Aetna Better Health® of Louisiana

Reimbursement Policy Statement Louisiana Medicaid

Original Issue Date	Next Annual Review	Effective Date
01-01-2018	08-14-2019	08-14-2018
Policy Name		**Policy Number**
La Policy Multiple Surgery Reduction-Physician (MPR-P)		**ABHLA-RP-0048**

Policy Type			
Medical	**Administrative**	**Pharmacy**	**Reimbursement**

Aetna Better Health of Louisiana implements comprehensive and robust policies to ensure alignment with Louisiana Department of Health (LDH) and to warrant that regulatory standards are met.

Aetna Better Health of Louisiana reimbursement policies are intended to provide a general reference for claims filing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims logic, benefits design and other factors not listed in this policy statement are considered in the development of reimbursement policies.

In addition to this Policy, reimbursement of rendered services are subject to member benefits, eligibility on the date of service, medical necessity, other plan policies and procedures, claim editing logic, provider contracts and all applicable authorization, notification and utilization management guidelines set forth by the Louisiana Department of Health (LDH) and The Centers of Medicare and Medicaid Services (CMS).

This policy does not ensure either an authorization or reimbursement of services. Please refer to the plan contract for the service(s) referenced therein. If there is a conflict between either this policy or the plan contract, then the plan contract will be the controlling document used to make an authorization or payment determination.

CONTENTS OF POLICY

Aetna Better Health® of Louisiana

A. Policy

Payment for two or more surgical services performed by the same physician on same day is limited to 100% of the allowable fee for the highest paying procedure and 50% of the second highest paying and all subsequent procedures. (i.e., 100/50/50) Add-on codes have been excluded from this calculation.

B. Overview

Multiple surgery reduction is the general industry term applied to the practice of paying decreasing pay percentages for multiple surgeries performed during the same surgical session. When more than one surgical procedure is submitted for a patient on the same date of service, the 51 modifier should be appended to the secondary code(s). Certain procedure codes are exempt from this process due to their status as "add-on" or "modifier 51 exempt" codes as defined in CPT.

C. Definitions

Multiple modifiers may be appended to a procedure code when appropriate. Billing multiple surgical procedures and bilateral procedures during the same surgical session should follow Medicaid policy for each type of modifier. Bilateral secondary procedures should be billed with modifiers 50/51 and if appropriate, will be reimbursed at 75% of the Medicaid allowable fee or 75% of the billed charges, whichever is lowest.

D. Reimbursement Guidelines

Claim Check allows the system to add or remove the -51 modifier (Multiple Procedures) from the claim, regardless of whether it was applied to the appropriate procedure(s), and then process the claim accordingly. Providers may see the specific Claim Check edits when the system identifies such cases.

The primary procedure will be paid at 100% of either the Medicaid allowable fee or the billed charge, whichever is lower. All other procedures will be paid at 50% of the Medicaid allowable fee, or 50% of the billed charge, whichever is less.

Modifier 51 does not bypass clinical edits, such as subset denials, redundant denials, or other types of clinical edits.

E. Codes/Condition of Coverage

Modifier -51 should be used for secondary procedures in accordance with CPT guidelines. If a procedure is performed more than once, indicate number in the unit's field.

Modifier -50 should be used for bilateral procedures. Bilateral procedures should be listed on the claim as a single line item, with modifier -50 and two in the unit's field.

F. Frequently Asked Questions

Q: What are the other pricing adjustments affected by the final line item allowance?

A: When multiple procedure fee reductions apply, other pricing adjustments may also apply before the final allowable amount for each line item is determined. For example, bilateral adjustments, assistant surgeon adjustments, co-surgery adjustments, related within global adjustments, etc.

Q: How do you determine the primary procedure code?

A:When multiple procedure fee reductions apply, the procedure code with the highest fee schedule amount is considered the primary procedure, regardless of the order in which the procedure codes are billed on the claim and regardless of which procedure code has the highest billed charges.

G. Review/Revision Date

Action	Date	Comments
Date Issued	01-01-2018	
Date Revised	04-16-2018	
Effective Date	08-14-2018	

H. Resources

Louisiana Department of Health State Contract, regulations, Provider Manual, fee schedules and notices
http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PS/PS.pdf

Individual state Medicaid regulations, manuals & fee schedules
http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services
https://www.ama-assn.org/

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
https://www.cms.gov/