UnitedHealthcare®

Reimbursement Policy

Bilateral Procedures

Policy Number	BIL10222014	**Approved By**	UnitedHealthcare Medicare Reimbursement Policy Committee	**Current Approval Date**	10/22/2014

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 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 reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare 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 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 due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare 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 services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the

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provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. CPT codes and descriptions are copyright 2010 American Medical Association (or such other date of publication of CPT). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to Government use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors, and other data contained therein, is copyright by the American Dental Association, 2002, 2004. All rights reserved. CDT is a registered trademark of the American Dental Association. Applicable FARS/DFARS apply.

Summary

Overview

The UnitedHealthcare Medicare and Retirement policy is developed based on the Centers for Medicare and Medicaid Services (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 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 "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 the appropriate bilateral adjusted payment amount as one payment amount (status indicator 1 and 3), and rank this with the remaining procedures. The appropriate multiple surgery reduction should be applied.

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Modifiers

Code	Description
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-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.)
LT	Left Side
RT	Right Side

Questions and Answers

1	**Q:**	If a code has the term 'bilateral' in its definition, can it be reported with modifier 50?
	A:	No. For example, the CPT code 40843, *Vestibuloplasty; posterior, bilateral* 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.
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 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.

References Included (but not limited to):

CMS Claims Processing Manual

Chapter 12; § 40 Physicians/Nonphysician Practitioners

Chapter 23 Fee Schedule Administration and Coding Requirements

CMS Transmittals

Transmittal 1777, Change Request 6526, Dated 07/24/2009 (Payment of Bilateral Procedures in a Method II Critical Access Hospital (CAH))

Others

How to Use the Searchable Medicare Physician Fee Schedule (MPFS), CMS Website

History

Date	Revisions
10/22/2014	New Policy

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