If You Modify, You Code

A LOOK AT MODIFIER -59

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Mistakes related to diagnosis coding and modifier usage can negatively impact reimbursement and potentially put the client and the billing company at risk. Many times I hear individuals who work for billing companies state, "We don't code, we just enter the charges that the physician group sends us." But further discussion reveals that these same employees assign or change diagnosis codes and/or modifiers during the billing or follow-up process.

The alteration of any diagnosis or procedure codes is considered coding. The fact that the original CPT® procedure code was assigned by the physician, or one of his staff members, does not automatically mean that the billing company will not participate in the coding process. An evaluation by the billing company is important to determine exactly what tasks are being performed for a client, who is performing that task, when the task is being performed, and what information is used.

In order to ensure accurate payment for the services performed, many times a two-digit modifier must be appended to communicate important information to the payer. Assigning modifiers incorrectly, or not appending them at all, can result in substantial revenue losses for an organization. Who assigns modifiers for your clients and when do they perform this critical step? The medical record must contain sufficient documentation and adequate definition of the service or procedure performed to support the use of a modifier. If the service is not documented, or the special circumstance is not indicated, a modifier should not be assigned.

Using Modifier -59

The remainder of this article will focus on a key modifier of concern that potentially impacts all specialties: the appropriate use of modifier 59. The concerns regarding the proper assignment of modifier 59 have been present for years, but unfortunately the problems have not gone away with time. There is a reason that the Office of Inspector General (OIG) still focuses on the misuse of this critical modifier. The OIG report can be found at **http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf.** While this report was published in 2005, it is still very relevant today and worth reading.

Modifier -59 was created by the American Medical Association (AMA) to allow separate reimbursement when multiple procedures are performed for the same patient on different anatomical sites, or at different sessions during the same day. The CPT® modifier definition is: ***Distinct procedural service:*** *Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.*

When multiple patient services are reported by the same physician on the same date of service, there may be a perception of "unbundling" when in fact, the services were performed under separate and distinct circumstances. Because insurance payers, including Medicare contractors, cannot identify these situations based solely on CPT® code assignment, the -59 modifier was established to permit unrelated services to bypass correct coding edits. Sometimes another modifier that better describes the particular situation should be used in place of modifier –59 but that is not always the case.

For example, modifier -59 is frequently utilized in reporting interventional procedures especially to indicate the following:

- Selective catheterizations in multiple families (36217, 36216-59)
- Multiple catheterizations or imaging studies utilizing the same code where the payer will not allow multiple units or the use of other modifiers to describe the situation. (75726, 75726-59, 36245, 36245-59)
- When designated criteria is met for billing both a diagnostic angiogram and the transcatheter therapy. (75710-59, 75960)

Remember that the addition of a modifier to a CPT® code does not ensure reimbursement. Modifiers that affect reimbursement, such as modifier -59, should never be routinely or automatically appended. It is important to remain current on the latest CPT® guidelines regarding modifiers; and it is equally important to become familiar with federal and commercial payers' guidelines. Claims that include modifiers should be monitored until you have determined a pattern of how their use affects payment.

Random audits of modifier usages will ensure that they are correctly applied and that documentation supports the separate nature of the services performed. ▲

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