

## Bilateral Procedures Policy, Professional for Louisiana

### **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 Community Plan reimbursement policies uses Current Procedural Terminology (CPT<sup>®</sup>), 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 Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.

**Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, 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 Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan 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 Community Plan Medicaid products.**

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

Current Procedural Terminology (CPT<sup>®</sup>) and Healthcare Common Procedure Coding System (HCPCS) codes on the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List describe unilateral procedures that can be performed on both sides of the body during the same session by the Same Individual Physician or Other Qualified Health Care Professional. 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 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

#### Bilateral Eligible List

The UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List 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 Community Plan to be eligible for bilateral services as indicated by the bilateral modifier 50.

UnitedHealthcare Community Plan 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 and is not subject to reductions under either the Multiple Procedure or Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Policies, 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.

For more information regarding the reduction of bilateral procedures, refer to the UnitedHealthcare Multiple Procedure and Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Policies.

[UnitedHealthcare Community Plan Bilateral Eligible Procedures List](#)

[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. A procedure code submitted with modifier 50 is a reimbursable service as set forth in this policy only when it is listed on the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List.

When a CPT or HCPCS code is reported with modifier 50 and the code is not listed on the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List, the code will not be reimbursed.

CPT or HCPCS codes with 'bilateral' or 'unilateral or bilateral' written in the description are not on UnitedHealthcare Community Plan's Bilateral Eligible Procedures Policy List and 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 modifier 59 *Distinct Procedural Service* or *XS Separate Structure* 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 59 or XS.

#### **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. For example:

40842 Vestibuloplasty; posterior, unilateral

40843 Vestibuloplasty; posterior, bilateral

[UnitedHealthcare Community Plan Codes with "bilateral" in the Description Policy List](#)

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 (reduced services) when the procedure is performed unilaterally. For more information on reimbursement for reduced services, see UnitedHealthcare's Reduced Services Policy.

For UnitedHealthcare Community Plan purposes, when both modifiers LT and RT are reported separately for codes with "bilateral" in the description, only one charge will be eligible for reimbursement up to the respective Maximum Frequency Per Day (MFD) value as the procedure is inherently bilateral. For additional information, refer to the Questions and Answers section, Q&A #3. For more information on maximum frequency per day values, see UnitedHealthcare's Maximum Frequency Per Day Policy.

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. For example:

31231 Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

[UnitedHealthcare Community Plan Codes with "unilateral" or "bilateral" in the Description Policy List](#)

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 Same Individual Physician or Other Qualified Health Care Professional, only one charge will be eligible for reimbursement up to the maximum frequency per day limit.

For maximum frequency per day limits, see UnitedHealthcare's Maximum Frequency Per Day Policy.

#### Modifier Definitions

Modifier	Modifier Description
50	<b>Bilateral Procedure</b> 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	<b>Distinct Procedural Service</b> Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than 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.
XS	Separate Structure. A service that is distinct because it was performed on a separate organ/structure.
LT	Left Side
RT	Right Side




#### Definitions

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

Questions and Answers	
<b>1</b>	<p><b>Q:</b> How should CPT or HCPCS codes such as 11400 (excision of benign lesion) be billed when they are performed on both sides of the body and are not CMS bilateral eligible?</p> <p><b>A:</b> An excision of a lesion is not truly bilateral. It should be billed with units, rather than the bilateral modifier.</p>
<b>2</b>	<p><b>Q:</b> If a code has the term 'bilateral' in its definition, can it be reported with modifier 50?</p> <p><b>A:</b> No. For example, the CPT code 40843, <i>Vestibuloplasty; posterior, bilateral</i> includes the term 'bilateral' and is inherently a bilateral procedure. This code does not appear on UnitedHealthcare Community Plan's Bilateral Eligible Procedures Policy List and may not be reported with modifier 50. To report unilateral performance of this procedure, use the appropriate unilateral CPT code 40842.</p>
<b>3</b>	<p><b>Q:</b> 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><b>A:</b> 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>
<b>4</b>	<p><b>Q:</b> Does one individual CPT or HCPCS code ever have more than one NPFS bilateral status indicator designation?</p> <p><b>A:</b> Yes, on occasion a code may have a global, professional, and technical component. The NPFS bilateral status indicator may vary between the components. When this occurs and one of the status indicators is bilateral eligible (e.g. NPFS bilateral indicator "1" or "3") and another is not bilateral eligible (e.g. NPFS bilateral indicator "0", "2" or "9"), the code is added to the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List.</p>
<b>5</b>	<p><b>Q:</b> What is the most appropriate way for a physician or other health care professional to bill UnitedHealthcare Community Plan for a Bilateral Procedure?</p> <p><b>A:</b> The procedure should be billed on one line with a modifier 50 and one unit with the full charge for both procedures.</p>
<b>6</b>	<p><b>Q:</b> What is the most appropriate way for a physician or other health care professional to report to UnitedHealthcare Community Plan for hand or foot codes that are on the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List, but the same procedure is performed bilaterally on only one digit of each hand or foot?</p> <p><b>A:</b> 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>
<b>7</b>	<p><b>Q:</b> What is the most appropriate way for a physician or other health care professional to report to UnitedHealthcare Community Plan for bilateral eligible spinal codes such as code 63035, <i>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)</i>, if the procedure is performed on multiple levels of the same spinal region?</p> <p><b>A:</b> If the laminotomy is performed bilaterally, report code 63020 or 63030 with modifier 50 for the first interspace. If a laminotomy of a second interspace is performed bilaterally, use add-on codes to represent additional levels rather than sides. In this instance, report code 63035 with modifier 50. If a laminotomy of additional interspaces (3 or more) is performed bilaterally, report code 63035 with modifiers 50, 59 or XS with the appropriate number of units.</p>
<b>8</b>	<p><b>Q:</b> Does UnitedHealthcare Community Plan accept modifier 50 on all codes where the CPT book indicates coding guidelines to report modifier 50 when performing the procedure bilaterally?</p>

	<p><b>A:</b> No. UnitedHealthcare Community Plan follows the CMS NPFS Bilateral Procedures payment indicators "1" or "3" to determine which codes are eligible for bilateral services. For example, CPT code <b>69210</b> <i>Removal impacted cerumen requiring instrumentation, unilateral</i> (even though the CPT book indicates to bill with modifier 50 if done bilaterally) would not be reimbursable if billed with a modifier 50 since the CMS NPFS payment indicator is "2", not "1" or "3".</p>
<b>9</b>	<p><b>Q:</b> Does UnitedHealthcare Community Plan apply a reduction to Bilateral Procedures with a payment indicator of "1" if the Multiple Procedure Reduction indicator is "0"?</p> <p><b>A:</b> Yes. UnitedHealthcare Community Plan applies a reduction to all Bilateral Procedures with a payment indicator of "1" when billed with a modifier 50 or on separate lines with modifiers LT and RT regardless of the Multiple Procedure Reduction indicator.</p>

**Attachments**

  <b>UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List</b>	Identifies those codes that UnitedHealthcare Community Plan will allow for Bilateral Procedures.
  <b>UnitedHealthcare Community Plan Codes with "bilateral" in the Description Policy List</b>	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.
  <b>UnitedHealthcare Community Plan Codes with "unilateral" or "bilateral" in the Description Policy List</b>	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**

Individual state Medicaid regulations, manuals & fee schedules
American Medical Association, <i>Current Procedural Terminology (CPT®)</i> and associated publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

**History**

<b>2/15/2021</b>	Removed reference to other state exceptions
<b>6/30/2019</b>	Policy Version Change Title section: Removed Annual Approval information & moved policy # to the header Policy List Change: Bilateral Eligible Procedures Policy List, Codes with "unilateral or bilateral" in the Description Policy List, and Codes with "bilateral" in the Description Policy Lists Updated

<b>1/1/2019</b>	Policy Version Change Bilateral Eligible Procedures Policy List, Codes with “unilateral or bilateral” in the Description Policy List, and Codes with “bilateral” in the Description Policy Lists Updated. History Section: Entries prior to 1/1/2017 archived
<b>9/30/2018</b>	Policy Version Change Added “Professional” to the title Policy List Change: Bilateral Eligible Procedures Policy List
<b>7/11/2018</b>	Policy Approval Date Change (No new version)
<b>7/1/2018</b>	Policy List Change: Codes with “unilateral or bilateral” in the Description Policy List
<b>1/1/2018</b>	Annual Policy Version Change Policy List Change: Bilateral Eligible Procedures Policy List, Codes with “unilateral or bilateral” in the Description Policy List, and Codes with “bilateral” in the Description Policy Lists Updated Application section: Removed Community and State and Medicare and Retirement information History Section: Entries prior to 1/1/2016 archived.
<b>10/1/2017</b>	Policy List Change: Bilateral Eligible Procedures Policy List
<b>7/12/2017</b>	Policy Approval Date Change (No new version)
<b>7/2/2017</b>	Application Section: Removed UnitedHealthcare Community Plan Medicare products as applying to this policy. Added location for UnitedHealthcare Community Plan Medicare reimbursement policies.
<b>4/2/2017</b>	Policy List Change: Bilateral Eligible Procedures Policy List
<b>2/12/2017</b>	Policy List Change: Bilateral Eligible Procedures Policy List State Exceptions: Added Missouri
<b>1/1/2017</b>	Annual Policy Version Change Policy List Change: Bilateral Eligible Procedures Policy List, Codes with “unilateral or bilateral” in the Description Policy List, and Codes with “bilateral” in the Description Policy Lists Updated. History Section: Entries prior to 1/1/2015 archived.
<b>1/6/2006</b>	Implemented by UnitedHealthcare Community & State