

BILATERAL SURGERIES: Claim Submission

The keys to submitting claims for bilateral services (procedures that are performed during the same operative session or same day on both sides of the body) are:

1. Finding and understanding the bilateral service indicator in the Medicare Physician Fee Schedule Database (MPFSDB), and
2. Submitting the correct modifier.

MODIFIERS

- CPT modifier 50 is defined as “bilateral procedure.” The units field for bilateral surgical procedures is 1.
 - **Exception:** Ambulatory Surgery Centers (ASCs) cannot submit CPT modifier 50 and will continue to use the units field to reflect bilateral services.
- Anatomic modifiers (HCPCS modifiers RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) may be submitted for unilateral services. Do not submit these modifiers for bilateral services.

BILATERAL SERVICES AND THE MPFSDB

- Use the CMS Physician Fee Schedule search to locate the bilateral indicator for the specific CPT or HCPCS code: <http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx>.
- Enter:
 - Year
 - Under “type of information,” select “Payment Policy Indicators”
 - Enter a single procedure code or a range
 - Select “All Modifiers”

Look in the “BILT SURG” column for the bilateral services indicator:

BILATERAL SURGERY INDICATORS AND CLAIM SUBMISSION

Bilateral Indicator	Definition	Submission Instructions
0	The concept of “bilateral” does not apply. The bilateral indicator is inappropriate for reason such as A) physiology, B) the code description states that it is an existing code for a bilateral procedure, or C) the procedure is not commonly performed as a bilateral procedure.	Do not submit these procedures with CPT modifier 50. These do not meet the bilateral criteria.
1	Valid for bilateral billing- bilateral claim submission criteria apply. Payment is adjusted for bilateral procedure applies if codes are submitted with CPT modifier 50. Payment is based on the lower of the billed amount or 150% of the Medicare fee schedule allowed amount.	Submit the procedure on a single detail line with CPT modifier 50 and a quantity of 1.
2	The payment adjustment for bilateral procedures does not apply. Relative Value Units (RVUs) are based on the procedure being performed as a bilateral procedure because: <ol style="list-style-type: none"> 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 	Do not submit these procedures with CPT modifier 50. These codes are already established as being performed bilaterally.
3	Radiological Procedures valid for bilateral criteria. These are radiology/diagnostic tests that are not subject to the special payment rules for other bilateral surgeries, and payment for each side is based on 100% of the fee schedule amount.	Submit the procedure on a single detail line with CPT modifier 50 and a quantity of 1.
9	Bilateral concept does not apply.	Do not submit these procedures with CPT modifier 50.

References & Resources:

- CMS Physician Fee Schedule Lookup: <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>
- CMS Medicare Claims Processing Manual (Pub.100-04), chapter 23, in the “Addendum – MPFSB Record Layout” (see Field 22): <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf>
- Payment for Multiple Procedures to ASCs: CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 14, section 40.5 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf>

