Codify
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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Reporting Related Codes? Use Modifiers -59 and -51 to Keep Claims Clear

Append -59 to show separate sessions, sites

If you're not up to speed on when to use modifiers -51 and -59, you could be losing out on many billing opportunities.

Consider this: When a patient requires a partial and a total ethmoidectomy in the same session, do you report only one code? If the physician performs both a complex and a layered closure, do you automatically assume you can't report the closure? If you answered "yes" to either of these questions, you may not be taking advantage of all situations in which you can use modifiers -59 and -51.

Modifier -59 Applies When Codes Are Close

Coders use modifier -59 (Distinct procedural service) to identify procedures that are distinctly separate from any other procedure or service the physician provides on the same date. In general, you should append modifier -59 to procedure codes when the physician:

1. performs a procedure during a different session or encounter,
2. treats a different site,
3. treats a different organ system, or
4. treats a separate injury.

"Consider modifier -59 your modifier of last resort, which should be used for breaking a bundle," adds **Michael A. Ferragamo, MD, FACS**, clinical assistant professor at the **State University of New York** in Stony Brook.

Modifier -59 is "used when multiple procedures in the same (code areas) are performed at the same time," says **Linda Parks, MA, CPC, CMC, CCP**, coding specialist in Marietta, Ga.

Be careful: Modifier -59 is not a license to unbundle, but it's a helpful modifier when used correctly, cautions **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME**, president of **Cash Flow Solutions, Inc.** in Brick, N.J.

Example #1: Let's take the scenario mentioned earlier, in which the patient undergoes a partial ethmoidectomy, 31254 (Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial [anterior]) on her left side and a total ethmoidectomy, **CPT 31255** (...with ethmoidectomy, total [anterior and posterior]) on her right side.

Normally, the partial ethmoidectomy is a component of the total ethmoindecotmy, and is therefore bundled, explains Cobuzzi. That means the only way to bill both a partial and a total ethmoidecotmy simultaneously is with a -59 modifier on the partial to indicate it is in a different location (i.e., a separate site). If you bill the partial ethmoidecotmy with the -51 modifier, it'll get bundled, she points out.

Example #2: The orthopedic surgeon performs a medial menisectomy and a chondroplasty in separate compartment of the right knee in the same session.

In this case, you should report 29881 (Arthroscopy, knee, surgical; with meniscectomy [medial OR lateral, including any meniscal shaving]) for the meniscectomy, and report 29877 (...debridement/shaving of articular cartilage [chondroplasty]) for the chondroplasty with modifier -59 appended. The modifier shows the carrier that the meniscectomy and the chondroplasty were separate procedures done in separate compartments.
If billing this procedure to Medicare, you would use G0289 (Arthroscopy, knee, surgical, for removal of loose body,

foreign body, debridement/shaving of articular cartilage [chondroplasty] at the time of other surgical knee ar-throscopy in a different compartment of the same knee) instead of 29877. Medi-care created this code for situations when 28977 is in a separate compartment of the knee than the primary procedure. You do not need to append -59 to report this code.

Example #3: Consider this case of separate sessions. A patient undergoes surgery in the morning but hemorrhages in the afternoon. He returns to the operating room and the surgeon performs an exploratory laparotomy and controls the bleeding. Normally, an exploratory and control of hemorrhage is considered part of the initial surgery, but because the physician performs it at a separate time and in a separate session, you would append modifier -59.

Remember: The higher the relative value units (RVUs) for a given code, the more you'll be paid for the procedure. Always attach modifier -59 to the code with the lower RVUs.

Not Sure? Check NCCI

If you're stuck on whether you should bill codes with modifier -59, check the National Correct Coding Initiative (NCCI) edits, Parks says. If the codes you are reporting have indicators of "1" next to them, this means you can append the modifier to bypass the edit. If the code has an indicator of "0," you cannot bypass the edit. The NCCI edits change quarterly, so be sure to keep abreast of all updates.

Time saver: Increase your modifier -59 reimbursement rate by using it only when absolutely necessary, experts say. However, don't be afraid to use modifier -59 if you have to just make sure you have exhausted all other options and you are using it as it was in-tended, as the "modifier of last resort."

Many private payors do not require a modifier for multiple-procedure scenarios or don't recognize -59 as a legitimate modifier. Check with your individual payor to see if modifier -59 is necessary when reporting multiple-procedure claims.

Tip: Each time you are unsure whether a carrier accepts modifier -59 or prefers some other modifier or reporting method, **call the carrier immediately and ask for clarification**, Parks says. Then, chart each carrier's policies on -59 so you know whether to use it the next time you file a claim.

Making these phone calls to carriers may take a little time initially, but once you get a chart with each insurance company's policy on modifier -59, your claims department will be streamlined dramatically.

Use Modifier -51 for Multiple Procedures

When your surgeon treats a patient who requires multiple procedures, you would include modifier -51 (Multiple procedures) on your claim.

Modifier -51 is "an informational-type modifier ... for use on the second, third, etc., surgical procedure performed on the same day," says **Barbara J. Girvin Riesser, RN, CCS, CCS-P, CPC**, of **Medical Management Resources** in Kansas City, Mo.

Example: A child falls off his bicycle and is taken to the ER with lacerations on his left arm and leg. The physician performs a layered closure on his arm and a complex closure on his leg. You should:

5. report 13121 (Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm) to represent the complex closure.
6. attach modifier -51 to 12032 (Layered closure of wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet], 2.6 to 7.5 cm) to represent the layered closure.

Why? The modifier is appropriate because it shows that the two procedures are actually separate and that you're not "double-dipping" with your claim, Riesser says. In other words, modifier -51 indicates to the insurance company that the procedures were unrelated to each other.

Check RVUs Before Ordering Codes

On modifier -51 claims, the code that stands alone is the code that will be fully paid, so make sure you attach modifier -51 to the code with the lower RVU. "Mod-ifier -51 may prevent the insurance company from changing the order of your codes because the most expensive procedure should be listed first," Riesser says.

Remember: While reimbursement rates for codes with modifier -59 attached vary by payor, expect half the normal reimbursement for codes with modifier -51 attached. Most payors have adopted Medi-care's policy paying 50 percent for codes with modifier -51 attached.