Eli's Rehab Report

Modifier -59 Versus -51: The Great Debate

Coders who are confused about whether to append modifier -59 (Distinct procedural service) or -51 (Multiple procedures) should remember that modifier -59 is most often used to report services not normally billed together, such as procedures bundled by Correct Coding Initiative (CCI) edits.

Modifier -59:The Unbundler?

According to CPT, modifier -59 is used for different sessions or encounters, different sites or organ systems, separate incisions/excisions, separate lesions, or separate injuries (or areas of injury).

For instance, a CCI edit prohibits billing both 95900 (Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study) and 95903 (Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study) on the same date because the F-wave study (95903) includes the services of the motor nerve conduction study (NCS) performed using 95900. Most Medicare carriers' policies state that performance of an F-wave study requires minimal additional work when performed with a motor nerve conduction study and, therefore, only one of the two codes can be billed per day when testing the same nerve.

However, if you perform both NCSs on the same day but on separate nerves, append modifier -59 to the second NCS code, says **Carlos Marquez, CPC,** assistant practice administrator at Affiliated Orthopedic Specialists, a Scottsdale, Ariz., practice. Because you are testing two different nerves, the service falls under CPT's "separate sites or organ systems" guideline, thus making modifier -59 appropriate.

For example, if the physiatrist performs a motor NCS without an F-wave study on a patient's left wrist, then performs a motor NCS study on the patient's right leg with the F-wave study, report the service "95900, 95903-59."

Do not reduce your fees when using modifier -59. Most payers will not cut reimbursement for it, but that depends on the procedure and your carrier's guidelines.

Keep in mind that modifier -59 should not be used indiscriminately as a way to increase payments or "protest" CCI coding edits. Because of its ability to unbundle CCI edits and increase payments, payers may give modifier -59 special scrutiny. According to the July 1999 CPT Assistant, "CPT guidelines clearly indicate that the -59 modifier is only used if no more descriptive modifier is available and the use of the modifier -59 best explains the circumstances."

Modifier -51 Will Cut Your Fee

CPT dictates, "When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the '-51' modifier to the additional procedure or service code(s)."

For instance, if the physiatrist provides two epidural injections of a neurolytic substance one each at a cervical (62281*, Injection/infusion of neurolytic substance [e.g., alcohol, phenol, iced saline solutions], with or without other therapeutic substance; epidural, cervical or thoracic) and lumbar level (62282*, ... epidural, lumbar, sacral [caudal]) the service should be reported 62282, 62281-51. Documentation must support each code independently, outlining the dosage, location and medical necessity for each injection.

Procedures appended with modifier -51 are never paid at 100 percent. Instead, the payer reasons that many of the "component services" that make up the physician's total effort when performing a particular service, such as

preoperative and postoperative care, are already paid as part of the primary procedure and need not be separately reimbursed for the second and subsequent services. Since Jan. 1, 1995, payment for the second through fifth procedures has been fixed at 50 percent of the total allowable relative value units (RVUs) for the particular CPT code, with the primary procedure paid in full.

Because modifier -51 results in an automatic fee reduction, always choose the highest-valued code as the primary procedure and attach modifier -51 to the lesser-valued procedure. Some payers, including many Medicare carriers, use software that automatically detects second and subsequent procedures and reimburses them accordingly, thereby making modifier -51 unnecessary. As always, request the payer's instructions in writing.

Assuming that the carrier does require modifier -51 for multiple procedures, the coder must consider still other factors before applying it. For example, modifier -51 should not be appended to any codes designated "modifier -51 exempt" because the RVUs assigned to them already take into account their status as "additional" procedures.

When submitting a claim with modifier -51, do not reduce your fees for the second and subsequent procedures. The payer will base reimbursement on the fees you have listed, so if you charge less than the full fee, your payment will be reduced by an additional 50 percent.