RB.004.A Modifier 50- Bilateral Procedure

Original Implementation Date : 03/21/2016
Version [A] Date: 03/3/2016
Last Reviewed Date: April 2024

PRODUCT VARIATIONS

This policy applies to all lines of business unless noted below.

Application of Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may vary based on individual contract.

POLICY STATEMENT

The intent of this policy is to communicate to professional providers the reporting requirements and reimbursement rules for Modifier 50 Bilateral Procedure.

POLICY GUIDELINES

Procedure codes with BILAT SURG indicator 1

- Report a bilateral procedure with Modifier 50 and one service unit on a single claim line.
- If a bilateral procedure is reported with other procedure codes on the same day, the bilateral adjustment is applied before applying any applicable multiple procedure rules.

Procedure codes with BILAT SURG indicator 3

- Payment is based on 100% for each procedure performed.
- Report a bilateral procedure with Modifier 50 and one service unit on a single claim line.
  - 200% reimbursement of the allowable amount will apply when performed bilaterally and reported with Modifier 50

Modifier LT or RT is used to indicate on which side of the body a service or procedure is performed. They do not indicate a bilateral service and should not be used to report a service or procedure performed bilaterally. Modifier 50 should be reported in the primary Modifier position. When the bilateral procedure has a professional and/or technical component, the TC/26 Modifier that reduces

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the fee schedule/allowable amount must be billed in the primary Modifier position and Modifier 50 in the secondary position.

Example 1	**Example 2**
Professional component -26, bilateral procedure - 50	Technical component - TC, bilateral procedure- 50
Ultrasound, breast 76641-26-50	Ultrasound, breast 76641-TC-50

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

CPT® is a registered trademark of the American Medical Association.

CPT Code	Description
N/A	N/A

HCPCS Code	Description
N/A	N/A

Modifier	Description
50	Bilateral procedures.

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the members' benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DESCRIPTION OF SERVICES

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

Modifier 50 Bilateral Procedure should be used to identify bilateral procedures performed at the same session, unless the CPT book directs otherwise.

The Centers for Medicare and Medicaid Services Physician Fee Schedule Database defines procedures that may be submitted as bilateral and how reimbursement is calculated.

Modifier 50 is considered a payment Modifier, rather than an informational Modifier. The addition of this modifier may affect payment depending on the procedure code and the Medicare Physician Fee Schedule Database Bilateral Surgery (BILAT SURG) indicator.

Below are the indicators:

0 = bilateral payment does not apply

1 = valid for bilateral payment

2 = bilateral payment already included

3 = bilateral payment does not apply for radiological procedure or diagnostic test

9 = bilateral payment does not apply

DEFINITIONS

N/A

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

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Policy Bulletins are developed by us to assist in administering plan benefits and constitute neither offers of coverage nor medical advice.

This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2024 review. No changes to document.	A	3/31/2016
2022 review. No changes to document.	A	3/31/2016
2020 review. No changes to document.	A	3/31/2016
2017 review. No changes to document.	A	3/31/2016
N/A – This is a new policy bulletin.	A	3/31/2016

REFERENCES

1) Refer to the Fee Schedule CMS Web page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU15A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending)

2) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

3) http://www.novitassolutions.com/webcenter/faces/oracle/webcenter/page/scopedMD/sad60252a_5537_4c5d_9350_ca405e36e159/Page133.jspx?contentId=00004345&_afrLoop=2741237662761000#!%40%40%3F_afrLoop%3D2741237662761000%26contentId%3D00004345%26_adf.ctrl-state%3Dl4gtbzypy_90

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