Part B Insider (Multispecialty) Coding Alert

PART B MYTHBUSTER: Look at All Other Options Before Using Modifier 59

Remember that modifier 59 can't solve all your unbundling woes.

Myth: Modifier 59 is an easy way to collect when you bill bundled procedures together, and allows you to gain extra reimbursement for your claims any time the Correct Coding Initiative (CCI) bundles procedures together.

Reality: In many cases, other modifiers represent your services more appropriately than modifier 59 (Distinct procedural service) -- and in other instances, no modifier will apply to your claim, and you'll instead have to accept the fact that two procedures might be bundled.

To avoid running afoul of CMS regulators, always be sure the doctor's operative notes make clear the distinct and separate nature of the procedure to which you are attaching modifier 59.

Although several modifiers allow practices to unbundle CCI edits, medical practices most often choose modifier 59 in order to separate code pairs. However, auditors are always on the lookout for inappropriately billed modifier 59 claims.

"Improper use of the 59 modifier will come back and bite you," notes **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CENTC, CHCC,** president of CRN Healthcare Solutions. "Modifier 59 refers to a separate procedure for a separate site or separate encounter."

In other words, you can't append modifier 59 just to get your claim paid -- you have to actually be able to justify using it.

Example: Suppose the physician performs a surgery, but has to return the patient to the OR for another procedure during the global period of the first surgery. The practice appends modifier 59 to the second surgical code and Medicare reimburses them, so they continue to bill future claims the same way.

"This practice is asking to be audited by using that modifier in this circumstance," says **Diane Nirk, CPC,** coder with The Orthopaedic Institute in Oklahoma City, Okla. "Modifiers 58, 78, or 79 are the appropriate ones to use for return to the OR during a global period."

Modifier of Last Resort

You should never use modifier 59 if another modifier (or no modifier at all) will tell the story more accurately. "When another already established modifier is appropriate, it should be used rather than modifier 59," notes CMS's MLN Matters article SE0715. "Modifier 59 is an important National Correct Coding Initiative (NCCI) associated modifier that is often used incorrectly, and it should only be used if no more descriptive modifier is available or when its use best explains the circumstances," the article indicates.

The 59 modifier may be reported to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries), MLN Matters notes.

Example: A physician attempts a percutaneous fracture fixation (26727) on a patient's left third finger but cannot complete the procedure. He converts to an open procedure and performs an open finger shaft fracture treatment (26735).

What NOT to do: The CCI bundles 26727 into 26735, but the edit contains a "1" modifier, which means you can separate the code pair if the physician documents two separate and distinct procedures, and you append a modifier. But in this case, because the physician converted a percutaneous procedure to an open one on the same finger, you are not justified in reporting both codes and appending modifier 59.

Caveat: If, however, the physician performed the open procedure on the patient's third finger and a percutaneous procedure on the patient's fourth finger, you should append modifier F2 (Left hand, third digit) to 26735, and append modifier F3 (Left hand, fourth digit) to 26727.

In some cases, however, your payer may not accept "F" modifiers -- in that circumstance, you should report modifier 59 instead.