Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Multiple and Bilateral Surgery — Professional and Facility Reimbursement

Effective Date:	Committee Approval Obtained:	Section:
03/01/20	**11/25/20**	**Coding**

*****The most current version of the 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.amerigroup.com.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup Medicare Advantage may:

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

Amerigroup Medicare Advantage 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage 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	Amerigroup Medicare Advantage allows reimbursement for multiple and bilateral surgical procedures 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. **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 to both professional and facility claims. Reimbursement is the total of: • 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure. • 50% for the secondary through 5th procedures. • 50% for the 6th and additional procedures only if determined to be medically necessary through clinical review. A single surgery procedure is subject to a multiple procedure reduction when submitted with multiple units. 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 is 150% of the fee schedule or contracted/negotiated rate of the procedure. 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.
History	• Biennial review approved 11/25/20: updated policy language to CMS alignment same day or same session; updated definition section, Reference Material • Biennial review approved 12/21/18: policy template updated

	• Review approved 02/23/18 and effective 03/01/20: same day language added; same session language removed; multiple units policy language added • Biennial review approved and effective 10/03/16: Unilateral or bilateral language corrected; endoscopy language removed • Initial review approved and effective 01/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contracts • National Uniform Billing Committee Guidelines • American Medical Association CPT Professional 2020 • Optum 360 EncoderPro 2020
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, physical medicine and rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by 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 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