PAYMENT POLICY ID NUMBER: 10-005

Original Effective Date: 01/26/2010

Revised: 02/13/2025

Bilateral Procedures- Professional & Institutional Billing

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR MEMBER BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

Bilateral Procedures are Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that describe unilateral procedures that can be performed on both sides of the body during the same session by the same individual physician or other health care professional. CPT® or HCPCS codes with bilateral in their intent or with bilateral written in their description should not be reported with the bilateral modifier 50, or modifiers LT and RT, because the codes are inclusive of the bilateral procedure.

REIMBURSEMENT INFORMATION:

For Florida Blue professional claims, bilateral procedures should be reported on a single line with modifier 50 and “1” units. Additionally, it is acceptable to report a bilateral procedure on two separate claim lines with “1” unit for each line along with modifier LT on one line and modifier RT on the other.

The Centers for Medicare & Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File “bilateral” status indicators “1” or “3” are considered by Florida Blue to be eligible for bilateral services as indicated by the bilateral modifier 50.

When a CPT® or HCPCS code is reported with modifier 50 and the code is not listed with a “bilateral” status indicator “1” or “3”, the code will not be reimbursed.

CPT® or HCPCS codes with ‘bilateral’ or ‘unilateral or bilateral’ written in the description will be reimbursed only once per date of service.

When bilateral procedures are reported on institutional claims, if a single line is billed with “1” unit and a modifier 50, the line will allow 150 percent of the fee schedule allowance consistent with Florida Blue Multiple Surgical Procedure Reduction Policy. Bilateral procedures billed as two claim lines with “1” unit each will price as described in the Facility Claims section below.

There may be instances when more specific anatomical modifiers for fingers, toes, eyelids, or coronary arteries should be used when billing bilateral procedures.

There are rare instances in which a bilateral service may be performed on multiple sites and not just bilaterally. In those instances, claims will be reviewed through the Florida Blue appeals process.

BILLING/CODING INFORMATION:

Professional Claims:

Florida Blue will apply CMS’s payment adjustment methodology to bilateral eligible procedures with a bilateral indicator of "1" regardless of the Multiple Procedure Indicator when the procedure code is reported bilaterally with a modifier 50 or on separate lines with modifiers LT and RT for the same structure. The procedure code will be eligible for reimbursement at 150% of the allowable amount for a single procedure code, not to exceed billed charges, with one side reimbursed at 100% and the other side reimbursed at 50% of the allowable amount. This update became effective May 01, 2024. When other reducible procedure codes are reported on the same date of service, an additional multiple procedure reduction may or may not be applied depending on which procedure code is ranked as primary.

When a bilateral eligible code with a bilateral indicator of "3" is reported with modifier 50 and is not subject to reductions under the multiple procedure/imaging reduction, the code will be eligible for reimbursement at 100% of the allowable amount for each side for a sum of 200% of the allowable amount not to exceed billed charges.

Note: When a procedure code description includes the verbiage “bilateral,” the procedure code should only be submitted once without modifier 50.

When a CPT® or HCPCS procedure code exists for both a unilateral and a bilateral procedure, select the code that best represents the procedure.

Consistent with CPT® guidelines, if a unilateral procedure has not been defined by CPT® or HCPCS and only a bilateral description of a procedure exists, report the code with “bilateral” in the description with modifier 52 (reduced services) when the procedure is performed unilaterally.

When a procedure with “unilateral or bilateral” written in the description is performed unilateral, then the CPT® or HCPCS procedure code need not be reported with modifier 52 since the procedure description already indicates that the service can be performed either unilaterally or bilaterally.

The use of modifiers LT or RT will be recognized as informational only when the procedure with “unilateral or bilateral” in description is performed on only one side. Consistent with CMS guidelines, when both modifiers LT and RT are reported separately on the same day by the same individual physician or other healthcare professional, only one charge will be eligible for reimbursement.

Facility Claims

Hospital and ambulatory surgical centers (ASC) should bill bilateral surgery one of two ways:

1. On a single claim line with one unit appended by modifier 50, or

2. On two separate claim lines each with one unit without modifier 50. However, an applicable modifier is required that identifies the services as unique or different otherwise they will be tagged as duplicative.

Example:

With 50 Modifier			
Revenue Code	CPT® Code/Modifier	Description	Charge
0360	19101-50	Biopsy of breast: open, incisional	$1,500.00
Without 50 Modifier			
Revenue Code	CPT® Code/Modifier	Description	Charge
0360	19101-RT	Biopsy of breast: open, incisional	$750.00
0360	19101-LT	Biopsy of breast: open, incisional	$750.00

Failure to bill bilateral procedures in one of these two ways will result in incorrect payment.

DEFINITIONS:

Modifier	Description
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 five 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 number and the addition of the modifier 52, signifying that the service is reduced.
LT	Left Side
RT	Right Side

RELATED PAYMENT POLICIES:

Multiple Surgical Procedure Reduction (Including Multiple Endoscopic Procedure Reduction) 10-026
Multiple Imaging Reduction 10-037

REFERENCES:

1. Centers for Medicare & Medicaid Services, National Physician Fee Schedule (NPFS) Relative Value File. https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files
2. American Medical Association, Current Procedural Terminology (CPT ®), Professional Edition

GUIDELINE UPDATE INFORMATION:

01/26/2010	New Payment Policy
05/31/2012	Revision – Changed name from BCBSF to Florida Blue

09/01/2015	Revised to include Facility Claim Instructions and additional information for professional claims.
10/11/2016	Annual Review
10/12/2017	Annual Review, title updated from Bilateral Procedures to Bilateral Procedures – Professional & Institutional Billing.
10/18/2018	Annual Review
10/17/2019	Annual Review
10/08/2020	Annual Review- Clarified reporting requirements for professional claims in Reimbursement Information section.
02/11/2021	Revision- Clarified reimbursement for endoscopic and non-endoscopic codes.
10/14/2021	Annual Review – no changes
10/20/2022	Annual Review – References reviewed and verified.
10/19/2023	Annual Review – References reviewed and updated.
11/14/2024	Annual Review – Billing/Coding Information-Professional Claims section revised to outline Florida Blue's payment adjustment methodology for bilateral eligible procedures. Additional Related Payment Policy added. References reviewed and updated.
02/13/2025	Revision – Clarifying language for professional claims added to the Billing/Coding Information section.