BlueCross BlueShield of North Carolina MEDICARE

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: **01/01/2021**

**** 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://www.bluecrossnc.com/providers/blue-medicare-providers/healthy-blue-medicare**. ****

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 a member's Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Medicare Advantage benefit plan if the service is covered for Healthy Blue + Medicare℠ (HMO D-SNP). 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, Blue Cross NC Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

https://www.bluecrossnc.com/providers/networks-programs/blue-medicare/healthy-blue-medicare

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Blue Cross NC Medicare Advantage 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

Blue Cross NC Medicare Advantage 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 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 for applicable surgical procedures must be billed with Modifier 51 to denote a multiple procedure. Facility claims should not be billed with Modifier 51. However, the following reductions apply to both physician 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.

Blue Cross NC Medicare Advantage does not apply 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.

A single surgery procedure is subject to a multiple procedure reduction when submitted with multiple units.

Bilateral Surgery

Professional provider and facility claims with applicable surgical procedures must be billed with Modifier 50 to denote a bilateral procedure. It is inappropriate to use Modifier LT or RT to identify bilateral procedures. Reimbursement is 150% of the fee schedule or contracted/negotiated rate of the procedure.

For procedure codes containing *bilateral*, or *unilateral or bilateral* in their description, no modifier is used and 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
01/01/2021	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • 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, 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 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