Eli's Rehab Report

Don't Settle for Unilateral Pay With Bilateral Procedures

Use modifier -50 to collect about $137 more for your facet injections

You're not alone if you have difficulty distinguishing between modifiers -LT and -RT and modifier -50. Fortunately, with the aid of the Medicare **Physician Fee Schedule** database and our experts'advice, you can select an appropriate modifier with confidence.

Turn to the Fee Schedule for Guidance

Before you decide between modifier -50 (Bilateral procedure) and modifiers -LT (Left side) or -RT (Right side) for a given claim, you should consult the 2004 Physician Fee Schedule database, which is available on the CMS Web site at http://www.cms.hhs.gov/providers/pufdownload/rvudown.asp.

If you find a "1" in column "T" (labeled "BILAT SURG") on the fee schedule spreadsheet database, you can append modifier -50 to the code. (Although the bilateral surgery indicator is in column "T" of the National Fee Schedule, please note that some regional carriers distribute their own fee schedules, on which the column label may vary.)

Example: The physiatrist performs a bilateral cervical facet joint injection (64470, Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level).

When you find 64470 in the Physician Fee Schedule database, you'll notice a "1" in column T, and you can therefore report 64470-50. Because most payers reimburse bilateral claims at 150 percent of the assigned fee schedule amount, you can expect about an additional $137.50 for this procedure (for a total payment of $412.50, based on national average payment using 2004 fee schedule figures for a nonfacility site of service).

"Depending upon payer rules, you will either have to only list the code once with the bilateral modifier appended (Medicare preference) or list the procedure twice and append modifier -50 to the second procedure," said **Deborah Berry, CPC**, during her presentation, "Modifiers, The Key to Reimbursement," at the American Academy of Professional Coders'2004 national conference in Atlanta.

-LT and -RT May Apply if Column T Lists a '0'

A "0" in column T tells you that you cannot use modifier -50. You may report modifiers -LT or -RT, however, either in combination or singly, to make your claim more specific.

Example: Tendon injection codes 20550-20551 contain a "0" in column T, meaning that you should not append modifier -50 to these procedures. However, if the physiatrist administers tendon sheath injections to the right and left hands for a diagnosis of trigger fingers, you can report the injections using 20550-RT (Injection[s]; single tendon sheath, or ligament, aponeurosis [e.g., plantar "fascia"]) and 20550-LT.

If you simply report 20550 x 2, payers might reject the second unit as a redundant (repeat) procedure. By specifying -RT and -LT, you clearly demonstrate injections to two different anatomic locations.

Note: To further demonstrate the separate nature of the injection sites, you should also append modifier -59 (Distinct procedural service) to the second unit of 20550.

CPT added the anatomic-specific modifiers -RT and -LT "to streamline the claims processing system, to allow for automated payment without having to request additional documentation to rule out duplicate or other inappropriate

billing," according to the January 2000 CPTAssistant.

Don't Expect to Use -50 or -LT/-RT With All Codes

If you find a number other than"1" or a "0" in the fee schedule database's column T, you should append neither modifier -50 nor modifiers -LT/-RT.

A "2" in column T of the database indicates that the code already specifies a bilateral procedure, so you should not append a modifier to denote a bilateral procedure.

Often, such codes will also specify "unilateral or bilateral" in their CPT descriptors. This also gives you a hint regarding whether the procedure will reimburse you more if you append modifier -50, says **Suzan Hvizdash, BSJ, CPC,** physician education specialist at the University of Pittsburgh's department of surgery. If the descriptor indicates a bilateral procedure, modifier -50 won't bring you more money.

Example: The fee schedule designates a "2" to code 64600 (Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch). Payers will consider modifier -50 irrelevant when you apply it to this code. Therefore, if the physiatrist performs a bilateral nerve destruction, report a single unit of 64600 with no modifiers.

If column T includes a "9," the concept of bilateral surgery does not apply to that code. Therefore, you should never claim modifier -50 or modifiers -LT/-RT in combination for that procedure.

Example: The Physician Fee Schedule database assigns a "9" to 97014 (Application of a modality to one or more areas; electrical stimulation [unattended]). A physiatrist or therapist who performs this procedure should report a single unit of 97014, regardless of the location of the electrical stimulation.

Seek Advice From Private Payers (in Writing)

When you deal with non-Medicare payers, you should ask how they advise you to report modifiers -50 and -LT/-RT. Not all private payers follow CMS guidelines -- some insurers will specify when they prefer modifier -50 and when they prefer modifiers -LT/-RT. Other payers prefer modifiers -LT/-RT in all circumstances because they think those modifiers are more specific than modifier -50.

Protect yourself: Always be sure to get the payers' coding recommendations and payment guidelines in writing to protect yourself in the event of audits or claim reviews.