Facility Bilateral or Anatomical Modifier Use

Marketplace

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as applicable, as well as the member's benefit plan document supersede the information in this policy. Additionally, to the extent there are any conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. Molina Healthcare adheres to the requirements of the Emergency Medical Treatment and Labor Act (EMTALA). If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Many surgical procedures may be performed bilaterally. Bilateral procedures are performed on both sides of the body during the same operative session or on the same day. An edit fires when a bilateral surgical procedure is billed without an anatomical modifier or without a modifier 50 as a bilateral anatomical marker. Procedure laterality modifiers are necessary for appropriate claim processing.

The AMA "CPT Manual" and the NCCI (National Correct Coding Initiative) program define modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered.

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component
- Service or procedure was performed by more than one physician
- **Unilateral procedure was performed**
- **Bilateral procedure was performed**

CMS defines modifiers that may be used under appropriate clinical circumstances to bypass certain NCCI PTP edits:

- **Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI**
- A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use.
- Appending a modifier to a code indicates records are available for review that support the modifiers use. It is important that NCCI PTP-associated modifiers only be used when appropriate. In general, these circumstances relate to separate patient encounters, separate time units, separate anatomic sites, or separate specimens.

The NCCI program requires that bilateral surgical procedures be reported using modifier 50 with one unit of service unless the code descriptor defines the procedure as "bilateral." If the code descriptor defines the procedure as a "bilateral" procedure, it shall be reported with one unit of service without modifier 50. If a bilateral surgical procedure is performed at different sites bilaterally, one unit of service may be reported for each site. That is, the

HCPCS/CPT code may be reported with modifier 50 and one unit of service for each site at which it was performed bilaterally.

Guidelines for bilateral procedures are as follows:

- The surgical procedure should be billed on a single line with modifier 50 and one unit when a bilateral procedure is performed and the CPT/HCPCS code does not describe a bilateral service.
- When a bilateral procedure is performed and there is a bilateral CPT/HCPCS code available, the bilateral code must be used.
- Modifier 50 should not be used to report procedures that are bilateral by definition or their descriptions include terminology such as “bilateral” or “unilateral”.
- Some procedure codes do not indicate on which side of the body that a procedure is performed. Modifiers LT or RT should be used to identify procedures which can be performed on opposite sides of the body such as joints, extremities, or paired organs, when performed unilaterally.
- Modifiers LT and RT should not be reported when the 50 modifier applies.
- Modifier 50 is required for radiology unless the code is written as a bilateral procedure or service.
- ASC specialty providers do not report modifier 50. For specific instructions for Ambulatory Surgical Centers, refer to Chapter 14 Ambulatory Surgical Centers, Section 40.5 of the "Medicare Claims Processing Manual" on the CMS website.

Medically Unlikely Edits (MUEs), prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE (Medically Unlikely Edits) for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

The MUE value for a surgical or diagnostic procedure may be based on the bilateral surgery indicator on the Medicare Physician Fee Schedule Database (MPFSDB).

Physician Fee Schedule Bilateral Payment Policy Indicators: OBJ:

Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to payment adjustment.

0 = 150 percent payment adjustment for bilateral procedures does not apply.

The bilateral adjustment is inappropriate for codes in this category because of: (a) physiology or anatomy, or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides, or (b) 150 percent of the fee schedule amount for a single code.

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.

2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.

The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

3 = The usual payment adjustment for bilateral procedures does not apply.

Services in this category are radiology procedures or other diagnostic tests not subject to the special payment rules for other bilateral procedures. If a procedure is billed with the 50 modifier, base payment on the lesser of the total actual charges for each side or 100% of the fee schedule amount for each side.

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9 = Concept does not apply.

Supplemental Information

Definitions

Term	Definition
Bilateral	A procedure performed on both sides of the body or of a body structure, right and left.
Unilateral	A procedure occurring on, or affecting only one side of an organ or structure of the body.
CPT	AMA (Against Medical Advice) Current Procedural Terminology.
HCPCS	Healthcare Common Procedure Coding System.

State Exceptions

State	Exception
Iowa	Iowa is excluded from this policy for Molina Marketplace as Molina Marketplace does not operate in Iowa.

Documentation History

Type	Date	Action
Effective Date	11/01/2020	New Policy
Revised Date	12/12/2024	Updated Links and Templates
Revised Date	03/31/2025	Added Iowa state exclusion.

References

Government Agencies https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

https://www.cms.gov/outreach-and-education/medicare-learning-network-

mln/mlnproducts/downloads/how_to_mpfs_booklet_icn901344.pdf https://www.cms.gov/files/document/physician-fee-schedule-

guide.pdf https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched

Professional Society Guidelines and Other Publications https://www.novitas-

solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00144531 Modifier 50 Fact Sheet

reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.