



Reimbursement policies are intended to supplement certain standard benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document always supersedes the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy.

Modifier 50 Bilateral Procedures

Policy Number: MAM50

Version 1.0

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Description

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

Reimbursement Information

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

HealthSpring will require a left (LT), right (RT), or modifier 50 for CPT codes with bilateral indicators 1 or 3 as applicable.

CPT code(s) with indicator 1 or 3 without a laterality modifier reported will be denied.

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 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 is a resource available for assistance in determining if a procedure is appropriate for use with modifier 50.

The MPFSDB table lists the following designations for bilateral procedures:

- 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.
- 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). Bilateral reimbursement reduction does not apply.

Correct use of Modifier LT, RT, and 50

- When reporting both the LT and RT extremities with codes 95885 and 95886, when unilateral use LT or RT and the correct number of units. For example, 95885 – RT 2 units represents right upper and lower extremities.
- When reporting both sides of different extremities with codes 95885 and 95886 use LT and RT with the correct number of units. For example, 95885 – LT 1 unit and 95885 – RT -59 1 unit.
- When bilateral report each set of extremities with a single unit and modifier 50. For example, if both upper and lower is performed report, 95885 – 50 2 unit.
- 20610 multiple extremities, if LT and RT for the right shoulder and left knee would be considered unilateral for each side and reported 20610 - RT 1 unit and 20610 – LT 1 unit
- 20610 for both shoulder and hip performed bilateral report 2 units with a modifier 50.

Incorrect use of modifiers LT, RT, and 50

- For codes 95885 and 95886 reporting only units with no modifiers
- Reporting LT and RT on the same claim line instead of modifier 50 to indicate bilateral procedure
- Reporting modifier 50 with units greater than one
- 20610 reported with 2 units and no modifier

References

[American College of Emergency Physicians](#). Accessed 04/13/2023

[Medicare Claims Processing Manual](#), Chapter 12, Section 30.6.11 Accessed 05/01/2023

[Medicare interactive](#). Accessed 05/01/2023

American Medical Association. Current Procedural Terminology 2024 (CPT) ©2023, Chicago, IL.

Understanding Modifiers: Comprehensive Instructions to Effective Modifier Applications, 2022, © 2021 Optum360, LLC

American Medical Association. Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage. 2022

Centers for Medicare and Medicaid Services, [Physician Fee Schedule](#). Accessed 05/10/2024

Policy Update History

Approval Date	Description
01/01/2026	New policy