PCHP Reimbursement Policy		
Topic: Multiple & Bilateral Surgery Modifier Usage – 50 & 51	Policy Number: PCHP.RI.011	Policy Section: Coding
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

For PCHP, reimbursement reductions apply to both physician and facility claims based on the same provider.

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 the designated add-on codes.

Reimbursement	Amount
Professional	100% of contract or fee schedule for highest medical necessary and billed procedure
Professional	50% for second through remaining medically necessary and billed procedure
Facility	100% of contract or fee schedule for highest medical necessary and billed procedure
Facility	0% for the secondary and additional procedures

A single surgical procedure is subject to multiple procedure reduction guidelines 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:

If a bilateral surgery uses a unilateral code, it should be reported on a single line with Modifier 50 for both professional and facility provider claims. Reimbursement is at 150% of the fee schedule or contracted/negotiated rate for the procedure.

When a surgical procedure code explicitly states bilateral, unilateral, or unilateral/bilateral, or is inherently bilateral, modifiers LT, RT, or 50 should not be appended. Reimbursement for these cases is based on 100% of the fee schedule or contracted/negotiated rate for the procedure.

In cases where a bilateral procedure is performed without an appropriate bilateral code available, a unilateral code must be used. The unilateral code should be billed twice with a quantity of one for each code, using modifiers LT and RT as necessary.

Claims for applicable surgical procedures submitted without the correct modifier to indicate a multiple or bilateral procedure may face denial. In cases where multiple bilateral procedures or a combination of multiple and bilateral procedures are performed during the same operative session, multiple procedure reductions apply.

PCHP reserves the right to perform clinical review of billed claims.

References:

This policy has been developed through consideration of the following:

- CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative.

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025