BlueCross BlueShield Minnesota

MEDICAID REIMBURSEMENT POLICY

Bilateral Procedure

Active

Section: Surgery/Interventional Procedure
Policy Number: 002
Effective Date: 07/01/24

Description

This policy addresses coding and reimbursement for bilateral procedures reported on a professional (837P) claim.

Policy Statement

A bilateral procedure is defined as a procedure that is performed on both sides of the body during the same operative session or on the same day. Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) determines reimbursement of bilateral procedures based on the Centers for Medicare and Medicaid Services (CMS) Bilateral Indicator assigned to the applicable procedure code(s) and the modifier(s) reported by the provider. A bilateral eligible procedure will be reimbursed at 150 percent of the fee schedule amount for the single code.

Bilateral Indicators:

Indicator	Description
0	**150% payment adjustment for bilateral procedures does not apply.** The bilateral adjustment is inappropriate for codes in this category: • Because of physiology or anatomy • The code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure
1	**150% payment adjustment for bilateral procedures applies.** Codes with a bilateral indicator assignment of 1 are considered bilateral if modifier 50 is present. When the code descriptor does not specify unilateral or bilateral and the procedure is performed bilaterally at the same operative session, the procedure should be reported with modifier 50 as a single line item and one unit of service. Modifiers RT (right side) and LT (left side) should not be used when modifier 50 applies.
2	**150% payment adjustment does not apply.** Payment is already based on the procedure being performed bilaterally because: • The code descriptor specifically states that the procedure is bilateral

	• The code descriptor states that the procedure may be performed either unilaterally or bilaterally • The procedure is usually performed as a bilateral procedure The procedure itself indicates a bilateral procedure and already includes payment for both sides when performed bilaterally at the same operative session. Report one unit of service as a single line item and do not append modifier 50.
3	**No bilateral payment adjustment.** The usual payment adjustment rules for bilateral procedures do not apply. These are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.
9	**Bilateral concept does not apply.**

Multiple Surgery Reduction
When a bilateral procedure, appended with modifier 50, is reported with other procedure codes on the same day, the bilateral adjustment of 150 percent will be applied, followed by the multiple surgery reduction of 50 percent if applicable. Refer to *Medicaid Surgery/Interventional Procedure – 005 Multiple Surgical Reduction Reimbursement Policy*.

Bilateral Radiology Procedures
According to the Minnesota Administrative Uniformity Committee (AUC) Companion Guide, bilateral radiology and other diagnostic procedures are reported as either:

- One line with a 50 modifier and one unit, or
- Two separate lines, one with RT modifier and one with LT modifier.

When bilateral radiology procedures are performed in an Ambulatory Surgical Center, professional bilateral radiology procedures are reported as two separate lines, one with RT modifier and one with LT modifier.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider

Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	50	LT	RT
ICD-10 Diagnosis:	N/A		
ICD-10 Procedure:	N/A		
CPT/HCPCS:	N/A		
Revenue Codes:	N/A		

Resources

Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
Minnesota Administrative Uniformity Committee (AUC) Companion Guides
National Physician Fee Schedule (NPFS) Relative Value File

Policy History

06/27/2023	Initial Committee Approval
06/25/2024	Annual Policy Review