Reimbursement Policy

Subject: **Modifiers 50 and 51: Multiple and Bilateral Surgery**	
Policy Number: **G-06010**	Policy Section: **Coding**
Last Approval Date: **08/28/2023**	Effective Date: **01/01/2022**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.healthybluela.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Healthy Blue covered the service for the member's Healthy Louisiana benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Healthy Blue strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Healthy Blue allows reimbursement for multiple and bilateral surgery unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. Reimbursement to both professional and facility providers is based on multiple and bilateral procedure rules in accordance with contracts and/or state guidelines for applicable surgical procedures.

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Multiple surgery
Separate reimbursement is allowed for multiple procedures performed on the same day or same session by the same provider. The following reductions apply.

Professional reimbursement is the total of:
- 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure.
- 50% for the secondary through fifth procedures.
- 50% for the sixth and additional procedures only if determined to be medically necessary through clinical review.

Facility reimbursement is the total of:
- 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure.
- 0% for the secondary and additional procedures.

A single surgery procedure is subject to a multiple procedure reduction when submitted with multiple units. Healthy Blue excludes long-acting reversible contraception (LARC) procedures from the multiple surgical reduction.

Professional provider claims for applicable surgical procedures must be billed with Modifier 51 to denote a multiple procedure. Facility claims should not be billed with Modifier 51.

Bilateral surgery
A bilateral surgery that uses a unilateral code should be reported on a single line with Modifier 50 for professional and facility provider claims. Reimbursement, for professional providers, is 150% of the fee schedule or contracted/negotiated rate of the procedure. Additional reimbursement of bilateral procedures is not allowed when billed by a hospital.

When a surgical procedure code contains the terminology bilateral, or unilateral or bilateral, or the code is considered inherently bilateral, modifiers LT, RT, or 50 should not be appended. Reimbursement is based on 100% of the fee schedule or contracted/negotiated rate for the procedure.

Claims with applicable surgical procedures billed without the correct modifier to denote a multiple or bilateral procedure may be denied. In the instance when more than one bilateral procedure or multiple and bilateral procedures are performed during the same operative session, multiple procedure reductions apply.

Related Coding

Standard correct coding applies

Policy History

08/28/2023	Review approved: updated policy title to include Modifiers 50 and 51 and removed *Professional and Facility Reimbursement*
11/25/2020	Review approved 11/25/2020 and effective 01/01/2022: updated policy language to CMS alignment same day or same session; updated Definition and Reference Material sections

12/21/2018	Review approved: policy template updated
02/23/2018	Review approved 02/23/2018and effective 01/01/2021: same-day language added; same session language removed; multiple units policy language added
09/01/2017	Effective 09/01/2017: policy template updated
10/03/2016	Review approved and effective: unilateral or bilateral language corrected; language for multiple bilateral procedures reimbursement standardized
05/12/2014	Review approved: hospital bilateral procedure reimbursement language added; policy template updated
03/26/2013	Review approved: multiple bilateral procedure reimbursement language updated
11/05/2012	Review approved and effective: multiple bilateral procedure language added; policy template updated
07/16/2012	Review approved and effective: policy template updated
08/16/2010	Review approved and effective: policy adapted from Multiple and Bilateral Surgery Reimbursement - Facility, #07-035, approved 09/10/2007 and Multiple and Bilateral Surgery Reimbursement - professional providers, #06-010, approved 04/19/2006; Modifier use and reimbursement reductions for facility claims clarified; reference material updated to indicate 2010 edition

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Current Procedural Terminology
- National Uniform Billing Committee Guidelines
- Optum EncoderPro 2023
- State contract
- State Medicaid

Definitions

Bilateral	Bilateral procedures are performed on both sides of the body during the same operative session.
Modifier 50	Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding Modifier 50 to the appropriate 5-digit code. Note: This modifier should not be appended to designated add-on codes.
Modifier 51	When multiple procedures, other than E/M services, physician medicine and rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session but the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending Modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to the designated add-on codes.
Modifier LT	Left side (used to identify procedures performed on the left side of the body)
Modifier RT	Right side (used to identify procedures performed on the right side of the body)

Multiple Surgeries	Distinct surgical procedures performed by a provider on the same patient during the same operative session.
Unilateral	Unilateral procedures are procedures performed on one side of the body
General Reimbursement Policy Definitions	

Related Policies and Materials

Modifiers 80, 81, 82, and AS: Assistant at Surgery
Modifiers LT and RT: Left Side/Right Side Procedures
Modifier Usage
Multiple Delivery Services
Multiple Procedure Payment Reduction