Codify
BY AAPC

Internal Medicine Coding Alert

Reporting Related Codes? Use Modifiers -59, -51 to Keep Claims Clear

Modifier -59 is for procedures you would not normally report together

When a patient requires multiple laceration repairs in the same session, do you report only one code? If the internist excises two lesions from the same body area, do you automatically assume one of the excisions isn't reportable?

If you answered "yes" to either of these questions, you may not be taking advantage of all situations in which you can use modifiers -59 and -51. Read on for more information on these modifiers, which may be helpful when you report related codes on the same claim.

Use Modifier -59 When Codes Are Close

Internal medicine coders use modifier -59 (Distinct procedural service) to identify procedures that are distinctly separate from any other procedure or service the physician provides on the same date.

In general, coders append modifier -59 to procedure codes when the physician:

sees a patient during a different session

treats a different site or organ system

sees a patient during a different encounter

treats a different organ system

treats a separate injury.

Modifier -59 is "used when multiple procedures in the same (code areas) are performed at the same time," says **Linda Parks, MA, CPC, CMC, CCP,** coding specialist in Marietta, Ga.

Example: An established patient reports to the office after falling down the stairs and cutting both his hands on a broken windowpane. The internist closes a simple 1.5-centimeter laceration on the right second finger, as well as an intermediate 6-centimeter laceration on the left palm. You should:

report 12042 (Layer closer of wounds of neck, hands, feet, and/or external genitalia; 2.6 cm to 7.5 cm)

attach modifier -59 to 12001 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities [including hands and feet]; 2.5 cm or less). Modifier -59 shows the carrier that the internist performed repairs on two different anatomic areas (right hand, left hand) and that the repairs were indeed separate.

If you don't use modifier -59 on the above example, you will most likely receive a denial from the insurance company stating that 12001 is bundled into the more extensive procedure (12042).

The modifier lets the insurance company know that although the codes are related to each other, the doctor performed the procedures on distinctly different areas, and they can be reimbursed separately.

Remember: Code Order Matters

The higher the relative value units (RVUs), the more you'll be paid for the procedure. Always attach modifier -59 to the code with the lower RVUs. The RVUs for 12042 are 4.32 for facilities and 6.16 for non-facilities, while 12001 is worth 2.35 for facilities and 3.86 for non-facilities.

Not sure on NCCI? If you're stuck on whether you should bill codes with modifier -59, check the National Correct Coding Initiative (NCCI) edits, Parks reminds coders. If the codes you are reporting have indicators of "1" next to them, this means you can append the modifier to bypass the edit. If the code has an indicator of "0," you cannot bypass the edit. The NCCI edits change quarterly, so be sure to keep abreast of all updates.

Time-saver: Increase your modifier -59 reimbursement rate by using -59 only when absolutely necessary, experts say. Many private payers do not require a modifier for multiple-procedure scenarios or don't recognize -59 as a legitimate modifier. Check with your individual payer to see if modifier -59 is necessary when reporting multiple-procedure claims.

Make Calls Now, Save Time Later

Tip: Each time you are unsure whether a carrier accepts modifier -59 or prefers some other modifier or reporting method, **call the carrier immediately and ask for clarification.** Then, chart each carrier's policies on -59 so you know whether or not to use it the next time you file a claim.

It may take a little time initially, but once you get a chart with each insurance company's policy on modifier -59, your claims department will be more streamlined.

However, don't be afraid to use modifier -59 if you have to -- just make sure you've exhausted all other options and you are using it as it was intended, as the "modifier of last resort."

Use Modifier -51 for Multiple Procedures

When your internist treats a patient who requires multiple procedures, you would include modifier -51 (Multiple procedures) on your claim.

Modifier -51 is "an informational-type modifier ... for use on the second, third, etc., surgical procedure performed on the same day," says **Barbara J. Girvin Riesser, RN, CCS, CCS-P, CPC**, of Medical Management Resources in Kansas City, Mo.

Example: A patient reports to the internist with a pair of benign lesions on her left leg -- one 0.8 cm and the other 2.2 cm. The internist shaves both lesions. You should:

report 11303 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm)

attach modifier -51 to 11301 (... lesion diameter 0.6 to 1.0 cm)

The modifier is appropriate because it shows that the two procedures -- while separate -- are close enough to cleanse and prep in the same session, Riesser says. Modifier -51 shows the insurance company that the procedures were unrelated to each other, even though the internist performed them on the same area of the body.

Check RVUs Before Ordering Codes

On modifier -51 claims, the code that stands alone is the code that will be fully paid, so make sure you attach modifier -51 to the code with the lower relative value units (RVUs).

"Modifier -51 prevents the insurance company from changing the order of your codes, because the most expensive procedure should be listed first," Riesser says.

Remember: While reimbursement rates for codes with modifier -59 attached vary by payer, expect half the normal reimbursement for codes with modifier -51 attached. (Most insurance companies have adopted Medicare's policy of paying 50 percent for codes with modifier -51 attached.)