Eli's Rehab Report

READER QUESTIONS: Figure Out Your Bilateral Fee

Question: How can I use the Medicare **Physician Fee Schedule** to determine an injection code's fee when I report modifier 50 or modifiers RT/LT?

California Subscriber

Answer: For injection codes, the RBRVS bilateral status indicator is "0," meaning that the 150 percent payment adjustment for bilateral procedures does not apply. If you report the procedure with modifier 50 (Bilateral procedure) or with modifiers RT (Right side) and LT (Left side), base the payment for the two sides on the lower of:

(a) the total actual charge for both sides, or
(b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code XXXXX is $125. The physician reports XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) because it is lower than the total actual charges for the left and right sides ($200).

The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

For example, codes that carry the "0" status, meaning you cannot report them bilaterally, include all the EMG codes (95860-95864), intralaminar epidural injections (62310-62311), some of the somatic nerve injection codes (64420-64421, 64425), some of the sympathetic nerve injection codes (64510, 64520), soft-tissue injection codes (20550-20551), and trigger point codes (20552-20553).