

Bilateral Procedures Policy, Professional

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 CMS 1500 forms and, when specified, to those 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 may 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.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes on the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List describe unilateral procedures that can be performed on both sides of the body during the same session by the Same Individual Physician or Other Qualified Health Care Professional. 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 Individual Physician or Other Qualified Health Care Professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

Bilateral Eligible List

The UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List 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 and is not subject to reductions under either the Multiple Procedure or Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Policies, 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 more information regarding the reduction of Bilateral Procedures, refer to the UnitedHealthcare Multiple Procedure and Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging Policies.

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. A procedure code submitted with modifier 50 is a reimbursable service as set forth in this policy only when it is listed on the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List.

When a CPT or HCPCS code is reported with modifier 50 and the code is not listed on the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List, the code will not be reimbursed.

CPT or HCPCS codes with "bilateral" or "unilateral or bilateral" written in the description are not on UnitedHealthcare Community Plan's Bilateral Eligible Procedures Policy List and 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 modifier 59 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 59 or XS.

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. For more information on reimbursement for reduced services, see UnitedHealthcare's Community Plan Reduced Services Policy.

For UnitedHealthcare Community Plan purposes, when both modifiers LT and RT are reported separately for codes with "bilateral" in the description, only one charge will be eligible for reimbursement up to the respective Maximum Frequency Per Day (MFD) value as the procedure is inherently bilateral. For additional information, refer to the Questions and Answers section, Q&A #3. For more information on maximum frequency per day values, see UnitedHealthcare's Community Plan Maximum Frequency Per Day Policy.

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 Same Individual Physician or Other Qualified Health Care Professional, only one charge will be eligible for reimbursement up to the maximum frequency per day limit. For maximum frequency per day limits, see UnitedHealthcare's Community Plan Maximum Frequency Per Day Policy.

Definitions

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| Bilateral Procedures | The same procedure performed on both sides of the body during the same session. |
| Same Individual Physician or Other Qualified Health Care Professional | The same individual rendering health care services reporting the same Federal Tax Identification number. |

State Exceptions

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| 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. |
| Missouri | Missouri is exempt from this policy. Bilateral Procedures are reimbursed based on the fee schedule. |
| North Carolina | North Carolina have their own code list allowable with mod 50. |
| Washington DC | Washington DC is exempt from this policy. Bilateral Procedures are reimbursed based on the fee schedule. |
| Wisconsin | Per Wisconsin Medicaid, modifier 50 is reimbursed per fee schedule. |

Questions and Answers

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| 1 | <p>Q: How should CPT or HCPCS codes such as for an excision of a lesion be billed when they are performed on both sides of the body and are not CMS bilateral eligible?</p> <p>A: An excision of a lesion is not truly bilateral. It should be billed with units, rather than the bilateral modifier.</p> |
| 2 | <p>Q: If a code has the term "bilateral" in its definition, can it be reported with modifier 50?</p> <p>A: No. For example, if a CPT code includes the term "bilateral" and is inherently a bilateral procedure, then the code does not appear on UnitedHealthcare Community Plan's Bilateral Eligible Procedures Policy List and may not be reported with modifier 50.</p> |
| 3 | <p>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?</p> <p>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.</p> |
| 4 | <p>Q: Does one individual CPT or HCPCS code ever have more than one NPFS bilateral status indicator designation?</p> <p>A: Yes, on occasion a code may have a global, professional, and technical component. The NPFS bilateral status indicator may vary between the components. When this occurs and one of the status indicators is bilateral eligible</p> |

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| | (e.g., NPFS bilateral indicator "1" or "3") and another is not bilateral eligible (e.g., NPFS bilateral indicator "0", "2" or "9"), the code is added to the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List. |
| 5 | <p>Q: What is the most appropriate way for a physician or other health care professional to bill UnitedHealthcare Community Plan for a Bilateral Procedure?</p> <p>A: The procedure should be billed on one line with a modifier 50 and one unit with the full charge for both procedures.</p> |
| 6 | <p>Q: What is the most appropriate way for a physician or other health care professional to report to UnitedHealthcare Community Plan for hand or foot codes that are on the UnitedHealthcare Community Plan Bilateral Eligible Procedures Policy List, but the same procedure is performed bilaterally on only one digit of each hand or foot?</p> <p>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]).</p> |
| 7 | <p>Q: What is the most appropriate way for a physician or other health care professional to report to UnitedHealthcare Community Plan for bilateral eligible spinal codes, such as a laminotomy, if the procedure is performed on multiple levels of the same spinal region?</p> <p>A: If the laminotomy is performed bilaterally, report the appropriate code with modifier 50 for the first interspace. If a laminotomy of a second interspace is performed bilaterally, use add-on codes to represent additional levels rather than sides. If a laminotomy of additional interspaces (3 or more) is performed bilaterally, report the appropriate code with modifiers 50, 59 or XS with the appropriate number of units.</p> |
| 8 | <p>Q: Does UnitedHealthcare Community Plan accept modifier 50 on all codes where the CPT book indicates coding guidelines to report modifier 50 when performing the procedure bilaterally?</p> <p>A: No. UnitedHealthcare Community Plan follows the CMS NPFS Bilateral Procedures payment indicators "1" or "3" to determine which codes are eligible for bilateral services.</p> |
| 9 | <p>Q: Does UnitedHealthcare Community Plan apply a reduction to Bilateral Procedures with a payment indicator of "1" if the Multiple Procedure Reduction indicator is "0"?</p> <p>A: Yes. UnitedHealthcare Community Plan applies a reduction to all Bilateral Procedures with a payment indicator of "1" when billed with a modifier 50 or on separate lines with modifiers LT and RT regardless of the Multiple Procedure Reduction indicator.</p> |

| Attachments | |
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| UnitedHealthcare Community Plan 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 <u>and</u> RT to be reported for the same date of service. |
| UnitedHealthcare Community Plan 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 <u>and</u> RT to be reported for the same date of service. |
| UnitedHealthcare Community Plan Bilateral Eligible Procedures | Identifies those codes that UnitedHealthcare Community Plan will allow for Bilateral Procedures. |
| NC Eligible Codes List | North Carolina code list allowable with modifier 50. |

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, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History

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| 3/29/2026 | Policy Version Change Attachments Section: Bilateral Eligible Procedures updated |
| 2/22/2026 | Policy Version Change Attachments Section: NC Eligible Codes List updated History Section: Entries prior to 2/22/2024 archived |
| 1/1/2026 | Policy Version Change Attachments Section: Codes with “bilateral” in the Description Policy List updated Attachments Section: Codes with “unilateral” or “bilateral” in the Description Policy List updated Attachments Section: Bilateral Eligible Procedures updated |
| 12/7/2025 | Policy Version Change State Exceptions: North Carolina added Policy List Change: NC Eligible Codes List added History Section: Entries prior to 12/7/2023 archived |
| 9/21/2025 | Policy Version Change Policy List Change: Bilateral Eligible Procedures updated |
| 7/23/2025 | Policy Version Change State Exceptions: Wisconsin updated |
| 6/29/2025 | Policy Version Change Policy List Change: Codes with “bilateral” in the Description Policy List updated and Bilateral Eligible Procedures updated |
| 5/18/2025 | Policy Version Change State Exceptions: Added Idaho History Section: Entries prior to 5/18/2023 archived |
| 1/24/2025 | Policy Version Change Policy List Change: Bilateral Eligible Procedures updated History Section: Entries prior to 1/24/2023 archived |
| 1/1/2025 | Policy Version Change Policy List Change: UnitedHealthcare Community Plan Codes with “unilateral” or “bilateral” in the Description Policy List, UnitedHealthcare Community Plan Codes with “bilateral” in the Description Policy List, and UnitedHealthcare Community Plan Bilateral Eligible Procedures updated |
| 9/22/2024 | Policy Version Change Policy List Change: UnitedHealthcare Community Plan Codes with “unilateral” or “bilateral” in the Description Policy List and UnitedHealthcare Community Plan Codes with “bilateral” in the Description Policy List updated |
| 6/30/2024 | Policy Version Change Policy List Change: UnitedHealthcare Community Plan Bilateral Eligible Procedures updated History Section: Entries prior to 6/30/2022 archived |

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| 5/24/2024 | Policy Version Change State Exceptions: Added Wisconsin |
| 5/12/2024 | Policy Version Change State Exceptions: Removed Arizona exception |
| 1/6/2006 | Implemented by UnitedHealthcare Community & State |