

Modifier- 59 Scrutinized

Modifier –59 *Distinct Procedural Service* is described by the American Medical Association’s CPT 2004 Professional Edition as, “For procedure(s)/services(s) not ordinarily performed or encountered on the same day by the same physician, but appropriate under certain circumstances (eg, different site or organ system, separate excision or lesion.)” Plainly stated, modifier –59 is used to bill procedures performed on the same date of service that represent a:

- different session or patient encounter
- different procedure or surgery
- different site or organ system
- separate incision/excision or lesion
- separate injury (or area of surgery in extensive injuries)

Physicians should only use –59 modifier when there is no other modifier more appropriate. You may only append modifier –59 to the lesser service(s).

There has been some controversy over proper use of the –59 modifier and otolaryngology offices have had trouble determining when it is appropriate to use the –59 modifier. Adding to this trouble is recent “monitoring” of the use of this modifier by private insurance carriers and the Centers for Medicare and Medicaid Services (CMS). In 2004, the OIG is joining other carriers in scrutinizing modifier -59 claims. All all have reported increased use of modifier –59 by physician offices, usually to override bundling edits and Medicare’s Correct Coding Initiative.

Make sure that when filing claims with the –59 modifier, your documentation supports it’s usage as a separate and distinct procedure. Remember, modifier -59 is not intended to report procedures that took extra time or were performed to facilitate or provide access to a primary procedure that was done. If you've met all of the above requirements, modifier -59 can be used to differentiate services.

For further information on this modifier, feel free to call the Practice Management Department at 877-722-6467.

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