AmeriHealth Caritas Next

A product of AmeriHealth Caritas Florida, Inc.

Multiple Procedure Payment Reduction

Reimbursement Policy ID: RPC.0033.FLEX

Recent review date: 03/2024

Next review date: 03/2026

AmeriHealth Caritas Next reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & 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. AmeriHealth Caritas Next 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 Surgery Procedures

The plan reimburses the lesser of two amounts: the provider's submitted charge or the following multiple procedure payment reduction.

- A primary procedure (i.e., the procedure with the highest maximum amount, designated in the CMS physician fee schedule) is paid at 100%.

- A secondary procedure (i.e., the procedure with the next highest maximum amount) is paid at 50%.
- Any additional procedures are paid at 25%.
- A bilateral procedure is paid at 150%.

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, the procedure with the highest payment amount in the CMS physician 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 CMS physician fee schedule, determined as stated below:

- A primary procedure is paid at 100%.
- Each additional total procedure is paid at 50%.
- The technical component alone of each additional procedure it is paid at 50%.
- The professional component alone of each additional procedure it is paid at 95%.

Multiple Therapy Procedures

If more than one skilled therapy service is rendered by the same non-institutional provider or provider group to a member on the same date, the service with the highest payment amount in the CMS 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 in the fee schedule to be determined in the following manner:

- For the first unit of a primary procedure, it is paid at 100%;
- For each additional unit or procedure within the same therapy discipline, it is paid at 50%.

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

Definitions

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. Centers for Medicare and Medicaid Services (CMS)
III. CMS Physician Fee Schedule
IV. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
V. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/JA6526.pdf
VI. https://med.noridianmedicare.com/web/jeb/specialties/radiology/mppr-certain-diagnostic-imaging-procedures

Attachments

N/A

Associated Policies

N/A

Policy History

04/2024	Revised preamble
03/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas Next from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added