Part B Insider (Multispecialty) Coding Alert

Bilateral Procedures: One Size Doesn't Fit All for Bilateral Services

Regs don't just differ between MACs--they also vary within the same MAC.

When you perform a procedure bilaterally, do you append one modifier to a single code, bill it twice on separate line items, or use anatomic site modifiers to identify where the procedure was performed? Interestingly, all of these methods may be correct for different insurers--and that's why bilateral billing can cause headaches for even the most seasoned coders and billers.

Background: Some procedures are inherently unilateral, so if you perform them bilaterally, you can collect extra reimbursement for them, typically by appending modifier 50 (Bilateral procedure), or by indicating the site you addressed with modifiers LT (Left side) and RT (Right side). For Medicare claims, bilateral billing is only appropriate when the bilateral surgery indicator for a particular code is "1" or "3" according to the Medicare Physician Fee Schedule.

Problem Exists Within Medicare and Beyond

Various Part B MACs may prescribe individual requests regarding whether you use modifier 50, modifiers LT/RT, or multiple units. For instance, Noridian Medicare requests that you append modifier 50 to the procedure code, with a "1" in the units field. However, Palmetto GBA indicates that you could report your procedure on a single line item with modifier 50 appended to it, or you have the alternate option of submitting the surgery on two lines, one with modifier RT appended, and one line with modifier LT appended.

In addition, even within particular MACs, the rules can vary. For instance, the Web site for WPS Medicare, a Part B MAC in four states, notes, "For the codes with an indicator of '1,' and provided bilaterally, Medicare will allow covered services at 150 percent of the Medicare Fee Schedule for that procedure code. When billing for bilateral services, you can submit your claim with:

- The procedure code on one line, with both the LT and RT modifiers, use two in the units field.
- The procedure code on one line with modifier 50 and one in the units field.
- The procedure code on two lines, with LT on one line and RT on the other line, with one unit per line."

ASC Regs: To complicate the bilateral billing matter even further, CMS maintains different rules for these procedures if you're coding for an ambulatory surgical center (ASC's) services. In a Q&A on the CMS Web site, the agency notes that for ASCs, "Bilateral procedures should be reported as a single unit on two separate lines or with '2' in the units field on one line." CMS won't recognize modifier 50 for ASC payment, according to CMS's advice (available at https://questions.cms.hhs.gov/app/answers/detail/a_id/9022/~/bilateral-proceduresunder-the-revised-asc-payment-system).

Keep A Bilateral Spreadsheet Handy

Even beyond Medicare, the bilateral billing rules vary dramatically. "CIGNA requires two lines with modifier 50 on the second line," says **Susan Unger, CPC,** billing supervisor with Bay Surgical Specialists PA in St. Petersburg, Fla. And to make matters even more confusing, "workers Comp carriers notoriously underpay bilateral surgery because they require bilateral surgery on two lines with a 50 modifier on the second line," Unger says. "If you bill on one line, 90 percent of the time they will only pay for one side."

Best bet: You can avoid delayed claims and denials by keeping track of how all of your contracted payers want you to report your bilateral surgeries.

"I have created a bilateral surgery spreadsheet for our billing department to use," Unger says. "I recommend contacting

each carrier for their bilateral surgery policy as each one varies. Also monitoring payments is crucial. This is an area where I have seen revenue lost if you don't watch it carefully."