Aetna Better Health® of Louisiana

(CC-L Reimbursement Policy Statement Louisiana Medicaid

Original Issue Date	Next Annual Review	Effective Date
01-01-2018	07-01-2019	07-01-2018
Policy Name		**Policy Number**
LA-Policy Incorrect Bilateral Increase (CC-Bilateral)		**ABHLA-RP-0046**

Policy Type			
Medical	**Administrative**	**Pharmacy**	**Reimbursement**

Aetna Better Health of Louisiana reimbursement policies are intended to provide a general reference for claims filing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims logic, benefits design and other factors not listed in this policy statement are considered in the development of reimbursement policies.

In addition to this Policy, reimbursement of rendered services are subject to member benefits, eligibility on the date of service, medical necessity, other plan policies and procedures, claim editing logic, provider contracts and all applicable authorization, notification and utilization management guidelines set forth by the Louisiana Department of Health (LDH) and the Centers for Medicare and Medicaid Services (CMS).

This policy does not ensure either an authorization or reimbursement of services. Please refer to the plan contract for the service(s) referenced therein. If there is a conflict between either this policy or the plan contract, then the plan contract will be the controlling document used to make an authorization or payment determination.

CONTENTS OF POLICY

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A. Policy

Aetna Better Health of Louisiana implements comprehensive and robust policies to ensure alignment with Louisiana Department of Health (LDH) and to warrant that regulatory standards are met. The effective date of implementation for this reimbursement policy is contingent upon the Louisiana Department of Health's endorsement.
Medicaid makes payment for bilateral procedures based on lesser of the actual charges or 150 percent of the Medicaid Physician Fee Schedule (MPFS) amount when the procedure is authorized as a bilateral procedure.

B. Overview

When performing a procedure on bilateral body parts, append payment modifier 50 to the appropriate code performed at the same session. The bilateral adjustment is inappropriate for (a) physiology or anatomy codes or (b) code descriptor that specifically states it is a unilateral procedure and there is an existing bilateral procedure code.

C. Definitions

Bilateral procedures are procedures performed on both sides of the body during the same operative session.
Modifier 50 is used to report bilateral procedures that are performed during the same operative session by the same physician in either separate operative areas (e.g. hands, feet, legs, arms, ears), or one (same) operative area (e.g. nose, eyes, breasts).

D. Reimbursement Guidelines

- Medicaid makes payment for bilateral procedures based on lesser of the actual charges or 150 percent of the Medicaid Physician Fee Schedule (MPFS) amount when the procedure is authorized as a bilateral procedure.
- Bilateral procedures rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicaid when the procedure is authorized as a bilateral procedure and is billed on type of bill (TOB) 85X with revenue code (RC) 96X, 97X or 98X and the 50 modifier (bilateral procedure).

E. Codes/Condition of Coverage

- Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session.
- When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported.
- If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure should be reported on a single line item with the 50 modifier and one service unit.

- Whenever the 50 modifier is appended, the appropriate number of service units is one.
- Modifiers LT (left side) and RT (right side) are not to be reported when the 50 modifier applies.
- Claims with the LT and RT modifiers will be returned to the provider (RTP) when modifier 50 applies.

F. Frequently Asked Questions

Q: What is the inappropriate use of Modifier 50?

- Using modifier 50 on a bilateral procedure performed on different areas of the right and left sides of the body.
- Appending modifier 50 to a procedure code that is defined by CPT as primarily bilateral or a bilateral service.
- Appending modifier 50 to a surgical CPT code, the description of which contains the words "one" or "both."
- Reporting bilateral procedures as two separate claim line items

Q: What is the appropriate use of Modifier 50?
A:One line appending modifier 50 or RT and LT using one unit of service
See Bilateral Surgery Rules within Medicare Physician Fee Schedule (MPFS) Indicator Descriptions

G. Review/Revision Date

Action	Date	Comments
Date Issued	01-01-2018	
Date Revised	05-01-2018	
Effective Date	07-01-2018	

H. Resources

Louisiana Department of Health State Contract, regulations, Provider Manual, fee schedules and notices
http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PS/PS.pdf

Individual state Medicaid regulations, manuals & fee schedules
http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services
https://www.ama-assn.org/

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Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/