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The Reporting of Bilateral Procedures Using Modifier -50

Modifier - 50 is used by providers and suppliers, other than ambulatory surgical centers (ASCs), to report bilateral procedures when the term “bilateral” is not included in the code descriptor of a CPT® code. Because this modifier is used when specific pain medicine procedures are performed bilaterally, this topic will be of particular interest to ASA members practice pain medicine. The intent of this modifier is to report an appropriate unilateral procedure when performed bilaterally, and there is no bilateral CPT code to report what has been done. The Centers for Medicare and Medicaid Services (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. These bilateral procedures are performed either on the same operative area (e.g. breast, nose, eyes) or in separate operative areas (e.g. feet, arms, legs).

In the past, Medicare allowed bilateral procedures when the term “bilateral” was not included in the code descriptor, to be reported by different methods that were correct only in certain circumstances. For example, CPT notes that facet joint injections as described by codes 64490 - 64495 are unilateral procedures; modifier 50 is to be appended when the procedure is done bilaterally, Common methods to report the scenario in which the injection was done bilaterally at one single lumbar level were:

- two units of service (UOS) reported on a single line with no modifier
Example:
64493, Units=2
- one UOS on each of the separate lines using the modifiers RT and LT;
Example:
64493-RT, Units = 1
64493-LT, Units = 1
- one UOS on one line using the modifier -50
Example:
64493-50, Units=1

Recently, CMS implemented a Medically Unlikely Edit (MUE) that will render the reporting of bilateral procedures where the term “bilateral” is not included in the CPT code descriptor, as unpayable when reported on two claim lines using the RT and LT modifiers or by reporting two units of service on a single line with no modifier. The

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National Correct Coding Initiative (NCCI) and the Medicare Claims Processing Manual now require the practitioner or supplier to report these procedures using a single unit of service on a single claim line using the -50 modifier – per the third bullet point above.

The recommendation for the coding of these specific bilateral procedures was made by Medicare and the Office of the Inspector General (OIG) after examining claims data relative to MUE levels. That review confirmed a pattern of inappropriate billing when multiple lines were used to bypass the MUEs. Medicare is also converting most MUEs into per day edits in the July 1, 2014 MUE update.

To avoid claims being denied, make sure your billing staff reviews the process for filing claims for bilateral procedures and services. Ensure that the -50 modifier is used in accordance with Medicare's claims submission instructions.

If a clerical error is identified after a claim has been submitted and denied, the provider may request for the claim to be reopened so the billing of the bilateral procedures can be corrected. A reopening is conducted at the discretion of the Medicare contractor and used to correct claims with clerical errors, which include minor errors and omissions; however, providers can typically submit claim adjustments in these situations.

Providers and billing staff need to be aware that for services denied based on NCCI edits, the Medicare beneficiary cannot be billed. Because the denials are based on incorrect coding rather than medical necessity, the provider cannot use an Advance Beneficiary Notice of Noncoverage (ABN) to seek payment from a Medicare beneficiary.

For more information, please see the CMS notification at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1422.pdf>