LifeWise
Health Plan of Washington

Payment Policy

cmi_051717

Title	**Modifier 50 - Bilateral Procedure**		
Number	**CP.PP.223.v3.2**		
Last Approval Date	03/04/24	**Original Effective Date**	01/01/05
Cross Reference	• *Modifier 62 – Two Surgeons* • *Modifier 80, 81, 82 – Assistant Surgeons (Physician)* • *Modifier AS – Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Services for Assistant at Surgery (Non-Physician)* • *Multiple Surgical Reductions* • *Site Specifying Modifiers*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services appended with Modifier 50 that are submitted on a CMS-1500 paper claim form or an 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products. Medicare Advantage products are not subject to this policy.
Policy	The Plan recognizes Modifier 50-*Bilateral Procedure* when appended to a service to indicate that a bilateral procedure has been performed on identical anatomic sites on opposite sides of the body during the same operative session or on the same day by the same provider. A bilateral procedure performed on identical anatomic sites on opposite sides of the body should be appended with modifier 50 and **billed on a single line with one unit of service**. If modifier 50 is appended to a code on a claim line, the modifiers RT and LT **should not be billed** on the same code on the same claim line. Modifiers LT and RT are not used to indicate a bilateral surgical procedure. Modifiers LT or RT should be used whenever a procedure is performed on only **one anatomic side**. Per the ICD-10-CM Official Guidelines for Coding and Reporting, some ICD-10-CM diagnosis codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral diagnosis code is provided and the condition is bilateral, assign separate diagnosis codes for both the left and right side. Conflicts between the laterality of the diagnosis code and the laterality of the procedure code, as defined by the site-specific modifiers, will result in non-reimbursement. For the site-specific anatomic locations of the eyelids, toes and fingers, the site specifying modifiers should be used rather than modifier 50 where applicable. Modifier 50 should not be used on procedures/codes that are bilateral by definition/description or their descriptions include such terminology as "bilateral", "unilateral or bilateral" or "one or both".

	The Plan primarily determines whether codes are eligible/billable for bilateral surgery based on the "Bilateral Surgery flag" in the current CMS National Physician Fee Schedule Relative Value Guide (LINK) as follows: • **0** = Payment adjustment does not apply; Do not use modifier 50 • **1** = Payment adjustment does apply; Use modifier 50 if bilateral; units = 1 • **2** = Payment adjustment does not apply; RVUs already reflect bilateral service; Do not use modifier 50; units = 1 • **3** = Payment adjustment does not apply; Do not use modifier 50; units = 1 or 2 • **9** = Concept does not apply Codes identified in the NPFS with a flag indicator of 9-*Concept does not apply* may utilize other professional resources within the company and outside of the company such as the AMA CPT codebook or Professional societies and colleges to make exceptions. Reimbursement for services appended with modifier 50 will be adjusted to 150% of the provider's applicable Fee Schedule allowed amount. If the bilateral procedure is performed during the same session as another procedure(s), the bilateral reimbursement adjustment is applied prior to any other multiple procedure reductions. When a surgeon works as a co-surgeon on a bilateral procedure in conjunction with another surgeon working on the opposite anatomic location, both surgeons bill the exact same procedure code appended with modifier 62-Two Surgeons. Assistant Surgeon modifiers 80, 81, 82 or AS would not be appropriate in this situation.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	• In those instances where there is a conflict between CMS guidelines and AMA/CPT guidelines regarding modifier 50, the Plan will use guidelines as established by the AMA/CPT. • This policy does not apply to any provider reimbursed using an ASC APC payment methodology
Laws, Regulations & Standards	None
References	• Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) • American Medical Association's (AMA) Current Procedural Terminology Codebook (CPT) • American Medical Association's CPT Assistant

This policy was published on March 6, 2024

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	03/04/24; 04/06/23; 05/12/22; 05/27/21; 06/15/20; 04/30/20; 05/24/19; 06/05/18; 08/11/17; 09/14/16; 03/14/16; 03/15/15; 03/31/14; 04/28/13; 05/05/12; 05/13/11; 01/27/11; 02/12/10; 04/01/09; 10/10/08; 09/24/07; 08/28/06; 08/29/05; 06/27/05; 07/30/04	
Version History	06/05/18	Clarified the sourcing used to determine bilateral surgery
	05/24/19	Clarified the descriptions of the "Bilateral Flag" from the CMS National Physician Fee Schedule
	04/30/20	Clarified how providers should bill when they act as a co-surgeon on a bilateral surgical procedure
	06/15/20	Clarified in the Purpose statement that the policy applies to professional services billed on a CMS-1500 or 837P claim form. Added a LINK to the CMS National Physician Fee schedule referenced. Identified in the Exception section that the policy does NOT apply to ASC providers.
	05/27/21	Added further clarification to paragraph 2 on how to bill a procedure code appended with modifier 50.
	05/12/22	Added a paragraph that for the site-specific anatomic locations of the eyelids, fingers and toes, the site specifying modifiers should be appended rather than modifier 50. Added paragraph to indicate that NPFS flag 9 services may use other resources if modifier 50 is applicable
	04/06/23	Annual review; no changes
	03/04/24	Added the third paragraph which discusses laterality and the correct use of modifiers LT, RT and 50.

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