Codify
BY AAPC

Outpatient Facility Coding Alert

Modifier Check: Ensure You're Coding Precisely With Modifiers 50 and 52

Tip: Fee schedules and payers help guide when you should report.

As the name implies, modifiers modify a procedure /service or an item under certain circumstances to correctly code for the exact procedure/service provided. Reporting some modifiers can be tricky, which means incorrect coding can lead to denials or incorrect reimbursement. Read on for the lowdown on two common modifiers for outpatient/ASC procedures: modifier 50 (Bilateral procedure) and modifier 52 (Reduced services).

Only Consider Modifier 50 for Same-Session Services

You can sometimes use modifier 50 to report bilateral procedures that the physician performs at the same treatment session. Modifier 50 is added to the procedure when performed on contralateral site and this should be reported as one unit.

Report modifier 50 for:

- Surgical procedures (CPT® codes 10000-69990)
- Radiology procedures as applicable
- Any bilateral procedure performed on both sides at the same session.

Do not report modifier 50 for:

- Procedures where the description includes bilateral procedures, for example, 27395 (Lengthening of hamstring tendon; multiple tendons, bilateral)
- Procedures identified as unilateral or bilateral, for example, 52290 (Cystourethroscopy, with urethral meatotomy, unilateral or bilateral).

Example: Mrs Jones has cysts on both her breasts. She has been asked to have the cyst fluid evaluated, and presents to the ASC. The surgeon inserts a needle into the cyst and withdraws the fluid contained in the cyst. He does it for both the breasts, and then sends the fluid to the lab. You will have to report code 19000 (Puncture aspiration of cyst of breast) and append modifier 50, as the surgeon performed the same procedure on both the breasts during the same operative session.

Understand When Modifiers LT and RT Apply

Modifiers LT (Left side) and RT (Right side) help to indicate the side of the body on which a service or procedure is performed. Modifiers LT and RT also can indicate that the procedure is performed on only one side of the body. This is specifically helpful when the procedure is performed on contralateral anatomic sites (for bones and joints), extremities (arms or legs), and paired organs (eyes, ears, lungs, ovaries, kidneys, etc).

Important: Do not submit a claim with modifiers RT or LT when using modifier 50. However, bear in mind that some payers will want you to report the procedure twice, once with modifier RT and the other with LT. Review and/or request payer guidance when in doubt.

How to code: Medicare and other payers that follow Medicare rules and require the use of modifier 50 require that the code be billed on one line with the unit be listed as a single unit:

XXXXX□50, Units = 1

Another variation is billing the code on two lines, with each line representing one unit and one line with the RT and one line with the LT modifier appended:

XXXXX□RT, Units = 1

XXXXX□LT, Units = 1

For procedures normally considered bilateral that are performed on one side, append the RT or the LT modifier as:

XXXXX□RT/LT, Units = 1

Know the Payment Implications

Reimbursement for modifier 50 depends upon the bilateral surgery indicator in the Medicare Physician Fee Schedule.

Example 1: If the "bilat surgery" indicator is "1," then when the service is submitted with modifier 50, the LT and RT or with 2 units of service, Medicare will allow the lower of the billed amount for both services or pay 150% of the allowed amount for a single service.

Example 2: If the "bilat surg" indicator is "3," then the Medicare allowed amount is for 2 units of service. If the service is submitted using a modifier 50 or the RT/LT or two units of service, then Medicare will reimburse at 200% of the fee schedule. Services in this category are generally radiology or other diagnostic tests and are not subject to the special payment rules for bilateral surgeries.

Think About Modifier 52 for Incomplete Service

You turn to modifier 52 when the service provided is reduced in comparison to the full service indicated in the description. When the physician does not perform the complete procedure or discontinues a procedure due to unforeseen circumstances, modifier 52 can be used.

Pay attention: Note that in the facility setting, for certain procedures requiring anesthesia, modifier 73 (Discontinued outpatient procedure prior to anesthesia administration) or 74 (Discontinued outpatient procedure after anesthesia administration) should be used in lieu of modifier 52.

Coding guidelines: When you include modifier 52 to indicate reduced services, the billing office should indicate what was different about the procedure (how was the service reduced) and approximately what percentage of the usual work was completed and/or not done. In some simple cases, this can be done with a brief statement of additional information on the claim itself. Most electronic clearinghouse services have fields to accommodate and transmit this additional information.

Keep these tips in mind to guide your coding with modifier 52:

- If the procedure code is time-based (e.g. "each 15 minutes" or "each additional hour"), indicate on the claim how much time was actually performed.
- When an inherently bilateral procedure is performed unilaterally, a claim notation can be made to indicate the procedure was only performed on one side (e.g., 64611 Chemodenervation of parotid and submandibular salivary glands, bilateral).
- If the nature and extent of the reduction cannot clearly and completely be explained with a notation on the claim itself, then a letter or statement should be attached to the claim, and the medical records documenting the service should also accompany the claim (e.g. operative report, radiology report, visit notes, etc). Generally this means that the claim cannot be submitted electronically and must drop to manual submission.

Remember: Always attach a brief note describing the nature and reason for the reduced service and all the documentation substantiating the claim. This will help the payer to better assess the situation, leading to fewer denials.

When you report modifier 52, Medicare will reimburse at 50 percent of the fee schedule rate.