



POLICY INFORMATION			
Policy Number:	POL-PP- 240	Original Effective Date:	6/1/2023
Version Number:	005	Revision Date:	6/1/2025
Policy Status:	Active	Next Revision Date:	6/1/2026

NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/> PROFESSIONAL	<input checked="" type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input checked="" type="checkbox"/> AMBULATORY SURGERY	<input type="checkbox"/> LAB	<input type="checkbox"/> OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA²	<input checked="" type="checkbox"/> FEP³	<input type="checkbox"/> DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.



Description/Application

A bilateral procedure is a medical procedure performed on both sides of the body, typically during the same operative session, by the same provider on identical anatomic sites. This means a procedure done on both the right and left sides of a body part, such as both knees or both eyes, during the same operation.

Billing for bilateral procedures can involve the use of modifiers like "-50" or "LT" and "RT" to indicate both sides were involved. Some procedures are inherently billed as bilateral and don't require separate modifiers. Payment adjustments may be applied to some bilateral procedures, meaning reimbursement can be higher than a single, unilateral procedure.

Policy

Professional Claims

Blue KC follows the Centers for Medicare (CMS) guidelines for bilateral codes. Bilateral codes are listed in the CMS National Fee Schedule (NPFS) with a bilateral status indicator of "1" or "3". Codes with these indicators are eligible for bilateral procedure reimbursement as follows:

- Codes with a bilateral status indicator of "1" are subject to a payment adjustment for bilateral procedures.
- Codes with a bilateral status indicator of "3" indicate the usual payment adjustment for bilateral procedures does not apply.

The CPT descriptors for some procedures specify that the procedure is bilateral. These codes are designated in the CMS Physician Fee Schedule with a bilateral indicator of "2". In such cases, the bilateral modifier should not be used.

Blue KC requires bilateral procedures to be submitted on one line appended with the -50 modifier.

Blue KC does not publish a list of surgeries that are considered bilateral. Blue KC follows the list that CMS has furnished to carriers, for approved codes.

<http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

The CMS Fee Schedule for Physician Service indicators for bilateral services are as follows:

0 = 150 percent payment adjustment for bilateral procedures does not apply.

1 = 150 percent payment adjustment for bilateral procedures applies.

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.

2 = 150 percent payment adjustment for bilateral procedure does not apply.

3 = The usual payment adjustment for bilateral procedures does not apply.

9 = Concept does not apply.

Ambulatory Surgery Center (ASC)

For ASC's who are reimbursed using CMS methodology, bilateral procedures should be reported as either a single



unit on two separate lines (appending the RT and LT modifiers) or with "2" in the unit's field on one line, for bilateral procedures to be paid correctly.

Example - Lavage by cannulation; maxillary sinus (antrum puncture by natural ostium) (CPT code 31020) is performed bilaterally in one operative session; Report 31020 on two separate lines with RT and LT or with "2" in the unit's field.

For ASC's whose reimbursement hasn't been updated to use CMS methodology, bilateral procedures should be reported on one line with "1" in the unit's field and modifier 50 appended.

Example - Lavage by cannulation; maxillary sinus (antrum puncture by natural ostium) (CPT code 31020) is performed bilaterally in one operative session; Report 31020 on one line with "1" in the unit's field and modifier 50 in the first modifier position.

Facility Claims

Bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate CPT or HCPCS code. The procedure should be billed on one line with modifier 50 and one unit with the full charge for both procedures.

Blue KC will apply payment adjustment 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.

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.

When other reducible procedure codes are reported on the same date of service, an additional multiple procedure/imaging reduction may or may not be applied to the line paid at 100% depending on whether another procedure code is ranked as primary or not.

When a bilateral eligible code with a bilateral indicator of "3" is reported with modifier 50, 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.

For contracts that have a percentage of billed reimbursement methodology, the bilateral procedure will be reimbursed at 75% of contracted allowable.

Coding

To view physician service indicators for bilateral procedures go to;
<https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu25a>

References and Resources

Current Procedural Terminology Manual
Centers for Medicare and Medicaid Services



Related Documents

N/A

Revision History

Date	Summary of Revisions
6/1/2023	New Policy
8/1/2023	Updates made to ASC language.
9/21/2023	9/21/2023: Added, " For contracts that have a percent of billed reimbursement methodology, the bilateral procedure will be reimbursed at 75% of contracted allowable."
7/09/2024	Annual review, no changes were made
6/1/2025	Annual review, no changes were made.