

# Socioeconomic tips of the month

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## Correct use of modifier -59

**M**uch uncertainty surrounds modifier -59 and its correct use. This month's socioeconomic tip is intended to allay some of this confusion so that surgeons properly code with modifier -59. Additionally, as requested by a reader, the distinction between modifiers -59 and -51 will be addressed.

### **History**

Modifier -59, distinct procedural service, is intended to describe instances in which physicians provide separate and distinct multiple services to a patient on a single date of service. Modifier -59 also may be appended to codes designated as "separate procedure" when carried out independently or considered to be unrelated or distinct from other procedures or services provided at the same time.

### **Modifier language**

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 identifies procedures/services that are not normally reported together but are appropriate under the circumstances. Such circumstances may be a different session or patient encounter, different procedure or operation, 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. The complete modifier -59 language is listed in Appendix A of *CPT* 2001. Examples of uses of modifier -59 are:

- Different session or patient encounter
- Different procedure or surgery
- Different site or organ system

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- Separate incision/excision
- Separate lesion
- Separate injury

As stated previously, modifier -59 may be appended to codes that are designated as "separate procedure," when the "separate procedure" code is carried out independently or is considered unrelated or distinct from other procedures/services provided at the time. The code designated as "separate procedure" may be reported by itself or in addition to other procedures/services by appending modifier -59.

Appending modifier -59 indicates that the procedure is not considered to be a component of another procedure, but is a distinct independent procedure. However, it is important to remember that if a "separate procedure" code is considered an integral component of a larger procedure, then it should not be reported separately.

### **Examples of modifier -59**

- If a colonoscopy is performed with biopsy of one lesion (45380) and removal of a second separate lesion (45384), then both codes would be reported. In this instance, modifier -59 would be appended to code 45384 to indicate that there is a separate incision/excision and different lesion. However, if a colonoscopy is performed with biopsy and removal of the same lesion, then only the removal of lesion is reported (45384). It is inappropriate to report a biopsy of lesion code and excision code when the same lesion is removed.

- If the physician excises two cysts (19120) through two separate incisions in the breast, then code 19120 would be reported twice. However, if both cysts were removed through the same incision, then code 19120 would be reported only once, as the code language reads, "one or more lesions." In this instance, as two separate incisions were made in the breast to remove two cysts, code 19120 would be reported twice. When reporting this service, it is important to recognize that some third-party payors may require you to report code 19120 one time and place a "2" in the units box of the Medicare 1500 form. However, if your third-party payor requires that the code be reported on two

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lines, then modifier -59 would be appended to the second use of 19120 to indicate that a separate incision/excision was performed to remove the cysts. Appending modifier -59 helps clarify that the physician performed a distinct procedural service.

- A surgeon examines the neck for primary hyperparathyroidism while exploring the parathyroids (60500), and encounters a thyroid nodule that is suspicious for malignancy. Due to the encounter of the unsuspected thyroid nodule, a thyroid lobectomy and isthmusectomy is performed (60220). Both procedures were performed by the same surgeon, at the same operative session, and through the same incision; therefore modifier -51 would be appended to code 60220 to indicate multiple procedures. However, as there were distinct disease processes, modifier -59 should also be appended to code 60220 to indicate a distinct procedural service was performed.

- A surgeon performs a cholecystectomy for cholelithiasis and splenectomy for splenic infarct on a patient with sickle cell anemia. CPT code 38100 would be reported for the splenectomy and code 47600 would be reported for the cholecystectomy. As code 38100 is a “separate procedure,” modifier -59 should be appended to indicate that the separate procedure is not considered to be a component of another procedure (the cholecystectomy), but is a distinct independent procedure.

### **When to use -59 versus -51**

Modifier -51 describes multiple procedures, other than evaluation and management services, performed during the same session by the same surgeon. Modifier -51 should not be appended to codes designated as “add-on” codes, as they are exempt from its use. Appendix E of the 2001 *CPT* manual lists all of the add-on codes. Appendix F identifies CPT codes exempt from the use of modifier -51, but that have not been designated as add-on codes. Following are four instances in which modifier -51 may be appended:


- Multiple medical procedures performed by the same provider during the same session.
- Multiple related operative procedures performed by the same provider during the same session.
- Operative procedures performed in combination by the same provider during the same session; which could be done by the same or separate incision

or involving the same or different anatomy.

- Combination of medical and operative procedures performed by the same provider during the same session.

It is important to recognize that modifier -59 language states that 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. Hopefully, using these guidelines and examples will help clarify when to use modifier -59 versus -51. As always, you should familiarize yourself with third-party payor reimbursement policies, as some third-party payors may not recognize some CPT modifiers.

### **Important CPT errata**

For 2001, CPT added a new code, 19295, which describes percutaneous image-guided placement of a metallic localization clip during breast biopsy. The parenthetical note following this code says to use code 19295 in conjunction with 19102. Although not specifically included in this parenthetical note, code 19103 may also be reported in addition to code 19295. The *CPT Assistant* included this statement in the January 2001 issue, with a note indicating that the CPT editorial panel is currently reviewing the revision of this cross-reference for CPT 2002. 

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This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Health Policy and Advocacy Department, tel. 202/337-2701; fax 202/337-4271; or e-mail [HealthPolicyAdvocacy@facs.org](mailto:HealthPolicyAdvocacy@facs.org).