

Coding Policy

Bilateral Services

CODING POLICY NUMBER: 14

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SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”). **The full Company portfolio of current coding policies is available online and can be [accessed here](#).**

POLICY APPLICATION

- Providence Health Plan Participating Providers Non-Participating Practitioners
 Commercial Medicaid/Oregon Health Plan Medicare

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Coding policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY STATEMENT

- I. Bilateral services are performed on both sides of the body during the same session or on the same day and are not otherwise identified as bilateral in the CPT code description.

- II. Only those services which qualify for the bilateral surgery payment adjustment on the Medicare Physician Fee Schedule (MPFS) (bilateral surgery indicator of “1”) may be billed with modifier -50.
- III. For bilateral services indicated with modifier -50, the second service is reimbursed at a lesser rate than the initial or primary service.

PROCEDURE

GENERAL

Company will reimburse service codes 10000 – 69999 with a bilateral indicator of “1” on the Medicare Physician Fee Schedule (MPFS) only when the line is billed with an appropriate bilateral, laterality, or anatomical modifier (50, LT, RT, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, LC, LD, RC, LM, RI).

Providers must report service codes and modifiers that most accurately and specifically describe the services performed. Modifiers must clearly identify the anatomical site, laterality, or bilateral nature of the procedure when required. Modifiers should only be appended when supported by documentation and appropriate for the service reported. Inappropriate, missing, incorrect, or non-specific modifier usage, including the substitution of non-specific modifiers when a more specific modifier is supported, does not meet reporting requirements and may result in line-item denial.

When a service code has a bilateral surgery indicator of “1” on the Medicare Physician Fee Schedule (MPFS), the plan will reimburse 150% of global fee when the service is performed bilaterally.

NOTE: Exceptions may apply when discrepancies exist between Company policies and/or AMA or other published information and CMS surgery indicators.

Billing Examples

- Bill code on one line with modifier 50 (preferred method)
 - 31200-50 Payment 150% of allowable
- Bill codes on two lines with modifier 50 on one of the codes
 - 31200 Payment 100% of allowable
 - 31200-50 Payment 50% of allowable
- Bill codes on two lines with modifier RT on one code and modifier LT on the other code
 - 31200-RT Payment 100% of allowable
 - 31200-LT Payment 50% of allowable

When bilateral surgeries are performed in conjunction with other surgeries, multiple surgery rules (Coding Policies 06.0, 06.1 and 06.2) will be applied first, so the bilateral procedure may be paid at the same rate for each line, i.e., 50% for each unit rather than 100% for one unit and 50% for the second unit.

30520	Payment 100% of allowable
31200	Payment 50% of allowable
31200-50	Payment 50% of allowable

CROSS REFERENCES

- Coding Policy 06.0 (Multiple Procedure Reductions)
- Coding Policy 06.1 (Multiple Endoscopy Procedure Reductions)
- Coding Policy 06.2 (Multiple Diagnostic Service Reductions)

REFERENCES

1. Centers for Medicare & Medicaid Services (cms.gov)
2. Medicare Physician Fee Schedule (MPFS) (cms.gov)
3. American Medical Association. Current Procedural Terminology (CPT)
4. Providence Health Plan Coding Edits

POLICY REVISION HISTORY

Date	Revision Summary
1/2023	Annual review (converted to new template 5/2023). Original policy effective date: 1/2000
1/2024	Annual review. No changes to policy.
1/2025	Annual review. No changes to policy.
1/2026	Annual review. Added cross references section.
5/2026	Interim update. Updated References section. Updated modifier requirements in General section to include anatomical modifiers and modifier reporting requirements.