

The complexities of coding bilateral procedures

by Jenny J. Jackson, MPH, CPC;
Charles D. Mabry, MD, FACS;
and Mark Savarise, MD, FACS

Incorrect use of modifiers is a widely recognized billing error on Medicare claims. The plethora of guidelines used by various coding rule-makers, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), and various insurers, increases the complexity of use. Furthermore, coding for bilateral procedures is particularly challenging because it is defined in various ways.

CMS defines a bilateral service as one in which the same procedure is performed on both sides of the body during the same operative session or on the same day.* AMA Current Procedural Terminology (CPT) indicates that “unless

otherwise identified in the listing, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate five digit code.”† The Healthcare Common Procedure Coding System (HCPCS) uses modifiers LT (left) and RT (right) instead of modifier 50.

In addition, some CPT and HCPCS codes are inherently bilateral by their description, such as CPT code 50300, *donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral*. Regardless of an individual payor’s approach to coding bilateral procedures, such codes should never be reported with the bilateral modifier 50 or modifiers LT and RT because they are inclusive of the bilateral procedure.

Reporting codes that can be performed bilaterally and are not otherwise identified

Medicare and payors that follow Medicare rules, including United Healthcare, Aetna,

Humana, and Cigna, require that the code be billed on one line, the unit be listed as 1, and modifier 50 be appended:

Example:
XXXXX-50, Units = 1

As discussed previously, the various third-party payors have different coverage guidelines for reporting bilateral procedures. For example, the Blue Cross Blue Shield (BCBS) Association is composed of multiple companies, and many of them have different local coding and coverage guidelines for bilateral procedures. For a list of local BCBS Association companies, go to www.bcbs.com/about-the-companies/; bilateral procedure rules will be listed under “Provider” and “Guidelines and Policies.”

Another variation for reporting bilateral procedures with modifier 50:

The code is billed on two lines, each with 1 unit, and one line has modifier 50:

*Centers for Medicare & Medicaid Services (CMS). Physician/nonphysician practitioners. Medicare Claims Processing Manual. Available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>. Accessed August 21, 2013.

†All specific references to CPT (Current Procedural Terminology) codes and descriptions are © 2012 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.

Example:
XXXXX, Units = 1
XXXXX-50, Units = 1

Reporting codes with bilateral in their intent or with bilateral written in their description

The code is billed on one line, the units are 1, and modifier 50 is inappropriate and should not be appended:

Example:
XXXXX, Units = 1

48|

When to apply modifiers LT and RT

In some instances, procedure codes do not indicate on which side of the body a procedure is performed. In those instances, the modifier LT or RT is used to indicate the side of the body on which a service or procedure is performed. Specifically, modifiers LT and RT should be used to identify procedures that can be performed on contralateral anatomic sites (such as bones, joints), paired organs (such as ears, eyes, nasal passages, kidneys, lungs, ovaries), or extremities (such as arms or legs). Modifiers LT and RT should be used to indicate that the procedure is performed on only one side of the body.

Medicare and other payors that follow Medicare rules as identified in the portion of this article centered on the use of modifier 50 require that the code be billed on one line, the unit

be listed as 1, and the RT and the LT modifiers be appended:

Example:
XXXXX-RT, LT, Units = 1

Another variation that may be preferred by payors not listed above is billing the code on two lines, each line with 1 unit and one line with RT and one line with LT modifiers appended:

Example:
XXXXX-RT, Units = 1
XXXXX-LT, Units = 1

When reporting bilateral procedures on a single line (for example, XXXXX-50 XXXXX RT, LT), the American College of Surgeons (ACS) recommends doubling the fee because payors will reimburse on the lesser of the fee submitted or payor allowable. Additionally, for billing purposes it is important to understand the payor's rules regarding multiple procedure payment reductions. We suggest watching your reimbursement closely to ensure the insurer pays 100 percent for the first procedure and according to the payor's multiple procedure payment formula for the second procedure (often 50 percent).

Third-party payors have different policies for reporting bilateral procedures on the claim form. It may be difficult to know how payors expect bilateral procedures to be represented on the claim form. Providers should not wait for denials

to identify a payor's bilateral procedures claim form policy. It is important to verify a payor's reporting preference to avoid payment denials because some payors may require one- or two-line entry or the use of HCPCS Level II RT and LT modifiers.

In an age of electronic health records, it may be unwise for providers to rely solely on software to accurately apply modifiers by payor preference. As a best practice, run regular payment audits to detect whether bilateral procedures are being paid correctly or denied.

Important steps to take when all services are not performed

If a unilateral procedure has not been defined by CPT or HCPCS guidelines and only a bilateral description of a procedure exists, for example, CPT code 27158, *osteotomy, pelvis, bilateral (eg, congenital malformation)*, report the code per the descriptor and with modifier 52 (reduced services) when the procedure is performed unilaterally. For additional information on HCPCS guidelines, visit www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/medhcpcsgeninfo/.

When a procedure with "unilateral or bilateral" written in the description is performed unilaterally, then the CPT or HCPCS procedure code need not be reported with modifier 52 since the procedure description

MEDICARE BILATERAL PAYMENT INDICATORS AND RULES

CMS has defined certain codes as subject to the bilateral payment rule and has assigned the codes a payment indicator in the Medicare physician fee schedule.

- **0-INDICATOR:** 150 percent payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes with this indicator because of physiology or anatomy or because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.
- **1-INDICATOR:** 150 percent payment adjustment for bilateral procedures applies. If a code is billed with the bilateral modifier (for example, with RT and LT modifiers or one line, one unit, and modifier 50 appended), payment is based on 150 percent of the fee schedule amount for a single code.
- **2-INDICATOR:** 150 percent payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes with this indicator because these procedure codes are already bilateral.
- **3-INDICATOR:** 150 percent payment adjustment for bilateral procedures does not apply. Payment will be based on the lower of 100 percent of the fee schedule for each side or actual charges for each side. Services in this category are generally radiology procedures or other diagnostic tests that are not subject to the special payment rules for other bilateral procedures.
- **9-INDICATOR:** 150 percent payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes with this indicator because the concept does not apply.

already indicates that the service may be performed either unilaterally or bilaterally.

Clinical scenario

A 68-year-old female undergoes stereotactic needle biopsy of an area of suspicious microcalcifications in the left and right breasts that reveals ductal carcinoma in situ. Review of the mammogram shows the areas biopsied are part of an extensive area of suspicious calcifications extending over a 7-centimeter area along a ductal distribution in each breast. Following review of surgical alternatives with the patient, and considering especially the patient's breast size relative to the extent of the calcifications, a bilateral mastectomy is planned. How is this scenario reported?

Medicare reporting

- 19303–50, *Mastectomy, simple, complete*, Units = 1
- Health Insurance Claim Form 1500 Line 1: Enter CPT code

19303 with modifier 50 (bilateral procedure) in the “Procedures, Services, or Supplies” field (Box 24D). In addition, double the charge in the “Charges” field (Box 24F). Also enter 1 in the “Days or Units” field (Box 24G).

Non-Medicare reporting variation

The code is billed on two lines, each with 1 unit, and one line has modifier 50:

- 19303, *Mastectomy, simple, complete*, Units = 1
- 19303–50, *Mastectomy, simple, complete*, Units = 1
- Health Insurance Claim Form 1500 Line 1: Enter CPT code 19303 with no modifier in the “Procedures, Services, or Supplies” field (Box 24D). Enter 1 in the “Days or Units” field (Box 24G).
- Health Insurance Claim Form 1500 Line 2: Enter CPT code 19303 with modifier 50 (bilateral procedure) in the “Procedures, Services, or Supplies” field (Box

24D). Also enter 1 in the “Days or Units” field (Box 24G). In this scenario there is no need to double the charge. Bill 100 percent on each line.

If you have additional coding questions, contact the American College of Surgeons Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain time, excluding holidays, or go to www.facs.org/ahp/pubs/tips/index.html. ♦

Editor’s note

Accurate coding is the responsibility of the provider. This summary is intended only to serve as a resource to assist in the billing process.