Bilateral Services and CPT Modifier 50

Bilateral services are procedures performed on both sides of the body during the same operative session or on the same day. The modifier "50" is not applicable to procedures that are bilateral by definition or their descriptions include the terminology as "bilateral" or "unilateral".

As defined in the CPT, Modifier 50 “Bilateral Procedure: Unless otherwise identified in the listing bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.”

Modifier "50" should follow the procedure code in Item 24d of the CMS-1500 claim form, or in the equivalent electronic field, when services are rendered bilaterally (unless the code does not require this modifier as described above).

Modifier 50, is used to report diagnostic, radiology and surgical procedures. Modifier 50 applies to any bilateral procedure performed on both sides at the same session. Do not use Modifiers RT and LT when modifier 50 applies. A bilateral procedure is reported on one line using modifier 50. The quantity entry to use when modifier -50 is reported is one.

NOTE: Use of modifiers applies to services/procedures performed on the same calendar day.

Reimbursement for bilateral services is determined using the Medicare Physician Fee Schedule Database (MPFSDB). The MPFSDB defines procedures that may be submitted as “bilateral” and how reimbursement is calculated.

- The “Bilateral Surgery Indicator” (Field 22) in the MPFSDB indicates how the bilateral service must be submitted to Medicare.
- To access this database, refer to the CMS Web site at: http://www.cms.hhs.gov/apps/pfslookup/step0.asp.
- The concept of a “bilateral service” applies when a procedure is performed on both sides of the body during the same operative session or on the same day.