40.7 – Claims for Bilateral Surgeries

(Rev. 1, 10-01-03)

A. General

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

The terminology for some procedure codes includes the terms "bilateral" (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or "unilateral or bilateral" (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as "bilateral" or "unilateral or bilateral" since the fee schedule reflects any additional work required for bilateral surgeries.

Field 22 of the MFSDB indicates whether the payment adjustment rules apply to a surgical procedure.

B. Billing Instructions for Bilateral Surgeries

If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier 50. They report such procedures as a single line item. (**NOTE:** This differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two line items.)

If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, physicians do not report the procedure with modifier 50.

C. Claims Processing System Requirements

Carriers must be able to:

1. Identify bilateral surgeries by the presence on the claim form or electronic submission of the 50 modifier or of the same code on separate lines reported once with modifier LT and once with modifier RT.
2. Access Field 34 or 35 of the MFSDB to determine the Medicare payment amount.
3. Access Field 22 of the MFSDB:
   - If Field 22 contains an indicator of "0," "2," or "3," the payment adjustment rules for bilateral surgeries do not apply. Base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply.

     NOTE: Some codes which have a bilateral indicator of "0" in the MFSDB 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. Where such a code is billed on multiple line items or with more than 1 in the units field and carriers have determined that the code may be reported more than once, bypass the "0" bilateral indicator and refer to the multiple surgery field for pricing.

   - If Field 22 contains an indicator of "1," the standard adjustment rules apply. Base payment on the lower of the billed amount or 150 percent of the fee schedule amount (Field 34 or 35). (Multiply the payment amount in Field 34 or 35 for the surgery by 150 percent and round to the nearest cent.)
4. Apply the requirements §§40 - 40.4 on global surgeries to bilateral surgeries.
5. Retain the 50 modifier in history for any bilateral surgeries paid at the adjusted amount.

   (**NOTE:** The 50 modifier is not retained for surgeries which are bilateral by definition such as code 27395.)

40.8 – Claims for Co-Surgeons and Team Surgeons

(Rev. 1, 10-01-03)

A. General

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

B. Billing Instructions

The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier 62. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the MFSDB. (See §40.8.C.5.).
- If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier 66. Field 25 of the MFSDB identifies certain services submitted with a 66 modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing "by report."
- If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services. (See §40.6 for multiple surgery payment rules.)

For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.

C. Claims Processing System Requirements

Carriers must be able to:

1. Identify a surgical procedure performed by two surgeons or a team of surgeons by the presence on the claim form or electronic submission of the 62 or 66 modifier.
2. Access Field 34 or 35 of the MFSDB to determine the fee schedule payment amount for the surgery.
3. Access Field 24 or 25, as appropriate, of the MFSDB. These fields provide guidance on whether two or team surgeons are generally required for the surgical procedure.
4. If the surgery is billed with a 62 or 66 modifier and Field 24 or 25 contains an indicator of "0," payment adjustment rules for two or team surgeons do not apply:
   - Carriers pay the first bill submitted, and base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply.
   - Carriers deny bills received subsequently from other physicians and use the appropriate MSN message in §§40.8.D. As these are medical necessity denials, the instructions in the ***Medicare Program Integrity Manual*** regarding denial of unassigned claims for medical necessity are applied.
5. If the surgery is billed with a 62 modifier and Field 24 contains an indicator of "1," suspend the claim for manual review of any