Codify by AAPC

Dermatology Coding Alert

Don't Settle for Unilateral Reimbursement for -50

4 tips maneuver you through complicated -LT and -RT pay

You\'re not alone if you have difficulty distinguishing between modifiers -LT and -RT and modifier -50. Fortunately, with the aid of the Medicare Physician Fee Schedule database and our experts\'advice, you can select an appropriate modifier with confidence.

Turn to the Fee Schedule for Guidance

Before you decide between modifier -50 (Bilateral procedure) and modifiers -LT (Left side) or -RT (Right side) for a given claim, you should consult the 2004 Physician Fee Schedule database, which is available on the CMS Web site at http://www.cms.hhs.gov/providers/pufdownload/rvudown.asp.

If you find a \"1\" in column \"T\" (labeled \"BILAT SURG\") of the fee schedule database, you can append modifier -50 to the code.

Example: The dermatologist performs a bilateral procedure to remove the ingrown and infected nail and nail matrix on the patient\'s right and left great toes. You should code this procedure with 11752 (Excision of nail and nail matrix, partial or complete [e.g., ingrown or deformed nail] for permanent removal; with amputation of tuft of distal phalanx) with modifier -50 to describe the bilateral procedure. You should also report 703.0 (Ingrowing nail) for the diagnosis.

When you find this code in the Physician Fee Schedule database, you\'ll notice a \"1\" in column T, and you can therefore report 11752 with modifier -50 attached to it. You can expect most payers to reimburse bilateral claims at 150 percent of the assigned fee schedule amount.

\"Depending upon payer rules, you will either have to list the procedure twice and append modifier -50 to the second procedure, or only list the code once with the bilateral modifier appended,\" said **Deborah Berry, CPC,** during her presentation, \"Modifiers: The Key to Reimbursement,\" at the American Academy of Professional Coders\' 2004 national conference in Atlanta.

-LT and -RT May Apply if Column T Lists a \'0\'

A \"0\" in column T tells you that you cannot use modifier -50. You may report modifiers -LT or -RT, however, either in combination or singly, to make your claim more specific.

Warning: If you simply report 20550 x 2 (Injection[s]; single tendon sheath, or ligament, aponeurosis [e.g., plantar \"fascia\"]), payers might reject the second unit as a redundant (repeat) procedure. By specifying -RT and -LT, you clearly demonstrate excisions to two different anatomic locations.

Note: To further demonstrate the separate nature of the excision sites, you should also append modifier -59 (Distinct procedural service) to the second unit of 20550.

CPT added the anatomic-specific modifiers -RTand -LT \"to streamline the claims processing system, to allow for automated payment without having to request additional documentation to rule out duplicate or other inappropriate billing,\" according to the January 2000 CPT Assistant.

Don\'t Expect to Use -50 or -LT/-RT With All Codes

If you don\'t find a \"1\" or a \"3\" in the fee schedule database\'s column T, you should append neither modifier -50 nor

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modifiers -LT/-RT, says **Jackie Miller, RHIA, CPC,** a senior consultant with Coding Strategies Inc. in Powder Springs, Ga.

A \"0\" in column T indicates that bilateral adjustment does not apply, either because of physiology/anatomy or because the code is unilateral and there is a different code for the bilateral procedure, Miller says.

A \"2\" in column T of the database indicates that the code already specifies a bilateral procedure, so you should not append a modifier to denote a procedure\'s bilateral nature. Often, such codes will also specify \"unilateral or bilateral\" in their CPT descriptors.

If column T includes a \"9,\" the concept of bilateral surgery does not apply to that code. Therefore, you should never claim modifier -50 or modifiers -LT/-RT in combination for that procedure.

Seek Advice From Private Payers in Writing

When dealing with non-Medicare payers, you should ask your insurers how they want you to report modifiers -50 and -LT/-RT. Not all private payers follow CMS guidelines. Some insurers will specify when they prefer modifier -50 and when they require modifiers -LT/-RT. Other payers prefer modifiers -LT/-RT in all circumstances because they think those modifiers are more specific than modifier -50.

Protect yourself: Always be sure to get the payers\' coding recommendations and payment guidelines in writing to protect yourself in the event of audits or claim reviews, coding experts say.

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