Summary

Bilateral services are procedures that can be performed on both sides of the body during the same session or on the same day by the same physician or other qualified health care professional.

Policy Statement

Medica follows the Centers for Medicare and Medicaid (CMS) guidelines for reimbursement of bilateral eligible codes. Bilateral eligible codes are listed in the CMS National Physician Fee Schedule (NPFS) with a bilateral status indicator of “1” or “3”. Codes with these indicators are eligible for bilateral procedure reimbursement as follows:

- Per CMS definition, codes with a bilateral status indicator of “1” are subject to a payment adjustment for bilateral procedures. When billed with the modifier 50 they will be reimbursed at 150% of the fee schedule amount for the single code.
- Per CMS definition, codes with a bilateral status indicator of “3” indicate the usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier 50 or is reported for both sides with modifiers RT and LT, they will be reimbursed at 100% of the fee schedule amount for each side.

Codes with bilateral in their intent or with bilateral written in their description are not eligible for bilateral procedure reimbursement because the code’s relative value unit (RVU) is inclusive of the bilateral procedure. These codes have a bilateral status indicator of “2” in the NPFS and should not be reported with the bilateral modifier 50, or with modifiers LT and RT.

Codes with a NPFS bilateral status indicator of “0” and “9” are not eligible for bilateral procedure reimbursement because the bilateral concept is not applicable for the procedure.

If a procedure is performed unilaterally but only a bilateral code description exists, submit the code with modifier 52 (reduced services) to indicate the procedure was performed unilaterally. Please refer to the Reduced Services policy.

If a procedure is performed unilaterally and the code description is “unilateral or bilateral,” appending modifier 52 is not necessary because the procedure description indicates it may be performed either unilaterally or bilaterally.

When billing for bilateral eligible services, submit the claim with:
- The procedure code on one line with modifier 50 and “1” in the units field.
- The procedure code on two lines, with modifier RT on one line and modifier LT on the other line, with “1” unit for each line.

Eligible bilateral procedures are subject to multiple procedure reductions. Please refer to the Multiple Procedure Reduction policy and to the Multiple Procedure Reduction Eligible Code List.

**Definitions**

**Modifier 50** – Bilateral Procedure. Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.

**Modifier 52** – Reduced Services. Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

**Modifier LT** – Left side. Used to identify procedures performed on the left side of the body.

**Modifier RT** – Right side. Used to identify procedures performed on the right side of the body.

**Code Lists**

- Bilateral Eligible Code List

**Resources**

- Centers for Medicare and Medicaid Services (CMS)
- Healthcare Common Procedure Coding System (HCPCS)
- National Physician Fee Schedule (NPFS)

**Effective Date**

04/01/1999

**Revision Updates**

- 10/08/2019  Annual policy review
- 07/01/2019  Code list update
- 01/01/2019  Code list update
- 01/01/2018  Code list update
- 09/01/2017  Annual policy review
- 10/01/2017  Code list update
- 02/01/2017  Code list update
Bilateral Procedures Policy