Codify
BY AAPC

Eli's Rehab Report

Coding: Avoid Modifier 59 Inaccuracy With This Guide

Consider 59 your modifier of last resort, experts say.

Many therapy practices have gotten caught in the same trap when billing Part B therapy services: incorrectly using Modifier 59 on claims that either don't represent a distinct service or lack enough documentation to support the services performed -- and the feds are watching. Over the past few years, the **Office of Inspector General** (OIG) has cracked down on Modifier 59 (Distinct procedural service) use, causing payment delays for practices who rely on the modifier too much, warns **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** manager of compliance education for the **University of Washington** Physicians Compliance Program in Seattle. Learn how and when to use Modifier 59 without putting yourself in regulators' crosshairs:

Ask Yourself: Is It Absolutely Necessary?

Overusing the 59 modifier can indicate to insurers that you routinely unbundle services, and they can initiate a review based on this suspicion, coding experts say. Your documentation must clearly identify the medical necessity and separate nature of the unbundled service.

CPT® guidelines clearly indicate "that the 59 modifier is only used if no more descriptive modifier is available and [its use] best explains the circumstances," according to MLN Matters article SE0715.

Example: Your therapist performs active wound care (97597-97598, Debridement [e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps], open wound, [e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm], including topical application[s], wound assessment, use of a whirlpool, when performed and instruction[s] for ongoing care, per session, total wound[s] surface area...]) and also re-examines a patient for a problem unrelated to the wound, such as for a fall.

You can report the re-evaluation with 97002 (Physical therapy re-evaluation), and the wound care with the appropriate code. You would need to append modifier 59 to 97002 because the National Correct Coding Initiative (NCCI) bundles 97002 into 97597 and 97598.

Watch Out for Specialty Snags

Remember that the need for modifier 59 is providerspecific, not discipline-specific. For example, suppose a patient has speech language pathology (SLP) treatment at your practice and the SLP bills one unit of 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual).

The patient then goes to PT, and the PT bills three units of 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility).

There are modifiers that would seem appropriate for this example, including GN (Services delivered under an outpatient speech language pathology plan of care), GO (Services delivered under an outpatient occupational therapy plan of care), and GP (Services delivered under an outpatient physical therapy plan of care).

However, CMS bundles re-eval codes into other codes -- including bundling physical therapy into speech treatment, explains **Pauline Franko, PT** with **Encompass Consulting & Education, LLC** in Tamarac, Fla. Therefore, only the 59 modifier will prevent the payer from denying those three units. You must report 97110-59 to earn your rightful reimbursement, she says.

Get Your Documentation in Ship Shape

Be sure that the PT's documentation supports the need for a formal re-evaluation and the fact that the therapist performed the two services at separate and distinct times.

Your therapist's documentation for the main procedure and the secondary procedure (which has 59 appended to it) should include enough detailed information about the patient's condition and the therapist's services to stand on their own if you removed the other service from the notes, Franko notes.

You Can Append 59 More Than Once

In rare cases, you may have to append modifier 59 more than once on the same claim form, says **Elisabeth Janeway, CPC,** president of **Carolina Healthcare Consultants** in Winston-Salem, N.C.

Example: The therapist spends 30 minutes training a stroke patient on cognitive skills to help improve her attention and memory. Immediately afterward, the therapist spends 15 minutes teaching the patient about how to use her new wheelchair.

The patient takes an hour break and then meets with the therapist and two other patients for group therapy, during which they work on arm strengthening exercises together. Janeway suggests you report the following codes:

- 97150 -- Therapeutic procedure(s), group (2 or more individuals)
- 97532-59 x 2 units -- Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-onone) patient contact by the provider, each 15 minutes
- 97542-59 -- Wheelchair management (e.g., assessment, fitting, training), each 15 minutes.

Because the NCCI bundles both 97532 and 97542 into 97150, you should append modifier 59 to both 97532 and 97542. Here, modifier 59 tells the payer that the procedures were not components of one another but were all medically necessary and separate from one another.