Codify
BY AAPC

Internal Medicine Coding Alert

Reader Question: Ask Private Payers for a -59 Alternative

Question: One of our private payers uses the National Correct Coding Initiative (NCCI) edits but does not recognize modifier -59, and this causes a lot of denials. What should we report instead?

Massachusetts Subscriber

Answer: Many private payers do not honor certain modifiers, and modifier -59 (Distinct procedural service) tops the list.

Because your insurer recognizes the NCCI edits, you should ask the payer how you should submit claims that would normally warrant modifier -59. You may need to ask such payers to include language in their participation contracts that advises how to process such claims. This way, you can ensure reimbursement when you perform two medically necessary services that other payers allow you to report using modifier -59.

For example, you could submit 94010-59 (Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation; distinct procedural service) for the physician's spirometry services. The insurer may ask you to submit the claims on separate claim forms or append a different modifier instead.

You may also want to negotiate your next contract to include the carrier's recognition of modifier -59. Or, if you are not under contract, you can begin seeing their patients only on a cash-payment basis. You can even try reporting the insurer to your state's insurance commission for not following accepted AMA or CMS guidelines.

In addition, make sure you are reporting modifier -59 only when you can report no other appropriate modifier. This way, you won't confuse modifier -59 use with situations in which another modifier, such as -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) or -76 (Repeat procedure by same physician), would be more appropriate.