Multiple Procedure Payment Reduction

Reimbursement Policy ID: RPC.0033.2400

Recent review date: 10/2023

Next review date: 08/2024

Select Health of South Carolina reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Select Health of South Carolina may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy addresses the provider payment reductions when multiple procedures that are specifically subject to the payment reduction are performed in the same episode of care. This includes surgeries, diagnostic radiology, and therapies performed on the same date.

Exceptions

N/A

Reimbursement Guidelines

Multiple Diagnostic Radiology Procedures

If more than one advanced imaging procedure (e.g., computed tomography, magnetic resonance imaging, ultrasound) is performed by the same provider or provider group for a patient in the same session, then the procedure with the highest payment amount in the South Carolina fee schedule is considered to be the primary procedure. The payment amount for a covered advanced imaging procedure is the lesser of the submitted charge or a percentage of the amount specified in South Carolina fee schedule, determined as stated below:

- A primary procedure is paid at 100%.
- Each additional procedure is paid at 50%.
- The technical component for each additional procedure is paid at 50%.
- The professional component for each additional procedure is paid at 95%.

Multiple Therapy Procedures

If more than one skilled therapy service of the same discipline is rendered by the same non-institutional provider or provider group to a member on the same date, then the service with the highest payment amount in the Select Health of South Carolina fee schedule is considered the primary procedure. Payment for a covered skilled therapy service is the lesser of the provider's submitted charge or a percentage of the amount specified in the fee schedule to be determined in the following manner:

- For the first unit of a primary procedure, it is paid at 100%; or
- For each additional unit or procedure within the same therapy discipline, it is paid at 80%.

NOTE: Services reported on claims must correspond to the services documented in the treatment or maintenance plan.

Multiple surgical procedures performed at the same operative session are separately reportable and billable. When multiple procedures are performed, the major procedure is submitted without a modifier and secondary procedures must be submitted with modifier 51 (unless the secondary codes are “add-on” or “modifier 51 exempt” codes). The procedure code generating the highest reimbursement will be paid at 100 percent of the allowable amount. All other procedure codes will be paid at 50 percent of the allowable amount. Bilateral procedures are those performed on both the right and left side of the body or organ. Physicians should bill bilateral procedures on two lines using modifier 50 on the second line item. The procedure code billed without modifier 50 will be paid at 100 percent of the allowable amount, and the procedure code billed with the modifier will be paid at 50 percent of the allowable.

Physicians

South Carolina DHHS contains some outliers to industry standards.

1. When multiple surgeries are performed at the same operative session, the procedure that reimburses the highest established rate will be considered the primary procedure and will be reimbursed at 100% of the established rate. All second and subsequent surgeries performed at the same operative setting will be reimbursed at 50% of the established rate. Procedure codes that are exempt from multiple surgical procedure reduction as outlined by the AMA in the CPT Standard Edition are reimbursed at 100%. *SC DHHS Physician Manual Page 245*
2. A list of surgical procedure codes and their rates can be found on the SCDHHS website (S and T List). Diagnostic and therapeutic procedures and non-surgical CPT codes, are not reimbursed as surgeries by Medicaid. *SC DHHS Hospital Manual Page 61*

Hospitals

For inpatient hospital, reimbursement for surgery is included in the DRG. For outpatient hospital, surgeries are processed as Reimbursement Type 1, which pays multiple surgical procedures at the highest surgical rate at an all-inclusive rate. For more information, consult the Outpatient Surgical Services — Reimbursement Type 1 section of the SCDHHS Hospital Services Manual: www.scdhhs.gov/provider-type/hospital-services-manual Multiple surgical procedures will be paid at the highest surgical rate. Surgical procedure codes and their rates can be found on the Outpatient Hospital fee schedule, located on the SCDHHS website at: www.scdhhs.gov/resource/fee-schedules. Surgeries covered by Medicaid that are not on the fee schedule will be assigned a

rate by SCDHHS. Diagnostic and therapeutic procedures and non-surgical CPT codes are not reimbursed as surgeries by Medicaid and will be paid at the next appropriate Reimbursement Type.

ASC's
For current ASC rates, please refer to the Ambulatory Surgery Fee Schedule, which is found on the SCDHHS website: www.scdhhs.gov/ resource/fee-schedules. Claims for facility fees will be paid at 100% of the established Medicaid rate for the primary surgical procedure or the charged rate, whichever is lower, and the second surgical procedure will be paid at 50% of the established Medicaid rate (per operative session). Certain codes covered in the ASC are considered medical and will pay at 100% of the allowed rate or the charged rate, whichever is lower.

Dental services in ASC's
When multiple dental services are performed at the same operative session, it is imperative that providers bill for the procedure with the highest payment grouping (primary code group) to be reimbursed at 100%. This primary procedure should not be billed with a modifier. All second and subsequent dental services performed during the same surgical operative session will be reimbursed at 50% of the established rate and must be billed using the U9 modifier.

Definitions

Advanced Diagnostic Imaging (ADI)
Advanced diagnostic procedures include, but are not limited to, magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging procedures, such as positron emission tomography (PET). ADI procedures do not include x-ray, ultrasound, fluoroscopy procedures, or diagnostic and screening mammography.

Episode of Care
An episode of care includes care related to a defined medical event (e.g., a procedure or an acute condition), including the care for the event itself, any precursors to the event (such as diagnostic tests or pre-op visits) and follow-up care (such as medications, rehab, or readmission). Episodes, which are built from the perspective of a patient's journey, offer a comprehensive view of the care involved in treating a condition for a patient.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. South Carolina Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

04/2024	Revised preamble
10/2023	Reimbursement Policy Committee Approval

08/2023	Removal of policy implemented by Select Health of South Carolina from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section