Payment Policy: Bilateral Procedures

Reference Number: CC.PP.037
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 12/01/2022

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Policy Overview
Bilateral services are procedures performed on both sides of the body during the same session or on the same day.

The purpose of this policy is to define the appropriate billing criteria for bilateral services.

Modifier -50 is used to indicate that a procedure or service was performed bilaterally during the same operative session. Use of modifier -50 is reserved for when a procedure is performed on a mirror image body part or organ, such as eyes, hands, etc. This modifier may be reported with any code from the surgery, radiology, pathology/laboratory, or medicine sections of the Current Procedural Terminology (CPT®) book but **only** on body parts or organs that have a mirror image.

Furthermore, services that by their code description are inherently bilateral should never have modifier -50 appended. Modifiers LT and RT should not be utilized when modifier -50 applies. Use of these modifiers is for informational purposes only when a procedure with "unilateral or bilateral" in the description is performed on only one side.

Application
Professional and Outpatient Institutional Providers

Reimbursement
Reimbursement guidelines require that the appropriate CPT® code be billed once with modifier -50 appended. The same code should not be billed twice, as the second submission will be denied whether it is billed with or without modifier -50.

All procedure codes listed on the CMS National Physician's Fee Schedule with bilateral status indicators of "1" or "3" are considered eligible for bilateral services as indicated by modifier -50. Modifier eligibility may also be based on procedure code descriptions, CPT guidelines, CMS directives and other nationally recognized sources.

Documentation Requirements
Modifier -50 is used only when the exact same service/code is reported for each bilateral anatomical site. Providers should report the bilateral procedures with one procedure code appended with modifier -50. This should appear on the claim form as one line item.

******Some health plans allow bilateral procedure billing on two service lines. These plans have been excluded from the claim reimbursement guidelines described above******

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

References

1. *Current Procedural Terminology (CPT®)*, 2022
2. Centers for Medicare and Medicaid Services (CMS) *Physician Fee Schedule* *https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched*
3. Centers for Medicare and Medicaid Services (CMS) *Claims Processing Manual* *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912*

Revision History	
11/11/2016	Initial Policy Draft Created
03/01/2018	Conducted review, updated policy.
04/01/2019	Conducted review and updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/12/2021	Annual Review completed; no policy changes required
12/01/2022	Annual review completed; removed tables to eliminate redundancy; added reference link to CMS Physician Fee Schedule

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.