UnitedHealthcare Community Plan

Revision to Maximum Frequency per Day and Bilateral Procedures Policies for Procedure Codes with Bilateral Surgery Indicator of "2"

UnitedHealthcare Community Plan's Maximum Frequency per Day (MFD) and Bilateral Procedures policies consider bilateral payment through the use of modifiers LT and RT as inappropriate for procedures, services and supplies where the concept of laterality does not apply. These policies allow payment up to the maximum frequency per day value for codes with "bilateral" or "unilateral or bilateral" in their description or for codes where the concept of laterality does not apply, whether submitted with or without modifiers LT and/or RT by the same individual physician or other health care professional on the same date of service for the same member.

Many of the codes whose descriptions have "bilateral" or "unilateral or bilateral" in their description also have a Centers for Medicare & Medicaid Services (CMS) National Physician Fee Schedule Bilateral Surgery indicator of 2, which is defined by CMS as, "150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure." In addition, some of the codes with a CMS Bilateral Surgery indicator of 2 do not have "bilateral" or "unilateral or bilateral" verbiage in their description, but they are also not eligible for bilateral reimbursement.

Effective for claims processed on or after Feb. 12, 2017, UnitedHealthcare Community Plan will no longer allow the Bilateral Surgery indicator 2 codes to be reimbursed for two sides when billed with modifiers LT and RT. While this concept applies to both the Bilateral Procedures and MFD policies, the MFD policy contains the complete list of codes for which the concept of laterality does not apply. This list includes all codes that have "bilateral" or "unilateral or bilateral" in their description and will also include all Bilateral Surgery indicator 2 codes.

Note Regarding Reimbursement Policies

As with all UnitedHealthcare Community Plan policies, other factors affecting reimbursement may supplement, modify or in some cases supersede this policy. These factors include but are not limited to federal and/or state regulatory requirements, physician or other provider contracts, and/or the member's benefit coverage documents.

Unless otherwise noted as follows, these reimbursement policies apply to services reported using the CMS-1500 or its electronic equivalent, or its successor form.

UnitedHealthcare Community Plan reimbursement policies do not address all issues related to reimbursement for services rendered to our members, such as the member's benefit plan documents; our medical policies; and the UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Likewise, retirement of a reimbursement policy affects only those system edits associated with the specific policy being retired. Retirement of a reimbursement policy is not a guarantee of payment. Other applicable reimbursement and medical policies and claims edits will continue to apply.

Once implemented, the policies may be viewed at UHCCommunityPlan.com > For Health Care Professionals (click on the appropriate state) > Reimbursement Policies.

In the event of an inconsistency or conflict between the information in this Provider Notification and the posted policy, the provisions of the posted reimbursement policy prevail. If you have any questions, please contact your Health Plan Representative or call the number on your Provider Remittance Advice/Explanation of Benefits.