Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Find the Fee Schedule Before Billing Bilateral

Modifier -50 may not apply as often as you think

If you've been having difficulty determining when to use modifiers -50 (Bilateral procedure), -LT (Left side) and -RT (Right side), you're not alone. But our experts' advice - and the Physician **fee schedule** database - can help you select the appropriate modifier with confidence every time.

First step: Before you decide between modifier -50, -LT, and -RT for a given claim, you should consult the 2004 Physician Fee Schedule database, which is available on the **Centers for Medicare & Medicaid Services** Web site at 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: An otolaryngologist performs a bilateral diagnostic sinus endoscopy (31233, Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy [via inferior meatus or canine fossa puncture]). When you find 31233 in the **Physician fee schedule** database, you'll notice a "1" in the "BILAT SURG" column, and you can therefore report 31233-50.

Depending on payer preference, you should either list the code once with the bilateral modifier appended (this is the method most Medicare carriers prefer) or list the procedure twice and append modifier -50 to the second procedure only, says **Heather Corcoran**, coding manager at **CGH Billing Services** in Louisville, KY.

Because most payers reimburse bilateral claims at 150 percent of the assigned fee schedule amount, you can usually expect about an additional $135 for this procedure (for a total payment of $410, based on national average payment using 2004 fee schedule figures).

The code descriptors often give you a hint regarding whether the procedure will garner more reimbursement if you append modifier -50, says **Suzan Hvizdash, BSJ, CPC**, physician education specialist at the **University of Pittsburgh's** department of surgery. If the descriptor indicates a bilateral procedure, modifier -50 won't bring you more money.

If you find a "0" in column "T" it means that modifier -50 is not allowed. You may report modifiers -LT or -RT, however, either in combination or singly, to enhance the specificity of your claim.

Example: Ligament, tendon sheath and tendon insertion/origin injections (20550-20551) contain a "0" in column T, meaning that you may not append modifier -50 to these procedures. But if the surgeon provides several injections to the right wrist and several more to the left wrist, you can report the injections using 20550-RT (Injection[s]; single tendon sheath, or ligament, aponeurosis [e.g., plantar "fascia"]) and 20550-LT, says **Allison Waxler**, practice management policy analyst at the **American Academy of Physical Medicine and Rehabilitation** in Chicago.

This is a more effective method than simply reporting 20550 x 2, because payers might reject the second unit as a redundant (repeat) procedure. By specifying -RT and -LT, you clearly demonstrate injections to two different anatomic locations.

Note: Modifier -59 (Distinct procedural service) should only be used when there is no other appropriate modifier that may be appended. Modifiers -RT and -LT can be appended in this situation, as they identify the "separate sites" much more effectively than -59.

If you find a "2" in column "T" it 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.

Example: CPT code 61253 specifies, "Burr hole(s) or trephine, infratentorial, unilateral or bilateral." The Physician Fee Schedule database assigns this code a "2" in column T. Therefore, if the surgeon drills burr holes on both sides of the skull, you should report a single unit of 61253, with no modifiers appended. The procedure is priced accordingly and the insurer will make no additional payment for a bilateral procedure.

If you find a "9" in column "T" 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.

Example: The implantation or replacement of a hearing aid, 69710 (Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone), has a bilateral status of "9" and therefore may never have a -50, -RT or -LT appended to it on a claim form.

To Bill or Not to Bill Your X-rays As Bilateral

When billing x-rays, the question often arises whether an office should bill bilateral x-rays using modifiers -RT, -LT or -50. For Medicare claims, appending modifier -50 is a no-no because the modifier was intended for surgical procedures, not radiology, says **Carla Mulcay, CPC, CPC-H CMC, RCC**, assistant director of coding at **Medquest Associates** in Alpharetta, Ga. In addition, many of the radiology procedure codes specify unilateral, bilateral or both in the code definition.

For example, in its radiology manual, **CIGNA Healthcare** states, "The most appropriate away to submit bilateral x-rays is to bill the procedure code on separate lines with the appropriate -RT and -LT modifiers (do not use the bilateral modifier -50)."

Therefore, to specify which foot on a Medicare claim for an x-ray, you can only append modifiers -LT and -RT. If it's a toe x-ray, one of the toe modifiers, like -T3 (Left foot, fourth digit), is the way to go. There may be some private carriers that require modifier -50, Mulcay warns, so you should check with the insurance carriers to find out what they prefer.

Don't be fooled: Always check the fee schedule; just because something appears to be bilateral doesn't always mean it is. In other words, never simply assume you're right.

Example: An office bills an occuloplastics procedure 21390 (Open treatment of orbital blowout fracture; periorbital approach, with alloplastic or other implant) performed on both orbits and appends modifier -50. But just because a person has two eyes does not mean the procedure is bilateral. Sure enough, the fee schedule lists a "0" in column T. So you may not append a -50, but you can distinguish the two procedures by appending modifier -59 and/or modifier -LT and -RT.

Avoid this common mistake: Don't use modifier -50 when billing for LeFort fractures. LeFort fractures, such as 23147 (Open treatment of nasomaxillary complex fracture [LeFort II type]; requiring multiple surgical approaches) are inherently bilateral and their repair may never be billed with modifier -50, so they have a status of "0." Saying "bilateral LeFort II fracture" is like saying the azure sky is blue.

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 get the payers' coding recommendations and payment guidelines in writing to protect yourself in the event of audits or claim reviews, coding experts advise.