Part B Insider (Multispecialty) Coding Alert

PART B MYTH BUSTER: Are You Setting This 59-Modifier Audit Bait?

Quick test can say for sure

Myth: If you do two bundled procedures in the same session but for different reasons, you can always use the 59 modifier to unbundle them.

Reality: You can use the 59 modifier only if the two procedures were in different sessions, were in different anatomical areas or were otherwise totally unrelated.

The recent MLN Matters Article SE0715 contained a host of examples showing when you can use the 59 modifier (see PBI, Vol. 8, No. 16). For example, you should bill bone marrow biopsy code 38221 **and** bone marrow aspiration code 38220 using the 59 modifier only if you have two separate injection sites.

But many providers believe that they can use the 59 modifier as long as they have different diagnoses or reasons for the procedures, says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CHCC,** director of outreach programs for the American Academy of Professional Coders, based in Salt Lake City. This is a no-no, and the HHS Office of Inspector General (OIG) has warned about this sort of overuse.

For example: A patient comes in for a colectomy for colon cancer, but the patient also has a ventral incarcerated hernia that requires a complex repair using mesh. The Correct Coding Initiative (CCI) considers hernia repair code 49561 to be part of partial colectomy code 44140, because the hernia repair is integral to the closure, Cobuzzi says.

Wrong: Many providers have believed they could stick a 59 modifier on the hernia repair code and bill it separately. After all, the hernia repair may be for a totally different reason than the colectomy, such as the patient's recurrent hernia. But the 59 modifier tells the payor the hernia repair happened at a separate session, which isn't true.

Correct answer: Instead, you could try appending the 22 modifier (Unusual procederual service) to the colectomy code because of the extra time and effort the complex hernia repair requires. Make sure the documentation supports the additional substantial complexity of the hernia repair and mesh implantation, Cobuzzi notes. You may have to fight for the additional money, she adds.

Note: The instructions say that if another modifier defines the site of the procedure better, you should use it instead of the 59 modifier, Cobuzzi notes. For example, you should use the LT and RT modifiers to indicate the left and right sides.

For example: The physician performed a partial ethmoidectomy (31254) on the left side and a total ethmoidectomy (31255) on the right side. So you would bill those with the LT and RT modifiers respectively.

Unfortunately, many payors, including some Medicare carriers, have a hard time recognizing these modifiers. So you may end up having to use the 59 modifier after all with some payors. Similarly, Medicare is supposed to pay for multiple units of lesion removal codes, but with some carriers you may have to bill the same code multiple times using the 59 modifier instead.

But usually you-ll use the 59 modifier for two separate sessions, Cobuzzi notes.

For example: A patient comes in complaining of nasal congestion, postnasal drip, headaches and dry mouth. The doctor does a diagnostic nasal endoscopy (31231) at 10 A.M. Then, that evening the same patient comes into the emergency room with a huge nosebleed. The ER physician can't stop the bleeding and calls in the patient's ear, nose and throat

(ENT) specialist. The ENT physician can bill for controlling the interior nosebleed (30903).

Normally, 31231 is bundled into 30903, but in this case the ENT physician is justified in using the 59 modifier. In this case, the column-two code is 30903, so you should append the 59 modifier to that code.