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Bilateral Procedures- Professional & Institutional Billing

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECTAT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICESPROVIDED TO TRULI MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

Bilateral Procedures are Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that describe unilateral procedures that can be performed on both sides of the body during the same session by the same individual physician or other 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 codes are inclusive of the bilateral procedure.

REIMBURSEMENT INFORMATION:

For Truli for Health professional claims, bilateral procedures should be reported on two separate claim lines with "1" unit for each line along with modifier LT on one line and modifier RT on the other. Additionally, it is acceptable to report a bilateral procedure on a single line with modifier 50 and "2" units.

The Centers for Medicare & Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File "bilateral" status indicators "1" or "3" are considered by Truli for Health to be eligible for bilateral services as indicated by the bilateral modifier 50.

When a CPT® or HCPCS code is reported with modifier 50 and the code is not listed with a "bilateral" status indicator "1" or "3", the code will not be reimbursed.

CPT® or HCPCS codes with 'bilateral' or 'unilateral or bilateral' written in the description will be reimbursed only once per date of service.

When bilateral procedures are reported on professional claims, non-endoscopic codes will be reimbursed at 100 percent of the fee schedule allowance for the first line, while the second line will allow at 50 percent consistent with Truli for Health Multiple Surgical Procedure Reduction Policy. Truli for Health uses the endoscopic groups defined by CMS to reimburse for multiple endoscopic procedures performed for the same patient on the same day. For additional information, see Payment Policy 10-026, Multiple Surgical Procedure Reduction (Including Multiple Endoscopic Procedure Reduction).

When bilateral procedures are reported on institutional claims, if a single line is billed with "1" unit and a modifier 50, the line will allow 150 percent of the fee schedule allowance consistent with Truli for Health Multiple Surgical Procedure Reduction Policy. Bilateral procedures billed as two claim lines with 1 unit each will price as described in the professional reimbursement above.

There may be instances when more specific anatomical modifiers for fingers, toes, eyelids, or coronary arteries should be used when billing bilateral procedures.

There are rare instances in which a bilateral service may be performed on multiple sites and not just bilaterally. In those instances, claims will be reviewed through the Truli for Health appeals process.

BILLING/CODING INFORMATION:

Professional Claims:

Bilateral procedures should be reported on two separate claim lines with "1" unit for each line along with modifiers LT/RT. Additionally, it is acceptable to report a bilateral procedure on a single line with modifier 50 and "2" units, such as when procedure code 67107 is performed on both eyes.

Either method below would be acceptable:

Line 1: 67107-LT
Line 2: 67107-RT
OR
Line 1: 67107-50 x 2 units

Note: When a procedure code description includes the verbiage "bilateral," the procedure code should only be submitted once without modifier 50.

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 (reduced services) when the procedure is performed unilaterally.

When a procedure with "unilateral or bilateral" written in the description is performed unilateral, 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 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 healthcare professional, only one charge will be eligible for reimbursement.

Facility Claims

Hospital and ambulatory surgical centers (ASC) should bill bilateral surgery one of two ways:

1. On a single claim line with one unit appended by modifier 50, or
2. On two separate claim lines each with one unit without modifier 50. However, an applicable modifier is required that identifies the services as unique or different otherwise they will be tagged as duplicative.

Example:

With 50 Modifier			
Revenue Code	CPT® Code/Modifier	Description	Charge
0360	19101-50	Biopsy of breast: open, incisional	$1,500.00
Without 50 Modifier			
Revenue Code	CPT® Code/Modifier	Description	Charge
0360	19101-RT	Biopsy of breast: open, incisional	$750.00
0360	19101-LT	Biopsy of breast: open, incisional	$750.00

Failure to bill bilateral procedures in one of these two ways will result in incorrect payment.

DEFINITIONS:

Modifier 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 five digit code.
Modifier 52	Reduced Services – Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier -52, signifying that the service is reduced.
Modifier LT	Left Side
Modifier RT	Right Side

RELATED MEDICAL COVERAGE GUIDELINES OR PAYMENT POLICIES:

Multiple Surgical Procedure Reduction (Including Multiple Endoscopic Procedure Reduction) 10-026

REFERENCES:

1. Centers for Medicare & Medicaid Services, “National Physician Fee Schedule (NPFS) Relative Value File.”
2. American Medical Association, Current Procedural Terminology (CPT ®), Professional Edition

GUIDELINE UPDATE INFORMATION

02/10/2021	Annual Review – Clarified reporting requirements for professional claims in Reimbursement Information section.
02/11/2021	Revision – Clarified reimbursement for endoscopic and non-endoscopic codes.
10/14/2021	Annual Review – no changes
10/20/2022	Annual Review – References reviewed and verified
10/19/2023	Annual Review – References reviewed and updated.