Eli's Rehab Report

Reader Question: Bilateral Bursitis

Question: I understand that using multiple modifiers can delay payment, but right and left modifiers can also clarify the service. One of our patients has bursitis on both ankles. Will using anatomic modifiers with modifier -59 (distinct procedural service) ensure prompt reimbursement?

New Hampshire Subscriber

Answer: You haven't said which procedure you are performing for the bursitis, but let's say you are billing for bursa injections (20600-20610). If you bill for two bursa injections of the ankle (20605), both with the ICD-9 code 726.79, without using modifiers, you will be taking the risk that Medicare may think you double-billed for the same ankle and reject one of the injection units. Therefore, be as specific as possible in your claim. Code the procedure as 20605-LT (726.79) for the left ankle, and 20605-RT (726.79) for the right ankle without using modifier -59. Most payers automatically add modifier -51 (multiple procedures) to such claims, so there is no need to append this modifier.

However, some payer systems don't accept -RT and -LT, so review your LMRP to determine which method your carrier prefers. In those situations only, you would be forced to use -59 instead of the anatomic modifiers, based on how the insurer's program interprets the modifiers.