Keystone First
Family of Health Plans

Bilateral Procedures

Reimbursement Policy ID: RPC.0006.0100

Recent review date: 07/2025

Next review date: 10/2027

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.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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. 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. 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

07/2025	Reimbursement Policy Committee Approval
07/2025	Annual review • No revisions
04/2025	Revised preamble
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 • Updated to Biennial policy.
08/2023	Removal of policy implemented by Keystone First from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added