LifeWise
Health Plan of Washington

Payment Policy

cmi_171626

Title	**Multiple Diagnostic Ophthalmology Services Reductions**		
Number	**CP.PP.402.v1.5**		
Last Approval Date	**10/03/24**	**Original Effective Date**	**11/01/16**
Cross Reference	• *Modifiers XE, XS, XP and XU – Separate Encounter, Separate Structure, Separate Practitioner and Unusual Overlapping Service* • *Modifier 51 – Multiple Procedures* • *Modifier 59 - Distinct Procedural Services* • *Modifier TC – Technical Component*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define how the Plan identifies applicable diagnostic ophthalmologic procedures that are subject to multiple procedure reduction and how that reduction is applied when submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Policy	Diagnostic ophthalmologic services, which are subject to a multiple diagnostic ophthalmologic reduction of the technical component, are identified by the Multiple Procedure Flag of **7** on the current CMS National Physician Fee Schedule Relative Value Guide (LINK): **Multiple Procedure Flag 7:** Subject to 20% reduction of the second highest and subsequent procedures to the TC of diagnostic ophthalmology services When two or more diagnostic ophthalmologic procedures are performed on the same patient, by the same physician or other qualified healthcare professional at the same session, these services are subject to the multiple ophthalmologic reduction concept. The following steps will occur to determine allowed amounts: • For a technical component only procedure code submitted with modifier TC, the allowed amount of the second and each subsequent procedure will be reduced by 20% on any diagnostic ophthalmologic procedure that is subject to the multiple ophthalmologic reduction concepts. • For a professional component only procedure code submitted with modifier 26, no reductions will be applied on any diagnostic ophthalmologic procedure that is subject to the multiple ophthalmologic reduction concepts. • For a global submission of a diagnostic ophthalmologic service that is subject to the multiple ophthalmologic reduction concepts, the allowed amount for the code will be separated into its technical and professional components, based on Relative Value Units (RVU) percentages. The technical component of the second and subsequent global codes will be reduced by 20% and then combined back with the professional component to create the reduced global allowed amount.

	<u>Multiple Procedures Rendered During the Same Session</u> When two or more diagnostic ophthalmologic procedures are performed on the **same patient** by the same physician or other qualified healthcare professional at the same session, these services are subject to the multiple ophthalmologic reduction concept. When these services are billed on separate claims, the services billed will be combined onto a single claim during claims processing. These combined services will then be subject to multiple diagnostic ophthalmologic reductions for the technical component of the applicable diagnostic ophthalmologic procedures. **<u>Multiple Procedures Rendered During Multiple "Separate and Distinct" Sessions or Encounters</u>** When multiple diagnostic ophthalmologic procedures which are subject to the multiple diagnostic ophthalmologic reduction are rendered to the same patient, on the same date of service, by the same provider **but** provided at **multiple separate and distinct sessions/encounters** (e.g., services rendered in the morning and then again later in the day), the services will need to be billed on two separate claims. These services rendered during the separate and distinct session/encounter on the same date of service will need to be billed with the appropriate distinct procedural services modifier, "***XE – Separate Encounter**,"* in order to identify the services as separate and distinct sessions/encounters rendered on the same date of service. The use of this modifier indicates that multiple ophthalmologic reductions should not apply. Documentation in the member's medical record/chart should reflect the multiple separate sessions/encounters in order to support the use of modifier XE.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined at the Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	This policy does not apply to any provider reimbursed using an ASC APC payment methodology.
Laws, Regulations & Standards	
References	• American Medical Association's Current Procedural Terminology (AMA/CPT) Codebook • Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	10/03/24; 07/08/24; 09/06/23; 10/13/22; 11/01/21; 11/04/20; 12/04/19; 12/06/18; 03/29/18; 06/13/17; 09/14/16; 06/26/16	
Version History	03/29/18	Annual review; no changes

This policy was published on November 27, 2024

	12/06/18	Correction in the discount taken on the technical portion of allowed amounts of applicable Ophthalmological diagnostic services
	12/04/19	Annual review; no changes
	11/04/20	• Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms. • Added link to the National Physician Fee Schedule Relative Value file. • Added a bullet to the Exceptions section indicating the policy does not apply to ASCs paid on APC payment methodology.
	11/01/21	Annual review; no changes
	10/13/22	Annual review; no changes
	09/06/23	Annual review; no changes
	07/08/24	Annual review; no changes
	10/03/24	Removed the following statement from the Exceptions section: “Claims history for Blue Card Home and Host claims and Federal Employee Program (FEP) claims will not subject to this policy.”

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