Outpatient Facility Coding Alert

Modifier Review: Brace Yourself with Modifier 59 for Distinct Procedural Services

Refer to Medicare's Correct Coding Initiative (CCI) before using Modifier 59

Modifier 59 (Distinct procedural service) indicates that two services which are generally not reported separately are appropriately reported separately under the circumstances not ordinarily encountered or performed on the same day by the same individual.

You report modifier 59 when there is a:

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

Starting point: The first step in determining whether modifier 59 is needed is to refer to Medicare's Correct Coding Initiative (CCI). The CCI lists code combinations that are generally not reimbursed separately. Private payers often use the CCI as a guide for their own bundling policies. When reporting CPT® codes with the designation "separate procedure" in conjunction with other procedure codes, be aware that these codes are often considered components of other services. If the procedures are distinct, then modifier 59 is required.

In some situations, when specific modifiers (like 51 for multiple procedures or 50 for bilateral procedures) cannot explain the scenario to the payers or when the code combinations are correct but there are reimbursement edits in place, it may be appropriate to report the services with modifier 59. Medicare recognizes use of this modifier to indicate that two or more procedures are performed at different anatomic sites or during different patient encounters on the same date of service.

Don't Misuse Modifier 59

The 59 modifier is one of the most misused modifiers. The most common reason it should be used is to indicate that two or more procedures were performed at the same visit but to different sites on the body.

Unfortunately, many times it is used to prevent a service from being bundled or added in with another service on the same claim. "Modifier 59 should never be used strictly to prevent a service from being bundled or to bypass the insurance carrier's edit system," says **Sarah L. Goodman, MBA, CPC-H, CCP, FCS**, president/CEO and principal consultant at SLG, Inc., headquartered in Raleigh, N.C.

Modifier 59 should also only be used if there is no other, more appropriate modifier to describe the relationship between two procedure codes. If there is another modifier that more accurately describes the services being billed, it should be used instead of the 59 modifier.

When using the 59 modifier to indicate a distinct and separate service, enough documentation should be in the patient's medical file that substantiates that the services were performed separately. "It may be a good idea to review the record to deem if the 59 modifier is being appropriately used before reimbursing the full amount for the modified CPT® code", adds Goodman.

It's important to note that use of the 59 modifier does not require that there should be a different or separate diagnosis code for each of the services billed. As such, simply using different diagnosis codes for each of the services performed

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does not support the use of the 59 modifier.

Caveat: Again, CPT® gives a warning statement: "When another, already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used." Therefore, if a multiple procedure modifier or a bilateral modifier can describe the situation, then do not use modifier 59.

Example: The surgeon documents injections to the patient's right hip joint and the right knee joint on the same day. Both procedures are defined by CPT® code 20610 [Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)]. You cannot include modifier 50 because the injections are on the same extremity at different joints. Modifier 51, indicating multiple procedures, does not differentiate the injections as being in different locations; if it is used, the second procedure might be denied as a duplicate submission. Modifier 59 is the correct modifier to use because it not only indicates a separate site, but it also meets the rule "when a more descriptive modifier will not explain the circumstances, then modifier 59 is used."

The goal is to be reimbursed for the second injection; expect a payment reduction because it is a second procedure performed during the same session, thus triggering the multiple procedure payment reduction in the physician setting, and in the hospital outpatient setting due to the status indicator of "T" assigned to the CPT®.

Pay Close Attention to Shoulder and Knee Cases

Don't append modifier 59 to an edit code pair describing two shoulder joint procedures unless you perform the procedure considered the component of the primary procedure on the opposite shoulder, according to new shoulder reporting guidelines from CMS.

This doesn't mean that you can report only one shoulder code for all cases. The new guidelines state if there are bundling issues, modifier 59 wouldn't be appropriate unless it's to report the procedure performed on the contralateral shoulder. If there are no bundling issues, modifier 59 is not applicable and procedures are reported to Medicare as usual.

Example: The doctor performs a shoulder arthroscopy that includes 29827 (Arthroscopy, shoulder, surgical; with rotator cuff repair), 29824 (... distal claviculectomy including distal articular surface [Mumford procedure]), and 29822 (... debridement, limited).Report 29824 and 29827 because 29822 is bundled into both the other codes.

CMS states not to append modifier 59 to 29822 unless this debridement procedure was performed on the opposite shoulder. Let's say the same procedures indicated above are performed, except the arthroscopic debridement performed was unrelated to those procedures performed and reported with 29827 and 29824, of which 29822 reflects being a component. You wouldn't report and/or append modifier 59 to 29822 unless this debridement procedure was performed on the opposite shoulder.

Coding chondroplasties with primary procedures also can be a real challenge, especially if you're reporting arthroscopic chondroplasties with removal of foreign or loose bodies in the knee.

You will turn to code 29877 (Arthroscopy, knee, surgical; debridement/shaving of articular cartilage [chondroplasty]) to report an arthroscopic chondroplasty which your surgeon does in the medial, lateral, and/or patellofemoral compartment(s). Exercise caution, however, to ensure that you report code 29877 only once per surgical session and only when your surgeon does the chondroplasty in a compartment different from that of the primary surgical procedure.

Caveat: You no longer append modifier 59 (Distinct procedural service) to indicate that your surgeon did the chondroplasty in a compartment different from that of the primary surgical procedure. The modifier 59 no longer applies when chondroplasty is performed with meniscectomy.

Rationale: CPT® 2012 introduced amended procedure descriptions for codes 29880 (Arthroscopy, knee, surgical; with meniscectomy [medial AND lateral, including any meniscal shaving] including debridement/shaving of articular cartilage [chondroplasty], same or separate compartment[s]), when performed) and 29881 (Arthroscopy, knee, surgical; with meniscectomy [medial OR lateral, including any meniscal shaving] including debridement/shaving of articular cartilage [chondroplasty], same or separate compartment[s], when performed) to include chondroplasty, regardless of the

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compartment in which it is performed, says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P**, Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA. "CPT® has made it clear that there are no circumstances under which it would be appropriate to report code 29877 in addition to either 29880 or 29881," she adds.

Let the Provider Append the Modifier

The biller should never be the one to add the 59 modifier to a claim, even if she knows that billing the services without the modifier will result in bundling or a denial, advices, medical billing experts , **Alice Scott and Michele Redmond**, co-owners of Solutions Medical Billing Inc in Rome, N Y in one of their articles., They suggests, "the 59 modifier should only be added by the provider or by a coder who has access to the patient's chart".

If you are the biller and you believe that the 59 modifier would be appropriate but was not indicated, you should go back to the provider to see if it was omitted by mistake. Don't just add the modifier to the claim without substantial evidence that it is needed.

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