Commercial and Medicare Advantage Claims Payment Policy

Subject: Bilateral Surgery/Modifier 50

Application: Commercial and Medicare Advantage Products
Policy Number: CP2008101
Related Policies: N/A

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Medicare: 12/2007
Revision Date:

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Overview

According to the American Medical Association, "*Modifier 50* is used to report bilateral procedures that are performed at the same operative session" (by the same physician). "Bilateral procedures are procedures typically performed on both sides of the body. The intent of this modifier is for it to be appended to the appropriate unilateral code as a one-line entry on the claim form indicating that the procedure was performed bilaterally."

Reimbursement Guidelines

- The Medicare Advantage and commercial policies apply to professional services only.
- According to the Current Procedural Terminology (CPT®) book, unless otherwise identified in the CPT® and Healthcare Common Procedure Coding System (HCPCS) listings, bilateral procedures that are performed at the same operative session should be identified by adding *modifier 50* to the appropriate five-digit code.
- One service performed bilaterally, and submitted appropriately with *modifier 50*, is one unit of service.

Medicare Advantage Payment Policy
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References and Definitions

Medicare Advantage Payment Policy

In addition to this policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

1. Procedure code descriptions that include the terms "bilateral" or "unilateral or bilateral" do not require the use of *modifier 50* when billed and bilateral payment adjustment rules do not apply. The *allowed* amount reflects the work of performing the service bilaterally.

2. When a procedure that does not specify bilateral in the code description is performed bilaterally, the code must be reported either: 1) with *modifier 50*, or 2) with modifiers RT and LT. Humana accepts both methods.
   - *Modifier 50* is to be reported as a single line item on the claim.
     Example:
     28292-50 (one unit) – Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride or Mayo type procedure.

   - Modifiers RT and LT are appended to the procedure code and are to be reported on separate lines.
     Examples:
     28292-RT (one unit) – Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride or Mayo type procedure.

     28292-LT (one unit) – Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride or Mayo type procedure.

3. The *Medicare Physician Fee Schedule (MPFS)* bilateral indicator field will be used to determine if the bilateral payment adjustment applies to a procedure.
   - **Indicator 0** – 150 percent payment adjustment for bilateral procedures does not apply
   - **Indicator 1** – 150 percent payment adjustment for bilateral procedures applies
   - **Indicator 2** – 150 percent payment adjustment for bilateral procedures does not apply
   - **Indicator 3** – The usual payment adjustment for bilateral procedures does not apply
   - **Indicator 9** – Concept does not apply

4. A bilaterally performed procedure to which a bilateral payment adjustment applies (as discussed above), is allowed at the lower of (a) the total actual charge for both sides or (b) 150 percent of the allowed amount for a single code. In certain circumstances, additional payment rules may apply.

5. When a code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.

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Commercial Payment Policy

In addition to this policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

1. A single claim line containing an inherently unilateral CPT code billed with *modifier 50* is recognized as two services, but processed as one unit. Humana considers 150 percent of the *allowable* for inherently unilateral surgical CPT codes when billed with a *modifier 50*. Health care providers may be asked to provide supporting documentation for reconsideration of additional units.

   Example:

CPT	MODIFIER	UNITS	PYMT
27455	50	1	150% of base *allowable*

2. When claims are billed with two or more of the same inherently unilateral CPT code where any line contains the *modifier 50*, the first line containing *modifier 50* is considered for payment at 150 percent and all subsequent lines with the same CPT code are subject to duplicate logic. Health care providers may be asked to provide supporting documentation for reconsideration of any line items denied in this process.

   Example:

CPT	MODIFIER	UNITS	PYMT
27455		1	Denied; reimbursement included in bilateral line
27455	50	1	150% of base *allowable*

3. Inherently bilateral procedures should not be billed with a *modifier 50* because the rate already reflects a bilateral increase. Therefore, if an inherently bilateral procedure is submitted with a *modifier 50* Humana only considers the *allowable* at 100 percent.

   Example:

CPT	MODIFIER	UNITS	PYMT
27392	50	1	100% of base *allowable*

4. If a code is categorized as both unilateral/bilateral and submitted with a *modifier 50*, Humana considers the code as an inherently bilateral code and the *allowable* will be considered at 100 percent.

   Example:

CPT	MODIFIER	UNITS	PYMT
30801	50	1	100% of base *allowable*

5. The applicable bilateral surgery increase (150%) will be applied before multiple surgery reduction logic based on highest base *allowable*. Commercial standard multiple surgery policy is 100/50/25. For this example we will assume 27392 is primary.

   Example:

CPT	MODIFIER	UNITS	PYMT
27392		1	100% of base *allowable*
27455	50	1	50% of 150% of base *allowable*

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Notes:

- For commercial lines of business Humana uses tables containing the American Medical Association (AMA) codes categorized as inherently unilateral, unilateral/bilateral or inherently bilateral.
- Humana crosswalks to the inherently bilateral code in instances where two unilateral codes are filed on two claim lines and an inherently bilateral code exists.

Definitions and References

Definitions of *italicized* terms used in this policy:

- ***Allowable (amount):*** The amount actually due to a health care provider for a covered service, including any member responsibility.
- ***Allow:*** When a Humana plan determines the allowable amount for a covered service.
- ***Medicare Physician Fee Schedule (MPFS) Relative Value file:*** A file published by the Centers for Medicare & Medicaid Services (CMS) that includes, among other information, relative value units and conversion factors for physician services.
- ***Modifier 50:*** Bilateral procedure.
- ***Modifier RT:*** Right side (used to identify procedures performed on the right side of the body).
- ***Modifier LT:*** Left side (used to identify procedures performed on the left side of the body).
- ***Relative Value Units (RVU):*** A numeric constant, published in the MPFS, indicating the standardized value of a professional procedure; the base Original Medicare fee schedule amount for a professional charge for a particular procedure in a particular situation is calculated by multiplying the RVU for that service by both the numeric constant (GPCI) for a particular area and the numeric constant (conversion factor) for a particular year.

Medicare Advantage Resources:

- Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners
  - Sec. 20.4
  - Sec. 40
  - Sec. 40.6.B
  - Sec. 40.6.C
  - Sec. 40.7.A
  - Sec. 40.7.B
  - Sec. 40.7.C
- Medicare Claims Processing Manual, Chapter 23, Fee Schedule Administration and Coding Requirements
  - MPFSDB Record Layouts
- Medicare Physician Fee Schedule (MPFS) Relative Value File
- American Medical Association's Current Procedural Terminology (CPT®) and associated publications and services
- Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

Original Medicare Guidelines:

- Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners
- Medicare Claims Processing Manual, Chapter 23, Fee Schedule Administration and Coding Requirements

Commercial Resources:

- American Medical Association's Current Procedural Terminology (CPT®) and associated publications and services
- Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

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