

Outpatient Facility Coding Alert

Modifier Review: Know Your Modifier 59 Better for Cleaner Claims

Modifier 59 (Distinct procedural service) is used when two codes are not normally reported together (for instance, one code may be bundled with the other), but may be billed together under certain circumstances (for instance, if the two procedures occurred at different anatomic locations during the same patient encounter).

Modifier 59 is the "modifier of last resort" because you should append it only when no other modifier is more appropriate (e.g., modifiers to describe laterality, such as LT, RT, and 50), and documentation supports a distinct or independent service.

Therefore, check before appending modifier 59, beginning with whether a better modifier exists. For example, report modifier 58 (Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period) instead of modifier 59 for staged procedures. For hospital outpatient billing, however, only use modifier 58 on the same date as the original procedure. Because you're reporting two services on the same date, modifier 58 can sometimes be more appropriate than 59.

According to Appendix A of CPT®, these distinct independent services can qualify for modifier 59:

- Different session
- Different procedure or surgery
- Different site or organ system
- Separate incision/excision
- Separate lesion
- Separate injury.

Beware of Exceptions

Seeing that a provider completed two services or procedures for a patient on the same date does not automatically mean you append modifier 59. Consider these scenarios:

If two polyps are removed □ for example, one from the ascending colon and one from the descending colon □ via cold biopsy, you report the removals using one CPT® code, 45380 (Colonoscopy, flexible; with biopsy, single or multiple), even though the lesions were in different locations.

If a bone marrow biopsy and aspiration are performed at two sites through the same incision, report only 38221 (Bone marrow; biopsy, needle or trocar). Do not additionally report 38220 (Bone marrow; aspiration only) with modifier 59.

If an orthopedic surgeon performs shoulder arthroscopy in an outpatient setting and the surgeon knows that he or she would subsequently repair the rotator cuff, he cannot bill for the diagnostic shoulder arthroscopy by appending modifier 59. He/she cannot do this as, according to the CPT® guidelines and the NCCI edits, the diagnostic arthroscopy is part of the surgical procedure.

Remember: Coders should not append modifier 59 when another modifier (e.g., FA, LT, or RT), better describes the circumstances, advises **Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS**, President, CEO, and principal consultant for SLG, Inc, in Raleigh, N.C.

Refrain from Thoughtless Use of Modifier 59

CMS publishes quarterly National Correct Coding Initiative (NCCI) edits to ensure correct coding and reduce improper

payments. Unfortunately, modifier 59 is often used incorrectly to bypass NCCI edits. Examples of such indiscriminate use are:

- Appending modifier 59 to a diagnostic procedure performed prior to a scheduled therapeutic procedure, when the basis for the diagnostic procedure did not lead to the decision for the therapeutic procedure
- Appending modifier 59 to a diagnostic procedure performed following a therapeutic procedure, when the diagnostic procedure is considered a component of the therapeutic procedure
- Appending modifier 59 to a claim just because the service was denied as a bundled service.

Since modifier 59 generally has chances of misuse (and abuse), the Office of Inspector General recommends that CMS perform pre- and post-payment reviews on claims submitted with modifier 59. To ensure your claims are clean, it helps to understand how NCCI edits work.

Don't Forget About the New Modifiers

Sometimes the misuse of modifier 59 and subsequent incorrect payments is unintentional. As audits have increased, CMS realized that more specific modifiers may be helpful in reducing this abuse.

The -X{EPSU} modifiers were introduced Jan. 1, 2015, as essentially a subset of modifier 59. CMS believes their usage will help reduce overpayment errors. The acronym EPSU is made up of the last letter of the new modifiers:

- Modifier XE □ Separate encounter
- Modifier XP □ Separate practitioner
- Modifier XS □ Separate structure
- Modifier XU □ Unusual non-overlapping service.

Note: Modifier 59 has not gone away and is continuing to be a valid modifier, according to Medicare. However, modifier 59 should not be used when a more appropriate modifier, like an XE, XP, XS or XU modifier, is available. Certain codes that are prone to incorrect billing may also require one of the new modifiers.