Overview

Bilateral procedures which are not otherwise identified in the code description and which are performed at the same session should be billed with modifier 50.

Reimbursement Policy

Modifier 50 eligibility is based on procedure code description, CPT guidelines, and The Centers for Medicare and Medicaid (CMS) Physician Fee Schedule bilateral indicator.

Cigna provides reimbursement at 100% of the fee schedule or other allowed amount for the first surgical procedure and 50% of the fee schedule or other allowed amount for the second surgical procedure when modifier 50 is appended correctly.

Non-surgical codes that are eligible for bilateral reimbursement are reimbursed at 200% of the fee schedule or other allowed amount when billed with modifier 50 and “2” units on one line. Non-surgical codes are reimbursed at 100% of the fee schedule or other allowed amount when billed with HCPCS modifiers RT/LT on separate lines with “1” unit per line.

Multiple bilateral procedures follow multiple surgery guidelines outlined in the modifier 51 policy.

NOTE: This policy does not include multiple procedure reduction radiology as outlined in policy R01.

General Background

Modifier 50 is used to report bilateral procedures that are performed during the same operative session. It is only applicable to services and/or procedures performed on identical anatomical sites, aspects or organs.
When determining whether modifier 50 should be appended to a procedure, the Current Procedural Terminology (CPT®) code descriptors should be carefully reviewed. Many CPT code descriptors are intended for use unilaterally; however, there are others that indicate the code is inherently bilateral. If the descriptor indicates unilateral and/or bilateral, it would not be appropriate for use with modifier 50. In addition, if there are codes specific to the procedure, one for unilateral and one for bilateral, the bilateral code would be appropriate for use if the procedures were performed during the same operative session by the same physician.

The CMS Medicare Physician Fee Schedule DataBase (MPFSDB) is a resource available for assistance in determining if a procedure is appropriate for use with modifier 50. The database can be viewed by accessing the CMS website at: http://www.cms.hhs.gov/apps/pfslookup.asp.

The MPFSDB table lists the following designations for bilateral procedures:

0 - Procedure codes with this indicator are **inappropriate** for use with modifier 50 due to either the physiology or anatomy or because the code specifically states that it is a unilateral procedure and another code for bilateral procedures exists.

1 - Procedure codes with this indicator are **appropriate** to be reported with modifier 50. These procedures are unilateral and can be performed on identical anatomical sites, aspects or organs.

2 - Procedure codes with this indicator are **inappropriate** for use with modifier 50 because the code descriptors state that the procedure may be performed either unilaterally or bilaterally. The fee schedule amount is already based on the procedure being performed bilaterally.

3 - Procedure codes with this indicator are **appropriate** for use with modifier 50. These are typically non-surgical services (e.g., Radiology and some Diagnostic testing codes). When these services are performed bilaterally, the modifier 50 with “2” units or HCPCS modifier RT and LT on separate lines would be appended to indicate the procedure was performed on both the right and left sides.

9 - Procedure codes with this indicator are **inappropriate** for use with modifier 50. The concept of bilateral does not apply to these codes.

**Correct use of Modifier 50**

- Modifier 50 is used to report procedures performed on both sides of the body (mirror image) during the same operative session.
- Modifier 50 applies to bilateral procedures performed on both sides during the same session.
- For codes with a CMS designation of “1”, the procedure code should be listed once with modifier 50 and the number of units should be listed as “1”; For codes with a CMS designation of “3”, the code should be listed with modifier 50 on one line with “2” units or RT/LT on separate lines and “1” unit per line.

**Incorrect use of Modifier 50**

- Modifier 50 may not be used to report surgical procedures identified by their CPT descriptor as bilateral or unilateral.
- Modifier 50 should not be used with HCPCS modifiers RT and LT. If the CPT code descriptor indicates a bilateral procedure (there is not CPT code for unilateral procedure), and the procedure was only performed on one side, it is appropriate to use HCPCS modifiers RT or LT with modifier 52 (Reduced Services).

**Incorrect use of modifiers LT and RT**

- Modifier LT and RT should not be reported on the same claim line. Instead, they should be reported on separate claim lines.

**References**


### Policy History/Update

<table>
<thead>
<tr>
<th>Date</th>
<th>Change/Update</th>
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<tbody>
<tr>
<td>08/14/2018</td>
<td>Policy template updated.</td>
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<tr>
<td>11/10/2016</td>
<td>Policy template updated.</td>
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<tr>
<td>07/10/2015</td>
<td>Policy updated to indicate Modifiers RT and LT should never be reported on the same line. Changed usual &amp; Customary (U&amp;C) /Maximum Reimbursable Charge (MRC) to other allowed amount.</td>
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<tr>
<td>05/23/2011</td>
<td>Policy template updated.</td>
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<tr>
<td>11/02/2009</td>
<td>Updated policy to clarify non-surgical bilateral procedure reimbursement/billing.</td>
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<tr>
<td>08/06/2009</td>
<td>Modifier 50 policy effective for former Great West Healthcare</td>
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<tr>
<td>02/27/2009</td>
<td>Updated format. Policy notification for former Great West Healthcare</td>
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<tr>
<td>05/29/2007</td>
<td>Modifier 50 policy effective for Cigna HealthCare</td>
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