Codify
BY AAPC

Modifier Coding Alert

Outpatient Modifiers: Surprise! Modifier 59 for Repeat Procedures May Not Fly

Payers are jumping on board with CMS's directive to use modifiers 76 or 91.

When several Medicare payers announced that they would no longer consider modifier 59 (Distinct procedural services)a valid modifier for repeat procedures, some coders may have overlooked the word "repeat" and thought that modifier 59 was not valid as a modifier for anything. Not true.

Several Part B payers are rejecting claims with modifier 59 based on guidance that went into effect on July 1, 2013 stating that you cannot use modifier 59 for repeat procedures. But that doesn't mean that modifier 59 doesn't have value elsewhere.

Read on to find out which other modifiers you should use for repeat procedures, and when you can legitimately use modifier 59.

Look at Guidance Given by These Payers

Several payers have published their own directives when it comes to the use of modifier 59. Here are a few examples:

Noridian:"Per a system-process change as of 07/01/13, modifier 59 is no longer considered a valid repeat modifier. Procedures billed with modifier 59 will be denied as exact duplicates." (med.noridianmedicare.com/web/jeb/alerts-and-notices/part-b-providers-submitting-modifier-59)

WPS:"Wisconsin Physician Services (WPS) Medicare has a large number of claims denying for incorrect modifier 59 usage. WPS Medicare researched these denied claims and found that modifier 76 (Repeat procedure or service by same physician or other qualified health care professional) would be the appropriate modifier to use for several of the denials." (www.wpsmedicare.com/j5macpartb/resources/modifiers/modifiers59and76.shtml)

Cahaba:"Claims billed with the same procedure code two or more times for the same date of service, should be submitted with the appropriate repeat procedure modifier rather than using modifier 59." (www.cahabagba.com/news/changes-to-modifier-59-important-notice)

Most important: Above all else, you need to find out what your provider allows. Some payers may have decided to not allow modifier 59 for any claim while others understand that 59 is not valid for repeat procedures.

No Worries, Modifier 76 to the Rescue

When one of your providers repeats a procedure or service subsequent to the original procedure or service, modifier 76 is your best choice.

Medicare contractors are encouraging practices to use modifier 76 or modifier 91 (Repeat clinical diagnostic laboratory test) instead of 59 for repeat procedures. Modifier 76 tells the payer that the repeat procedure is not the same as the original procedure. Without modifier 76 on the repeat procedure, the payer will deny the second procedure as a duplicate.

A provider may repeat a procedure because the patient did not respond well to the first procedure or because the first procedure was not successful. A provider may also repeat a radiology procedure to render a definitive diagnosis.

Providers often take multiple x-rays that reflect different views of the same anatomic area to get a better idea of the

patient's condition. For example, if a patient has chest pain or a possible fracture, the provider may order several radiological views of those sites. Append modifier 76 to the radiology code that the same provider repeats.

Example: A radiologist reviews two chest x-rays (71010, [Radiologic examination, chest; single view, frontal]) on the same day for the same patient. If you plan on using modifier 59, you might think you should code 71010 first and then 71010-59. That wouldn't support a repeated procedure because modifier 59 suggests an exact duplicate procedure. You would instead report 71010 and then 71010-76 indicating that the second x-ray was a repeat procedure.

See Modifier 59 as the Unbundler

You should use modifier 59 to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.

"Medicare never wants you to use the 59 modifier," says **Suzan Berman (Hauptman), MPM, CPC, CEMC, CEDC**, manager of physician compliance auditing at Allegheny Health Network in Pittsburgh, Penn. "However, the question of when a procedure that is usually bundled into the primary procedure should stand on its own needs to be considered. For example, an excision of a mass would include the closure, but because of extenuating circumstances (patient's anatomy, location of mass, mass size itself, etc.) a more involved closure was performed. The physician wants to illustrate that the closure was separately identifiable and should be paid for in addition to the primary procedure. The notes should certainly reflect why the closure was more intricate than a normal closure."