Bilateral Procedures

Reimbursement Policy ID: RPC.0006.5420

Recent review date: 01/2026

Next review date: 10/2027

Healthy DC 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. Healthy DC 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.

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.

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) that are performed during the same operative session, or on the same day by the same provider.

Healthy DC recognizes modifier 50, and adjusts reimbursement accordingly, when appended to a service to indicate that a bilateral procedure, as described above, has been performed.

Exceptions

The use of modifier 50 is not applicable with procedures or 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

Healthy DC determines whether claims are eligible for reimbursement for bilateral surgery based on the “Bilateral Surgery” indicator in the Medicare Physician Fee Schedule Database (MPFSDB).

- 0 indicates a unilateral code; modifier 50 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.

Indicator “1” on procedure codes are considered eligible for bilateral services reimbursement and must be submitted as a **one-line entry** with modifier 50 and units = 1 to be reimbursed. Allowed procedure codes submitted with modifier 50 will be reimbursed at 150% of the District of Columbia Department of Health Care Finance (DHCF) Medicaid fee schedule.

Definitions

Bilateral Procedure
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).
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases, 10th revision, (ICD-10-CM).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI)
VI. District of Columbia Department of Health Care Finance (DHCF) Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

11/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble

04/2024	Revised preamble
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section