Dermatology Coding Alert

Master Your Modifier 59 Usage With 4 Guidelines

Make sure you're adhering to the correct criteria or suffer being 'red flagged.'

A modifier in the right place at the right time is likely to get you a prompt and fair reimbursement. You use one of the most important modifiers in dermatology is 59 (Distinct procedural service) so often that you think you know everything there is to know about it. Get to know modifier 59 and avoid hitting a blank wall before it's too late.

Guideline 1: Know Mod 59's Criteria When You See It

The right combination of a dermatological procedure and a modifier can make or break your claim. "Every modifier tells a story," says **Susan Ward, CPC, CPC-H, CPC-I, CPCD, CEMC, CPRC,** coding and billing manager in Phoenix. Through modifiers, payers know what transpires in the operative process without having to go read every operative report.

Modifier 59 indicates that a significant, separately identifiable procedure has been performed during the same operative session. This modifier encompasses treatment for multiple primary, unrelated problems and may represent a different surgery, a different site, a different lesion, a different injury, or a different area of injury.

Example: A patient is in the office to have a previously biopsied BCC of the right cheek excision. You would use 1164x (Excision of malignant lesions). However, during the procedure, the physician notices a suspicious lesion on the left cheek. He then takes a biopsy using the shave method. You would report this procedure as 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) with modifier 59 appended.

Guideline 2: Don't Overuse Modifier 59

You should use caution when using modifier 59 and check if another modifier isn't more appropriate. Anatomical or bilateral modifiers may be more appropriate to use than 59. "In those instances where an anatomic or the bilateral modifier is not more appropriate, modifier 59 may be appropriate. On the first line the code is reported without the modifier. On subsequent lines, the code is reported with modifier 59 and the unit of service is equal to one," the memo says.

Why: You have to prove within the operative report that the dermatologist did a significantly, separately identifiable procedure, and there is no other way to explain it to the payer, Ward says.

Just like any modifier, the risks in using or overusing modifier 59 come into play when you use it incorrectly, Ward adds. "As coders it is our responsibility to verify when procedures performed are bundled together in respect to Correct Coding Initiative (CCI) edits. In not doing so and just appending modifier 59 to codes that we feel need it, we open ourselves and our practices to being 'red flagged' for a possible audit," she continues.

Usually dubbed as a "modifier of a last resort," modifier 59's descriptor says that you should only use it "if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances."

Guideline 3: Distinguish Modifiers 59, 51

Don't confuse modifier 59 with modifier 51 (Multiple procedures), which is used to identify secondary procedures or services provided along with the primary procedure. "I see modifier 51 as an indicator to payers that multiple procedures were done during one operative session," says **Sylvia Thompson, CPC,** billing supervisor of Rady Children's Hospital in San Diego. She gets to facilitate the issuance of reimbursement by indicating which of the multiple procedures is "primary." "Many payers allow for 100 percent of allowable for only the primary procedure and drop payment for

subsequent procedures to 75, 50, or even 25 percent," she adds.

Meanwhile, modifier 59 is more of a "bundling/unbundling" modifier, which is "typically used to indicate that procedures normally considered 'components' of one another (therefore not separately reimbursable) are in certain cases to be looked at 'individually,'" Thompson says.

Vital: Always attach modifier 59 to the lesser valued of the two services or to the code -- regardless of value -- that would otherwise be denied or is a component of another, more comprehensive code.

Guideline 4: Equip Yourself With Reminders

Overall, there are 7 key points to remember when you're using modifier 59. They are:

• Documentation is vital to support medical necessity. Be sure that your patient's medical record is welldocumented.

• This modifier may represent a different body site or organ system.

• This modifier may represent a separate lesion.

• This modifier may represent a different area of injury.

• This modifier may represent a different procedure.

• This modifier may represent a separate incision or excision.

• This modifier represents a distinct and independent procedure/surgery/encounter from other services performed.

Remember that modifier 59 is a handy storyteller for coding and billing dermatological procedures. However, be ready to drop it when you don't need it, and you might dodge a potential audit.