n05738

Bilateral Procedures

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

This reimbursement policy outlines Network Health's process, for all lines of business, when claims are submitted for bilateral procedures.

Policy Detail:

Network Health (NH) follows the bilateral rule status indicators as determined by the Centers for Medicare and Medicaid Services (CMS) on the National Physician Fee Schedule (NPFS) Relative Value File. Codes with the bilateral status indicator of "1" are considered eligible bilateral services when submitted with a bilateral procedure modifier.

I. Bilateral Procedure:

A. When a procedure is performed on both sides of the body during the same operative session, the surgical procedure is considered bilateral.

B. CPT or HCPCS codes with bilateral in their intent, or with bilateral written in their description should not be reported as bilateral because the code is inclusive of the bilateral procedure.

1. The modifier(s) for the left (LT) side or the right (RT) side may be appended when the procedure is *valid* for a bilateral procedure, however the procedure was only performed on one side.

C. Network Health follows our Claims Editing System (CES), and the Healthcare Common Procedure Coding System (HCPCS) modifiers indicating the left side, or the right side may individually accumulate towards the maximum frequency per day (MFD) values independently of each other.

D. When the code description in the Current Procedural Terminology (CPT) book does not identify the procedure as bilateral or unilateral, the procedure should be reported with the appropriate bilateral procedure modifier.

II. Claim Submissions:

Network Health will accept the following billing scenarios:

A. Modifier 50:

1. The Provider may bill a single line of service on a professional or facility claim with one (1) unit for claim processing.

B. Modifier LT/RT:

1. The Provider may bill two (2) lines of service on a professional or facility claim with one (1) unit per service line for claim processing.

    a. Example: Line 1 - Procedure Code XXXXX-LT 1 unit
    Line 2 - Procedure Code XXXXX-RT 1 unit

2. The Provider may not bill a single line of service with an LT modifier or an RT modifier with a quantity of two (2).

III. **Reimbursement**:

A. Claims submitted for bilateral services will be reimbursed based on the provider(s) billing preference.

B. When the procedure is submitted on a single line of service with one (1) unit, reimbursement will be at one hundred and fifty percent (150%) of the allowed amount.

C. When services are for a Commercial member, and the procedure is submitted on two (2) lines of service, reimbursement will be at one hundred percent (100%) of the allowed amount for one side, and fifty percent (50%) of the allowed amount for the subsequent side.

D. When services are for a Medicare Advantage member and the procedure is submitted on two (2) lines of services, the reimbursement will be displayed on a single line.

Definitions:

Modifier 50 – Bilateral Procedure
Modifier LT – Left side (used to identify procedures performed on the left side of the body)
Modifier RT – Right side (used to identify procedures performed on the right side of the body)

Regulatory Citations:

Centers for Medicare and Medicaid Services (CMS)

Related Documents:

Multiple and Endoscopic Procedure

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