Pain Management Coding Alert

Reader question: Watch Those Modifiers When Reporting Bilateral Injections

Question: We have been facing challenges for reporting bilateral procedures like injection codes 64483 (Injection[s], anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance [fluoroscopy or CT]; lumbar or sacral, single level) and 27096 (Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance [fluoroscopy or CT] including arthrography when performed). Is it better to report modifiers LT and RT to each injection or append modifier 50 to one injection code?

Alabama Subscriber

Answer: You can submit your bilateral procedures claims with one of the following:

1. Report the procedure code on one line, write "1" in the units field, and append modifier 50 (Bilateral procedure).

2. Report the procedure code on one line, write "2" in the units field, and use the LT (Left side) and RT (Right side) modifiers.

3. Report the procedure code on two lines, write "1" in the units field, and use modifier LT on one line and RT on the other.

Check point: Make sure that the procedure that you are reporting meets the definition of bilaterality, i.e. the procedure was performed at a mirror-image anatomic site. Also note that payer guidelines for modifier 50 usage may differ.

According to Medicare, modifier 50 is only appropriate when the bilateral surgery indicator is "1" or "3." Medicare allows covered services at 150 percent of the Medicare Fee Schedule for the service codes that have an indicator of "1" when the service is provided bilaterally, such as joint injections of the right and left knees.

For these situations, report the procedure code once (such as 20610, Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee, subacromial bursa]; without ultrasound guidance) and append modifier 50 with one unit of service. However, do not include modifier 50 when your physician performs the service on different areas of same side of the body, for example injection of the right shoulder and the right knee.

Caution: Also, do not append modifier 50 when the CPT® descriptor designates the procedure as "bilateral," for example, code 64615 (Chemodenervation of muscle[s]; muscle[s] innervated by facial, trigeminal, cervical spinal and accessory nerves, **bilateral** [e.g., for chronic migraine]). Finally, some payers may want you to report a bilateral procedure on two lines of service and append modifier 50 to the second line of service. Check to verify which way the payer in question wants you to complete claims so you won't be denied for incorrect submission.