Reimbursement Policy
Modifier 50 and 51: Multiple and Bilateral Surgery

Policy Number: **G-06010**
Policy Section: **Coding**
Last Approval Date: **12/18/2025**
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Policy

The health plan allows reimbursement for multiple and bilateral surgical procedures unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement for professional and facility providers is based on multiple and bilateral procedure rules in accordance with contracts and/or state guidelines for applicable surgical procedures.

Multiple Surgery

Separate reimbursement is allowed for multiple procedures performed on the same day or same session by the same provider. The following reductions apply to both professional and facility claims.

Reimbursement is the total of:

- 100% of the fee schedule or the contracted/negotiated rate for the highest-valued procedure.
- 50% for the secondary through the fifth procedures.
- 50% for the sixth and additional procedures only if determined to be medically necessary through clinical review.

A single surgical procedure is subject to multiple procedure reduction guidelines when submitted with multiple units.

Modifier 51 is not required for the multiple procedure surgical reduction.

The health plan excludes LARC procedures from the multiple surgical reduction for facilities.

Bilateral Surgery
A bilateral surgery that uses a unilateral code should be reported on a single line with modifier 50, for professional and facility provider claims. Reimbursement is 150% of the fee schedule or contracted/negotiated rate of the procedure.

When a surgical procedure code contains the terminology *bilateral*, *unilateral or bilateral*, or the code is considered inherently bilateral, modifiers LT, RT, or 50 should not be appended. 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 not be eligible for reimbursement. 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.

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:** Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (such as 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.

- **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

- Maximum Units Per Day
- Modifier Usage
- Modifiers 80, 81, 82, and AS: Assistant at Surgery
- Modifiers LT and RT: Left-Side and Right-Side Procedures
- Multiple Delivery Services
- Multiple Procedure Payment Reduction

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- National Uniform Billing Committee Guidelines
- Optum EncoderPro 2025
- State contract
- State Medicaid

Policy History

- **12/18/2025 -** Review approved and effective: no changes
- **08/28/2023 -** Review approved and effective: updated policy title to include Modifiers 50 and 51 and removed *Professional and Facility Reimbursement*
- **07/20/2022 -** Regulatory update: Modifier 51 is not required for multiple procedure reduction
- **11/25/2020 -** Review approved and effective: Updated policy language to CMS alignment same day or same session; updated Definition and Reference Material sections
- **12/21/2018 -** Review approved: Policy template updated

- **02/23/2018 -** Review approved and effective 03/01/2020: Same day language added; same session language removed; multiple units policy language added
- **10/03/2016 -** Review approved and effective: multiple surgery reimbursement standard updated and *unilateral or bilateral* language corrected
- **08/04/2015 -** Initial approval and effective 04/01/2016

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 benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural 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, we may:

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

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.