Reimbursement Policy	
Title: Bilateral Procedures	
Policy Number: RP-P-125X	**Application:** All Medica Members
Last Reviewed: 12/8/2022	**Effective Date:** 04/01/1999
Related Policies: Multiple Procedure Reduction, Reduced Services	

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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 modifiers 50, LT or RT.

Codes with an NPFS bilateral status indicator of 0 or 9 are not eligible for bilateral procedure reimbursement because the bilateral concept is not applicable for these procedures.

If a procedure is performed unilaterally, however only a code with a bilateral 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.

Modifiers:	
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.
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 code and the addition of modifier 52, signifying the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
LT	Left Side. Used to identify procedures performed on the left side of the body.
RT	Right Side. Used to identify procedures performed on the right side of the body.

Code Lists:
Bilateral Eligible Code List

Definitions:
Bilateral Procedures – The same procedure performed on both sides of the body during the same session.
NPFS – National Physician Fee Schedule.

Q & A:
Q: If a code has the term 'bilateral' in its definition, yet the procedure was only performed on one side, how should this be reported? **A:** If a code exists for the comparable unilateral procedure, report the appropriate unilateral code. If a code does not exist for the comparable unilateral procedure, report the bilateral code with modifier 52 appended. In this instance, modifiers LT or RT may be reported in another modifier position on the same claim line to describe which side the reduced procedure was performed on.

Resources:
Centers for Medicare and Medicaid Services (CMS)
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
National Physician Fee Schedule (NPFS)

Effective Date:	04/01/1999

Revision Updates:	
12/8/2022	Annual Policy Review
12/30/2021	Code List Update
08/10/2021	Code List Update
06/27/2021	Code List Update
06/04/2021	Annual Policy Review
01/01/2020	Code List Update