Eli's Rehab Report

Reader Question: Modifier -50 Is Carrier-Specific

Question: When we perform bilateral procedures, should we bill the procedure code twice, with modifier -50 appended to the first entry and no modifier appended to the second listing?

Kansas Subscriber

Answer: The answer depends on the insurer. Most Medicare carriers require that you report bilateral services on one line only, for example, 95934-50 (H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle; Bilateral procedure). Some private payers, however, prefer the services on two lines, as follows:

95934

95934-50.

Some coders report that billing on two lines (as in the second example) causes the insurer to reject the second code as a duplication of services, allowing reimbursement only for the first procedure (which is unilateral).

If this is the case with your provider, ask whether you can report on two lines using the -LT (Left side) and -RT (Right side) modifiers instead of modifier -50. Your claim would appear this way:

95934-LT

95934-RT.

If your carrier wont send you a written copy of its bilateral billing rules, you should track bilateral procedure reimbursement rates. The claims that trigger the most denials are most likely those that feature bilateral billing protocol that your insurer dislikes.

Although this trial and error method isnt optimal, it may be the only way to determine how your carrier prefers that you submit bilateral claims, in absence of specific payer guidelines.