Commercial Reimbursement Policy

Subject: **Modifiers 50 and 51: Multiple and Bilateral Surgery - Professional**	
Policy Number: **C-08004**	Policy Section: **Coding**
Last Approval Date: **10/30/2023**	Effective Date: **10/30/2023**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem member's 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, Anthem 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive 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

Anthem allows reimbursement for multiple and bilateral surgical procedures. Reimbursement is based on Centers for Medicare & Medicaid Services (CMS) standard multiple and bilateral procedure rules unless provider, state, or federal contracts and/or requirements indicate otherwise.

Standard Multiple Surgery Reimbursement:
Separate reimbursement is allowed when multiple procedures are performed during the same operative session by the same provider.

- Reimbursement is 100% of the allowance for the procedure with the highest Relative Value Unit (RVU) or allowance amount.
- Reimbursement is 50% of the allowance for each subsequent procedure eligible for separate reimbursement.

A single surgical procedure is subject to the standard multiple surgery reduction when submitted with multiple units.

When multiple procedures are performed on the same date of service and one line includes a site-specific modifier, the Health Plan requires that all subsequent procedure codes also include a site-specific modifier when applicable.

Bilateral surgical procedure reimbursement:
A bilateral surgery that uses a unilateral code should be reported on a single line with modifier 50, using one (1) unit of service. Reimbursement is 150% of the allowance for the procedure code.

In the below instances, the Health Plan will apply the applicable standard multiple surgical reimbursement or multiple arthroscopic and endoscopic surgical procedure reimbursement guidelines.

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 since the description of the code defines it as a bilateral procedure. Such services should only be reported on one (1) line with one (1) unit.

When a bilateral surgical procedure, that uses a unilateral code, is reported with multiple surgical procedures, the RVU will increase to 150%, and apply the standard or arthroscopic/endoscopic multiple surgical reduction if applicable.

When standard multiple surgery reimbursement is NOT applicable:
- Add-on codes as defined by CPT Appendix D, and HCPCS code G0289
- Modifier 51 exempt codes as defined by CPT Appendix E
- Venipuncture: the Health Plan does not consider it to be a surgical procedure
- When two physicians or other qualified health care providers work separately on each side of the patient.

Multiple arthroscopic and endoscopic surgical procedure reimbursement:
Reimbursement for multiple arthroscopic and endoscopic surgical procedures is determined by the base family as defined by Centers for Medicare & Medicaid Services (CMS). When services provided by the same physician or qualified health care provider, during the same operative session reimbursement guidelines are:
- Within the same base family

    - 100% of the allowance for the procedure with the highest RVU or maximum allowance for the place of service and date of service.
    - Each subsequent procedure reimbursement amount as identified in the Related Coding section below.
- Not within the same base family
    - Subject to the standard multiple surgery reimbursement calculation as outlined above.

Related Coding

Code	Description	Comments
29806 – 29825, 29827 – 29828	Shoulder arthroscopy Base Code 29805	100% primary; 30% subsequent
29834 – 29838	Elbow arthroscopy Base Code 29830	100% primary; 25% subsequent
29843– 29847	Wrist arthroscopy Base Code 29840	100% primary; 25% subsequent
29861 – 29863, 29914 – 29916	Hip arthroscopy Base Code 29860	100% primary; 25% subsequent
29871 – 29887	Knee arthroscopy Base Code 29870	100% primary; 35% subsequent
31623– 31625, 31628 – 31631, 31634 – 31636, 31638, 31640, 31641, 31645, 31647, 31648, 31660, 31661	Bronchoscopy Base Code 31622	100% primary; 25% subsequent
43210, 43233, 43236– 43259, 43266, 43270, 43290, 43291, 43497	Esophagogastroduodenoscopy (EGD) Base Code 43235	100% primary; 25% subsequent
45379– 45393, 45398	Colonoscopy Base Code 45378	100% primary; 25% subsequent
43261 – 43265, 43274 – 43278	Endoscopic Retrograde Cholangiopancreatography (ERCP) Base Code 43260	100% primary; 25% subsequent
G0289	Knee arthroscopy	Multiple surgery reimbursement is not applicable

Policy History

10/30/2023	Review approved: added Base Codes to Related Coding section; updated Reference and Research section; added Modifiers 50 and 51 to policy title

03/08/2023	Revision approved 03/08/2023 and effective 08/01/2023: added 43290 and 43291 Esophagogastroduodenoscopy family in the Related Coding section per CMS change updated 01/01/2023
03/07/2022	Review approved 03/07/2022 and effective 01/01/2023: added CPT 43497 to Related Coding Section in EGD section, base code is 43235 with a reduction of 100% primary and 25% subsequent. Codes 45395 and 45397 from the colonoscopy code span.
03/04/2020	Review approved 03/04/2020 and effective 09/15/2020: updated, and organized policy language, added definitions.
06/01/2019	Policy template updated; added definitions section and related coding table
06/06/2017	Review approved 06/06/2017 and effective 08/01/2017: Added colonoscopy codes 45378-45398; updated policy language to include site specific modifier
01/03/2017	Review approved: deleted codes G6024 and G6025 from endoscopy table; added language to disclaimer for Medicare Advantage Employer groups.
01/05/2016	Revision approved: updated coding effective 01/01/2016
01/06/2015	Revision approved: updated coding effective 01/01/2015
01/07/2014	Revision approved: updated Endoscopy/Arthroscopy 2014 coding effective 01/01/2014
01/08/2013	Review approved: Added new codes to endoscopic table: 31647, 31648, 31660, 31661 (bronchoscopies)
09/11/2012	Review approved: changed policy name to “Multiple and Bilateral Surgery Processing”; updated language for bilateral surgery processing.
05/01/2012	Review approved: updated language to reference “highest RVU for the date of service”; added language for bilateral reimbursement. Removed 29826 from endoscopy table
01/10/2012	Review approved: removed language on claim review for 8 or more surgeries.
06/07/2011	Revision: removed exemptions for New York & Northeast for MSR for codes submitted with mod 26 and 66
01/01/2011	Revision: policy Language Updated
06/03/2010	Review approved: removed codes 31626-31627 from Multiple Endoscopy Section
06/01/2009	Review approved: added 36415 and 36416 to the exception table. Revised multiple surgery processing rules; deleted language on two line bilateral billing.
11/07/2008	Revision: added Endoscopic retrograde cholangiopancreatography (ERCP) to the coding grid.
04/18/2008	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023

Definitions

Bilateral	Bilateral procedures are procedures 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 (see Appendix D).
Modifier 51	Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg. 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 (see Appendix D).
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

Distinct Procedural Services - Modifiers 59, XE, XP, XS, XU - Professional
Modifier Rules - Professional
Scope of License - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.