Codify
BY AAPC

Pain Management Coding Alert

Reader Questions: Check MUEs Before Reporting Multiple Lines

Question: Medicare is denying our claims for bilateral carpal tunnel injections by saying they exceed the amount able to be billed in one day. I usually bill it at 20526-RT then 20526-LT with diagnosis 354.0. Do I need to use a modifier 51?

Wisconsin Subscriber

Answer: When reporting Medicare physician services, you should bill bilateral procedures with modifier 50 (Bilateral procedure) and one unit of service as one line item. The modifier 50 is in place of modifiers RT (Right side) and LT (Left side) that other payers sometimes prefer to clarify unilateral or bilateral services.

Code 354.0 (Carpal tunnel syndrome) is an acceptable diagnosis. ICD-9 notes that the diagnosis includes median nerve entrapment and partial thenar atrophy.

Your denials could be due to 20526 (Injection, therapeutic [e.g., local anesthetic, corticosteroid], carpal tunnel) having a Medically Unlikely Edit (MUE) limit of one, or a maximum of one unit of service per date of service. By reporting 20526 as a single line item with modifier 50, your claim should be approved.