JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.017
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	Subject **Bilateral Procedures**	*Supersedes Date*	09/15/2023
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This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Anatomic Modifier, Bilateral, Modifier 50, Surgical Procedure

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding

principles, and follows the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these variations. When there is an update, policies will be published on our website.

II. PURPOSE

To provide guidance on billing and reimbursement of diagnostic, radiological or surgical procedures that are performed on both sides of the body on the same day or during the same operative session, for participating and nonparticipating providers submitting claims to JHHP. Providers must bill for the reimbursement of covered services that are within the provider's scope of practice under state and federal law. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

III. POLICY STATMENT

JHHP closely aligns to CMS guidance for this policy, which may differ from the CPT coding guidelines. JHHP has identified CPT codes and HCPCS code that are not payable, not covered, or are considered bundled (not separately reimbursed) and applicable to this policy. Due to changes in regulatory, CMS and State guidance, and provider contracts, additional codes may apply. Each line of business possesses its own unique guidelines for benefit and payment purposes, as such JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. GENERAL BILLING GUIDELINES & PAYMENT METHODOLOGY FOR BILATERAL PROCEDURES AND SERVICES

1. When applicable, JHHP pays for multiple surgeries by ranking from the highest physician fee schedule amount to the lowest, with 100% of allowable for major procedures, or first surgical procedure and 50% allowable for all other procedures.
2. Descriptors for some HCPCS/CPT procedure codes include the term "bilateral" or the phrase "unilateral or bilateral". If a procedure is performed bilaterally, report the bilateral procedure code, if available.
3. When there is no code describing bilateral services, report the bilateral service on one claim line, adding modifier -50, bilateral procedure, or on two lines – first line without modifier 50, and second line with the 50 modifier.
4. A provider/supplier shall not unbundle a bilateral procedure code into two, unilateral procedure codes.
5. Claims for multiple bilateral procedures will be processed follow multiple surgery guidelines outlined in the JHHP Multiple Procedures: Modifier 51. Please see policy for additional information.
6. CPT code descriptors often define correct coding relationships where two codes may not be reported separately with one another at the same anatomic site and/or same patient encounter.

7. The Medically Unlikely Edits (MUE) value for a surgical or diagnostic procedure may be based on the bilateral surgery indicator on the Medicare Physician Fee Schedule (MPFS).
8. The appropriate diagnosis code must be reported when billing for certain bilateral services. If the appropriate diagnosis is not reported, the claim may be pended for review or denied.
9. Bundling edits, PTP edits, NCCI, and MUEs, are all applicable to this policy and will be utilized to prevent payment or overpayments, for the inappropriate billing of a number/quantity of the same service on a single day.
    a. Refer to the JHHP reimbursement policy on NCCI and MUE Edits for coding guidance and additional information.
    b. Refer to Medicare and Medicaid NCCI Policy Manual and the Medicare Claims Processing Manual for coding guidance and additional information.
10. In alignment with CMS, JHHP will deny claims absent of the appropriate modifier or a narrative to support that the service was separate and unique, in order to reduce the erroneous duplicative billing that can occur.
11. Services requiring a prior authorization must be approved prior to services being rendered or the claim may be denied. Prior authorization is not a guarantee of payment.
12. Appropriate documentation must support all codes billed. Claims for some services may be pended for further review.
    - As supported by Section 1815(a) and Section 1833(e) of the Social Security Act, Section 422.214(a)(2) of Title 42 of the Code of Federal Regulations, contract provisions and other relevant guidance, JHHP reserves the right to request itemized bills in order to confirm proper billing, prior to payment, when necessary.
13. Any improper billing may result in payment reduction or denial for specific charges.
    - JHHP may conduct medical record documentation reviews on a randomly selected sample of practitioners or on providers who render services outside their regular scope of practice or assigned specialty.
    - Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.

V. USE of MODIFIER 50 BILLING GUIDELINES

1. JHHP billing expectations and reimbursement for modifier 50 is based on the procedure code's bilateral indicator found in the CMS Physician Fee Schedule (PFS).
2. JHHP will reimburse surgical services at 100% of the allowed amount for the first surgical procedure and 50% of the fee schedule or other allowed amount for the second surgical procedure when modifier 50 is correctly applied.
3. For bilateral procedures, do not bill the same code on two separate lines using the modifiers -RT (right side) and –LT (left side). Modifiers -RT and -LT are not acceptable substitutes for modifier 50 and will not process correctly. However, for bilateral codes with an indicator of 3, modifiers LT and RT should be billed instead of modifier 50.
4. Do use modifier 50 on bilateral body organs (e.g., kidneys, ureters, and hands).
5. Do not use modifier 50 when "one or both" is in the code description.
6. Consistent with CMS guidelines, providers shall not report LT/RT Anatomic modifiers in addition to modifier 50. These modifiers may be used without modifier 50, but *not* in addition to modifier 50.

VI. BILATERAL SURGERY INDICATOR GUIDELINES

1. Do not use modifier 50 when the Bilateral Surgery Indicator is 0, 2, 3, or 9.
    A. **Bilateral Surgery Indicator "0"**
        i. If the bilateral surgery indicator is "0," a bilateral procedure must be reported with "1" unit of service.
        ii. When the indicator "0" is designated, it means that the physiology, anatomy, or the code descriptor specifically states the procedure is unilateral or there is an existing code for the bilateral procedure.
        iii. Some codes which have a bilateral indicator of "0" may be performed more than once on a given day. These are services that would never be considered bilateral and thus should not be billed with modifier 50.

iv. 50% payment adjustment for bilateral procedures does not apply. 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.

B. **Bilateral Surgery Indicator "1"**
   i. If the bilateral surgery indicator is "1," a bilateral surgical procedure must be reported with the first line without modifier 50 and one line with modifier 50, when applicable.
   ii. The standard CMS adjustment rules apply for codes with a bilateral indicator of "1".

C. **Bilateral Surgery Indicator "2"**
   i. If the bilateral surgery indicator is "2," a bilateral procedure must be reported with one unit of service.
   ii. The procedure is priced as a bilateral procedure because (1) the code descriptor defines the procedure as bilateral; (2) the code descriptor states that the procedure is performed unilaterally or bilaterally; or (3) the procedure is usually performed as a bilateral procedure.

D. **Bilateral Surgery Indicator "3"**
   i. If the bilateral surgery indicator is "3", the code should not be listed with modifier 50.
   ii. 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.

E. **Bilateral Surgery Indicator "9"**
   i. If the bilateral surgery indicator is "9," the bilateral payment methodology does not apply, and no additional payment will be made.

VII. EXCEPTIONS and EXCLUSIONS

A. **PPMCO:** JHHP will process and reimburse claims for bilateral services/procedures in accordance to the Code of Maryland Regulations (COMAR) and Maryland Department of Health (MDH) guidance. Please consult the authoritative guidance found on the MDH website to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.
   - JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
   - Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
      - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

B. **USFHP-** JHHP will process and reimburse claims for bilateral services/procedures, in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

VIII. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
Bilateral Procedure	A procedure which can be performed on both sides of the body during the same session.
Unilateral Procedure	Unilateral procedures are procedures performed on one side of the body.

Physician or Other Qualified Health Care Professional (OQHCP)	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN).

Modifiers

Modifier	Definition
50	Bilateral procedure performed on both sides of the body.
51	Multiple procedures performed same date of service by the same provider.
59	Distinct Procedural Service
LT	Left side
RT	Right side

Bilateral Surgical Indicators

Surgical Indicator	Description
0	Indicates a unilateral code; Services may be unilateral, or another procedure code exists for services performed bilaterally. These services are never to be considered bilateral and the bilateral procedure concept does not apply.
1	Bilateral surgery rules apply.
2	Indicates a bilateral code; Code description may include terms like “bilateral” or “unilateral or bilateral”. Bilateral surgery concept does not apply.
3	Indicates primary radiology procedures and diagnostic tests; These codes are not considered bilateral and the bilateral procedures concept does not apply.
9	Indicates that the bilateral surgery concept does not apply.

IX. REFERENCES

This policy has been developed through consideration of the following:

- CMS PFS Relative Value Files
- CMS Regulations & Guidance
- COMAR- Maryland Department of Health- Maryland Medicaid Administration

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- CPT® Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- JHHP Reimbursement Policies
- Maryland Department of Health
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual CH. 12- Physicians/Nonphysician Practitioners
- NCCI for Medicaid | CMS
- NCCI for Medicare | CMS
- TRICARE Reimbursement Manual

X. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
10/16/2024	Revision	Updated policy language, formatting and references	Reimbursement Policy Committee (RPC)
7/05/23	New	Initial Release	Reimbursement Authorizations and Coding Committee (RAC)