RB.004.A Modifier 50, Bilateral Procedure

Health Partners Plans

Title: Modifier 50, Bilateral Procedure
Policy #: RB.004.A
Type: Claim Payment
Sub-Type: RB (Reimbursement)

Implementation Date: 3/31/2016
Version Date [A]: 3/31/2016
Last Reviewed: 7/1/2016
Notification Release: N/A

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PRODUCT VARIATIONS

This policy applies to all HealthPartners Plan (HPP) lines-of-business unless noted below.

POLICY STATEMENT

The intent of this Health Partners Plans (HPP) policy is to communicate to professional providers the reporting requirements and reimbursement rules for Modifier 50 Bilateral Procedure.

POLICY GUIDELINES

Procedure codes with BILAT SURG indicator 1

- Report a bilateral procedure with Modifier 50 and one service unit on a single claim line
- If a bilateral procedure is reported with other procedure codes on the same day, the bilateral adjustment is applied before applying any applicable multiple procedure rules

Procedure codes with BILAT SURG indicator 3

- Payment is based on 100% for each procedure performed
- Report a bilateral procedure with Modifier 50 and one service unit on a single claim line
  - 200% reimbursement of the allowable amount will apply when performed bilaterally and reported with Modifier 50

Modifier LT or RT is used to indicate on which side of the body a service or procedure is performed. They do not indicate a bilateral service and should not be used to report a service or procedure performed bilaterally. Modifier 50 should be reported in the primary Modifier position. When the bilateral procedure has a professional and/or technical component, the TC/26 Modifier that reduces the fee schedule/allowable amount must be billed in the primary Modifier position and Modifier 50 in the secondary position.

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Example 1	Example 2
Professional component -26, bilateral procedure - 50	Technical component - TC, bilateral procedure- 50
Ultrasound, breast 76641-26-50	Ultrasound, breast 76641-TC-50

CODING

NOTE: The Current Procedural Terminology (CPT®) codes and Healthcare Common Procedure Coding System (HCPCS) codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

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ICD-10 Code	Description
N/A	N/A

BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage. This policy is invoked only when the requested service is an eligible benefit as defined in the Member's applicable benefit contract on the date the service was rendered. Services determined by the Plan to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all lines of business.

DESCRIPTION OF SERVICES

Bilateral Procedures are procedures performed on both sides of the body during the same operative session or on the same day.

Modifier 50 Bilateral Procedure should be used to identify bilateral procedures performed at the same session, unless the CPT book directs otherwise.

The Centers for Medicare and Medicaid Services Physician Fee Schedule Database defines procedures that may be submitted as bilateral and how reimbursement is calculated.

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Modifier 50 is considered a payment Modifier, rather than an informational Modifier. The addition of this modifier may effect payment depending on the procedure code and the Medicare Physician Fee Schedule Database Bilateral Surgery (BILAT SURG) indicator.

Below are the indicators:

0 = bilateral payment does not apply

1 = valid for bilateral payment

2 = bilateral payment already included

3 = bilateral payment does not apply for radiological procedure or diagnostic test

9 = bilateral payment does not apply

CLINICAL EVIDENCE

N/A

DEFINITIONS

N/A

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Effective Date
N/A – This is a new policy bulletin.	A	3/31/2016

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REFERENCES

Refer to the Fee Schedule CMS Web page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU15A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending)

1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
2. http://www.novitas-solutions.com/webcenter/faces/oracle/webcenter/page/scopedMD/sad60252a_5537_4c5d_9350_ca405e36e159/Page133.jspx?contentId=00004345&_afrLoop=2741237662761000#!%40%40%3F_afrLoop%3D2741237662761000%26contentId%3D00004345%26_adf.ctrl-state%3Dl4gtbzypy_90