Bilateral Procedures Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 Medicare Advantage reimbursement policies 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 (CMS 1450). 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 resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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, 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 UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

The UnitedHealthcare Medicare Advantage policy is developed based on the CMS National Physician Fee Schedule (NPFS) Relative Value File status indicators. Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

The terminology for some procedures in the Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) will include the term “bilateral” or “unilateral or bilateral”. For these procedures the Bilateral Procedure payment adjustment rule will not apply. For procedures that do not have the term “bilateral” or “unilateral or bilateral”, a modifier 50 should be billed.

For the purpose of this policy, the Same Individual Physician or Other Qualified Health Care Professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

If a procedure can be billed bilaterally, the provider should bill the service with a modifier 50. If the procedure is identified by the terminology as bilateral or unilateral, the 50 modifier should not be reported. When the modifier 50 is billed and the status indicator is a “1” or “3”, one service unit should be billed. Modifiers LT (left side) and RT (right side) should not be reported when the 50 modifier applies. The payment adjustment for services billed with the bilateral modifier (50) will be based on the “bilateral” status indicator in the NPFS. There are four “bilateral” service status used on the NPFS.

When the bilateral indicator of “0” is reported, a 150% payment bilateral adjustment does not apply. The bilateral adjustment is not appropriate because of physiology or anatomy or because the code descriptor specifically states it is a unilateral procedure and there is an existing code for the Bilateral Procedure.

When the bilateral indicator of "1" is reported, a 150% payment adjustment for Bilateral Procedures will apply. If the procedure is billed with the bilateral modifier or is reported twice on the same day by any other means, (e.g., with modifier RT/LT or with 2 in the units field.) the payment will be based on the lower of the total actual charge for both sides or 150% of the fee schedule amount for a single code.

When the bilateral indicator of "2" is reported, a 150% payment adjustment does not apply. The RVUs are already based on the procedure being performed as bilateral. The code descriptor specifically states the procedure is bilateral, the procedure is usually performed as a Bilateral Procedure, or the code descriptor specifically states the procedure is performed either unilaterally or bilaterally. If the procedure is billed with the bilateral modifier or is reported twice on the same day by any other means, (e.g., with modifier RT/LT or with 2 in the units field.) the payment will be based on the lower of the total actual charge for both sides or 100% of the fee schedule amount for a single code.

When a bilateral indicator of "3" is reported the usual payment adjustment for Bilateral Procedures does not apply. If the procedure is billed with the bilateral modifier or is reported twice on the same day by any other means, (e.g., with modifier RT/LT or with 2 in the units field.) the payment will be based on the lower of the actual charge for each side or 100% of the fee schedule amount for each side.

When a bilateral indicator of "9" is reported the bilateral concept does not apply.

Multiple Surgeries
If bilateral surgeries are billed with other procedures, consider the Bilateral Procedures with a payment amount of 150% for both sides or 100% of the fee schedule for each side (based on the status indicator 1 or 3) as one payment amount, and rank this with the remaining procedures. The appropriate multiple surgery reduction should be applied.

Definitions

Bilateral Procedures	The same procedure performed on both sides of the body during the same session.
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.

Questions and Answers

1	**Q:** If a code has the term 'bilateral' in its definition, can it be reported with modifier 50?

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	A: No. For example, the CPT code 40843, *Vestibuloplasty; posterior, bilateral* includes the term 'bilateral' and is inherently a Bilateral Procedure. To report unilateral performance of this procedure, use the appropriate unilateral CPT code 40842.
2	**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? **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.
3	**Q:** What is the most appropriate way for a physician or other health care professional to bill UnitedHealthcare Medicare Advantage for a Bilateral Procedure? **A:** The procedure should be billed on one line with a modifier 50 and one unit with the full charge for both procedures.
4	**Q:** Should modifier 50 be used for bilateral services billed by the Ambulatory Surgery Center (CMS Specialty 49)? **A**: Per the CMS Manual and National Correct Coding Initiative (NCCI) rules the Ambulatory Surgical Center (ASC), is excluded from the bilateral modifier requirement and should be billed on two lines with an LT/RT modifier.

Codes

Code Section

National Physician Fee Schedule Relative Value Files

HCPCS Release & Code Sets

Modifier code section

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.
59	**Distinct Procedural Service** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-evaluation and management services (non-E/M) performed on the same day. Modifier 59 is used to identify procedures/services, other than Evaluation and Management (E/M) services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
LT	Left Side
RT	Right Side

Resources

www.cms.gov

CMS Claims Processing Manual

MLN Matters Articles SE1422, ICN 901344

CMS NPFS

HCPCS Release & Code Sets

History	
6/7/2019	Annual Anniversary Date and Version Change • Policy template updated • History Section: Entries prior to 6/1/2017 archived • Resources sections: Removed reference to CMS Transmittal 1777 • Archived entries prior to 6/7/2017
8/31/2018	Policy Version Change Policy number changed from 2018R0023A to 2018R9009A Added the word ‘Professional’ to the policy title
7/11/2018	Annual Review (Version Change) History Section: Entries prior to 10/14/2015 archived
7/12/2017	Annual Review (No new version)
10/22/2014	New Policy

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