

# Billing for Bilateral Services

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## Scope

This guide is intended for use by medical professionals billing for professional fees on a HCFA1500 form. Ambulatory Surgical Centers (ASC) should follow the guidelines for billing bilateral services outlined in the Medicare Claims Processing Manual, Chapter 14 - Ambulatory Surgical Centers.

## Modifier 50

Modifier 50 is defined as Bilateral service. This modifier should be appended to professional service procedure codes when a procedure is performed on both sides of the body.

Bilateral is defined as the same procedure being performed:

- On identical anatomic sites on both sides of the body
- On same day within the same operative session
- By the same provider

When billing for professional services using modifier 50, the service should be billed on a single claim line with one unit. Billing for multiple units may result in partial or full denial of the claim. Use of modifiers RT/LT/50 on the same line will result in a denial of the line item. Billing multiple lines with modifier 50 on both lines will likely be subject to Medically Unlikely Edit (MUE) denials as defined by the National Correct Coding Initiative (NCCI).

## Example of Correct Use of Modifier 50

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Relate A-L to service line below (24E)										22. RESUBMISSION CODE				
A.	M06.261			B.	M06.262			C.		D.		23. PRIOR AUTHORIZATION NUMBER		
E.				F.				G.		H.				
I.				J.				K.		L.				
24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F. \$ CHARGES		G.
From To						EMG	(Explain Unusual Circumstances)				DIAGNOSIS POINTER			DAYS OR UNITS
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER						
01	01	24	01	01	24	11	20610	50			A,B	150	00	1

It is appropriate to append modifier 50 when:	Do not use modifier 50 when:
<ul style="list-style-type: none"> <li>• Procedure code indicates it's a unilateral procedure</li> <li>• The service is conducted on the identical anatomic sites on opposite sides of the body</li> </ul>	<ul style="list-style-type: none"> <li>• Procedure was performed on non-identical anatomic sites. NOTE: Use modifiers RT and LT with the appropriate anatomical diagnosis for each line</li> <li>• The procedure code description includes the terminology "bilateral" or "bilateral or unilateral"</li> <li>• The procedure was performed on midline organs such as bladder, uterus, esophagus or nasal septum</li> <li>• The procedure was performed on different areas of same side of body</li> </ul>

Not all procedures are eligible to be billed as bilateral. The Center for Medicare and Medicaid Services (CMS) indicates which codes are eligible to be billed as bilateral on the Medicare physician fee schedule (MPFS). Only codes with a MPFS bilateral indicator of "1" are eligible for increased reimbursement when billed with modifier 50.

If a code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral pricing adjustment is applied before applying any applicable multiple procedure pricing rules.

## Modifiers LT and RT

Modifiers LT (left) or RT (right) are used to indicate the side of the body on which a service or procedure is performed.

It is appropriate to bill for the same surgical service on two separate lines using the LT modifier on one line and the RT modifier on the other line when the same procedure was performed on non-identical anatomic sites on opposite sides of the body. Eg. Major joint injection in the left shoulder and right knee on the same day by the same provider.

Each line should have an appropriate diagnosis that corresponds with the appropriate anatomic location of the procedure that supports that the service was not a bilateral service.

## Example of Correct Use of Modifiers LT and RT

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below w/24E											22. RESUBMISSION CODE				
A. M06.261(right knee)			B. M06.212 (left shoulder)			C. _____		D. _____		E. _____		23. PRIOR AUTHORIZATION NUM			
E. _____			F. _____			G. _____		H. _____		I. _____		J. _____			
K. _____			L. _____												
24 A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	
MM	DD	YY	MM	DD	YY										
01	01	24	01	01	24	11			20610	RT			100	00	1
01	01	24	01	01	24	11			20610	LT			100	00	1

When billing for services that are eligible to be billed as bilateral, those services should be reported on a single line, for one unit, using modifier 50. Separating services on two lines using the LT and RT modifiers may result in a MUE denial of professional claims.

Modifiers LT and RT should not be appended to the same claim line with multiple units. Correct use of these modifiers is appending them to separate line items with the appropriate number of units to match how many times the procedure was performed on the single side of the body.

## CareOregon Application of 410-130-0380

Per OAR 410-130-0380, "Bilateral procedures must be billed on two lines unless a single code identifies a bilateral procedure. Use modifier -50 only on the second line."

CareOregon continues to accept claims when bilateral services are billed on two separate lines and will pay the appropriate bilateral service rates on the line item containing modifier 50. The second line on the same claim, in the absence of a modifier indicating that it is a separate procedure (eg. Modifier XS or 59), will be denied as a duplicate to the line item with modifier 50.

## References

Oregon Health Authority, Chapter 410, Division 120 Medical Assistance Program, Billing 410-120-1280

<https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=313885>

Oregon Health Authority, Chapter 410, Division 130 Medical-Surgical Services, Surgery Guidelines 410-130-0380

<https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=85450>

Center for Medicare & Medicaid Services, Medicare National Correct Coding Initiative (NCCI) Edits

<https://www.cms.gov/medicare/coding-billing/ncci-medicare>

These guidelines have been developed to accompany and complement the official conventions and instructions provided within the American Medical Association's Current Procedural Terminology (CPT) itself. Additions and deletions conform it to the most recent publications of CPT and HCPCS Level II and to changes in CareOregon and its affiliates coverage policy and payment status, and as such these guidelines are current as of 01/01/2023. Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. CareOregon and its affiliates make no claim, promise or guarantee of any kind about the accuracy, completeness or adequacy of the content for a specific claim, situation or provider office application, and expressly disclaim liability for errors and omissions in such content. As CPT codes change annually, you should reference the current version of published coding guidelines and/or recommendations from nationally recognized coding organizations for the most detailed and up-to-date information.

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