PAYMENT POLICY ID NUMBER: 10-005

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Revised: 05/31/12

Bilateral Procedures

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DESCRIPTION:

Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes on the Bilateral Eligible List describe unilateral procedures that can be performed on both sides of the body during the same session by the same individual physician or health care professional. CPT or HCPCS 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, because the codes are inclusive of the bilateral procedure.

Florida Blue requires bilateral procedures be reported as two separate claim lines. On one of the two lines, modifier 50 may be used, with the other line reported without a modifier. Instead of using modifier 50, it is also acceptable to append modifier LT to one line and modifier RT to the other to report that the procedure was performed on two separate sites.

When a CPT or HCPCS code is reported with modifier 50 and the code is not listed on the Bilateral Eligible Policy list, the code will not be reimbursed.

CPT or HCPCS codes with 'bilateral' or 'unilateral or bilateral' written in the description are not on the Bilateral Eligible List and will be reimbursed only once per date of service.

REIMBURSEMENT INFORMATION:

The Bilateral Eligible List is developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File status indicators.
All codes in the NPFS with the “bilateral” status indicators “1” or “3” are considered by Florida Blue to be eligible for bilateral services as indicated by the bilateral modifier 50.

When bilateral procedures are reported, one line will allow at 100% of the fee schedule allowance while the second line will allow at 50% consistent with Florida Blue Multiple Procedure Reduction Policy. For additional information, see Payment Policy P-0000003, Multiple Surgeries and Procedures.

There are rare instances in which a bilateral service may be performed on multiple sites and not just bilaterally. In those instances, claims will be reviewed through Florida Blue appeals process.

**BILLING/CODING INFORMATION:**

When reporting bilateral surgical procedures, the appropriate code for the first procedure should be reported. The second procedure should be identified by the same procedure code and by adding modifier 50. It is also acceptable to report both procedures indicating modifiers LT/RT. For example if code 67107 is performed for each eye, either method below would be acceptable:

- Line 1: 67107
- Line 2: 67107-50
- OR
- Line 1: 67107-LT
- Line 2: 67107-RT

Exception: When a procedure code description includes the verbiage “bilateral,” the procedure code should only be submitted once without modifier 50.

When a CPT or HCPCS procedure code exists for both a unilateral and a bilateral procedure, select the code that best represents the procedure.

Consistent with CPT guidelines, if a unilateral procedure has not been defined by CPT or HCPCS and only a bilateral description of a procedure exists, report the code with “bilateral” in the description with modifier 52 (reduced services) when the procedure is performed unilaterally.

When a procedure with “unilateral or bilateral” written in the description is performed unilateral, then the CPT or HCPCS procedure code need not be reported with modifier 52 since the procedure description already indicates that the service can be performed either unilaterally or bilaterally.

The use of modifiers LT or RT will be recognized as informational only when the procedure with “unilateral or bilateral” in description is performed on only one side. Consistent with CMS guidelines, when both modifiers LT and RT are reported separately on the same day by the same individual physician or healthcare professional, only one charge will be eligible for reimbursement.

**DEFINITIONS:**

- **Modifier 50 – Bilateral Procedure** – Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate five digit code.

- **Modifier 52 – Reduced Services** – Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the
service provided can be identified by its usual procedure number and the addition of the modifier -52, signifying that the service is reduced.

Modifier LT – Left Side

Modifier RT – Right Side

Bilateral Procedures – The same procedure performed on both sides of the body during the same session.

REFERENCES:

1. Centers for Medicare and Medicaid Services, "National Physician Fee Schedule (NPFS) Relative Value File."

COMMITTEE APPROVAL:

This Payment Policy was approved by the Florida Blue Payment Policy Committee on 01/26/10.

GUIDELINE UPDATE INFORMATION:

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