Clover

Clover Health Bilateral Procedure Reimbursement Policy

Policy #RP-009

Policy Title	Clover Health Bilateral Reimbursement Policy
Policy Department	Payment Strategy and Operations
Effective Date	1/1/2022
Revision Date(s)	1/1/2022
Next Review Date	

Disclaimer:

Clover Health applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

CMS defines a bilateral service as one in which the same procedure is performed on both sides of the body during the same operative session or on the same day. This policy will outline how Clover Health will process claims for bilateral procedures submitted by both contracted and non-contracted providers for all Clover Health plans.

Definitions:

- **Bilateral Procedure**:
  - A bilateral service is one in which the same procedure is performed on both sides of the body during the same operative session or on the same day.

Policy:

Clover will process claims based on the modifiers reported, as well as the Center for Medicare & Medicaid Services (CMS) bilateral guidelines for procedures on the Medicare Physician Fee Schedule (MPFS) and their assigned bilateral indicators.

Bilateral surgeries are the same procedures performed on an anatomically paired body site during the same operative session or on the same day. If a procedure is not identified by its terminology as a unilateral or bilateral procedure, physicians must report a bilateral service on one line item with the modifier 50 when allowed. If the 50 modifier is not allowed, report the service on two separate lines, and append the RT modifier to one line and the LT modifier to the other line.

Bilateral MPFS Indicators:

Indicator	Description
0	Bilateral surgery rules do not apply. Do not use modifier 50.
1	Bilateral surgery rules apply. Use 50 modifier if bilateral and bill with 1 unit.
2	Bilateral surgery rules do not apply. Do not submit with modifier 50. Bilateral pricing will apply. Submit with 1 unit.
3	Bilateral rules do not apply. Do not append modifier 50.
9	Bilateral concept does not apply

The MPFS defines the indicators in the bilateral column as follows:

0=150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the 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.

The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 = 150 percent payment adjustment for bilateral procedures applies. If a code is billed with

the bilateral modifier or is reported twice on the same day by any other means (such as with RT and LT modifiers or with a 2 in the units field), payment is based 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.
If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral adjustment is applied before applying any applicable multiple procedure rules.

'2=150 percent payment adjustment does not apply. RVUs 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 or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100 percent of the fee schedule for a single code.

'3=The usual payment adjustment for bilateral procedures does not apply. If the 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), base the 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 percent of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.'

9 = Concept does not apply.

References
Internet Only Manual, Publication 100-4, Medicare Claims Processing Manual, Chapter 12, Section 40.7
Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files
Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements