	Reimbursement Policy
Subject: Multiple and Bilateral Surgery~~:~~ — Professional and Facility Reimbursement	

Effective Date:	Committee Approval Obtained:	Section:
~~01/01/21~~[XX/XX/XX]	~~12/21/18~~[11/25/20]	**Coding**

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

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Healthy Blue if the service is covered by a 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 CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating 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.

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue strives to minimize these variations.

Healthy Blue reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Healthy Blue allows reimbursement ~~to professional providers and facilities~~ 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 ~~performed on the same day by the same provider to the same patient.~~. **Multiple surgery**

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

performed on the same day or same session by the same provider. The following ~~reimbursements~~reductions apply ~~to professional claims:~~.
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.

~~The following reimbursements apply to facility~~Professional provider claims~~:~~

- ~~100% of the fee schedule or contracted/negotiated rate~~ for ~~the highest valued procedure~~
- ~~0% for the secondary and additional~~applicable surgical procedures

~~Healthy Blue does not apply~~ must be billed with Modifier 51 to denote a multiple procedure ~~reduction reimbursement to Modifier 51-exempt (also known as MS-exempt) or add-on procedure codes since the fee allowance and/or Relative Value is already reduced for the procedure itself~~. Facility claims should not be billed with Modifier 51.

Bilateral surgery

~~Healthy Blue will not allow reimbursement of~~A bilateral ~~procedures when billed by~~surgery that uses a ~~hospital. Professional provider claims with applicable surgical procedures must~~unilateral code should be ~~billed~~reported on a single line with Modifier 50 ~~to denote a bilateral procedure. It is inappropriate to use Modifier LT or RT to identify bilateral procedures.~~, for professional and facility provider claims. Reimbursement is 150% of the fee schedule or contracted/negotiated rate of the procedure.

~~For~~When a surgical procedure ~~codes containing "~~code contains the terminology bilateral~~",~~ or ~~"~~unilateral or bilateral~~" in their description, no modifier~~, or the code is ~~used, and~~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.
History	• Bilateral review approved **11/25/20** and effective [XX/XX/XX]: updated policy language to CMS alignment same day or same session; updated Definition and Reference Material sections • Biennial review approved **12/21/18**: policy template updated • Review approved **02/23/18** and effective **01/01/21**: same-day language added; same session language removed; multiple units policy language added • Effective **09/01/17**: policy template updated • Biennial review approved and effective **10/03/16**: "Unilateral or bilateral" language corrected; language for multiple bilateral procedures reimbursement standardized • Biennial review approved **05/12/14**: hospital bilateral procedure reimbursement language added; policy template updated • Review approved **03/26/13**: multiple bilateral procedure reimbursement language updated • Review approved and effective **11/05/12**: multiple bilateral procedure language added; policy template updated • Biennial review approved and effective **07/16/12**: policy template updated • Review approved and effective **08/16/10**: policy adapted from Multiple and Bilateral Surgery Reimbursement — Facility, #07-035, approved **09/10/07** and Multiple and Bilateral Surgery Reimbursement — professional providers, #06-010, approved **04/19/06**; 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 • State Medicaid • State contracts • National Uniform Billing Committee Guidelines • American Medical Associatin CPT Professional 2020 • Optum360 EncoderPro 2020
Definitions	• **~~Modifier 50~~Bilateral**: Bilateral procedures are performed on ~~identical~~both sides of the body ~~on the same day~~ 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 ~~Evaluation and Management, physical~~than E/M services, physician medicine~~,~~ and rehabilitation services or provision of supplies (e.g., vaccines), are

	performed by at the same physician on session but the same day 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	• Assistant at Surgery (Modifiers 80/81/82/AS) • Modifiers LT and RT: Left Side/Right Side Procedures • Modifier Usage • Multiple Delivery Services • Multiple Procedure Payment Reduction
Related Materials	• None