Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-014		
Subject:	Bilateral and Multiple Surgical Procedures		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	July 24, 2023	**Revised Date:**	July 2023
Date Reviewed:	July 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries may not be billed separately and are not separately reimbursed.

REIMBURSEMENT GUIDELINES:

When multiple procedures (Modifier 51) including multiple bilateral procedures are performed during the same operative session by the same physician or associate are reimbursed:

- 100% allowable for highest paying surgical procedure
- 50% allowable for all additional surgical procedures

Reimbursement for Multiple Surgical Services performed as a result of Trauma

This direction is not applicable to New York.

Multiple surgical procedures performed as a result of trauma (i.e., emergency or life-threatening situations) are reimbursed:

- 100% allowable for highest paying surgical procedure
- 75% allowable for the second highest paying procedure
- 50% allowable for all additional surgical procedures

Note: Trauma services are reported with the modifier ST.

- **Medicare Advantage Provision**

When multiple procedures (Modifier 51) are performed during the same operative session by the same physician or associate, reimbursement for the procedures will follow these rules:

- 100% allowable for highest paying surgical procedure
- 50% allowable for the second through the fifth surgical procedures

Subsequent procedures are paid on a "by report" basis. Payment should be made at no less than 50% for each subsequent procedure beyond five. This applies to procedures performed during the same operative session or on the same day by the same physician.

Reimbursement for Bilateral Services

Reimbursement for bilateral services is based on the modifier(s) reported as well as the CMS bilateral indicator found on the Medicare Physician Fee Schedule. The bilateral indicators along with their payment rules are listed below.

- **0** - 150 percent payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or with modifiers RT and LT, Highmark will base payment for the two sides on the lower of: (a) the total actual charge for both sides, or (b) 100 percent of the fee schedule amount for a single code. Codes with this identifier are typically unilateral, and modifier -- 50 is not billable.
- **1** - 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), Highmark will base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.
- **2** - 150 percent payment adjustment for bilateral procedure does not apply. Fees are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), Highmark will base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code. Codes with this identifier are typically identified as bilateral in the code description and modifier -50 is not billable.
- **3** - The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), Highmark will base payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee

schedule amount for each side. Codes with this identifier are typically radiology procedures or other diagnostic tests not subject to bilateral rules.
- **9** - Codes with this identifier do not apply to the bilateral concept. Modifier -50 is not billable.

Note: For commercial claims, the Plan may vary from CMS rules for codes with CMS bilateral indicator 0 or 9 as deemed appropriate.

Exclusions to Multiple Procedure Reduction Rules

- Procedures deemed to be Modifier 51-exempt (See AMA CPT Manual Appendix E)
- Procedures deemed to be add-on procedures (See AMA CPT Manual Appendix D)
- Services submitted with Modifier 78 or Modifier 55

Additional Information

Add-on procedures reported without a primary procedure will be denied as non-billable to the member by a participating, preferred, or network provider.

Bilateral surgeries are procedures performed on both sides of the body at the same operative session or on the same day. Multiple surgical reductions may also apply.

Individual consideration *may* be given to multiple surgical procedures performed by a physician and/or associate when the surgical procedure warrants physicians of different specialties. Medical records are required to be submitted for coverage determination in this situation.

Coverage for multiple surgical procedures is determined by individual or group customer benefits.

Delaware Mandate

Effective January 1, 2000, the Delaware Insurance Department (DOI) adopted Regulation 1311 which sets standards of payment for multiple surgical procedures. The stated purpose of this regulation is to ensure that health insurers provide proper payment to healthcare providers when more than one surgical service is performed on the same patient, by the same physician, on the same day.

This regulation applies to individual and group health benefit policies subject to Delaware law and to those self-insured accounts that elect to follow this Delaware mandate. DOI Regulation 1311 requires when more than one surgical service is performed on the same patient, by the same physician and on the same day, Insurers shall make payment to the providers as follows:

(1) One hundred percent (100%) of the fee schedule for the procedure which has the highest regular fee schedule amount; and

(2) For each additional procedure, performed through the same incision or separate incisions, as set forth in the National Correct Coding Manual established by Administer Federal under contract with the Health Care Financing Administration, not less than fifty percent (50%) of the fee schedule amount.

Reference: CMS Online Manual Pub. 100-04, Chapter 12, Sections 40.6, 40.7

When multiple surgical procedures are reported, reimbursement should be based on the following guidelines:

- 100% of the allowance for the highest valued procedure
- 50% for the second through fifth procedures.

Subsequent procedures are paid on a "by report" basis. Payment should be made at no less than 50% for each subsequent procedure beyond five. This applies to procedures performed during the same operative session or on the same day by the same physician.

Note: The above section titled Delaware Mandate applies to Delaware claims.

DEFINITIONS:

Modifier	Definition
50	Bilateral procedure.
51	Multiple procedures.
55	Postop management only.
78	Unplanned return to the operating/procedure room with same physician or other qualified healthcare professional following initial procedure.
LT	Left side (used to identify procedures performed on the left side of the body).
RT	Right side (used to identify procedures performed on the right side of the body).
ST	Related to trauma or injury.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- CMS Online Manual Pub. 100-04, Chapter 12, Sections 40.6, 40.7

POLICY UPDATE HISTORY INFORMATION:

12 / 2017	Implementation
7 / 2019	Revised reimbursement guidelines to include updated bilateral rules
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy

5 / 2022	Added direction for multiple surgeries involving trauma for Commercial only
6 / 2022	Clarified definition of multiple surgery
7 / 2023	Administrative policy review with no changes in policy direction

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-014		
Subject:	Bilateral and Multiple Surgical Procedures		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	June 27, 2022	**Revised Date:**	June 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

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DEFINITION:

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries may not be billed separately and are not separately reimbursed.

REIMBURSEMENT GUIDELINES:

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Reimbursement for Multiple Surgical Services performed as a result of Trauma

This direction is not applicable to New York.

Multiple surgical procedures performed as a result of trauma (i.e., emergency or life-threatening situations) are reimbursed:

- 100% allowable for highest paying surgical procedure
- 75% allowable for the second highest paying procedure
- 50% allowable for all additional surgical procedures

Note: Trauma services are reported with the modifier ST.

➢ Medicare Advantage Provision

When multiple procedures (Modifier 51) are performed during the same operative session by the same physician or associate, reimbursement for the procedures will follow these rules:

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Subsequent procedures are paid on a "by report" basis. Payment should be made at no less than 50% for each subsequent procedure beyond five. This applies to procedures performed during the same operative session or on the same day by the same physician.

Reimbursement for Bilateral Services

Reimbursement for bilateral services is based on the modifier(s) reported as well as the CMS bilateral indicator found on the Medicare Physician Fee Schedule. The bilateral indicators along with their payment rules are listed below.

- **0** - 150 percent payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or with modifiers RT and LT, Highmark will base payment for the two sides on the lower of: (a) the total actual charge for both sides, or (b) 100 percent of the fee schedule amount for a single code. Codes with this identifier are typically unilateral, and modifier -- 50 is not billable.
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or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. Codes with this identifier are typically radiology procedures or other diagnostic tests not subject to bilateral rules.

- **9** - Codes with this identifier do not apply to the bilateral concept. Modifier -50 is not billable.

Note: For commercial claims, the Plan may vary from CMS rules for codes with CMS bilateral indicator 0 or 9 as deemed appropriate.

Exclusions to Multiple Procedure Reduction Rules

- Procedures deemed to be Modifier 51-exempt (See AMA CPT Manual Appendix E)
- Procedures deemed to be add-on procedures (See AMA CPT Manual Appendix D)
- Services submitted with Modifier 78 or Modifier 55

Additional Information

Add-on procedures reported without a primary procedure will be denied as non-billable to the member by a participating, preferred, or network provider.

Bilateral surgeries are procedures performed on both sides of the body at the same operative session or on the same day. Multiple surgical reductions may also apply.

Individual consideration *may* be given to multiple surgical procedures performed by a physician and/or associate when the surgical procedure warrants physicians of different specialties. Medical records are required to be submitted for coverage determination in this situation.

Coverage for multiple surgical procedures is determined by individual or group customer benefits.

Delaware Mandate

Effective January 1, 2000, the Delaware Insurance Department (DOI) adopted Regulation 1311 which sets standards of payment for multiple surgical procedures. The stated purpose of this regulation is to ensure that health insurers provide proper payment to healthcare providers when more than one surgical service is performed on the same patient, by the same physician, on the same day.

This regulation applies to individual and group health benefit policies subject to Delaware law and to those self-insured accounts that elect to follow this Delaware mandate. DOI Regulation 1311 requires when more than one surgical service is performed on the same patient, by the same physician and on the same day, Insurers shall make payment to the providers as follows:

(1) One hundred percent (100%) of the fee schedule for the procedure which has the highest regular fee schedule amount; and

(2) For each additional procedure, performed through the same incision or separate incisions, as set forth in the National Correct Coding Manual established by Administer Federal under contract with the Health Care Financing Administration, not less than fifty percent (50%) of the fee schedule amount.

Reference: CMS Online Manual Pub. 100-04, Chapter 12, Sections 40.6, 40.7

When multiple surgical procedures are reported, reimbursement should be based on the following guidelines:

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- 50% for the second through fifth procedures.

Subsequent procedures are paid on a "by report" basis. Payment should be made at no less than 50% for each subsequent procedure beyond five. This applies to procedures performed during the same operative session or on the same day by the same physician.

Note: The above section titled Delaware Mandate applies to Delaware claims.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- CMS Online Manual Pub. 100-04, Chapter 12, Sections 40.6, 40.7

POLICY UPDATE HISTORY INFORMATION:

12 / 2017	Implementation
7 / 2019	Revised reimbursement guidelines to include updated bilateral rules
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
5 / 2022	Added direction for multiple surgeries involving trauma for Commercial only
6 / 2022	Clarified definition of multiple surgery

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-014		
Subject:	Bilateral and Multiple Surgical Procedures		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	May 2, 2022	**Revised Date:**	May 2022
Date Reviewed:	March 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

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➢ **Medicare Advantage Provision**

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Exclusions to Multiple Procedure Reduction Rules

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Additional Information

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ADDITIONAL BILLING INFORMATION AND GUIDELINES:

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POLICY UPDATE HISTORY INFORMATION:

12 / 2017	Implementation
7 / 2019	Revised reimbursement guidelines to include updated bilateral rules
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
5 / 2022	Added direction for multiple surgeries involving trauma for Commercial only

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-014		
Subject:	Bilateral and Multiple Surgical Procedures		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
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Note: The above section titled Delaware Mandate applies to Delaware claims.

RELATED HIGHMARK POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- S-100: Multiple Surgical Procedures

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- CMS Online Manual Pub. 100-04, Chapter 12, Sections 40.6, 40.7

POLICY UPDATE HISTORY INFORMATION:

12 / 2017	Implementation
7 / 2019	Revised reimbursement guidelines to include updated bilateral rules
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1 / 2022	Added Delaware Medicare Advantage applicable to the policy

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-014		
Subject:	Bilateral and Multiple Surgical Procedures		
Effective Date:	October 1, 2017	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
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Multiple surgeries are separate procedures performed by the same physician, on the same patient, at the same operative session, or on the same day. Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. Intraoperative services, incidental surgeries, or components of more major surgeries may not be billed separately. Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. Multiple surgical reductions may also apply.

REIMBURSEMENT GUIDELINES:

When multiple procedures (Modifier 51) including multiple bilateral procedures are performed during the same operative session by the same physician or associate are reimbursed:

- 100% allowable for highest paying surgical procedure
- 50% allowable for all additional surgical procedures

➢ **Medicare Advantage Provision**

When multiple procedures (Modifier 51) are performed during the same operative session by the same physician or associate, reimbursement for the procedures will follow these rules:

- 100% allowable for highest paying surgical procedure

- 50% allowable for the second through the fifth surgical procedures

Subsequent procedures are paid on a "by report" basis. Payment should be made at no less than 50% for each subsequent procedure beyond five. This applies to procedures performed during the same operative session or on the same day by the same physician.

Reimbursement for Bilateral Services

Reimbursement for bilateral services is based on the modifier(s) reported as well as the CMS bilateral indicator found on the Medicare Physician Fee Schedule. The bilateral indicators along with their payment rules are listed below.

- **0** - 150 percent payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or with modifiers RT and LT, Highmark will base payment for the two sides on the lower of: (a) the total actual charge for both sides, or (b) 100 percent of the fee schedule amount for a single code. Codes with this identifier are typically unilateral, and modifier -- 50 is not billable.
- **1** - 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), Highmark will base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.
- **2** - 150 percent payment adjustment for bilateral procedure does not apply. Fees are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), Highmark will base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code. Codes with this identifier are typically identified as bilateral in the code description and modifier -50 is not billable.
- **3** - The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), Highmark will base payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. Codes with this identifier are typically radiology procedures or other diagnostic tests not subject to bilateral rules.
- **9** - Codes with this identifier do not apply to the bilateral concept. Modifier -50 is not billable.

Note: For commercial claims, the Plan may vary from CMS rules for codes with CMS bilateral indicator 0 or 9 as deemed appropriate.

Exclusions to Multiple Procedure Rules

- Procedures deemed to be Modifier 51-exempt (See AMA CPT Manual Appendix E)
- Procedures deemed to be add-on procedures (See AMA CPT Manual Appendix D)
- Services submitted with Modifier 78 or Modifier 55

Additional Information

Add-on procedures reported without a primary procedure will be denied as non-billable to the member by a participating, preferred, or network provider.

Bilateral surgeries are procedures performed on both sides of the body at the same operative session or on the same day.

Individual consideration can be given to multiple surgical procedures performed by a physician and/or associate when the surgical procedure warrants physicians of different specialties. Medical records are required to be submitted for coverage determination in this situation.

Coverage for multiple surgical procedures is determined by individual or group customer benefits.

Delaware Mandate

Effective January 1, 2000, the Delaware Insurance Department (DOI) adopted Regulation 1311 which sets standards of payment for multiple surgical procedures. The stated purpose of this regulation is to ensure that health insurers provide proper payment to healthcare providers when more than one surgical service is performed on the same patient, by the same physician, on the same day.

This regulation applies to individual and group health benefit policies subject to Delaware law and to those self-insured accounts that elect to follow this Delaware mandate. DOI Regulation 1311 requires when more than one surgical service is performed on the same patient, by the same physician and on the same day, Insurers shall make payment to the providers as follows:

(1) One hundred percent (100%) of the fee schedule for the procedure which has the highest regular fee schedule amount; and

(2) For each additional procedure, performed through the same incision or separate incisions, as set forth in the National Correct Coding Manual established by Administer Federal under contract with the Health Care Financing Administration, not less than fifty percent (50%) of the fee schedule amount.

Reference: CMS Online Manual Pub. 100-04, Chapter 12, Sections 40.6, 40.7

When multiple surgical procedures are reported, reimbursement should be based on the following guidelines:

- 100% of the allowance for the highest valued procedure
- 50% for the second through fifth procedures.

Subsequent procedures are paid on a “by report” basis. Payment should be made at no less than 50% for each subsequent procedure beyond five. This applies to procedures performed during the same operative session or on the same day by the same physician.

Note: The above section titled Delaware Mandate applies to Delaware claims.

RELATED HIGHMARK POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- S-100: Multiple Surgical Procedures

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- CMS Online Manual Pub. 100-04, Chapter 12, Sections 40.6, 40.7

POLICY UPDATE HISTORY INFORMATION:

12 / 2017	Implementation
7 / 2019	Revised reimbursement guidelines to include updated bilateral rules
11 / 2021	Added NY region applicable to the policy