

N – Bilateral Procedures

***DRAFT – PLEASE DO NOT DISTRIBUTE**

Rules Committee Recommendation

Bilateral payment adjustment and reporting rule

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this recommendation, the payer may make a decision to deny the claim line, this will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Modifier Involved

50 – Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

This rule is applicable for the specific situations identified for this modifier. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

Bilateral payment adjustment rule

Procedures subject to the bilateral payment adjustment rule are listed in the column labeled BILT SURG of the 2013 Medicare Physician Fee Schedule (MPFS)¹ with a status indicator of 1. Visit <http://www.cms.gov/apps/physician-fee-schedule/> to access the MPFS.

The only time a bilateral payment adjustment may be made is when 1) The code is eligible for the adjustment; 2) the code is billed with modifier 50; 3) the code is billed on one line; and 4) the units are 1.

The bilateral concept does not apply to procedure codes that are outlined in the column labeled BILT SURG of the MPFS with a status indicator of 0, 2, 3 or 9. If a procedure code with a status

¹ References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> to access the MPFS Relative Value file.

indicator of 0, 2, 3 or 9 is billed on one or more lines with 1 or more units, with modifier 50 or modifiers RT and LT do not apply a bilateral payment adjustment.

If bilateral procedures are performed with other procedures for the same patient during the same session by the same physician, apply the bilateral payment adjustment rule first, then apply any other applicable payment adjustment (e.g. multiple procedure).

Coding guidelines

Use the following administrative guidelines if the criteria as outlined above are not met:

- Valid modifier 50 code is billed on two or more lines, each with 1 or more units, and one or more lines has modifier 50 - ACTION: Deny the lines or adjudicate one line using bilateral payment adjustment, deny other lines with the same procedure code if no additional modifier is appropriately appended
- Valid modifier 50 code is billed on two or more lines, each with 1 or more units, and no modifiers – ACTION: Deny the lines or adjudicate one line with no bilateral payment adjustment, deny other lines with same procedure code

One line bilateral coding without bilateral payment adjustment

Procedure codes outlined in the column labeled BILT SURG of the MPFS with a status indicator of 2 are inherently bilateral. Use of modifier 50 is inappropriate. Procedure codes with a status indicator of 2 should be billed on one line with 1 unit. Modifier 50 should not be appended.

- Use the following administrative guidelines if the above criteria are not met:
 - If procedure codes with a status indicator of 2 are billed on more than one line, and may or may not have a Modifier 50 appended on one or more lines, billed with 1 or more units on one or more lines – ACTION: Deny the line(s) or adjudicate one line with no bilateral payment adjustment, deny other line(s) with same procedure code and modifier 50 or no other **appropriate modifier**.

Two line bilateral coding without bilateral payment adjustment

Procedure codes outlined in the column labeled BILT SURG of the MPFS with a status indicator of 3 are bilateral eligible. They are not subject to the bilateral payment adjustment.

- Procedure codes with a status indicator of 3 should be billed on two lines, each line with 1 unit and one line with RT and one line with LT modifiers appended.
- Use the following administrative guidelines if the above criteria are not met:
 - If procedure codes with a status indicator of 3 are billed on one line with RT and LT modifiers, and 1 or more units – ACTION: Deny the lines or adjudicate one line with unilateral pricing.
 - If procedure codes with a status indicator of 3 are billed on more than two lines with at least one line with RT and one line with LT and 1 or more units on these lines – ACTION: Adjudicate the combination of one RT line and one LT line with no bilateral payment adjustment. Deny other line(s) for same procedure code with RT/LT modifier and no other **appropriate modifier**.

Listing of Status Indicators

The MPFS has identified five status indicators (0,1, 2, 3 and 9) used to outline the payment adjustment for each procedure code. The Edit Committee is looking further into the MPFS as it relates to the bilateral concept. The Rules Committee has outlined the following recommendations as they relate to the status indicators:

- Procedure codes listed in the column labeled BILT SURG of the MPFS with a status indicator of 0 are not eligible for the bilateral payment adjustment rule. Either the procedure cannot be performed bilaterally due to anatomical constraints or there is a code that more adequately describes the bilateral procedure.
- Procedure codes listed in the column labeled BILT SURG of the MPFS with a status indicator of 1 are eligible for bilateral payment adjustment and should be reported on one line appended with modifier 50, with 1 in the units box.
- Procedure codes listed in the column labeled BILT SURG of the MPFS with a status indicator of 2 are not eligible for the bilateral payment adjustment rule. These procedure codes are already bilateral.
- Procedure codes listed in the column labeled BILT SURG of the MPFS with a status indicator of 3 are not eligible for the bilateral payment adjustment rule. Report these codes on two lines with RT and LT or other **appropriate modifiers**. There is one payment per line. Status indicator 3 codes are eligible for 1 unit per line.
- Procedure codes listed in the column labeled BILT SURG of the MPFS with a status indicator of 9 are not eligible for the bilateral payment adjustment rule because the concept does not apply.

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The Current Procedural Terminology (CPT[®])² coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for bilateral service and modifier 50 were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual³ were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Exceptions

Refer to Appendix A for exceptions to the Rules Committee Recommendation.

MCCTF comments

As defined in CPT, Modifier 50 “Bilateral procedure description: Unless otherwise identified in the listing bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.” A bilateral service is one in which the same procedure is performed on both sides of the body during the same operative session or on the same day.

Modifier definition

This type of edit will identify incorrect billing when the CPT/HCPCS descriptors of the service/procedure code, or the related coding guidelines imply either unilateral or bilateral restrictions.

² Copyright 2013 American Medical Association. All rights reserved.

³ Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

Modifier 50: Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

Status indicator definitions

The following are status indicator definitions that are outlined in Field 8 of the Medicare Physician Fee Schedule (MPFS) for Bilateral Surgery⁴. **Note:** The specific amounts associated with the differentiated payments are not within the purview of the Medical Clean Claims Transparency and Uniformity Act. Payment rule recommendations should not include budget restraints, political influences or benefit limitations. Percent payment adjustments and fee schedule amounts are listed below solely because they are outlined in the status indicator definitions as defined in the MFSDDB and should not be considered as a recommendation of the Rules Committee.

0 = 150 percent payment adjustment for bilateral procedures does not apply. If a procedure is reported with modifier -50 or with modifiers RT and LT, Medicare bases payment for the two sides on the lower of:

(a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is \$125. The physician reports code XXXXX-LT with an actual charge of \$100 and XXXXX-RT with an actual charge of \$100.

Payment would be based on the fee schedule amount (\$125) since it is lower than the total actual charges for the left and right sides (\$200). The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 = 150 percent payment adjustment for bilateral procedures applies. If a code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), payment is based for these codes when reported as bilateral procedures on the lower of:

(a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.

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

2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If a procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), payment is based for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code YYYYY is \$125. The physician reports code YYYYY-LT with an actual charge of \$100 and YYYYY-RT with an actual charge of \$100.

Payment would be based on the fee schedule amount (\$125) since it is lower than the total actual charges for the left and right sides (\$200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

⁴ Information taken from “How to Use the Searchable Medicare Physician Fee Schedule (MPFS)”, Centers for Medicare & Medicaid Services.

3 = The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), Medicare bases payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, the fee schedule amount for a bilateral procedure is determined before applying any applicable multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

9 = Concept does not apply.

Federation outreach

American Academy of Orthopaedic Surgeons (AAOS)

This recommendation has been viewed Matt Twetten and Joanne Willer. It was recommended the CPT codes 27215-27218 follow the Rules Committee Recommendations when billed bilaterally.

American College of Radiology (ACR)

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

American College of Surgeons (ACS)

This recommendation was sent to Jennifer Jackson for review.

Federation Payment Policy Workgroup

This recommendation was sent to the Federation Payment Policy Workgroup for review.

N – Bilateral Procedures

***DRAFT – PLEASE DO NOT DISTRIBUTE**

Appendix A

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The Current Procedural Terminology (CPT[®])⁵ coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for bilateral service and modifier 50 were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual⁶ were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Exceptions

At the time of the initial review, the following exceptions were identified. This may not be a comprehensive listing of appropriate exceptions.

Surgery

The orthopaedic procedure codes listed below have the following status indicator in the MPFS:

I = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code **NOT** subject to a 90 day grace period.)

These codes were reviewed by CPT and, when performed bilaterally, are subject to the bilateral payment adjustment rule. These codes should be considered to have a CMS 2013 Medicare Physician Fee Schedule (MPFS)⁷ status indicator of 1.

- | | |
|-------|--|
| 27215 | Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed |
| 27216 | Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum) |
| 27217 | Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami) |
| 27218 | Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/ or sacrum) |

⁵ Copyright 2013 American Medical Association. All rights reserved.

⁶ Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

⁷ References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> to access the MPFS Relative Value file.

Category III CPT Codes

The following Category III CPT codes for emerging technology are not represented in the MPFS. These codes were reviewed by CPT and, when performed bilaterally, are subject to the bilateral payment adjustment rule. These codes should be considered to have a CMS 2013 Medicare Physician Fee Schedule (MPFS)⁸ status indicator of 1.

0187T	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral
0037T	Open subclavian to carotid artery transposition performed in conjunction with endovascular thoracic aneurysm repair, by neck incision, unilateral
0135T	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy

⁸ References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> to access the MPFS Relative Value file.