

Bilateral Procedures

Reimbursement Policy ID: RPC.0006.0100

Recent review date: 09/2024

Next review date: 10/2025

Keystone First reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

A bilateral procedure is a procedure performed on identical anatomic sites, on opposite sides of the body (mirror image) during the same operative session, or on the same day by the same provider.

Keystone First recognizes modifier 50 and adjusts reimbursement accordingly when appropriate anatomical modifiers are appended to indicate that a bilateral procedure, as described above, has been performed.

Exceptions

Anatomical modifiers are not applicable to procedures codes that are bilateral in intent or that have bilateral in their description. Some examples of descriptions may include the terms "unilateral or bilateral," "one or both," and "bilateral."

Reimbursement Guidelines

Keystone First determines reimbursement eligibility for bilateral procedures using the "Bilateral Surgery" indicator in the Medicare Physician Fee Schedule Database (MPFSDB).

- 0 indicates a unilateral code; modifier will not be reimbursed.
- 1 indicates modifier 50 may be reimbursable.

- 2 indicates a bilateral code; modifier 50 is not eligible for reimbursement.
- 3 indicates a primary radiology code; modifier 50 is not eligible for reimbursement.
- 9 indicates that the concept of a bilateral procedure does not apply.

Procedure codes on the Pennsylvania Department of Human Services (DHS) Medicaid fee schedule with MPFSDB Bilateral Indicator “1” are considered eligible for bilateral services reimbursement when performed bilaterally. Claims can be submitted as a **one-line entry** with two units and a 50 modifier, or as a **two-line entry** with a quantity of “1” and modifier LT appended to one line and RT appended on the second line. Both claim lines should be reported with the same procedure code. Allowed procedure codes submitted as above will be reimbursed at 125% of the Pennsylvania Department of Human Services (DHS) Medicaid rate, except where provider contract terms stipulate otherwise.

Definitions

Bilateral Procedure

The same procedures that are performed on both the left and the right side of a patient’s body during the same operative session or on the same day.

Modifier

An indicator used in conjunction with a CPT code to denote that a service or procedure that has been performed has been altered by a circumstance without changing the definition of the CPT code.

Edit Sources

- I. Current Procedural Terminology (CPT) and associated publications and services.
- II. Centers for Medicare and Medicaid Services (CMS).
- III. Medicare Physician Fee Schedule Database. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup>
- IV. Pennsylvania Department of Human Services (DHS) Medicaid Fee Schedule(s).
- V. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>

Attachments

N/A

Associated Policies

N/A

Policy History

09/2024	Updated to indicate one line or two-line entry submission
04/2024	Revised preamble
01/2024	Reimbursement Policy Committee Approval
12/2023	Annual review - No major changes <ul style="list-style-type: none"> • Updated to Biennial policy.
08/2023	Removal of policy implemented by Keystone First from Policy History section
01/2023	Template revised

	<ul style="list-style-type: none">• Preamble revised• Applicable Claim Types table removed• Coding section renamed to Reimbursement Guidelines• Associated Policies section added
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