# Optometry Coding & Billing Alert

## Modifier Review: Brace Yourself with Modifier 59 for Distinct Procedural Services

**Refer to Medicare's Correct Coding Initiative (CCI) before using Modifier 59**

Modifier 59 (Distinct procedural service) indicates that two services which are generally not reported separately are appropriately reported separately under the circumstances not ordinarily encountered or performed on the same day by the same individual.

You report modifier 59 when there is a:

- Different encounter or session;
- Different procedure;
- Different site; or
- Separate incision, excision, injury, lesion, or body part.

**Starting point:** The first step in determining whether modifier 59 is needed is to refer to Medicare's Correct Coding Initiative (CCI). The CCI lists code combinations that are generally not reimbursed separately. Private payers often use the CCI as a guide for their own bundling policies. When reporting CPT® codes with the designation "separate procedure" in conjunction with other procedure codes, be aware that these codes are often considered components of other services. If the procedures are distinct, then modifier 59 is required.

In some situations, when specific modifiers (like 51 for multiple procedures or 50 for bilateral procedures) cannot explain the scenario to the payers or when the code combinations are correct but there are reimbursement edits in place, it may be appropriate to report the services with modifier 59. Medicare recognizes use of this modifier to indicate that two or more procedures are performed at different anatomic sites or during different patient encounters on the same date of service.

**Don't Misuse Modifier 59**

The 59 modifier is one of the most misused modifiers. The most common reason it should be used is to indicate that two or more procedures were performed at the same visit but to different sites on the body.

Unfortunately, many times it is used to prevent a service from being bundled or added in with another service on the same claim. "Modifier 59 should never be used strictly to prevent a service from being bundled or to bypass the insurance carrier's edit system," says **Sarah L. Goodman, MBA, CPC-H, CCP, FCS**, president/CEO and principal consultant at SLG, Inc., headquartered in Raleigh, N.C.

Modifier 59 should also only be used if there is no other, more appropriate modifier to describe the relationship between two procedure codes. If there is another modifier that more accurately describes the services being billed, it should be used instead of the 59 modifier.

When using the 59 modifier to indicate a distinct and separate service, enough documentation should be in the patient's medical file that substantiates that the services were performed separately. "It may be a good idea to review the record to deem if the 59 modifier is being appropriately used before reimbursing the full amount for the modified CPT® code", adds Goodman.

It's important to note that use of the 59 modifier does not require that there should be a different or separate diagnosis code for each of the services billed. As such, simply using different diagnosis codes for each of the services performed

does not support the use of the 59 modifier.

**Caveat:** Again, CPT® gives a warning statement: "When another, already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."  Therefore, if a multiple procedure modifier or a bilateral modifier can describe the situation, then do not use modifier 59.

**Don't miss:** Medicare is establishing four new subcategories of modifier 59. For more details, see "CMS Debuts 4 New Modifiers to Substitute for 59" in Optometry Coding Alert Vol. 12 No. 7.