	Policy Number: 1004
	Subject: Bilateral Procedures
	Impact: Reimbursement impacting all lines
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Primary Authors: Code Governance Committee **Effective Date:** 10/01/2019	**Origination Date:** 10/31/2018 **Review Frequency:** Yearly **Review Coordinator:**
Review Dates: 11/23/2019	**Committees:** Code Governance

Policy: Bilateral Procedures

Purpose

The purpose of this Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes. Claims should be coded appropriately according to industry standard coding guidelines (including, but not limited to, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits, and other CMS guidelines).

Fee determinations will be based on the applicable provider contract language and WPS/Arise/Aspirus Arise reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.

Reimbursement Requirements

1. WPS/Arise/Aspirus Arise reimburses for bilateral procedures when coded with one unit of a bilateral (50) modifier. It is never appropriate to code more than one unit of a surgery when using a 50 modifier. Services coded with a 50 modifier should adhere to the AMA guidelines for appropriate use.upon request.

AMA Guidelines

Modifier	Description	Usage
50	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 five-digit code	Modifier applies to surgical procedures (CPT codes 10040-69990) and to radiology procedures performed bilaterally. ▪ Used to report bilateral procedures performed in the same operative session. Identify that a second (bilateral) procedure has been performed by adding modifier 50 to the procedure code. Do not report two line items to indicate a bilateral procedure. ▪ Do not use modifier with surgical procedures identified by their terminology as "bilateral" (e.g., 27395, lengthening of hamstring tendon, multiple, bilateral), or as "unilateral or bilateral" (e.g., 52290, cystourethroscopy, with meatotomy, unilateral or bilateral). ▪ Applies to any bilateral procedure performed on both sides at the same session. ▪ Report only one unit of service in FL 46 when modifier 50 is reported.

Reimbursement Rate

A. Bilateral procedures utilizing the 50 modifier will be reimbursed at 150% of the rate of a typical unilateral surgical reimbursement.