



REIMBURSEMENT POLICY STATEMENT OHIO MEDICAID

Original Issue Date		Next Annual Review		Effective Date	
07/01/2013		01/02/2020		01/02/2019	
Policy Name				Policy Number	
Bilateral Procedures				PY-0012	
Policy Type					
Medical	Administrative	Pharmacy	REIMBURSEMENT		

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management 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 federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy 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.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. SUBJECT

Bilateral Procedures

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

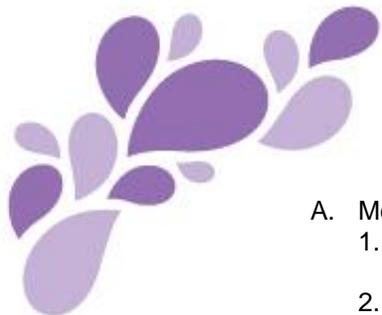
It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

C. 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.
- **Modifier** - is 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.

D. POLICY

- I. CareSource will reimburse for bilateral procedures when medically necessary.
- II. CareSource will reimburse for bilateral procedures when providers submit their claim with appropriate CPT/HCPCS codes and modifier.
 - A. 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).
 - B. Modifiers LT and RT may also be 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.
 1. 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.
 2. Modifier 50 should not be used to report diagnostic and radiology facility services.
 3. Institutional claims received for an outpatient radiology service appended with modifier 50 will be denied.
- III. 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.



- A. Modifiers LT or RT are required when appropriate to identify:
 1. 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).
 2. A procedure is performed on only one side.
 3. Hospital diagnostic test and radiology services performed on the right and left sides of the body.
 - **NOTE:** Use of modifiers applies to services/procedures performed on the same calendar day.
 - **NOTE:** 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.

- IV. 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.

- V. 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 LT or RT. These services are generally radiologic and other diagnostic services.
 - D. Codes that have an indicator of “0” that are billed using LT or RT receive reimbursement for a single code.

- VI. The CareSource maximum for bilateral procedures is 150% of the contracted amount allowed for the same procedures performed unilaterally when the code is billed on a single line with the 50 modifier.

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.	Do not submit these procedures with CPT modifier 50.
9	Bilateral concept does not apply.	Do not submit these procedures with CPT modifier 50.



**E. CONDITIONS OF COVERAGE
AUTHORIZATION PERIOD**

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

DATE		ACTION
Date Issued	07/01/2013	
Date Revised	01/02/2019	Revision
Date Effective	02/02/2019	

H. REFERENCES

1. Surgical services. (2015, July 03). Retrieved August 15, 2016, from <http://codes.ohio.gov/oac/5160-4-22>.

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

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