Codify
BY AAPC

Outpatient Facility Coding Alert

Modifier Refresher: Use Modifier 59 to Indicate That the Two Procedures Are Separate and Distinct

Remember to support your claim with medical records.

Modifier 59 (Distinct procedural service) indicates that two services which are generally not reported separately are appropriately submitted this way because of the circumstances. Because of the unexpected filing together, it is very important that you have well documented medical records to substantiate your usage of modifier 59.

Here are two examples of code pairs, which usually cannot be billed together by a provider for the same patient on the same date of service, but can be billed together by appending modifier 59 to bypass the code edit.

Key point: Attach modifier 59 to the CPT® code listed in Column 2 of the edits, when applicable.

Example 1: The surgeon performs laser destruction of one premalignant lesion and biopsies another lesion to the subcutaneous layer. The codes you'll report are: 17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion

- 11100 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion.

According to CCI edits, 17000 is a Column 1 code paired with 11100 as the Column 2 code. You can include modifier 59 with 11100 if the surgeon performs the procedures at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. However, if he performs the procedures on different sides of the body, you should append modifiers RT (Right side) and LT (Left side) or another pair of anatomic modifiers as appropriate to each procedure code instead of reporting modifier 59.

Example 2: The physician pares a callus on the patient's foot and debrides three of her toenails. You'll report 11055 (Paring or cutting of benign hyperkeratotic lesion [eg, corn or callus]; single lesion) and 11720 (Debridement of nail[s] by any method[s]; one to five).

Code 11055 is a Column 1 code for 11720, the Column 2 code.

Do not report 11720 or modifier 59 if any of the nails the physician debrides are on the same toe from which he removed the hyprkeratotic lesion. You can submit both codes and append modifier 59 to 11720 if the physician debridement and paring/cutting are on the same foot as long as the corn being treated is not adjacent to one of the debrided toenails.

Keep a Checklist of When Modifier 59 Applies

Currently, you can report modifier 59 when there is a:

- Different encounter or session;
- Different procedure;
- Different site; or
- Separate incision, excision, injury, lesion, or body part.

However, CMS says modifier 59 is:

- Infrequently (and usually correctly) used to identify a separate encounter;
- Less commonly (and less correctly) used to define a separate anatomic site; and

- More commonly (and frequently incorrectly) used to define a distinct service.

Consequently, the 59 modifier often overrides the edit in the exact circumstance for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment, and thus has created four new HCPCS modifiers (referred to as the X{EPSU} modifiers) to define specific subsets of modifier 59, which become effective January 1, 2015:

- XE (Separate encounter), a service that is distinct because it occurred during a separate encounter
- XS (Separate structure), a service that is distinct because it was performed on a separate organ/structure,
- XP (Separate practitioner), a service that is distinct because it was performed by a different practitioner; and
- XU (Unusual non-overlapping service), the use of a service that is distinct because it does not overlap usual components of the main service.