Bilateral Procedures

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Important Note About This Policy

Oscar's reimbursement policies serve as a guide to assist providers with accurate claims submission and outline the basis for reimbursement if the service is a covered benefit. Coverage does not guarantee reimbursement; services must meet authorization and medical necessity guidelines for the procedure, diagnosis, and member's state of residence.

Our policies provide general reference for described services and do not cover every aspect of reimbursement. Other factors may supplement, modify, or supersede this policy, including legislative mandates, provider contracts, member benefit documents, and/or other reimbursement, medical, or drug policies. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

Providers are responsible for submission of accurate documentation of services performed. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Oscar routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later. Oscar communicates policy updates to providers via update notifications.

Description

Bilateral procedures are procedures performed on both sides of the body during the same encounter on the same day on the same member by a single provider or providers in the same group practice. Oscar follows the bilateral procedure CMS standards in the NPFS (National Physician Fee Schedule) for adjustment of payment.

Policy

Oscar will apply CMS's payment adjustment methodology to the fee schedule amount of bilateral eligible procedures when the procedure code is reported bilaterally as a single line with modifier 50 or on separate lines with modifiers LT and RT for the same structure.Modifier 50 is not applicable to procedures that are bilateral by definition or procedures with descriptions that include such terminology as "bilateral" or "unilateral or bilateral." . Additionally, when a bilateral procedure is performed during the same session as another procedure, the service may also be eligible for multiple procedure reduction as per Oscar's Multiple Procedures policy.

Reimbursement Guidelines

Procedures ***Eligible*** for Bilateral Payment Adjustment:

Status Indicator 1:

- If the procedure is reported on a single line with the 50 bilateral modifier, a payment adjustment of 150% of the fee schedule amount will be applied.
- If the procedure is reported on separate lines with LT and RT modifiers, a payment adjustment of 75% of the fee schedule amount will be applied to each line for a sum of 150%.

Status Indicator 3:
Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures with CMS status indicator 1.

- If the procedure is reported on a single line with modifier 50, a payment adjustment of 200% of the fee schedule amount will be applied.
- If the procedure is reported on separate lines with LT and RT modifiers, a payment adjustment of 100% of the fee schedule amount will be applied to each line for a sum of 200%.

Procedures ***Ineligible*** for Bilateral Payment Adjustment:

Status Indicator 0:
Bilateral concept is not applicable for these procedures due to anatomy or physiology, or the code descriptor specifically states it is a unilateral procedure and there is already an existing code for the bilateral procedure.

- If the procedure is submitted with modifier -50 the claim will be denied for inappropriate modifier use.

Status Indicator 2:
Payment for these services is already considered bilateral.

- If the procedure is submitted with modifier 50 the claim will be denied for inappropriate modifier use.

Status Indicator 9:
Bilateral concept is not applicable for these procedures.

If the procedure is submitted with modifier 50 the claim will be denied for inappropriate modifier use.

Billing and Coding

When billing for bilateral eligible services, the claim should be submitted with either:

- The procedure code on one line with modifier 50 and 1 in the units field.
- The procedure code on two lines, with modifier LT on one line and modifier RT on the other line, with 1 unit for each line.

Modifiers

When reporting codes with bilateral status indicators 1 or 3 as performed either unilaterally or bilaterally, an appropriate anatomical or bilateral modifier must be appended to the service. Failure to append an appropriate modifier will result in a denial of the line. Please see Oscar's Modifier Guidelines reimbursement policy for more information on bilateral and anatomical modifiers.

If a bilateral status indicator 2 service is performed unilaterally, however only a code with a bilateral description exists, the bilateral code should be submitted with modifier 52 and the appropriate anatomical modifier RT/LT to indicate the procedure was performed unilaterally. The reimbursement will be reduced by 50% of the fee schedule amount.

Related Policies

Modifier Guidelines
Multiple Procedures

References

1. CMS Medicare Claims Processing Manual, Ch. 23
2. CMS National Physician Fee Schedule

Publication History

Date	Action/Description
10/09/2015	Original Documentation

11/01/2015	Initial Policy Approval
06/25/2024	Policy Reviewed, Updated format and added definition and dating convention. No Changes to intent of policy.
11/03/2025	Annual Review; Updated Policy section to allow for reporting of services with modifier 50 or LT/RT and to address multiple procedures; Updated Reimbursement Guidelines section to detail reimbursement when services are billed with modifier 50 versus LT/RT modifiers, inappropriate modifier use, and added information regarding status indicators 0 and 9; Updated Billing and Coding section to provide guidance on billing and modifier use; Added Related Policies section.
10/12/2026	Annual Review. Added disclaimer; Updated Billing and Coding section to provide guidance on the use of anatomical modifiers RT/LT when appending modifier 52 to services with bilateral status indicator 2.