Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Keep Auditors Out With This Modifier -59 Checklist

You can avoid overusing -59 by simply consulting the CCI

If you treat modifier -59 as a license to unbundle, it's only a matter of time before the feds come knocking at your door.

According to CPT, you should apply modifier -59 (Distinct procedural service) if the two codes you wish to bill meet the following criteria:

the same physician does not ordinarily perform the procedures on the same day, but the services are necessary under the circumstances; and

the codes fit into any of five situations: different sessions or encounters, different sites or organ systems, separate incisions/excisions, separate lesions or separate injuries (or areas of injury).

If you apply modifier -59, a carrier will usually pay on the claim. But that doesn't necessarily mean you deserve payment - and that's where you can get into trouble. Use this expert coder's checklist to ensure your practice isn't in legal danger due to overuse of -59:

1. Check if the NCCI allows you to use -59. To guard against overuse, identify all the code pairs you most commonly report with a modifier -59. Then look to the National Correct Coding Initiative (NCCI) for the final word, says **Shannon O. Smith, CRTT, CPC,** consultant auditor with **Doctors Management** in Knoxville, TN.

If the NCCI lists the modifier indicator "0" on a code pair you want to report together, you're not supposed to use -59 to bypass the bundling edit. A modifier indicator "1" means NCCI allows -59 or another modifier to unbundle the two codes.

2. Make sure -59 is the most appropriate modifier. CPT instructs you to use modifier -59 only "if no more descriptive modifier is available." For this reason, many coding experts refer to -59 as the "modifier of last resort." You should feel confident applying -59 only after you've verified that no other modifier would be better.

Many times you deserve payment for two procedures one physician performs on the same day, but you should use another modifier such as -76/-77 (Repeat procedures), -58 (Staged or related service), -78 (Return to the operating room) or -79 (Unrelated procedure) instead of -59.

Example #1: A surgeon performs an excisional biopsy of the breast (19120 - Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion [except 19140], open, male or female, one or more lesions), which includes a 90-day global period. The pathology report, which returns a few days later, indicates a malignant tumor. The surgeon decides to perform a modified radical mastectomy (19240).

In this case, you may be tempted to append -59 because you know the payer will bundle the mastectomy into 19120's 90-day global period. However, the physician performed these two services on different days, making -59 the incorrect choice.

Right choice: You should append modifier -58 (Staged or related procedure or service by the same physician during the postoperative period) to 19240 to indicate a staged procedure, which means that the payer should not bundle the mastectomy into 19120's 90-day global period.

Typically, you append modifier -58 to identify a staged procedure - a procedure that requires more than one operative session to complete.

Example #2: An endocrinologist performs a fine needle aspiration (FNA) for thyroid biopsy without imaging guidance. He makes five passes through a right-sided thyroid nodule and three passes through a left-sided nodule. Because you know you deserve additional payment for the work the physician did on both sides of the neck, you may be tempted to report 10021 (Fine needle aspiration; without imaging guidance) twice and append -59 to the second code. But because the physician did not perform two distinctly separate procedures, -59 is incorrect.

Right choice: In this case, you should report only one 10021 code and append modifier -50 (Bilateral procedure). Modifier -50 will increase your reimbursement by fifty percent and indicate to the payer that your physician did more work than unilateral code 10021 normally indicates.

3. Link a different diagnosis code to each procedure code. If the same diagnosis code justifies both CPT codes you're reporting, that's a key indicator the two services are not distinctly separate and do not merit -59, Smith says.

For instance, in the endocrinology example above you would only have one ICD-9 code, such as 241.0 (Nontoxic uninodular goiter), to report for the patient's thyroid nodule. This single diagnosis tells you and the payer that the thyroid biopsies on both sides of the neck are related - not separate and distinct.

Not always: You may encounter a situation where one ICD-9 code does in fact justify two distinctly separate procedures, Smith says. And in such a situation you should go ahead and append -59. However, you'll probably have a fight on your hands with the insurance company, she warns. You'll have to produce documentation that proves the services were not related.

4. Monitor your -59 usage on a daily basis. You should always review claims for accuracy before you send them out, and that's the best way to systematically detect errors, says **Kim Frieben, CPC,** a director at **Conemaugh Health Initiatives Billing** in Johnstown, PA.

Audit as well: "Claims review has to be a daily activity," Smith agrees. But you should also perform routine audits where you look at your most-reported codes with -59 to determine if you're using the modifier appropriately.

Gather information: You should use every coding resource available to you to make the proper determinations about using -59. Check the CMS Web site to see if the procedure codes you report with -59 have a National Coverage Decision (NCD) or Local Coverage Decision (LCD). These documents may provide you with information on bundled services and appropriate ICD-9 codes for a given procedure, Smith says. Of course, the NCCI is also a must-have resource.

Go ahead: If you're confident you've done all you can to ensure -59 is the correct coding choice, you should feel comfortable appending the modifier. Check out the example below of appropriate -59 usage:

Example: Your physician orders and interprets a two-view chest x-ray at 9 a.m., but the patient's condition worsens and the physician orders a one-view chest x-ray at 2 p.m. on the same day. You should report 71020 (Radiologic examination, chest, two views, frontal and lateral) for the morning x-ray, and 71010-59 (Radiologic examination, chest; single view, frontal) for the afternoon chest x-ray. Because the patient's condition worsened over the course of the day, you will have a different and more severe diagnosis to report with the afternoon x-ray - and this documentation will keep the payer off your back.