Billing for Bilateral Services

Last revised: August 2024

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

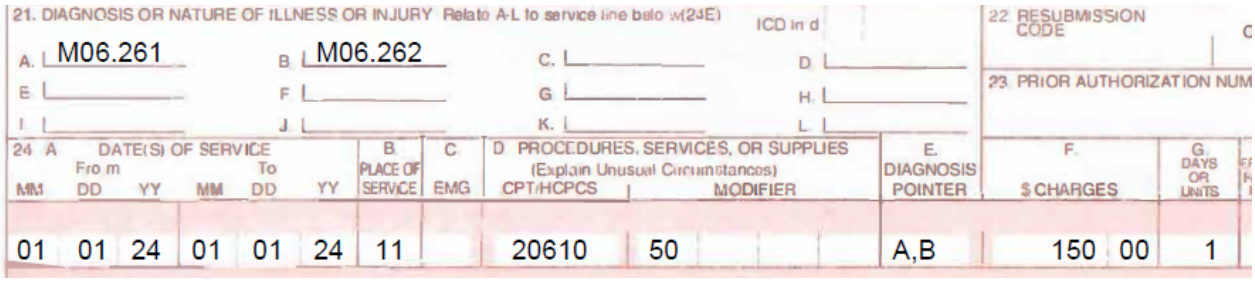
Modifier 50 is defined as Bilateral service. This modifier should be appended to professional service procedure codes when a procedure is performed on both sides of the body.

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) ICD Ind

A. M06.261 B. M06.262 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUM

24 A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	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
1 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:
• Procedure code indicates it's a unilateral procedure • The service is conducted on the identical anatomic sites on opposite sides of the body	• Procedure was performed on non-identical anatomic sites. NOTE: Use modifiers RT and LT with the appropriate anatomical diagnosis for each line • The procedure code description includes the terminology "bilateral" or "bilateral or unilateral" • The procedure was performed on midline organs such as bladder, uterus, esophagus or nasal septum • The procedure was performed on different areas of same side of body

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 (24E) ICD Ind

A. M06.261(right knee) B. M06.212 (left shoulder) C. D.

E. F. G. H.

I. J. K. L.

22 RESUBMISSION CODE

23 PRIOR AUTHORIZATION NUM

	24 A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	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
1	01	01	24	01	01	24	11		20610	RT	A	100 00	1
2	01	01	24	01	01	24	11		20610	LT	B	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

OHP-24825102-0903