Internal Medicine Coding Alert

Modifiers: Stay On The Right (And Left) Side Of Modifier 50 Decisions

Hint: Read the CPT® code descriptors carefully.

At times, a provider will need to perform the same procedure on both sides of the patient's body.

When this occurs, you might be able to report the procedure code with modifier 50 (Bilateral procedure) appended but not always, say those in the know.

The rundown: Code correctly with modifier 50, and you can expect 150 percent payment for the procedure(s) based on the Medicare Physician Fee Schedule. Append the modifier incorrectly, however, and it could spell trouble in the form of a denial.

Got questions on when to use modifier 50? Check out this expert input for the answers you need.

Report Identical Procedures with Modifier 50

Two of the easiest ways to find out if an encounter meets modifier 50 criteria are checking procedure notes and reading the CPT® code descriptors.

"Apply modifier 50 whenever the exact same procedure, the same exact CPT® code, is performed on bilateral structures of the body," says **Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC**, internal audit manager with PeaceHealth in Vancouver, Wash.

Example: Let's say a patient reports with suspected foreign bodies (FBs) in both ears. The internist finds and removes a small pebble from both external ear canals without general anesthesia. You would report these services as 69200 (Removal foreign body from external auditory canal; without general anesthesia) with modifier 50 appended to show that the physician performed the procedure on both ears.

Remember: Non-Medicare payers vary as to how they pay for modifier 50, and you cannot assume that they will apply the same rules as Medicare. If you are unsure of a private payer's stance on modifier 50, check with a payer representative before filing a bilateral claim.

Read Descriptors Closely

"The 50 modifier is necessary when the procedure is being done on both sides of the body, but doesn't already have the [bilateral] verbiage in the description of the code," explains **Suzan Hauptman, CPC, CEMC, CEDC**, senior principal of ACE Med group in Pittsburgh, Pa.

To Hauptman's point, there are often clues in the CPT® code descriptors that indicate whether a procedure is unilateral or bilateral. If you pay attention to the descriptors, you'll have the first hint on whether you'll need modifier 50 for the claim.

Example: A patient reports to the physician with a nosebleed in both nostrils. The physician stops the bleeding in both nostrils with limited cautery and packing. On the claim, you'd report 30901 (Control nasal hemorrhage, anterior, simple [limited cautery and/or packing] any method) with modifier 50 appended to show that the procedure was bilateral.

Big clue: Beneath the 30901 descriptor in CPT® 2017, there is a parenthetical note stating "To report bilateral procedure, use 30901 with modifier 50." This verbiage should alert you to modifier 50 opportunities if the provider performs a procedure on both sides of a patient's body.

Know When Modifier 50 Won't Work

Keep in mind that there are some codes that do not allow the use of the 50 modifier to reflect performance of the exact same CPT® code on bilateral anatomy.

Example: The code 30300 (Removal foreign body, intranasal; office type procedure) does not recognize the 50 modifier even when the provider performs the procedure bilaterally. So, if the provider removes a foreign body from each of a patient's nostrils, you cannot report 30300-50, according to rules in the Medicare Physician Fee Schedule.

The only option for this encounter is to report 30300 and 30300 with modifier 59 (Distinct procedural service), or the appropriate X modifier, appended to indicate that the provider removed two different foreign bodies from two different sites. You still might not get paid for both procedure codes, however.

Remember, Some Codes Are Already Bilateral

Coders beware: Not all bilateral services are ripe for coding with modifier 50. At times, physicians will perform a procedure whose description refers to "unilateral or bilateral" or "one or two sides." This means that the value of the codes is the same whether they are performed on one or both sides of the body, and you'll only submit a single code. The difference is in the code descriptors, Bucknam explains.

"Note some procedures have separate codes for unilateral or bilateral, depending on which is done," says Bucknam. For these encounters, it would be inappropriate to use modifier 50 on the unilateral code instead of choosing the bilateral code, she adds.

Resource: You can also check the indicator in the "BILAT" column of the Medicare Physician Fee Schedule. "Use modifier 50 with CPT® codes that have indicators 1 or 3. Codes with indicators 0, 2, and 9 should never be billed with modifier 50," Bucknam says. You can find the fee schedule at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

LT/RT or 50? Know Your Payer

Modifier 50 is not the only modifier you might use on a "two-sided" claim. Coders use modifiers LT (Left side) and RT (Right side) most often when coding for a procedure on one side of the body which, at some point, might be performed on the other side, says Hauptman.

Caveat: Some payers prefer you use RT and LT instead of 50, including some Medicare payers. The most common methods of reporting bilateral procedures are:

- One unit of service with modifier 50 on one line. (This is how Medicare instructs providers to submit claims for bilateral services.)
- One unit of service on each of two lines with modifier RT on one line and modifier LT on the second line.
- One unit of service on each of two lines with modifier RT on one line and modifiers 50/LT on the second line.
- Two units of service on one line with the modifier 50.
- Two units of service on one line with no modifier.

"Medicare typically wants the service reported on one line with modifier 50 and 1 unit, but other payers have other rules and you can lose a lot of money if you don't follow those rules," says Bucknam.

If you are unsure about a payer's bilateral procedure coding policy, contact a representative before filing a bilateral claim.