Bilateral Procedures

Payment Policy ID: RPC.0006.7700

Recent review date: 11/2022

Next review date: 11/2023

AmeriHealth Caritas Ohio claim payment policies and the resulting edits are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies, and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual, and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify, or in some cases supersede medical/claim payment policy. These factors may include but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services

Policy Overview

A bilateral procedure is a procedure performed on identical anatomic sites, on opposite sides of the body (mirror image) that are performed during the same operative session, or on the same day by the same provider.

AmeriHealth Caritas recognizes modifier 50, and adjusts reimbursement accordingly, when appended to a service to indicate that a bilateral procedure has been performed on identical anatomic sites, on opposite sides of the body during the same operative session or on the same day by the same provider when medically necessary.

Exceptions

The use of Modifier 50 is not applicable with procedures or codes that are bilateral in intent or that have bilateral in their description. Some examples of descriptions may include the terms "unilateral or bilateral", "one or both", and "bilateral".

Coding

AmeriHealth Caritas determines whether claims are eligible for reimbursement for bilateral surgery based on the "Bilateral Surgery" indicator in the Medicare Physician Fee Schedule Database (MPFSDB).

- "0" indicates a unilateral code; modifier 50 will not be reimbursed
- "1" indicates modifier 50 may be reimbursable
- "2" indicates a bilateral code; modifier 50 is not eligible for reimbursement
- '3' indicates a primary radiology code; modifier 50 is not eligible for reimbursement
- '9' indicates that the concept of a bilateral procedure does not apply.

Indicator “1” on procedure codes are considered eligible for bilateral services reimbursement and must be submitted as a **one-line entry** with 50 modifier and 1=unit in order to be reimbursed. Allowed procedure codes submitted with modifier 50 will be reimbursed at 150% of the Ohio Medicaid fee schedule.

Definitions

Bilateral Procedure
Same procedures that are performed on both the left and the right side of a patient’s body during the same operative session or on the same day.

Modifier
An indicator used in conjunction with a CPT code to denote that a service or procedure that has been performed has been altered by a circumstance without changing the definition of the CPT code.

Applicable Claim Types

	Facility	Professional
Medicare	**No**	**No**
Medicaid	**Yes**	**Yes**
ACA Exchange	**No**	**No**

Edit Sources

I. *Current Procedural Terminology* (CPT©), *Healthcare Common Procedure Coding System* (HCPCS©), *International Statistical Classification of Diseases and Related Health Problems* (ICD©), and associated publications and services.
II. Centers for Medicare and Medicaid Services (CMS).
III. Ohio Medicaid Fee Schedule(s).
IV. *Medicare Physician Fee Schedule Database.* *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup*
V. *https://codes.ohio.gov/ohio-administrative-code/rule-5160-4-22*

Attachments

N/A

Policy History

12/01/2022	Policy Implemented by AmeriHealth Caritas
10/13/2022	Reimbursement Policy Committee Approval