Reimbursement is based on member benefits and eligibility, medical necessity review, where applicable, coordination of benefits, adherence to Plan policies, clinical coding criteria, and the BMC HealthNet Plan agreement with the rendering or dispensing provider. Plan policies may be amended at BMC HealthNet Plan’s discretion. All Plan policies are developed in accordance with state, federal and accrediting organization guidelines and requirements, including NCQA.

Origination Date: 10/24/2011

The Plan reimburses covered services based on the provider’s contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-authorization
Please refer to the Plan’s Authorization Requirements Matrix at www.bmchp.org.

Policy Statement

This policy is intended to serve as a general guide for reimbursement. Please refer to the MassHealth Member Handbook, BMC HealthNet Plan Qualified Health Plans, including ConnectorCare, the Commonwealth Care or Commercial Evidence of Coverage (EOC), Schedule of Benefits (SOB) and your provider contract for specific terms of coverage and reimbursement. Unless otherwise specified in writing, reimbursement will be made at the lesser of the billed charges, or the contractual schedule of payments. Use of this policy does not guarantee payment.

Product Applicability

☐ All Plan* Products

Boston Medical Center HealthNet Plan*
☒ MassHealth
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Commonwealth Care
☒ Commonwealth Choice/Employer Choice

Well Sense Health Plan*
☐ New Hampshire Medicaid
☐

Effective Date: 01/01/2012
Revision Effective Date: 02/01/2014
Policy Number: 4.607

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Origination Date: 10/24/2011

BMC HealthNet Plan – Bilateral and Multiple Procedure Reduction
In general, the Plan will apply Multiple Procedure Reductions on procedures in accordance with those methodologies utilized by the Centers for Medicare and Medicaid Services (CMS). The CMS National Physician Fee Schedule Relative Value File (NPFS) and Medicare Physician Fee Schedule Data Base (MPFSDB) are utilized to determine which procedures are subject to the multiple procedures, bilateral, endoscopic, and multiple imaging reduction concepts.

**Bilateral Procedures**
Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

The terminology for some procedure codes includes the terms “bilateral” (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or “unilateral or bilateral” (e.g., code 52290; cystoscopy, with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as “bilateral” or “unilateral or bilateral” since the fee schedule reflects any additional work required for bilateral surgeries. Since an inherently bilateral procedure incorporates both anatomical sites, it would be inappropriate to bill modifiers LT or RT with the procedure. The Plan enforces correct coding and will deny procedures billed with inappropriate modifiers.

Field 22 of the MPFSDB indicates whether the payment adjustment rules apply to a surgical procedure.

If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier 50. Report such procedures as a single line item. Bilateral procedures should be reported with one unit appended to the procedure. Units billed beyond the 1 unit maximum will not be eligible for reimbursement.

If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, physicians do not report the procedure with modifier 50.

**Inappropriate Appending of Modifier 50**
There are many procedure codes for which modifier 50 would not be applicable. As an example, CPT code 41100, biopsy of tongue; anterior two-thirds, would not be classified as a bilateral procedure. Appending modifier 50 to these procedures will result in a denied line.

**Reimbursement for Bilateral Procedures**
If a reimbursable surgical procedure is performed bilaterally in a single operative session, the full maximum fee is either 150% of the payment group rate for the operative procedure or the contracted amount. Reimbursement is based on multiple surgical
reductions. The first side is reimbursed at 100%, while the alternate side is reimbursed at 50%. The reimbursement of inherently bilateral procedures has already taken into consideration the bilateral adjustment for the procedure. All bilateral adjustments are made prior to other multiple procedure reduction rules.

Paravertebral Facet Joint and Transforaminal Injection Procedures
Injections of the same spinal level performed on both sides of the spine will be considered bilateral injections and should be reported with modifier 50 and one (1) unit. It is inappropriate to bill bilateral injections using modifier LT or RT. Additional levels must be reported with the applicable add-on code(s). For example, report 64490-50 for a single level bilateral injection, 64491-50 for a second level bilateral injection, and 64492-50 for the third and any additional levels where a bilateral injection is performed.

Outpatient Facility Multiple Procedures (Effective 2/1/2014)
If more than one reimbursable procedure is performed during the same session the primary procedure will be reimbursed at 100% of the contracted allowable rate and all subsequent reimbursable procedures are reimbursed at 50% of the contracted allowable rate. Time based procedures performed in the operating room or services reimbursed under Payment Amount Per Episode (PAPE) will be excluded from this policy.

Professional Multiple Procedures
If more than one reimbursable procedure is performed during the same session the primary procedure will be reimbursed at 100% of the contracted allowable rate and all subsequent reimbursable procedures are reimbursed at 50% of the contracted allowable rate.

Multiple Endoscopic Procedures
When multiple endoscopies with the same base code are reported, the highest valued endoscopy is paid 100% plus the difference between the allowed amount for each subsequent endoscopy and the base code allowed amount. When multiple endoscopies with the same base code are reported with a non-endoscopic procedure, endoscopic reductions first apply and then standard multiple procedure reductions are applied, considering the endoscopic family as one procedure. If an endoscopic procedure is reported with other codes that are not endoscopies, standard multiple procedure reductions apply.

In the MPFSDB these procedures are identified in the multiple procedure field with an indicator 3 and the base procedure code is located in the endo base field. Examples of procedures with a multiple procedure indicator 3 are colonoscopies, arthroscopies, and cystoscopies.
Multiple Endoscopy Example (Same Group)

Formula
- Code A (Highest) 100% of the Contracted rate
- Code B (Lowest) Contracted rate minus contracted rate Base Code = Allowable Amount

Multiple Radiologic Procedures
Services Effective 6/1/2013: Multiple Radiologic policy applicable to outpatient services reported on UB-04, CMS-1500 or its electronic equivalent.

Services Prior to 6/1/3013: Multiple Radiologic policy applicable to services reported on CMS-1500 or its electronic equivalent.

When two or more eligible imaging procedures are performed on the same patient by the same individual physician or other healthcare provider at the same session, the Plan will reduce the allowed amount for the technical component (TC) and professional component (PC) of the second and each subsequent procedure accordingly: payment for the subsequent procedure(s) will be the lower of (1) the actual charge or (2) the contracted amount for the technical component reduced by 50% and the contracted amount for the professional component reduced by 25%. In the MPFSDB these procedures are identified in the multiple procedure field with an indicator 4. Examples of procedures eligible for multiple radiologic reductions are MRIs, CTs, and select ultrasounds.

Formula
- Code A (Highest) 100% of the Contracted rate
- Code B (Lowest) TC Contracted rate minus 50% = TC Allowable Amount
  PC Contracted rate minus 25% = PC Allowable Amount
  TC Allowable + PC Allowable = Code B Allowable

Service Limitations
N/A

Applicable Coding
Codes may not be all inclusive as the American Medical Association (AMA), Centers for Medicare & Medicaid (CMS), and the American Hospital Associations (AHA) code updates may occur more frequently or at different intervals than policy updates. The codes included in this policy are intended for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.
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Origination Date: 10/24/2011

References

Legal and Regulatory References


Other References


In addition to the above regulations, any bulletin issued to amend or otherwise change the above regulations are herein incorporated as references.

Policy History and Approval Dates

Review Dates/Revisions
10/24/2011 – Initial Approval
10/13/2012 – New multiple radiologic procedure guidelines
03/28/2013 – Updated multiple radiologic procedure guidelines
10/23/2013 – Added outpatient facility multiple procedure reductions
12/05/2013 – Updated template and product applicability section for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare

Approval Dates
Original Effective Date: 01/01/2012
Original Internal Approval: 10/24/2011
Original Regulatory Approval: N/A