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Procedure 1207- Bilateral Procedures

Lines of Business: All

Purpose: This guideline describes bilateral procedures and the application of multiple procedure reductions.

Procedure: Network Health follows the bilateral rules status indicators as determined by the Centers for Medicare and Medicaid Services (CMS) on the National Physician Fee Schedule (NPFS) Relative Value File. Codes with the "bilateral" status indicator of "1" are considered by Network Health to be eligible bilateral services as indicated by the bilateral procedure modifier. Additionally, Network Health also follows our Claims Editing System which utilizes a "blended" list in determining procedure codes that are eligible for a bilateral procedure modifier. Therefore, in addition to codes identified as eligible by the NPFS for bilateral procedure reporting, codes that can be sourced to either a definitive or an interpretive CMS or CPT source for a bilateral procedure modifier have procedure – modifier relationships.

When practice sourcing conflicts with the eligibility regarding the use of the bilateral procedure modifier and the given procedure code, Network Health's Claims Editing System individually evaluates each coding relationship for clinical appropriateness. Therefore a procedure – modifier relationship with the bilateral procedure modifier, despite the NPFS bilateral indicator of "1", is not appropriate.

Bilateral Procedure: When a procedure is performed on both sides of the body during the same operative session, the surgical procedure is considered bilateral. When the code description in the CPT code book does not identify the procedure as "bilateral" or "unilateral," the procedure should be reported with a bilateral procedure modifier.

CPT or HCPCS codes with bilateral in their intent or with bilateral written in their description should not be reported with the bilateral procedure modifier, because the code is inclusive of the bilateral procedure. The HCPCS modifiers for the left or the right side can be appended when the procedure is valid for a bilateral procedure modifier but the procedure was only performed on one side.

A bilateral service should be reported as a single line item, with the bilateral procedure modifier, one unit, and the billed amount at full charge for both procedures. This indicates that one procedure is being performed bilaterally.

Network Health follows our Claims Editing System and the HCPCS modifiers indicating the right or left side individually accumulate towards maximum frequency per day (MFD) values independently of each other.

See below for examples of billing on same and different claim lines.

HCPCS code billed for 1 unit of Right side and 1 unit of Left side on **different claim lines:**

Claim line 1: HCPCS code + right side modifier + quantity of 1 unit = 1 unit for the right side
Claim line 2: HCPCS code + left side modifier + quantity of 1 unit= 1 unit for the left side

HCPCS code billed for 1 unit of Right side and 1 unit of Left side on **same claim line:**
Claim line 1: HCPCS code + both right side and left side modifiers + quantity of 2 units= 1 for the left and 1 for the right side

When billed over the allowed units, claim will deny with ansi code 151 - Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. The distinct procedural service modifier may be appended to any additional units when appropriate and documentation supports. Additional units will need to be submitted on a separate claim line.

When multiple bilateral procedures are performed, the same rules should be followed; however the multiple procedure modifier should also be billed on the second and subsequent bilateral procedures listed. When a bilateral procedure is performed with other procedure codes on the same date of service, the bilateral procedure is considered the first highest valued procedure and then multiple procedure rules will be applied to the remainder.

In rare instances a bilateral service may be performed on multiple sites and not just bilaterally. In those instances, the use of the distinct procedural service modifier to report the additional units beyond the bilateral services performed will indicate that the services were performed on a different site or organ system. Medical records must support the use of the distinct procedural service modifier.

This guideline is not a guarantee of coverage or payment. The claim(s) will be denied if it does not meet with all the terms and provisions of the members Certificate of Coverage. Actual benefits will be determined when the claim(s) or bill(s) are submitted to NHP/NHIC/NHAS. NHP/NHIC/NHAS reserves the right to periodically review and update all claim guidelines, policies and procedures.

HMO plans underwritten by Network Health Plan. POS Plans underwritten by Network Health Insurance Corporation, or Network Health Insurance Corporation and Network Health Plan. Self-funded HMO and POS plans administered by Network Health Administrative Services, LLC.

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