Modifier 50 – Bilateral Procedure

Last Updated: 3/12/2025 **Last Reviewed: 3/12/2025** **Originally Effective: 1/1/2000**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM057**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** Details below

Reimbursement Guidelines

A. General

1. Bilateral services are to be reported with modifier 50 according to the guidelines outlined in this policy.
2. Modifier 50 may not be submitted in combination with modifiers 53, 73, or 74 on the same line item. Only a unilateral procedure may be reported as discontinued.
3. If a single code identifies the bilateral procedure performed, report that code instead of the unilateral procedure code with modifier 50.
4. A procedure code may not be reported for bilateral services with modifiers LT & RT on a single line item instead of reporting modifier 50. [6]
5. If bilateral procedures are reported with other procedure codes on the same day, multiple surgery procedure adjustments apply as usual in addition to the bilateral payment adjustment. Other payment adjustments (e.g., assistant surgeon, related procedure within postoperative period, multiple procedure reductions, etc.) also apply, when appropriate.
6. The remainder of the bilateral procedure billing and pricing guidelines vary somewhat based upon the procedure code billed and which bilateral procedure indicator is assigned to that procedure code on the National Medicare Physician Fee Schedule Database (MPFSDB). See specifics below.

B. Bilateral Procedure Indicator of "1"

1. Bilateral procedure fee adjustments are applied to procedure codes with a bilateral procedure indicator of "1" on the MPFSDB. These procedures will be reimbursed at 150% of the usual applicable fee schedule rate.
2. The guidelines for codes with bilateral indicator of "1" depends upon the type of provider.
   a. For Ambulatory Surgery Centers requirements vary based on line of business:
      i. For Commercial plans: Bilateral services are to be reported as a one-line entry using modifier 50 and units = 1.

         If bilateral services are reported with modifier 50 and units = 2, the service will be denied for incorrect billing and a corrected claim will be needed.
         The denial EX code will be:
         t71 A modifier reported on this line does not match the number of units billed.

         835 CARC/RARC denial combination:
         CARC 16 Claim/service lacks information or has submission/billing error(s).
         RARC M53 Missing/incomplete/invalid days or units of service.

      ii. For Medicare Advantage plans: Report as two procedures, either as a single unit on two separate lines or with "2" in the units field on one claim line.[3]

iii. For Medicaid plans: Report bilateral services on two lines, with modifier 50 appended to the second line only.[4, 5]

b. For all other types of providers, these bilateral services are to be reported as a one-line entry using modifier 50 and units = 1.

If bilateral services are reported with modifier 50 and units = 2, the service will be denied for incorrect billing and a corrected claim will be needed.
The denial EX code will be:

t71 *A modifier reported on this line does not match the number of units billed.*

835 CARC/RARC denial combination:

CARC 16 *Claim/service lacks information or has submission/billing error(s).*
RARC M53 *Missing/incomplete/invalid days or units of service.*

3. Keep in mind that other modifiers or pricing adjustments may also apply before the final allowable amount for the line item is calculated. (For example, multiple procedure reductions, co-surgeon or assistant surgeon pricing adjustments, related procedure within postoperative period, etc.)

4. Note: Although the 2020 CPT book Add-on Code guidelines were updated to instruct that modifier 50 (bilateral) is not to be used with add-on procedure codes, Moda Health follows the CMS MPFSDB bilateral procedure indicator settings. So long as an add-on procedure code lists a MPFSDB bilateral indicator of "1" Moda Health will continue to enforce the MUE limit of "1" unit for these add-on codes and require that bilateral services be reported as a one-line entry using modifier 50 and units = 1.

C. Bilateral Procedure Indicator of "3"

1. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for procedure codes with a bilateral procedure indicator of "1."

2. Pricing:
   a. Procedure codes with a bilateral procedure indicator of "3" are not subject to the 150% bilateral fee adjustment rules applied to indicator "1" codes.
   b. Instead, bilateral services of these procedure codes will be reimbursed at 200% of the usual applicable fee schedule rate (100% for right side and 100% for left side).

3. Billing requirements:
   a. Bilateral services for codes with a bilateral procedure indicator of "3" may be reported in one of the following methods:
      i. A one-line entry using modifier 50 and units = 1.
      ii. Two separate line items with one unit each, one with modifier RT appended, and the other with modifier LT appended.
   b. Procedure codes with a bilateral procedure indicator of "3" may not be reported with modifier 50 with two units, either on a single line item or two separate line items of one unit each.

D. Bilateral Procedure Indicator of "2"

1. Services in this category are already considered bilateral services and the RVUs and fee allowance are already based on the procedure being performed as a bilateral procedure.

2. For a procedure code with a bilateral indicator of "2" and an MUE limit of 1 unit with an MUE indicator of "2" (Date of Service), then no more than one unit of service is allowable per date of service, because the procedure code includes bilateral services.

3. Billing requirements:
   a. When services are performed bilaterally, report the procedure code with units = 1 and without modifier 50.
   b. When services are performed unilaterally, report the procedure code with modifier 52 and units = 1.
4. Processing:
   a. If these procedure codes are submitted with modifier 50, the line item will be denied for incorrect coding.
   b. If these procedure codes are submitted with units = 2, the MUE limit will apply a denial.
      i. There is no modifier bypass or reconsideration upon appeal for MUE limit denials with an MUE indicator of "2."
      ii. Due to system limitations, some of the MUE edits will apply the denial to all billed units on the line item, and others will allow units up to the MUE limit and deny the excess units (as Original Medicare does).
         1) If all of the units on the line are denied, a corrected claim will be needed with either billed units equal to the MUE limit, or the units split onto individual line items.
         2) If part of the units are allowed and part are denied, no corrected claim is needed, and any appeal of the denied units will be upheld.

E. Bilateral Procedure Indicator of "0" or "9"

1. Billing requirements:
   Procedure codes with a bilateral procedure indicator of "0" or "9" should not be submitted with modifier 50 appended. Modifier 50 is invalid for these procedure codes.
2. Processing:
   If these procedure codes are submitted with modifier 50, the line item will be denied for incorrect coding.

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
ASC	Ambulatory Surgery Center
ASO	Administrative Services Only
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MPFS MPFSD MPFSDB	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MUE	Medically Unlikely Edits
NCCI	National Correct Coding Initiative (aka "CCI")
PTP	Procedure-To-Procedure (a type of CCI edit)
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	Relative Value Unit

Modifier Definitions

Modifier	Modifier Description & Definition
Modifier 50	**Bilateral Procedure -** Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.

Medicare Physician Fee Schedule Database (MPFSDB) Bilateral Procedure Indicators

Indicator	Indicator Definition
0 –	150 percent payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor 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 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 applicable multiple procedure rules.
2 –	150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.
3 –	The usual payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.
9 –	Bilateral concept does not apply.

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Modifier 52 – Reduced Services." Moda Health Reimbursement Policy Manual, RPM003.
C. "Modifier 53 – Discontinued Procedure." Moda Health Reimbursement Policy Manual, RPM018.
D. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.
E. "Modifier 51 - Multiple Procedure Fee Reductions." Moda Health Reimbursement Policy Manual, RPM022.
F. "Modifiers 73 & 74 - Discontinued Procedures For Facilities." Moda Health Reimbursement Policy Manual, RPM049.
G. "Medically Unlikely Edits (MUEs)." Moda Health Reimbursement Policy Manual, RPM056.

Resources

1. American Medical Association. "Coding Tip: Use of the Bilateral Modifier." *CPT Assistant,* January/Spring 1992: 19.
2. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, Addendum - MPFSDB Record Layouts.
3. CMS. "Payment for Multiple Procedures." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 14 - Ambulatory Surgical Centers, § 40.5. Last accessed April 10, 2023.
4. OAR. OAR 410-130-0365. Section 6.d. Last accessed April 10, 2023. https://oregon.public.law/rules/oar_410-130-0365. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=85445 .
5. OAR. OAR 410-130-0380. Section 8.f. Last accessed April 10, 2023. https://oregon.public.law/rules/oar_410-130-0380 . https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=85450 .
6. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.3.2. Last accessed March 7, 2023.

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
3/12/2025	Clarified denial explanation codes for codes with bilateral indicator "1". Formatting updates. Minor rephrasing. No policy changes.
3/13/2024	Clarified that other pricing adjustments apply in addition to the bilateral pricing adjustment. Clarified processing and proper coding of codes with bilateral indicator "2". No policy changes.
2/14/2024	Last reviewed date updated. No changes.
4/12/2023	Clarified proper coding of unilateral procedures. Clarified proper coding of codes with bilateral indicator "1." Coding Guidelines & Sources and Resources updated. No policy changes.
10/12/2022	Idaho added to Scope. Acronyms updated. Policy History entries prior to 2022 omitted (in archive storage). No policy changes.
4/18/2018	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
Prior to 1/1/2000	Original Effective Date (with or without formal documentation). Policy based on CMS bilateral policy.