Dermatology Coding Alert

'1' May Help You Stay on Top of Your Modifier -59 Reporting

As OIG heightens scrutiny, keep your distinct procedures on the straight and narrow

Don\'t assume that modifier -59 is a quick fix when you\'re looking for a way to unbundle procedures. If you habitually tack modifier -59 onto bundled procedure codes, you could be asking for denials and audits.

Beware: In its recently released 2005 Work Plan, the Office of Inspector General (OIG) at the Department of Health and Human Services stated that it intends to scrutinize claims that include modifiers used to bypass NCCI edits. Therefore, it\'s more important than ever before to ensure that you\'re using modifier -59 (Distinct procedural service) appropriately.

Although several modifiers allow practices to unbundle National Correct Coding Initiative (NCCI) edits, dermatology practices most often choose modifier -59 in order to separate code pairs.

Best practice: To avoid running afoul of CMS regulators, always be sure the dermatologist\'s operative notes make clear the distinct and separate nature of the procedure to which you are attaching modifier -59.

Follow our experts\' advice to determine when you should - and should not - append modifier -59 to your claims.

Modifier -59 Works When Codes Are Close

Dermatology coders use modifier -59 to identify procedures that are distinctly separate from any other procedure or service the physician provides on the same date.

Example: The dermatologist removes three lesions from the left arm, sizes 1 cm (benign), 1.5 cm (benign) and 2.5 cm (malignant).
In this case, you should report:

1. 11401 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs; excised diameter 0.6 to 1.0 cm) with 216.6 (Benign neoplasm of skin; skin of upper limb, including shoulder) for the first lesion
2. 11402 (...; excised diameter 1.1 to 2.0 cm) with modifier -59 and 216.6 for the second lesion
3. 11603 (Excision, malignant lesion including margins, trunk, arms or legs; lesion diameter 2.1 to 3.0 cm) and 12032 (Layer closure of wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 2.6 cm to 7.5 cm) with modifier -59 and 173.6 (Other malignant neoplasm of skin; skin of upper limb, including shoulder) for the third lesion.

Think of it this way: Here, modifier -59 tells the payer that the procedures were not components of one another but were all medically necessary and separate from one another, says **Heather Corcoran**, coding manager at CGH Billing Services in Louisville, Ky.

Beware: Increase your modifier -59 reimbursement rate by using it only when absolutely necessary. If you overuse this modifier, you may indicate routine unbundling of services to insurers, and they can initiate a review based on this suspicion, coding experts say. Your documentation must clearly identify the medical necessity and separateness of the unbundled service.

If Other Modifiers Will Do the Job, Avoid -59

You should never use modifier -59 if another modifier (or no modifier at all) will tell the story more accurately. CPT guidelines clearly indicate \"that the -59 modifier is only used if no more descriptive modifier is available and [its use]

best explains the circumstances,\" according to the July 1999 CPT Assistant.

In other words, -59 \"is the modifier of last resort,\" as **Marcella Bucknam, CPC, CCS-P, CPC-H**, HIM program coordinator at Clarkson College in Omaha, Neb., describes it.

Note: See our modifier -59 decision tool on page 94 to help you determine when you should select modifier -59 rather than other modifiers.

Coding example: Dermatologist A performed a puncture aspiration of an abdominal hematoma (10160) during the morning. Later that day, Dermatologist B repeated the same procedure because the hematoma required additional drainage.

You report the procedure Dermatologist A completed with 10160 (Puncture aspiration of abscess, hematoma, bulla or cyst) and report the repeat procedure by Dermatologist B with 10160 and modifier -77 (Repeat procedure by another physician) to notify payers that two dermatologists performed the procedures.

You should not report modifier -59 in this case because -77 better describes that two different physicians completed two separate, repeated procedures.

Remember: Modifier -59 is the modifier of last resort. So, if another modifier better describes the work the physician(s) completed, then that modifier trumps -59.