curative

TITLE:	BILATERAL PROCEDURES
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	03/16/2026
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this P&P.

3.1. **Bilateral Procedure** The same procedure performed on both sides of the body and identified by the same CPT/HCPCS code, occurring during the same operative session.

3.2. **Same Individual Provider** The Same Individual Physician or other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification number.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Reimbursement Guidelines

Modifier -50 is used to identify services performed on both sides of the body by the Same Individual Provider during the same operative session. This modifier should be applied to eligible CPT/HCPCS codes when bilateral services are reported on professional claims. The Bilateral Procedure should be reported on one line with the -50 modifier, one unit and the charge for both sides of the procedure. Claim lines billed incorrectly with modifier 50 may be denied.

Curative Health identifies the eligible Bilateral Procedures based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File (RVU) file Bilateral Indicators. The CPT book guidance may vary from the NPFS indicators, however, the NPFS file is the source utilized by Curative Health to determine eligibility. Codes with an indicator of “1” or “3” are eligible to be reported as bilateral. Modifiers RT and/or LT should only be applied when a procedure is performed unilaterally.

When a code is reported as bilateral with a -50 modifier and it does not have a bilateral eligible indicator, it will not be reimbursed. Codes containing the terms “bilateral”, “unilateral”, “unilateral or bilateral” or those that are inherently bilateral are not eligible to have the bilateral modifier -50 applied.

Any multiple procedure reductions are applied after the bilateral calculation. Payment calculations are based on the contracted or negotiated rate for the services rendered.

Bilateral Indicator 1: Code is bilateral eligible.

The eligible codes with indicator “1” will have bilateral payment methodology adjustments applied. The payment calculation will be eligible for 150% of the allowed amount of the procedure code, not to exceed the billed charges. Payment for one side will be 100% of the allowed amount and the other side will be 50% of the allowed amount.

Bilateral Indicator 3: Code is bilateral eligible, but the 150% payment does not apply.

The eligible codes with indicator “3” will be reimbursed based on the units of service performed. Codes with this indicator are generally radiology procedures and payment is calculated at 100% of the allowed amount for each side.

Bilateral Indicators 0: Code is not bilateral eligible.

Codes with indicators “0” or “9” will not have the bilateral payment methodology adjustments applied. Indicator “0” codes are not considered bilateral eligible due to anatomy, or the code description states “unilateral” and there is a bilateral code.

Bilateral Indicator 2: Code is not bilateral eligible.

Codes with indicator “2” will not have the bilateral payment methodology adjustment applied. These codes either have “bilateral” in the description, the description indicates the procedure may be either unilateral or bilateral, or the procedure is usually performed bilaterally.

Bilateral Indicator 9: Code is not bilateral eligible.

Codes with indicator “9”, the concept of a bilateral procedure does not apply.

5. REFERENCE DOCUMENTS AND MATERIALS

5.1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

5.2. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

5.3. Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

5.4. Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 12 Physicians/NonPhysician Practitioners

6. COLLABORATING DEPARTMENTS

6.1. Claims

6.2. Compliance

6.3. Medical Management

6.4. Network

6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
3/16/2026	CJ Wisecarver	001	Initial Version