| Amerigroup An Anthem Company | **Reimbursement Policy** |
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**Subject: Multiple and Bilateral Surgery — Professional and Facility Reimbursement**

| Effective Date: | Committee Approval Obtained: | Section: |
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| **11/25/20** | **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/TX**. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

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 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, Amerigroup may:

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

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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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

Amerigroup 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.

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| **Policy** | Amerigroup allows reimbursement for multiple and bilateral surgery unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement for 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**<br>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 physician and facility claims. Facility reimbursement is the total of:<br>• 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure.<br>• 50% for the secondary through fifth procedures.<br>• 50% for the sixth and additional procedures only if determined to be medically necessary through clinical review.<br><br>Professional reimbursement is the total of:<br>• 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure.<br>• 0% for the secondary and additional procedures.<br><br>A single surgical procedure is subject to multiple procedure reduction guidelines when submitted with multiple units.<br><br>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.<br><br>**Bilateral surgery**<br>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.<br><br>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.<br><br>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. |
| **Exemptions** | • Amerigroup Texas, Inc. and Amerigroup Insurance Company:<br>o Reimburse ambulatory surgical center (ASC) and hospital-based ambulatory center (HASC) facilities for only |

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| | the procedure with the highest surgical code grouping when multiple surgical procedures are performed on the same day.<br>o When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of 1 for each code, for all procedures use modifiers LT and RT as appropriate. |
| **History** | • Biennial review approved and effective 11/25/20: updated policy language to CMS alignment same day or same session; updated Definition and Reference Material sections; Exhibit A removed<br>• Biennial review approved and effective 10/03/16: policy language updated; Exhibit A updated<br>• Biennial review approved 05/12/14: Exhibit A updated<br>• Effective 07/29/13: Exhibit A added<br>• 03/26/13: Disclaimer statement updated<br>• Biennial review approved and effective 07/16/12: policy template updated<br>• 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 fee 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:<br>• CMS<br>• State Medicaid<br>• Amerigroup state contracts<br>• National Uniform Billing Committee Guidelines<br>• American Medical Association CPT Professional 2020<br>• Optum360 EncoderPro 2020 |
| **Definitions** | • **Bilateral:** Bilateral procedures are performed on both sides of the body during the same operative session.<br>• **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.<br>• **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 |

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| | 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.<br>• **Modifier LT**: left side (used to identify procedures performed on the left side of the body)<br>• **Modifier RT**: right side (used to identify procedures performed on the right side of the body)<br>• **Multiple Surgeries**: distinct surgical procedures performed by a provider on the same patient during the same operative session<br>• **Unilateral:** Unilateral procedures are procedures performed on one side of the body.<br>• **General Reimbursement Policy Definitions** |
| **Related Policies** | • Assistant at Surgery (Modifiers 80/81/82/AS)<br>• Modifiers LT and RT: Left Side/Right Side Procedures<br>• Modifier Usage<br>• Multiple Delivery Services<br>• Multiple Procedure Payment Reduction |
| **Related Materials** | • None |