

Modifier Coding Alert

Payer Policies: Reduce Denials with Correct Use of Modifier 50

Get started by reviewing modifier 50/RT/LT policies from three payers.

Don't get caught in a situation where you try to use both modifier 50 (Bilateral procedure) and either an RT (Right side) or LT (Left side) modifier. You should only use one, but which one depends on your payer – making the wrong choice could land your claim in the reject pile.

Empower yourself by reading further to learn the ins and outs of these three modifiers, and, as a bonus, become familiar with a few payers' policies to save yourself time and frustration.

Make 50 Your Go-To Modifier for Bilateral Procedures

You should use modifier 50 to identify a diagnostic, radiology, or surgical procedure that your physician performed on both sides of a patient during the same session. Bilateral procedures are more complex and take more time than a single side surgical session. Payers seeing modifier 50 know that a procedure was performed on both sides and will likely increase your reimbursement accordingly.

Example: One of your physicians performs arthrocentesis of both right and left elbows for bursitis of the elbows. You would report 20605 (Arthrocentesis, aspiration and/or injection; intermediate joint or bursa [eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]) and attach modifier 50. CPT® code 20605 has a bilateral surgery indicator "1," which means the 150 percent adjustment for bilateral procedures applies.

Don't Add 50 Along with RT or LT

You should not report bilateral procedures with both modifier 50 and RT or LT. Your claim will be returned if you use RT and LT when modifier 50 applies.

There are three common methods of coding bilateral procedures on a claim as follows:

- One unit of service with modifier 50 on one line
- One unit of service on each of two lines with RT on one line and LT on the other line
- Two units of service on one line with no modifier.

"Problems occur if claims indicate modifier 50 and also LT or RT – it's one or the other," explains **Catherine A. Brink, BS, CMM, CPC, CMSCS**, president of HealthCare Resource Management Inc. in Spring Lake, N.J. To know which way to report, ask your payers for guidance.

Take a Glimpse at 3 Policies

Contacting your payers is always a good idea in order to learn what their policy is on modifier use. Start your 50 versus RT/LT research with a review of the following three examples of payer policies.

Payer 1: Palmetto GBA instructs that you should refer to the Medicare physician fee schedule database (MPFSDB) to determine if CPT® modifier 50 is applicable to a particular procedure code. On its Website (www.palmettogba.com/palmetto/providers.nsf/DocsCat/Jurisdiction-11-Part-B~8EEL958265), Palmetto gets more specific on what not to do in the following guidance:

- "Do not submit modifier 50 on procedures for midline organs such as the bladder, uterus, esophagus, and nasal septum."

- "If a (subsequent) bilateral procedure requires a return to the operating room after the initial surgery, and the bilateral indicator in the MPFSDB is 1 or 2, do not submit modifier 50. Modifiers 50 and 78 (Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period) cannot be submitted for the same service. Instead, submit the surgery procedure code with the CPT® modifier 78 and HCPCS modifier RT on one detail line, and submit the same surgery procedure code with CPT® modifier 78 and HCPCS modifier LT on a separate detail line."
- "For special instructions regarding bilateral facet joint injections (64490-64495, Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT], ...), refer to www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6518.pdf."

Payer 2: UnitedHealthcare Community Plan considers all codes with the bilateral status indicators "1" or "3" in the physician fee schedule "eligible for bilateral services as indicated by the bilateral modifier 50," according to a policy brief ([www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/reimbursementpolicies/Bilateral-Procedures-Policy-\(R0023\).pdf](http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/reimbursementpolicies/Bilateral-Procedures-Policy-(R0023).pdf)).

The policy goes on to explain that you should bill the procedure "on one line with modifier 50 and one unit with the full charge for both procedures" and "use of modifiers LT or RT will be recognized as informational only when the procedure with 'unilateral or bilateral' in the description is performed on only one side. Consistent with CMS guidelines, when both modifiers LT and RT are reported separately on the same day by the Same Individual Physician or Other Health Care Professional, only one charge will be eligible for reimbursement up to the maximum frequency per day limit."

Payer 3: In its bilateral payment policy, Harvard Pilgrim Health Care explains that you should use modifiers LT and RT when the procedure is valid for a modifier 50 but the procedure is only performed on one side.

The policy also states that you should bill bilateral diagnostic, radiology, and surgical procedures performed on both sides of the body during the same operative session or on the same day on one line with the procedure code and modifier 50 attached.

Harvard Pilgrim bases modifier 50 eligibility on the procedure description, CPT® guidelines, CMS directives, and nationally recognized sources, such as Journal of AHIMA and CPT® Assistant.

You won't use modifier 50 when the procedure is bilateral by definition or when the description includes the words "bilateral" or "unilateral."

To read more about the Harvard Pilgrim policies, visit www.harvardpilgrim.org/pls/portal/url/item/1663579977ad4d9d93d59cf7170e1e1f.