

Bilateral Procedures Policy, Facility

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. UnitedHealthcare Value & Balance Exchange 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.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Value & Balance Exchange’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Value & Balance Exchange 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 UnitedHealthcare Value & Balance Exchange 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 physician or other provider contracts, the enrollee’s benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Value & Balance Exchange due to programming or other constraints; however, UnitedHealthcare Value & Balance Exchange strives to minimize these variations.

UnitedHealthcare Value & Balance Exchange 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 reimbursement policy applies to UnitedHealthcare Value & Balance Exchange products.

This reimbursement policy applies to services reported using the UB-04 claim form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network outpatient hospital claims, including, but not limited to, non-network authorized, and percent of charge contract facilities.

Policy

Overview

Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes describe unilateral procedures that can be performed on both sides of the body during the same session by the Same Facility. CPT or HCPCS codes with bilateral in their intent or with bilateral written in their description should not be reported with the bilateral modifier 50, or modifiers LT and RT, because the code is inclusive of the Bilateral Procedure.

For the purpose of this policy, the Same Facility is the same facility rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

Bilateral Eligible Codes

The UnitedHealthcare Value & Balance Exchange Bilateral Procedures Facility Policy is developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File

status indicators. All codes in the NPFS with a "bilateral" indicator of "1" or "3" are considered by UnitedHealthcare Value & Balance Exchange to be eligible for bilateral services as indicated by the bilateral modifier 50.

UnitedHealthcare Value & Balance Exchange will apply CMS's payment adjustment methodology to bilateral eligible procedures with a bilateral indicator of "1" regardless of the Multiple Procedure Indicator when the procedure code is reported bilaterally with a modifier 50 or on separate lines with modifiers LT and RT for the same structure. The procedure code will be eligible for reimbursement at 150% of the allowable amount for a single procedure code, not to exceed billed charges, with one side reimbursed at 100% and the other side reimbursed at 50% of the allowable amount. When other reducible procedure codes are reported on the same date of service, an additional multiple procedure/imaging reduction may or may not be applied to the line paid at 100% depending on whether another procedure code is ranked as primary or not.

When a bilateral eligible code with a bilateral indicator of "3" is reported with modifier 50, the code will be eligible for reimbursement at 100% of the allowable amount for each side for a sum of 200% of the allowable amount not to exceed billed charges.

[CMS Files for Download](#)

Bilateral Modifier (50)

Bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate CPT or HCPCS code. The procedure should be billed on one line with modifier 50 and one unit with the full charge for both procedures.

CPT or HCPCS codes with 'bilateral' or 'unilateral or bilateral' written in the description will not be reimbursed with modifier 50.

There are rare instances in which a bilateral service may be performed on multiple sites and not just bilaterally. In those instances, use appropriate modifier to report the additional units beyond the bilateral services performed indicating that the services were performed on a different site or organ system. Medical record documentation must support the use of modifier appended.

Procedure Codes with the Term "bilateral" in the Description

When CPT or HCPCS codes with "bilateral" or "unilateral or bilateral" written in the description are reported, special consideration will be given when reported with modifiers LT or RT.

When a CPT or HCPCS procedure code exists for both a unilateral and a Bilateral Procedure, select the code that best represents the procedure.

Consistent with CPT guidelines, if a unilateral procedure has not been defined by CPT or HCPCS and only a bilateral description of a procedure exists, report the code with "bilateral" in the description with modifier 52 when the procedure is performed unilaterally.




When a procedure with "unilateral or bilateral" written in the description is performed unilaterally, then the CPT or HCPCS procedure code need not be reported with modifier 52 since the procedure description already indicates that the service can be performed either unilaterally or bilaterally.

The use of modifiers LT or RT will be recognized as informational only when the procedure with "unilateral or bilateral" in the description is performed on only one side. Consistent with CMS guidelines, when both modifiers LT and RT are reported separately on the same day by the Facility, only one charge will be eligible for reimbursement.

Definitions

Same Facility	The same Facility rendering health care services reporting the same Federal Tax Identification number.
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Questions and Answers	
1	<p>Q: If a code has the term 'bilateral' in its definition, can it be reported with modifier 50?</p> <p>A: No. For example, the CPT code 40843 includes the term 'bilateral' and is inherently a bilateral procedure. To report unilateral performance of this procedure, use the appropriate unilateral CPT code 40842.</p>
2	<p>Q: If a code has the term 'bilateral' in its definition, yet the procedure was only performed on one side, how should this be reported?</p> <p>A: If a code exists for the comparable unilateral procedure, report the appropriate unilateral code. If a code does not exist for the comparable unilateral procedure, report the bilateral code with modifier 52 appended. In this instance, modifiers LT or RT may be reported in another modifier position on the same claim line to describe which side the reduced procedure was performed on.</p>
3	<p>Q: What is the most appropriate way for a facility to report to UnitedHealthcare Value & Balance Exchange for hand or foot codes that are bilateral eligible procedure codes, but the same procedure is performed bilaterally on only one digit of each hand or foot?</p> <p>A: If the same procedure is performed on the same digit on each hand or foot, report the procedure with modifier 50. If the same procedure is performed on a different digit or multiple digits of each hand or foot, report the procedure with the appropriate digit modifiers (e.g. FA or F1-9 [fingers], TA or T1-9 [toes]).</p>

Attachments	
 Bilateral Eligible Procedures Policy List	Identifies those codes that UnitedHealthcare Value & Balance Exchange will allow for Bilateral Procedures
 Codes with “Bilateral” in the Description Policy List	This is a list of codes with the term "bilateral" in the code description that would not allow modifier 50 or modifiers LT <u>and</u> RT to be reported for the same date of service.
 Codes with “Unilateral” or “Bilateral” in the Description Policy List	This is a list of codes with the terms "unilateral or bilateral" in the code description that would not allow modifier 50 or modifiers LT <u>and</u> RT to be reported for the same date of service.

Resources
American Medical Association, <i>Current Procedural Terminology (CPT®)</i> and associated publications and services
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History	
1/1/2021	Policy implemented by UnitedHealthcare Value & Balance Exchange