moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM057
Policy Title:	Modifier 50 - Bilateral Procedure		
Section:	Modifier	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2000	Initially Published:	4/18/2018
Last Updated:	3/6/2024	Last Reviewed:	3/13/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		3/13/2024	

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. (CMS[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.
        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. (CMS[3])
        iii. For Medicaid plans: Report bilateral services on two lines, with modifier 50 appended to the second line only. (OAR[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.
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 without modifier 50 and units = 1.
    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.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association

Acronym or Abbreviation		Definition
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
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
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)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
UB	=	Uniform Bill

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.

Indicator	Indicator Definition
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.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Use of the Bilateral Modifier

In 1991, many of the bilateral codes were deleted from CPT. This was done to standardize how bilateral procedures were reported.

The intent of the CPT Editorial Panel is for all modifiers to be appended to the appropriate code as a one-line entry. Hence, the reader was directed to report the unilateral code with the -50 modifier appended to that code as a one-line entry on the claim form to indicate the procedure was performed bilaterally.

For example: 49500-50

… …

Some of our readers have indicated that their local third party payors have requested that they repeat a code and append the -50 modifier to the code on the second line of the claim form.

For example: 49500 49500-50

Although it is intended by the Editorial Panel that the code be listed only once, check with your local third party payors to determine what is their preferred way for you to report bilateral procedures." (AMA[1])

"OAR 410-130-0365

Ambulatory Surgical Center and Birthing Center Services
(6) (d) For billing instructions regarding multiple procedures, see rule 410-130-0380." (OAR[4])

"OAR 410-130-0380

Surgery Guidelines
(8) (f) Bilateral procedures must be billed on two lines unless a single code identifies a bilateral procedure. Use modifier -50 only on the second line; ..." (OAR[5])

Cross References

A. "Modifier 52 – Reduced Services." Moda Health Reimbursement Policy Manual, RPM003.

B. "Modifier 53 – Discontinued Procedure." Moda Health Reimbursement Policy Manual, RPM018.

C. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.

D. "Modifier 51 - Multiple Procedure Fee Reductions." Moda Health Reimbursement Policy Manual, RPM022.

E. "Modifiers 73 & 74 - Discontinued Procedures For Facilities." Moda Health Reimbursement Policy Manual, RPM049.

F. "Medically Unlikely Edits (MUEs)." Moda Health Reimbursement Policy Manual, RPM056.

References & 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.

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g., T3 = Left foot, fourth digit)

- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** 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 information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
3/13/2024	Clarification/Update: Section A.5: Added for clarity. Section D: new section added specific to bilateral indicator "2" with expanded verbiage in response to provider inquiries/appeals.
2/14/2024	Annual review: Last reviewed date updated. No changes.

Date	Summary of Update
4/12/2023	Clarification/update: Section A.2, clarification. Section A.3 & 4 added for clarification. Section B.2: Guidelines clarified for bilateral indicator "1." Coding Guidelines & Sources: 2 entries added. Cross References: Hyperlinks added. References & Resources: 3 entries added.
10/12/2022	Formatting/Update: Change to new header; includes Idaho. Acronym table: 1 entry added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
4/18/2018	Policy 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.