DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Medically Unlikely Edits (MUE) and Bilateral Surgical Procedures

Note: This article was revised with more details and examples and was re-issued on January 17, 2018. Providers who perform bilateral surgical procedures should review the entire article.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare Administrative Contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries using the Physician Fee Schedule (PFS).

Provider Action Needed

The purpose of this article is to inform providers that Medically Unlikely Edits (MUEs) may render certain claim lines for bilateral surgical procedures unpayable. Providers and suppliers billing using the PFS are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and One Unit of Service (UOS).

Make sure your billing staffs examine their process for filing claims for bilateral surgical procedures and services to ensure the -50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

Background

Healthcare Common Procedure Coding System (HCPCS) coding for bilateral surgical procedures differs from CPT coding guidelines.

Coding claims for surgical procedures performed bilaterally depends on:

- The HCPCS code descriptor,
- The "Bilateral Indicator" assigned to the HCPCS code (that is, whether special payment rules apply), and
- The nature of the service.

The "National Correct Coding Initiative (NCCI)" manual specifies that modifier -50 is used to report bilateral surgical procedures as a single UOS. The NCCI manual warns that MUE edits based on established CMS policies may limit units of service and are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently, many bilateral procedures have an MUE value of 1.

Bilateral indicators only apply to the Physician Fee Schedule (PFS) and not to other Medicare payment systems.

Bilateral Indicators

Bilateral Indicator	What Does this Bilateral Indicator Mean?
0	**No bilateral payment adjustment** 150% 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 and (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). 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% Bilateral payment adjustment** 150% payment adjustment for bilateral procedures applies. If the 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), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.

Bilateral Indicator	What Does this Bilateral Indicator Mean?
2	**Bilateral procedure** 150% 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% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.
3	**No bilateral payment adjustment** 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% 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.

Examples of Correct Coding for Bilateral Surgical Procedures for PFS

Bilateral Indicator	Expected Units of Service if performed bilaterally	Modifier based on Laterality	HCPCS code descriptor and *Explanation of Correct Coding*
1	1	50	23515 Open treatment of clavicular fracture, includes internal fixation, when performed. *The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier "-50" as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.*
2	1		52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral.** *The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50".*
2	1		64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). *The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50".*

Examples of Incorrect Coding for Bilateral Surgical Procedures for PFS

Bilateral Indicator	Expected Units of Service if performed bilaterally	Modifier based on Laterality	Second Modifier	HCPCS code descriptor and *Explanation of Incorrect Coding*
1	1	RT	LT	23515 Open treatment of clavicular fracture, includes internal fixation, when performed. *The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier "-50" as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.*
2	1		LT	52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral.** *The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50". Do not report the procedure using two line items using RT and LT modifiers.*
2	1	RT		52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral.** *The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50". Do not report the procedure using two line items using RT and LT modifiers.*

Bilateral Indicator	Expected Units of Service if performed bilaterally	Modifier based on Laterality	Second Modifier	HCPCS code descriptor and *Explanation of Incorrect Coding*
2	2			64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). *The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report two UOS.*
2	1	50		64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). *The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report the procedure with modifier "-50".*

Request for Reopening of a Claim

For all MUE edit denials, including both MAI of 2 and 3, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening (i.e., a Clerical Error Reopening (CER)) to correct its billing of the claim as an alternative to filing a formal appeal. Providers can request a CER through their Medical Administrative Contractor. Providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral surgical service because it was billed with two UOS instead of being billed with one UOS and a -50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the -50 modifier to avoid future denials and delays in payment.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

You may also want to review the following publications:

- For information on Clerical Error Reopenings (CERs) consult the Claims Processing Manual Pub. 100-04 Chapter 34 and work with your Medicare Administrative Contractor
- For information on MUE Adjudication Indicators (MAIs) review the Revised Modification to the Medically Unlikely Edit (MUE) Program available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8853.pdf
- For information on Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS) consult the Claims Processing Manual Pub. 100-04 Chapter 4 Section 20.6 - Use of Modifiers
- A podcast transcript on the MUEs at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/2015-05-21-Medically-Unlikely-Edits-Compliant-PodcastTranscript.pdf.
- MLN Matters article MM6526 "Payment of Bilateral Procedures in a Method II Critical Access Hospital (CAH)" at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6526.pdf.

Document History

Date of Change	Description
January 17, 2018	This article was revised with more details and examples and was re-issued.
June 30, 2014	Initial article released.