



Modifier 51 Reimbursement Policy

Policy Number	0050	Annual Approval Date	04/2020	Approved By	Optum Reimbursement and Technology Committee Optum Quality and Improvement Committee
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IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. Optum reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding Optum's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to Client enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This policy applies to all products, all network and non-network rehabilitation providers. This includes non-network authorized, and percent of charge contract providers.

Fee schedule/provider contract/client contract may supersede

Policy

Overview

This policy describes Optum requirements for the reimbursement of CPT codes appended by modifier -51.

Reimbursement Guidelines

Modifier -51: Multiple Procedures

Description: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provisions of supplies are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier -51.
Note: This modifier should not be appended to designated "add-on" and "exempt" codes.

Guidelines: Additional procedures should be appended with modifier -51, as long as they are not considered incidental or bundled. These services are subject to multiple procedure fee reduction to reflect their secondary nature. Eligible Procedures or services appended with modifier -51 are reimbursed at 50% of the allowable payment schedule.



Background Information

A modifier provides the means by which the reporting health care practitioner can indicate that a CPT descriptor code (service or procedure), which has been performed, has been altered by a specific circumstance or in some way *without changing the definition of the CPT code*. Modifiers increase the specificity of certain CPT codes.

CPT code modifiers are comprised of two digits, either numeric (Level I; AMA) or alphabetic (Level II; CMS), and are listed after a procedural code by a hyphen.

Modifiers have two different applications: (1) to identify circumstances that significantly alter a service or procedures where reimbursement will be affected; and (2) for informational purposes without impact on reimbursement. For the purposes of this policy, the applications of select Level I (AMA) and Level II (CMS) modifiers have been assessed for their impact on reimbursement determinations.

CPT coding modifiers are used to communicate that something is *atypical* about a particular claim. Circumstances where the use of a modifier include, if the service: (a) has been increased or decreased; (b) has both a professional and technical component; (c) only part of the service was performed; (d) an independent or adjunctive procedure was performed; (e) if unusual events occurred; and (f) is expected to be denied as not appropriate and/or necessary.

Resources

- American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
- Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services

History / Updates

10/11/2007	New
10/2008	Annual review and update
02/2009	Annual review and update
04/2010	Annual review and update
04/2011	Annual review and update
04/2012	Annual review and update
02/2013	Annual review and update of the <i>Description</i> of modifier -51
04/2014	Annual review and update
04/2015	Annual review and update
04/2016	Annual review and update
04/2017	Annual review and update
04/2018	Annual review and update
04/2019	Annual review and update
0/2020	Annual review and update

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