



Bilateral Education

The purpose of this job aid is to provide clarification regarding the use of modifier 50 when billing Medicare.

Providers Types Affected

All Medicare physician and providers

Definition

Bilateral: Having, or relating to, two sides. For example, the right and left arm.

Key Points

First, it is important to note that Current Procedural Terminology (CPT) coding instructions and Medicare guidelines for use of the 50 modifier on claims are not the same. CPT instructs the use of the 50 modifier when billing for services provided bilaterally. In contrast, Medicare uses the modifier 50 mainly for reimbursement purposes and thus restricts the use of the modifier on claims.

For Medicare purposes, use modifier 50 as indicated by the Medicare Physician Fee Schedule Relative Value File (Medicare Physician Fee Schedule Database). The MPFSRVU (MPFSDB) indicators in the bilateral surgery column of the database instruct carriers how to reimburse for services. For Medicare claims, modifier 50 is only appropriate when the bilateral surgery indicator is "1" or "3" and the service(s) provided must have been done bilaterally.

The "0" in the Bilat Surg Column on the MPFSRVU means that the bilateral concept does not apply for this code. From the Medicare claim processing perspective, Medicare will not price claims for this procedure according to bilateral pricing reimbursement, which is 150% of the fee schedule amount. For codes with a "0" indicator, if more than one procedure is billed per day, the appropriate way to submit the procedure code would be to bill each unit on a separate line. The National Correct Coding Initiative (NCCI) edits, duplicate edits, and global surgery edits also need consideration. Therefore, it may be necessary to append appropriate modifiers such as 59, 76, 77, 78, or 79. Medicare providers must decide on the appropriate modifier based on the service(s) provided. The documentation in the medical record must support the use of the modifier chosen.

For the codes with an indicator of "1", and provided bilaterally, Medicare will allow covered services at 150% of the Medicare Fee Schedule for that procedure code. When billing for bilateral services, you can submit your claim with:

- The procedure code on one line, with both the LT and RT modifiers, use two in the units field.
- The procedure code on one line with modifier 50 and one in the units field.
- The procedure code on two lines, with LT on one line and RT on the other line, with one unit per line.



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If the service is not done bilaterally, only the LT or the RT would be billed according to the documentation. Bilateral reimbursement would not apply in this situation.

An indicator of a "2" means that Medicare reimbursement for these procedures already reflect bilateral reimbursement; therefore, the 50 modifier is not appropriate. When a procedure code with an indicator of "2" is billed with a 50 modifier, the claim will deny. When billing for services provided bilaterally that have a "2" indicator, use only one unit of service and no 50 modifier.

An indicator of "3" indicates the usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with a modifier 50, and one in the units, or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), allowed amount is based on 100% of the Medicare Fee Schedule for each side. Services in this category are generally radiology procedures or other diagnostic tests.

Appropriate Usage for Modifier 50 for Medicare

- When the procedure is done bilaterally AND the MPFSDB indicator for the procedure is "1" or "3", report the procedure code once; append with modifier 50 and report with one unit of service.
- This modifier is only appropriate when the service is performed on two bilateral body parts.

Inappropriate Usage for Modifier 50 for Medicare

- Reporting this modifier when the service is performed on different areas of the same side of the body.
- The BILT SURG indicator is 0,2 or 9.
- On a procedure code that is described as bilateral in its CPT description.
- Do not report a bilateral procedure on two lines of service and append modifier 50 to the second line of service.

Important Links:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp>