Codify
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Part B Insider (Multispecialty) Coding Alert

Coding: Can't Decide Between -51 and -59? Here's How to Choose

Physicians, coders and payers alike often have trouble distinguishing between modifiers -59 (Distinct procedural service) and -51 (Multiple procedures) because they have similar applications. But a quick review of coding guidelines - and as a last resort, a well-placed call to the insurer - can help you choose between the modifiers with confidence.

Use -59 to 'Unbundle'

CPT specifies that you should use modifier -59 to indicate a procedure or service that is "distinct or independent from other services performed on the same day" and, further, that the two services/procedures are "not normally reported together, but are appropriate under the circumstances." Specifically, CPT allows you to apply modifier -59 in five situations:

1. procedures performed at different sessions or encounters
2. procedures performed at different sites or organ systems
3. procedures performed at separate incisions/excisions
4. procedures performed at separate lesions
5. procedures performed at separate injuries (or areas of injury).

Note that the two procedures may correspond to different diagnoses, but not necessarily so. Also remember that modifier -59 never applies to E/M services.

Generally, modifier -59 should not lead to a reduction in reimbursement - but keep in mind that you should not use modifier -59 indiscriminately to increase reimbursement or protest NCCI coding edits. Because of its ability to override NCCI Edits and increase payments, payers give modifier -59 claims special scrutiny. Therefore, always keep thorough notes available, outlining the separate and distinct nature of the billed procedures, to substantiate its use.

Occasionally, reimbursement with modifier -59 is carrier- or situation-driven. Be sure to ask for the payer's modifier -59 policy in writing so you can anticipate these circumstances and protest any reduction not specified in the payer's guidelines.

And remember that modifier -59 "is the modifier of last resort," as **Marcella Bucknam, CPC, CCS-P, CPC-H**, HIM program coordinator at Clarkson College in Omaha, Neb., describes it.

Because modifier -51 results in an automatic fee reduction, physicians must use it with care or risk losing reimbursement that they are entitled to.

Always choose the highest-valued code as the primary procedure and attach modifier -51 to the lesser-valued procedure(s), says **Catherine Brink, CMM, CPC**, president of **Healthcare Resource Management Inc**., a physician practice management consulting firm in Spring Lake, N.J.

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