Internal Medicine Coding Alert

Draw Distinction Between Modifiers -51 and -59 to Avoid Denials

CPT language describing modifiers -59 (distinct procedural service) and -51 (multiple procedures) can confuse internists and coders alike when billing for separate procedures. **Stephanie Jones, NRCMA, NRAHA, CPC,** director of audit programs for eCompliance Doc., says it helps to change the wording to clarify the difference. She suggests adding the word "related" to the definition of modifier -51 to read "multiple (related) procedures." She describes modifier -59 as "distinct, multiple (unrelated) procedures."

"When the doctor is considering appending modifier -51 he or she can say, 'I've done multiple related things today, and, payer, you shouldn't pay me for the full amount of the secondary procedure,'" Jones says. Modifier 51 alerts carriers to reduce payment on the second through fifth procedures by 50 percent or less. Because the patient is already on the table and under anesthesia and the incision is made, the second procedure needs less work.

"When applying modifier -59, the doctor says, 'I did things that required me to do the entire procedure, so, payer, it is appropriate to pay me because I did all the work for both procedures,'" she says.

Definitions Revamped

Modifier -51 allows an internist to receive payment for his or her services when performing multiple procedures. Because the patient is already prepped for a major procedure, all other procedures done at the same time require appending modifier -51. This informs the payer that although the internist's work did not require a start-to-finish approach, the service still warrants partial reimbursement. The major surgical procedure is reported without the modifier. Modifier -51 is always appended to the lower-valued (lowest relative value unit) code. The rule for modifier -59, on the other hand, is not as black and white, which is part of the reason many coders still have trouble distinguishing the differences between the two modifiers.

In an effort to eliminate some of the coding confusion, CPT revised the descriptor of modifier -51 in 1997. The new definition stated that, unlike modifier -59, modifier -51 could not be appended to designated "add-on" codes, in other words, codes that are bundled. Modifier -59 was designed to unbundle codes when the procedures were distinctly separate.

Modifier -59 is appended solely to surgery procedure codes. It is never used on E/M codes.

In 1999, CPT clarified the differences between modifier -51 and -59 by deleting the words "on the same day" from the definition of modifier -51.

Using Modifier -51

Internists should bill the full value for both procedures -- even when appending modifier -51 -- because the carrier will automatically reduce the lesser-valued procedure by 50 percent. There is a chance Medicare will still reduce the code appended with the -51 modifier and the provider will receive only 25 percent for the service.

Requirements for modifier -51 often vary from carrier to carrier. When deciding if modifier -51 is appropriate, you must consider whether the services involved multiple related surgeries during the same session by the same provider, and if the surgeries are performed in combination through the same or another incision of the same anatomical site. The services can also be a combination of medical and surgical procedures.

Scenario: An established male patient presents to his internist with a lesion on his chest and hand. Removal of both is

considered medically necessary. The internist removes the lesions during the same visit. Although both 11401 (excision of benign lesion on trunk, arms or legs; lesion diameter 0.6 to 1.0 cm) and 11421 (excision of benign lesion on scalp, neck, hands, feet, genitalia; lesion diameter of 0.6 to 1.0 cm) should be billed, attach modifier -51 to the additional procedure or the one with the lower value. (The relative value unit [RVU] for 11401 is 3.42, and 3.60 for 11421.) In this case, report 11421 and 11401-51. Appropriate coding for removal of two lesions at one visit is a carrier-specific decision. It is not important to know what order the procedures were performed, only to list them from the highest to lowest value.

"Append modifier -51 to the procedure with the lower relative value if there are two lesions involved," says **Glenn Littenberg, MD,** a member of the CPT Advisory Panel and a practicing gastroenterologist in Pasadena, Calif. You will receive 100 percent for the most expensive procedure and usually 50 percent for the procedure with lesser value. For instance, if there is an excision of a malignant lesion with a complex repair, the closure code should get priority because it has the higher value. Some carriers will bundle the two procedures, saying the repair is a natural result of an excision. However, CPT guidelines state that only a simple closure is included in the removal of a lesion. Intermediate and complex repairs may be coded additionally.

Using Modifier -59

Modifier -59 indicates that procedures are unrelated or distinct from any other procedures/services an internist provides at that time. Modifier -59 also allows internists to be paid independently for procedures that are usually combined or bundled. The modifier identifies that the procedure is distinctly separate and, therefore, not a component of another procedure. Modifier -59 can be used to indicate that a service was performed during a different session or patient encounter. If a procedure involves operating on a different anatomical site or organ system or if the procedure entails a separate incision/ excision, modifier -59 can be used to identify two different services.

For instance, if a patient presents with a laceration to the shoulder and a laceration to the face from falling down, the physician treats each as a separate injury even though the wounds were caused by the same accident. It is important to note that modifier -59 does not guarantee payment. It tells Medicare that the services were distinct and separate.

"If modifier -59 is applied to induce payment to any codes without a separate incision, a separate anatomical site or completely distinct service, it would be inappropriate and, in fact, fraudulent," Jones says.

Modifier -59 should be appended to the component code bundled into the comprehensive code. Usually, if the services are not distinct and independent the comprehensive code already includes the payment of the component code.

When an internist performs two procedures that are typically bundled together on one anatomical site, report only the comprehensive procedure code. For example, if an internist performs a lesion removal with a biopsy, code only for the lesion removal because the biopsy is bundled in with the lesion removal code. However, if there are two separate lesions, one to be removed and one just to be biopsied, code both using modifier -59 on the component procedure. Also, if the same procedure is performed on two or more separate anatomical sites, use modifier -59 to distinguish the multiple sites.

Scenario: For CPT coding, if an actinic keratosis lesion is biopsied and subsequently removed during the same operative session, report only the code for the removal of the lesion (i.e., 11400, excision, benign lesion, except skin tag [unless listed elsewhere], trunk, arms or legs; lesions diameter 0.5 cm or less). However, if an actinic keratosis lesion is biopsied and a separate actinic keratosis lesion is removed during the same operative session, report a code for the biopsy of one lesion (i.e., 11100, biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed [separate procedure]; single lesion) and an additional code for the removal of the separate lesion (i.e., 11400). Apply modifier -59 to 11400 to indicate a separate and distinct service.

Note: See the news brief on page 79 for information about Medicare's national policy for reporting actinic keratosis.

Modifier -59 usually goes on the lesser valued of the two bundled services. However, sometimes attaching modifier -59 to the code with the highest allowable RVU is appropriate if that code is a component of the comprehensive code. Modifier -59 is typically appended to the code (regardless of value) that would otherwise be denied or is a component of

another, more comprehensive code.

Scenario: A patient presents to the office with chest pain. The internist performs an EKG (93000, electrocardiogram, routine ECG with at least 12 leads; with interpretation and report), which is found to be abnormal, so the physician does a stress test (93015, cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report) on the same day.

These two services are different because they require different precision in the placement of the leads and are clearly two separate services. If the EKG is done first, and based on the results of that EKG it is necessary to do the stress test, append modifier -59 to the EKG code. Or if the patient is unable to complete the stress test and is later monitored with an EKG, this could also be reported, but modifier -59 must be appended to the EKG code. Because they are bundled together in the national Correct Coding Initiative (CCI), the EKG is the component procedure of the more comprehensive procedure, the stress test. (The transitional nonfacility total RVU for 93000 is .76, and 2.98 for 93015.)

Use CCI To Determine When To Append Modifiers

The best resource is the CCI, which was adopted by CMS to avoid payment of incorrectly coded claims. "The CCI will allow us to know if a code is bundled," Jones says.

If the CPT code for a medical procedure is listed in the CCI as bundled into the code for another procedure, Medicare will not reimburse for both codes.

"Modifier -59 was devised to allow for unbundling," Littenberg says. The following illustrates the appropriate use of modifier -59 to unbundle codes common to internal medicine.

Scenario: Internists commonly use joint injections in the treatment of osteoarthritis. Trigger point injections are used to treat muscle pain. Typically the trigger point injection is bundled into the major joint injection code. However, sometimes trigger point injections (which are often components of a joint injection) can be used alone to treat certain ailments.

Modifier -59 is used when multiple trigger point injections are done on different muscles. For example, if trigger point injections are performed on the right and left trapezius muscles, the two injections would be billed using 20550 for the first injection and appending modifier -59 to 20550 for the second injection.

Sometimes, an internist will perform trigger point injections and joint injections on different parts of the body. Because trigger point injection codes are bundled into joint injection codes, modifier -59 must be used to indicate two separate and distinct services.

For instance, an internist treats a patient with lower back pain with a trigger point injection while opting to use a major joint injection for the patient's shoulder pain. Codes 20550 (injection, tendon sheath, ligament, trigger points or ganglion cyst) and 20610 (arthrocentisis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) are two injection codes that are bundled together. The CCI bundles code 20550 into code 20610, meaning the RVUs for trigger point injection of a tendon sheath, ligament or ganglion cyst have already been calculated into the RVUs of the major joint injection. (The 2001 transitional nonfacility total RVU for 20610 is 2.55, and 2.49 for 20550.)

Medicare will not reimburse for both 20610 and 20550 unless they are performed in different anatomical sites. When billed together, 20550 will be denied. If it is appropriate to bill both codes (i.e., the trigger point injection is not a direct result of the major joint injection or the procedures are performed on two separate sites), modifier -59 should be appended to 20550.

Use Modifiers -59 and -51 Together

Occasionally, coders advocate the use of both modifiers at the same time. When an internist performs a sigmoidoscopy

(45333, sigmoidoscopy, flexible; with removal of tumor[s], polyp[s], or other lesion[s] by hot biopsy forceps or bipolar cautery) and performs biopsies in an area of the colon and then performs a polypectomy by snare technique (45385, colonoscopy by snare technique) in another area, both the biopsy and snare removal are billable. The second or lesser procedure should include the -51 modifier for multiple procedures and also the -59 modifier, showing this was a separate, distinct procedure and was performed during the same operative session. The use of both codes illustrates a multiple procedure that is normally bundled but should be unbundled because it was performed on two separate sites.

Because there is no hard-and-fast guideline on when to use which modifier, internists should know the policies of their local Medicare and private insurance payers.