	Reimbursement Policy	
Subject: Multiple and Bilateral Surgery: Professional and Facility Reimbursement		
Effective Date: **10/03/16**	Committee Approval Obtained: **10/03/16**	Section: **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.amerigroup.com/ia.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Amerigroup Iowa, Inc. 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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.

Policy	Amerigroup 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 at the same session by the same provider.

	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 percent of the fee schedule or contracted/negotiated rate for the highest valued procedure. • 50 percent for the secondary through the fifth procedures. • 50 percent for the sixth and additional procedures only if determined to be medically necessary through clinical review. Amerigroup 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. **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 percent 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 percent 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 and effective **10/03/16**: Policy language updated • Initial review approved **08/04/15** and effective **04/01/16**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contract • National Uniform Billing Committee Guidelines

	• Optum Learning: Understanding Modifiers, 2016 Edition
Definitions	• **Modifier 50:** bilateral procedures performed on identical sides of the body on the same day during the same operative session • **Modifier 51:** multiple procedures, other E&M, physical medicine, and rehabilitation services performed by the same physician on the same day during the same operative session • **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 Procedure Payment Reduction
Related Materials	• None