pre-and post-procedure work.

3. In some instances, codes may be billed with on two separate lines using –LT and –RT modifiers to represent a bilateral procedure. Since these are billed on separate lines the multiple procedure concept may be applied instead of a bilateral payment adjustment if applicable.

4. This concept only applies to same provider/group, same patient and for same date of service. This concept is not applied to add-on codes or procedures designated by CPT® as Modifier -51 exempt.

D. Modifier -50.

1. Applied as indication that a bilateral procedure/service was provided when applicable.

E. Modifier -51.

1. Health Plan does not require modifier -51 to be billed.

F. Multiple Procedure Ranking.

1. Health Plan utilizes the CMS Total RVUs to determine the ranking of primary, secondary and subsequent procedures when those services are performed in a facility setting.

2. When procedures are performed in a non-facility place of service, the procedures are ranked by the CMS Non-Facility RVUs.

3. When a procedure does not have an assigned CMS RVU, they default to the secondary or subsequent ranking when reported with other procedures that have an RVU value higher than 0.00 and are subject to the multiple procedure concept.

G. Multiple Procedure Reduction Codes with no assigned CMS RVU.

1. 0.00 RVU Codes: Some codes are not assigned an RVU or assigned an RVU of 0.00 due to the nature of the service (example: unlisted codes). These are ranked as secondary or subsequent procedures when reported with other procedures that are subject to the multiple procedure concept. If multiple procedures with no assigned CMS RVU or an assigned RVU of 0.00 are billed on the same claim, the codes are ranked by charges.

H. Multiple Procedures reported with payment modifiers.

1. When multiple procedures are billed with one or more payment modifiers, the appropriate recalculation occurs as defined by the intent of the modifier(s) applied.

2. For example, if two different procedures are billed that are eligible for the multiple procedure reduction in addition to modifier -50, the first ranked code calculates as 150% of the contracted rate for the service to reflect the Modifier -50 payment adjustment, the second ranked code calculates at 75% of the contracted rate for the service to reflect the MPR and Modifier -50 payment adjustment.

I. Bilateral Reduced Services Modifier -52.

1. On rare occasion a procedure that CPT® defines as “bilateral” may be performed unilaterally. In these instances, modifier -52 must be applied, in the first modifier position, along with, either and -LT or -RT, in the second modifier position, to specify location.

J. Multiple Procedures reported with modifier -78.

1. It may be necessary to indicate that an additional procedure was performed during the postoperative period of the initial procedure. This additional procedure is unplanned but related to the initial procedure and requires a return to the operating room.

2. Procedures reported with a modifier -78 and have a 10 or 90 day global period are not subject to the multiple procedure concept when applied appropriately and supported by documentation.

K. DME billed with –LT and –RT modifiers.

1. The -RT and -LT modifiers must be applied when billing two of the same item or accessory on the same date of service when the intent is for the items to be used bilaterally.

2. Suppliers should bill each item on two separate lines using the -LT and -RT modifiers and corresponding units for each side.

3. Do not use the combination RTLT modifiers on the same claim line with multiple units of service, this may be rejected as incorrect coding.

L. Bilateral procedures billed by an Ambulatory Surgical Center (ASC).

1. While the use of modifier -50 is not prohibited, the modifier is not recognized for payment adjustments and if applied on an ASC claim may result in incorrect payment or denials to ASCs.

2. Please report bilateral procedures performed at and billed by an ASC as two separate lines, once with modifier -LT and once with modifier -RT or a single line with "2" in the unit field.

3. A multiple procedure payment adjustment will apply to all bilateral procedures subject to multiple procedure discounting.

4.0 Documentation Requirements:

The medical record must reflect a complete and accurate summary of the services performed and billed. When submitting for reimbursement of bilateral procedures, the documentation should clearly identify the anatomic location(s). When submitting for reimbursement of procedures billed with other payment modifiers, documentation must support the application of those modifiers as well.

5.0 Verification of Compliance:

Claims are subject to audit, prepayment and post payment, to validate compliance with the terms and conditions of this policy.

6.0 Terms & Definitions:

Add-On Codes. A HCPCS/CPT code that describes a service that, with one exception (99291), is always performed in conjunction with another primary service. An add-on code must be billed with the primary service in order to be eligible for reimbursement.

Bilateral Procedure. A procedure performed at the same session involving both sides of an anatomical site.

Multiple Procedure Payment Adjustment. When a healthcare provider performs multiple procedures during a single patient encounter, the procedures will be ranked according to their Relative Valued Units and reimbursed based on ranking. The primary (highest RVU) will be reimbursed at 100 percent of the contract rate for the procedure/service and the second and all subsequent procedures will be reimbursed at a reduced percentage of the contracted rate for the procedure/service. The percentage adjustment is dependent on the service category. In most cases the payment reduction is 50% for secondary and subsequent procedures/services. This adjustment only applies to same provider/group, same patient and for same date of service. This payment adjustment is not applied to add-on codes or procedures designated by CPT® as Modifier -51 exempt.

Payment Modifier. A modifier that directly affects payment, drives a recalculation of reimbursement for a code, either identifying a situational need for an increase or decrease in reimbursement.

Payment Policy Indicators. Detailed information within the MPFS file regarding global surgery days, multiple surgery indicators, bilateral eligibility, co-surgeon eligibility, applicability of professional and technical components etc.

Unilateral Procedure. Having, or relating to only one side of the body or anatomic site.

7.0 References, Citations & Resources:

1. Current edition of the American Medical Association (AMA) CPT®.
2. CMS Internet-Only Manual, Publication 100-04, Chapter 12, Section 40.6.
3. CMS Internet-Only Manual, Publication 100-04, Chapter 12, Section 40.7.
4. CMS Medicare Physician Fee Schedule (MPFS); https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.
5. http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ASCPayment/index.html.

8.0 Revision History:

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Revision Date	Reason for Revision
11/20	Annual review, no changes, approved by CCSC 3/2/21