-59 Modifier, Not a License to Unbundle!

Bundling is not always understandable, why one procedure is considered incidental or mutually exclusive to another, yet these bundles exist, either with Medicare through the National Correct Coding Initiative (NCCI) or with private payors through software edit packages they purchase. So, physicians who are unhappy with these edits, who feel these edits are unfair and inappropriate are always looking for ways around them. After all, they feel justified, the edits are wrong and therefore they deserve payment, don't they?

For example, an Orthopaedic Surgeon tries to repair a shoulder with extensive calcification and tendon involvement via arthroscopy as using a scope involves the smallest incision, the shortest healing time and minimized pain for the patient. On performing the arthroscopy, the surgeon finds that he/she cannot complete the procedure via the scope due to the extensive tendon involvement and has to also do a "mini" open procedure. He/she does the equivalent work of a full arthroscopy and open procedures, yet on coding the surgery, is told that the open procedure bundles the scope and only the open procedure can be billed.

This surgeon considers this absurd. He/she considers this an incentive to not perform the more conservative approach of the scope first, encouraging the surgeon to perform open procedures first and feels that he/she should be paid for the complex surgery he/she performed. So he/she does research to find out to be paid for the two "valid" surgeries performed on this patient.

A modifier is found to the Doctor's delight, the universal bundling overriding modifier, -59. So, he/she thinks that it is appropriate to use the –59 in this case since in the surgeon's opinion this bundle is "wrong" and both procedures are payable.

By using –59 the doctor will be paid for both procedures, but the payment will be made for the wrong reasons. The payment will be made on assumptions that the –59 flags, but unfortunately, in this case, those assumptions are not applicable, which means that the payment the doctor received for this case was obtained fraudulently, no matter how sincere and honest he/she thought they were being and how right the coding was thought to be. "Unfair", or a "bad bundle" in the eyes of the doctor, coder or biller are not in the definition of –59 and do not trigger the use of –59.

Since "unfair" or "bad bundling" is not applicable to –59, let's look at what –59 was designed for and the correct usage for –59. And, let's look at what the payor thought when the doctor used the -59 and why the payor paid the doctor with the –59.

-59 is described by AMA CPT as: *"-59 **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. However, 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."*

In reading the above description of the –59 modifier, one can see that the –59 modifier was created to override bundling edits for specific reasons, *"under certain circumstances"*. These circumstances are when these codes, which would normally not be paid together, should be paid together on that date of service. Examples of proper use of the –59 include multiple operative sessions in the day, for example, a patient has a diagnostic colonoscopy (45378) in the morning. Later that day the patient starts bleeding and has to have a colonoscopy with control of bleeding (45382). A diagnostic colonoscopy is considered incidental to a colonoscopy with control of bleeding and therefore both would not be paid if billed together without benefit of a modifier. However, since these two procedures were done during different operative sessions, it is appropriate to use the –59 modifier. You would place the –59 modifier on the diagnostic colonoscopy (45378). Although this procedure was done first, it was the lower RVU procedure and the –59 modifier is placed with the lower RVU procedure.

Another example of proper use of the –59 modifier is in intementegurary section. Doctor excised 2 malignant lesions, performed a simple closure on one and did an adjacent tissue transfer on the second. Since the preparation of the site for the adjacent tissue transfer is included in the procedure, you do not code the excision of the lesion. However, for the second lesion, the one not involved in the adjacent tissue transfer, one must use the –59 to tell the payor that this lesion removal is "not related" to the lesion removed for the adjacent tissue removal. The –59 on that second lesion will get it paid appropriately, along with the flap (adjacent tissue transfer). If the doctor had only excised only lesion and used the –59 because he/she thought it unfair that the two were bundled, he/she would have been paid, but the payors assumption in paying that claim would have been that the –59 was for a second, **separate** lesion, from the one that belonged to the flap. On audit, this would be uncovered as incorrect and the money paid will be due back to the payor and the physician may be accused of misdoing in the coding.

Another common use of the –59 modifier is in orthopaedic surgery. The knee has three compartments and when scope procedures are done, they are often done in one or two compartments. Procedures such as a menesectomy or condraplasty, which are bundled if done in the same compartment are not bundled if done in different compartments. The only way to inform the payor and get paid that they are done in different compartments is to use the –59 modifier to indicate the different site.

So, in the first example, when the surgeon who was unhappy with the bundling rules with the shoulder, and uses the-59 to override the bundling edits to be paid for the two normally bundled procedures. The reason that the payor paid for these two procedures is that they were being told by the –59 modifier that the doctor did the scope on one shoulder and the open procedure was done on the other shoulder, a different site. If not a different site, it could be construed as a different operating session later in the day. Since neither of these were the case, the –59 was inappropriately used and therefore the money was inappropriately paid and the doctor is participating in improper coding and payment for services he/she did not deliver.

As a rule of thumb, before using a –59 modifier, one has to ask themselves if there is an appropriate modifier that applies and would be more appropriate, such as –50. Then one has to ask why the –59 modifier is being used, and usually the answer is “to get paid”. When that is the answer, make sure the answer to the next question is correct and that is: In order to qualify for the –59, the procedures must fulfill the requirements of being a different operative session or patient encounter, separate site or organ system, separate injury, separate incision/excision not normally encountered in the same day. If you can comfortably answer yes to the above, you can appropriately use the –59 modifier and can defend the use of this modifier. If used in the correct situations for the right reasons, this is a powerful modifier. Used for the wrong reasons in the wrong situations, this is a very dangerous modifier and therefore this modifier needs careful, informed handling.