Codify by AAPC

Part B Insider (Multispecialty) Coding Alert

Modifiers: Examples Illuminate Differences Between Modifiers -51 and -59

Use -59 if procedures are separated by time or by location

Consultant **Ken Lobo** with Lobo Solutions Inc. in Poway, Calif., gives two scenarios that may help to clarify the difference between modifiers -51 (Multiple procedures) and -59 (Distinct procedural service):

Scenario one: A surgeon performs one surgical procedure on a patient's knee and a second on the patient's elbow. The surgeon must open each site, perform repairs and close each site. You should use modifier -59.

Scenario two: A surgeon opens a patient's skull to remove two hematomas in different portions of the brain, and then performs repair and reconstruction of the skull base. You use **CPT 61312** (Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural) for the main procedure. You'd add 61314 (Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural), 61618 (Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base) and 62141 (Cranioplasty for skull defect; larger than 5 cm diameter) for all the things the surgeon did once the skull was opened. Code 61312 covers closing the skull as well as opening it. You should attach modifier -51 to codes 61314, 61618 and 62141.

You can also use modifier -59 if operations are separated by time instead of by physical location, says consultant **Laureen Jandroep** with A+ Medical Management & Education in Absecon, N.J. "The example I always use is a patient comes in to have exploratory laparotomy," which doesn't find anything, Jandroep says. "Later that day, something comes up and they need to remove something, like an ovary."

"Modifier -59 is primarily used when a surgeon performs two procedures on a patient that normally would not be performed on the same day," Lobo says. "If the second procedure cannot use any of the work done by the first procedure and must be done in its entirety, then modifier -59 is appropriate."

If you believe your subsequent codes will be reduced by the carrier because you used modifier -51 or the carrier will apply it, you should
make sure to put the most expensive code first, Jandroep says. "Obviously, you want the most expensive procedure paid in full."

Some Part B carriers, such as Empire Medicare Services in New Jersey, don't want providers to apply modifier -51 to their own claims. The carriers would rather apply the modifier to claims after the provider has submitted them. Empire will have its computers calculate a 50 percent reduction for the second and following codes, Jandroep says.

In some cases, you could use modifiers -RT and -LT if the procedures happen on either side of the body, Jandroep adds.

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