Optometry Coding & Billing Alert

3 Tips Unlock the Secrets of Modifier 59 Success

Hint: Look to modifier indicators,separate sites for clues to proper use.

When an optometrist performs two medically necessary procedures during the same session, knowing the ins and outs of modifier 59 can mean the difference between getting paid for both procedures and having one procedure denied by the insurer.

The problem: Modifier 59 (Distinct procedural service) is one of the most misunderstood, overused, and abused modifiers. Avoid problems -- and get your claims paid compliantly ��\" by following these proven tips:

Tip 1: Know When to Use Modifier 59

The Office of Inspector General (OIG) and many payers, including Medicare, continually review physicians' modifier 59 use. In fact, according to a 2005 review by the OIG and an independent contractor, 40 percent of code pairs studied did not meet program requirements for proper modifier 59 use.

There are circumstances when you can -- and should -- use modifier 59, however. For instance, you may use modifier 59 to identify procedures that are distinctly separate from another procedure provided by your physician on the same day. In addition, you may append 59 to your claim when your physician:

• sees a patient during a different session on the same day;

• treats a different site or organ system;

• makes a separate incision/excision;

• tends to a different lesion; or

• treats a separate injury.

This all boils down to two key questions:

1. Is the second procedure (which is normally bundled with the first procedure) performed at a different site than the first service?

2. Was it done during a separate encounter on the same day?

Important: You can never append modifier 59 to E/M services, says **Claudia Kernaghan, CPC,** coder for Nevada Imaging Centers in Las Vegas. If you're reporting a separately identifiable E/M service with another procedure on the same day, you'll append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code.

Tip 2: CCI Limits Codes You Can Report Separately

You should always check the Correct Coding Initiative (CCI) edits to determine if two or more procedures are bundled. The CCI edits are updated quarterly and new additions and deletions may have occurred which may change your billing circumstances. The CCI edits may list two codes as "mutually exclusive" of one another or pair them together ("bundle" them). If you see reference to "column 1" and "column 2" codes, CCI bundles the procedures and normally you would not report them together except when it is appropriate to do so.

Unbundling is not automatic: Be aware, Kernaghan says, that you can't automatically override a CCI edit with modifier 59 just because documentation supports a separate site, incision, or patient encounter.

Here's why: Before appending modifier 59, check the modifier indicator for the bundled code pair. You'll find the modifier indicator in Column F of the CCI Excel spreadsheet, which you can download from www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp.

A modifier indicator of "0" means that you may not unbundle the edit combination under any circumstances.

Alternately, a "1" indicator opens the possibility for you to override an edit using a modifier if your documentation supports that the procedures are distinct from one another and meets the criteria described in the definition of modifier 59.

Example: A patient with glaucoma presents for annual right eye optical coherence tomography (OCT) checks (92135, Scanning computerized ophthalmic diagnostic imaging, posterior segment, [e.g., scanning laser] with interpretation and report, unilateral) and theoptometrist also decides to obtain fundus photos of the left eye (92250, Fundus photography with interpretation and report).

CCI bundles 92135 and 92250 as mutually exclusive with a "1" modifier indicator, which indicates you may separately report them, when appropriate, using modifier 59. Therefore, when the optometrist performs the services on different eyes, report both services with modifier 59 appended to the column 2 code:

• 92135-RT

• 92250-59-LT.

Clear documentation is essential in the event of a payer review, cautions **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** consulting manager for Pershing, Yoakley, and Associates in Clearwater, Fla.

Tip 3: Always Prove Necessity With Documentation

When you're trying to decide whether you should append modifier 59, use a logical approach. Ask: Did the second procedure require a separate approach or was it performed on a separate anatomical site?

Although modifier 59 is on the OIG watch list, there is less risk of overusing it if it's well-supported, says **Rena Hall, CPC,** billing/insurance specialist of the Kansas City Neurosurgery Group in Missouri.

Important: Never use modifier 59 just to get paid for a procedure. "Make sure there is well-documented support for a separate and distinct procedure meeting the criteria for unbundling and appending modifier 59," Hall says.

In addition, CPT instructions dictate that if a more specific modifier describes the situation, you should not use modifier 59. Because the modifier has the potential to bypass CCI edits, coders use this modifier too often, confirms **Suzan Berman (Hvizdash), CPC, CEMC, CEDC,** senior manager of coding and compliance with the UPMC departments of Surgery and Anesthesiology. Modifier 59 "should be the modifier of last resort and only used when the procedure was clearly distinct and different from that of the other procedure," she adds.