UnitedHealthcare Community Plan

REIMBURSEMENT POLICY
UB-04
Policy Number 2026F7020B

Bilateral Procedures Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design, and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the UB-04 form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities, including but not limited to, non-network authorized and percent of charge contract facilities.

Policy

Overview

Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes describe unilateral procedures that can be performed on both sides of the body during the same session by the Same Facility. CPT or HCPCS codes with bilateral in their intent or with bilateral written in their description should not be reported with the bilateral modifier 50, or modifiers LT and RT, because the code is inclusive of the Bilateral Procedure.

For the purpose of this policy, the Same Facility is the same facility rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

Bilateral Eligible Codes

The UnitedHealthcare Community Plan Bilateral Procedures Facility Policy is developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File status indicators. All codes in the NPFS with a "bilateral" indicator of "1" or "3" are considered by UnitedHealthcare Community Plan to be

eligible for bilateral services as indicated by the bilateral modifier 50.

UnitedHealthcare Community Plan will apply CMS's payment adjustment methodology 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 or on separate lines with modifiers LT and RT for the same structure. 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.

CMS Files for Download

Bilateral Modifier (50)

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.

CPT or HCPCS codes with 'bilateral' or 'unilateral or bilateral' written in the description will not be reimbursed with modifier 50.

There are rare instances in which a bilateral service may be performed on multiple sites and not just bilaterally. In those instances, use appropriate modifier to report the additional units beyond the bilateral services performed indicating that the services were performed on a different site or organ system. Medical record documentation must support the use of modifier appended.

Procedure Codes with the Term "bilateral" in the Description

When CPT or HCPCS codes with "bilateral" or "unilateral or bilateral" written in the description are reported, special consideration will be given when reported with modifiers LT or RT.

When a CPT or HCPCS procedure code exists for both a unilateral and a Bilateral Procedure, select the code that best represents the procedure.

Consistent with CPT guidelines, if a unilateral procedure has not been defined by CPT or HCPCS and only a bilateral description of a procedure exists, report the code with "bilateral" in the description with modifier 52 when the procedure is performed unilaterally.

When a procedure with "unilateral or bilateral" written in the description is performed unilaterally, then the CPT or HCPCS procedure code need not be reported with modifier 52 since the procedure description already indicates that the service can be performed either unilaterally or bilaterally.

The use of modifiers LT or RT will be recognized as informational only when the procedure with "unilateral or bilateral" in the description is performed on only one side. Consistent with CMS guidelines, when both modifiers LT and RT are reported separately on the same day by the Facility, only one charge will be eligible for reimbursement.

Definitions	
Same Facility	The same Facility rendering health care services reporting the same Federal Tax Identification number.

State Exceptions	
Colorado	For the state of Colorado, codes with a "bilateral" indicator of "1" or "3" are reimbursed at 180% of the allowable amount.
Idaho	If a secondary procedure is billed with modifier 50 in the same session, it will be priced at the billed amount or 75% of Medicaid's allowed amount, whichever is less.

Questions and Answers	
1	**Q:** If a code has the term 'bilateral' in its definition, can it be reported with modifier 50? **A:** No. For example, the CPT code 40843 includes the term 'bilateral' and is inherently a bilateral procedure. To report unilateral performance of this procedure, use the appropriate unilateral CPT code 40842.
2	**Q:** If a code has the term 'bilateral' in its definition, yet the procedure was only performed on one side, how should this be reported? **A:** If a code exists for the comparable unilateral procedure, report the appropriate unilateral code. If a code does not exist for the comparable unilateral procedure, report the bilateral code with modifier 52 appended. In this instance, modifiers LT or RT may be reported in another modifier position on the same claim line to describe which side the reduced procedure was performed on.
3	**Q:** What is the most appropriate way for a facility to report to UnitedHealthcare Community Plan for hand or foot codes that are bilateral eligible procedure codes, but the same procedure is performed bilaterally on only one digit of each hand or foot? **A:** If the same procedure is performed on the same digit on each hand or foot, report the procedure with modifier 50. If the same procedure is performed on a different digit or multiple digits of each hand or foot, report the procedure with the appropriate digit modifiers (e.g., FA or F1-9 [fingers], TA or T1-9 [toes]).

Attachments	
Bilateral Eligible Procedures Policy List	Identifies those codes that UnitedHealthcare Community Plan will allow for Bilateral Procedures.
Codes with "bilateral" in the Description Policy List	This is a list of codes with the term "bilateral" in the code description that would not allow modifier 50 or modifiers LT and RT to be reported for the same date of service.
Codes with "unilateral" or "bilateral" in the Description Policy List	This is a list of codes with the terms "unilateral or bilateral" in the code description that would not allow modifier 50 or modifiers LT and RT to be reported for the same date of service.

Resources
Individual state Medicaid regulations, manuals & fee schedules
American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History

3/29/2026	Policy Version Change Attachments Section: Bilateral Eligible Procedures Policy List updated History section: Entries prior to 3/29/2024 archived
1/1/2026	Policy Version Change Attachments Section: Bilateral Eligible Procedures Policy List updated Attachments Section: Codes with “bilateral” in the Description Policy List updated Attachments Section: Codes with “unilateral” or “bilateral” in the Description Policy List updated History section: Entries prior to 1/1/2024 archived
9/21/2025	Policy Version Change Attachments Section: Bilateral Eligible Procedures Policy List updated
6/29/2025	Policy Version Change Attachments Section: Bilateral Eligible Procedures Policy List updated and Codes with “bilateral” in the Description Policy List updated History section: Entries prior to 6/29/2023 archived
5/18/2025	Policy Version Change State Exceptions section: Idaho Added History section: Entries prior to 5/18/2023 archived
1/24/2025	Policy Version Change Attachments Section: Updated Bilateral Eligible Procedures Policy List
1/1/2025	Policy Version Change Attachments Section: Codes with “unilateral or bilateral” in the Description Policy List, Bilateral Description Policy List and Bilateral Eligible Procedures Codes updated
9/22/2024	Policy Version Change Attachments Section: Bilateral Description Policy List and Codes with “unilateral or bilateral” in the Description Policy List updated
6/30/2024	Policy Version Change Attachments Section: Bilateral Eligible Procedures Policy List updated
6/12/2019	Policy Implemented by United Healthcare Community and State

Back To Top