Payment Policy

Subject: Bilateral Procedures
(effective 7/1/2013 for facilities)

Policy

CareSource will reimburse for bilateral procedures when the proper modifiers 50, LT, and RT are used. Modifier 50 is not to be utilized if the CPT code description specifies the procedure as bilateral.

Definitions

"**Bilateral procedures**" are defined as surgical operations performed on both the right and left side of a patient's body during the same operative session requiring separate sterile fields and a separate surgical incision. *(from www.cms.gov)*

"**Modifier**" means a reporting indicator used in conjunction with a CPT code to denote that a medical service or procedure that has been performed has been altered by a specific circumstance while remaining unchanged in its definition or CPT code. *(from 907 KAR 3:010)*

Provider Reimbursement Guidelines

Modifier 50
Modifier 50 is used to report bilateral procedures (procedures described with the same CPT code) that are performed at the same operative session by the same physician on bilateral body structures (identical anatomic sites on opposite sides of the body). The use of modifier 50 is applicable only to services and/or procedures performed on identical anatomic sites or organs (e.g., eyes, ears, kidneys).

Modifiers LT and RT may also used to report services rendered on identical anatomic sites; however the use of these modifiers is not interchangeable with use of modifier 50. Modifiers LT and RT should only be used when the bilateral surgery rules do not apply. The bilateral surgery rules apply to procedures with a bilateral indicator of “1”, as defined by the Centers for Medicare & Medicaid (“CMS”). When the fee schedule has a bilateral indicator of “0” or “3”, as defined by CMS, use modifiers LT and RT to describe procedures performed on identical anatomic sites.

A bilateral procedure is reported on one line using modifier 50. Use a quantity entry of one when modifier 50 is reported. Do not submit two line items to report a bilateral procedure using modifier 50.

Modifier 50 should not be used to report diagnostic and radiology facility services.

Institutional claims received for an outpatient radiology service appended with modifier 50 will be denied.

Bilateral Indicator	Definition	Submission Instructions
0	Bilateral surgery payment rules do not apply, do not use modifier 50.	Do not submit these procedures with CPT modifier 50.
1	Bilateral surgery payment rules apply (150%). Use modifier 50 if bilateral. Units = 1	Submit the procedure on a single detail line with CPT modifier 50 and a quantity of "1."
2	Bilateral surgery payment rules do not apply. Already priced as bilateral. Do not use modifier 50. Units = 1	Submit the procedure with a quantity of "1." Do not submit these procedures with CPT modifier 50.
3	Bilateral surgery payment rules do not apply. Do not use modifier 50. Units = 1 or 2.	Submit the procedure on a single detail line with CPT modifier 50 and a quantity of "2."
9	Bilateral concept does not apply.	Do not submit these procedures with CPT modifier 50.

Modifiers LT or RT

Surgical codes that are considered bilateral codes but are performed unilaterally on only one side of the body should be billed on one line unmodified or on one line with either the LT or the RT modifier indicating the side of the body on which the procedure was performed.

Modifiers LT or RT are required when appropriate to identify:

- Hospital procedures performed on identical anatomic sites on the right and left sides of the body (e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries).
- A procedure is performed on only one side.
- Hospital diagnostic test and radiology services performed on the right and left sides of the body.

Surgical codes that are considered bilateral codes but are performed more than once on one or each side of the body and/or body part indicated by the code definition must be billed using only the LT and RT modifiers on each line to demonstrate the procedure was performed more than once on one or each side.

Although bilateral indicators "0" and "3" can be billed with the LT and RT modifiers, there are some differences between the two indicators;

a. Some codes with an indicator of "0" may be performed more than once on a given day. However, even if performed on opposite sides of the body, these services would never be considered bilateral.
b. Codes with an indicator of "0" can never be billed with modifier 50.
c. Codes with an indicator of "3" can be billed with 50 or LT/RT. These services are generally radiologic and other diagnostic services.
d. Codes that have an indicator of "3" that are billed bilaterally receive reimbursement for each code billed.
e. Codes that have an indicator of "0" that are billed using LT/RT receive reimbursement for a single code.

The CareSource maximum for bilateral procedures is one hundred fifty per cent of the contracted amount allowed for the same procedures performed unilaterally when the code is billed on a single line with the 50 modifier.

NOTE: Use of modifiers applies to services/procedures performed on the same calendar day.

Related Policies & References

OAC Chapter 5160-4-22(E) “Physician Services, Surgical Services”

907 KAR 3.010 Reimbursement for physicians services

State Exceptions

NONE

Document Revision History

10/31/2013 – OAC Rule renumbered from “5101:3-4-22,” per Legislative Service Commission Guidelines.