ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Bilateral Procedures-OH MCD-AD-1055	06/01/2023
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject

Bilateral Procedures

B. Background

CareSource processes bilateral procedures in accordance with The Centers for Medicare and Medicaid Services (CMS) guidelines. Bilateral procedures are those performed on both sides of the body, during the same operative episode by the same provider. CareSource applies CMS guidelines for professional reimbursement of bilateral procedures. Reimbursement is based on the bilateral surgery payment policy indicator assigned to the procedure code on the Medicare Physician Fee Schedule.

C. Definitions

- **Bilateral Procedures** – Procedures performed on both sides of the body during the same session or on the same day.
- **Modifier** – A reporting indicator used in conjunction with a Current Procedural Terminology (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.

D. Policy

I. CareSource 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.

A. In instances where there is a conflict between CMS guidelines and AMA/CPT guidelines regarding modifier 50, CareSource will use guidelines as established by CMS to align with the Ohio Department of Medicaid (ODM) fee schedule.

II. Providers and facilities should refer to CMS for appropriate modifiers and bilateral indicators when submitting claims.

III. General billing guidelines apply when using CPT.

A. Unless CMS specifies differently:

1. General billing guidelines for CPT codes descriptions should be followed and appropriate units should be used.
2. CPT 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.
3. CPT codes, with unilateral in their intent or with unilateral written in their description, may be reported with the bilateral modifier 50, or modifiers LT and RT.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

DATES		ACTION
Date Issued	06/01/2021	New policy
Date Revised	02/03/2021 01/18/2023	Policy converted from reimbursement policy PY-0012. No changes to content. Updated references.
Date Effective	06/01/2023	
Date Archived		

H. References

1. Centers for Medicare & Medicaid. (12/06/2022). Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing. Retrieved on January 5, 2023, from www.cms.gov
2. Centers for Medicare & Medicaid. (12/08/2022). Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners. Retrieved on January 5, 2023, from www.cms.gov
3. Centers for Medicare & Medicaid. (12/~~08~~ 22/2017). Medicare Claims Processing Manual Chapter 14 - Ambulatory Surgical Centers. Retrieved on January 5, 2023, from www.cms.gov
4. Centers for Medicare & Medicaid. (12/02/2022). Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements. Retrieved on January 5, 2023 from www.cms.gov