SPECIAL eBULLETIN

FOR PROFESSIONAL PROVIDERS **MARCH 29, 2019**

CHANGE IN BILATERAL PROCEDURE REPORTING RULES

Effective for claims processed on or after July 1, 2019, Highmark will be updating the reporting guidelines for bilateral services. This change is to more closely follow CMS bilateral rules and simplify billing practices for professional providers.

REPORTING GUIDELINES FOR BILATERAL PROCEDURES

There are several ways to report bilateral procedures. When reporting procedures that were performed bilaterally, you must report the correct number of services to correspond with the modifier(s) you report.

Right and Left Modifiers (RT & LT)

- If you report bilateral services on two lines of service, report modifier RT on one line and modifier LT on the other. The number of services on each line should be 1. This option is selected when the services occur on the same day but not during the same operative session. Do not use RT & LT when modifier -50 is appropriate.

Bilateral Modifier (-50)

- Modifier -50 is used for bilateral procedures that are performed at the same operative session. If you report modifier -50 to indicate a bilateral procedure, report the procedure on one claim line. The number of services should be 1*.
  *Note - Previous Highmark direction was to report 2 units of service with modifier -50.

Multiple services on the same side of body

- If you report multiple services performed on the same side of the body, report the appropriate modifier for laterality (RT or LT) and the applicable number of units.
- If you report multiple services for the same side of the body on separate claim lines, you must append modifier -76 on the second line that reports the same procedure code for correct payment to be made.

EXAMPLES OF CORRECT CODING FOR BILATERAL PROCEDURES

Procedure Code	Description	Bilateral Indicator	Modifier Reported	Units Reported	Rationale
23515	OPEN TREATMENT OF CLAVICULAR FRACTURE, INCLUDES INTERNAL FIXATION, WHEN PERFORMED	1	-50	1	Code description does not identify procedure as bilateral. Report modifier -50 with 1 unit of service for bilateral services.
64488	CYSTOURETHROSCOPY; WITH URETERAL MEATOTOMY, UNILATERAL OR BILATERAL	2		1	Code description identifies procedure as bilateral. Report procedure code without a modifier and 1 unit of service.
52290	TRANSVERSUS ABDOMINIS PLANE (TAP) BLOCK (ABDOMINAL PLANE BLOCK, RECTUS SHEATH BLOCK) BILATERAL; BY INJECTIONS (INCLUDES IMAGING GUIDANCE, WHEN PERFORMED)	2		1	Code description identifies procedure as unilateral or bilateral. Report procedure code without a modifier and 1 unit of service.
73070	RADIOLOGIC EXAMINATION, ELBOW; TWO VIEWS	3	-50	1	Code description does not identify procedure as bilateral. Report modifier -50 with 1 unit of service for bilateral services.

EXAMPLES OF INCORRECT CODING FOR BILATERAL PROCEDURES

Procedure Code	Description	Bilateral Indicator	Modifier Reported	Modifier Reported	Units Reported	Rationale
23515	OPEN TREATMENT OF CLAVICULAR FRACTURE, INCLUDES INTERNAL FIXATION, WHEN PERFORMED	1	RT	LT	2	Do not use modifiers RT and LT on same claim line when modifier -50 applies.
64488	CYSTOURETHROSCOPY; WITH URETERAL MEATOTOMY, UNILATERAL OR BILATERAL	2	-50		2	Code description identifies procedure as bilateral. Do not use modifier -50 or report 2 units of service.
52290	TRANSVERSUS ABDOMINIS PLANE (TAP) BLOCK (ABDOMINAL PLANE BLOCK, RECTUS SHEATH BLOCK) BILATERAL; BY INJECTIONS (INCLUDES IMAGING GUIDANCE, WHEN PERFORMED)	2	-50		1	Code description identifies procedure as unilateral or bilateral. Do not use modifier -50 or report 2 units of service.
73070	RADIOLOGIC EXAMINATION, ELBOW; TWO VIEWS	3	RT	LT	2	Do not use modifiers RT and LT on same claim line when modifier -50 applies.

REIMBURSEMENT GUIDELINES FOR BILATERAL PROCEDURES

Reimbursement for bilateral services is based on the modifier(s) reported as well as the CMS bilateral indicator found on the Medicare Physician Fee Schedule. The bilateral indicators along with their payment rules are listed below.

- 0 - 150 percent payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or with modifiers RT and LT, Highmark will base 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. Codes with this identifier are typically unilateral, and modifier --50 is not billable.
- 1 - 150 percent payment adjustment for bilateral procedures applies. If 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), Highmark will base payment 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.
- 2 - 150 percent payment adjustment for bilateral procedure does not apply. Fees are already based on the procedure being performed as a bilateral procedure. If the 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), Highmark will base payment 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. Codes with this identifier are typically identified as bilateral in the code description and modifier -50 is not billable.
- 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), Highmark will base 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% of the fee schedule amount for each side. Codes with this identifier are typically radiology procedures or other diagnostic tests not subject to bilateral rules.
- 9 - Codes with this identifier do not apply to the bilateral concept. Modifier -50 is not billable.

REVIEW HIGHMARK'S BILATERAL PROCEDURE CODING GUIDELINES

You can review Highmark’s bilateral procedure coding guidelines in the Highmark Provider Manual’s Chapter 6, Unit 4, section “Reporting Bilateral Procedures.” Visit the Provider Resource Center and click **MANUALS** in the top navigation bar, and click the **Highmark Provider Manual** link.