The Differences Between Modifiers 51 and 59

Mary Legrand, RN, MA, CCS-P, CPC

One of the most frequently asked questions about modifiers is “When do I use modifier 51 and when do I use modifier 59?” This article differentiates the use of these modifiers when two or more procedures are performed on the same day.

About Modifier 51

Modifier 51 (multiple procedures) is used to inform payers that two or more procedures are being reported on the same day. A claim form (CMS 1500) that has modifier 51 appended to a CPT code(s) tells the payer to apply the multiple procedure payment formula to the CPT code(s) linked to the modifier 51, assuming the payer accepts this modifier.

Some payers may not accept or require the use of this modifier because their computer systems are already programmed to automatically apply the multiple procedure reduction to the lesser-valued code(s). It is important to remember the following conditions that apply to the use of modifier 51:

- No special rules related to the reporting of the code combinations can apply.
- The CPT code(s) cannot be an add-on (CPT Appendix D) or modifier 51 exempt (CPT Appendix E) codes.
- The CPT code(s) must be stand-alone procedures and not inclusive to other procedures performed at the same time.
- Unless your contract with the payer includes a “carve out,” the subsequent procedure(s) is(are) subject to the payer’s multiple procedure payment formula.

The following examples show correct coding and appropriate use of modifier 51; special coding rules (other than documentation of the work and medical necessity) are not required to report the code combination.

Joint Injections

Table 1 shows the coding that should be used when a physician performs an arthroscopic rotator cuff repair (29827), arthroscopic distal clavicle resection (29824), and arthroscopic subacromial decompresion (29826) during the same session.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Expected Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>20605</td>
<td>51</td>
<td>100%</td>
</tr>
<tr>
<td>20610</td>
<td>51</td>
<td>50%</td>
</tr>
</tbody>
</table>

Arthroscopic Shoulder Surgery

Table 2 shows the coding that should be used when a physician performs an arthroscopic rotator cuff repair (29827), arthroscopic distal clavicle resection (29824), and arthroscopic subacromial decompresion (29826) during the same session.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Expected Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>29827</td>
<td>51</td>
<td>100%</td>
</tr>
<tr>
<td>29824</td>
<td>51</td>
<td>50% arthroscopic payment reduction (Medicare)</td>
</tr>
<tr>
<td>29826</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Spine Surgery

Table 3 shows the appropriate coding for a posterolateral fusion at L3-L4 and L4-L5 (22612, 22614), laminectomy, facetectomy, foramotomy and decompression at L3-L4 and L4-L5 (63047, 63048), posterior segmental instrumentation at L3-L5, and bone graft harvested from the iliac crest (20937).

CPT codes 22612 and 63047 are stand-alone codes; when reported together, the lesser-valued procedure is subject to the multiple procedure payment formula. CPT codes 22614, 63048, 22842, and 20937 are add-on codes and are not subject to the multiple procedure payment formula. To report these add-on codes, a parent or index code must be present. CPT code 22612 is a parent code to 22614, 22842, and 20937. CPT code 22614 is a parent code to 63048, 22842, and 20937.

A laminctomy is not considered inclusive to the posterolateral fusion (22612) and special coding rules (other than documentation and medical necessity) do not have to be met to report this code combination. Thus, modifier 51 is the most appropriate modifier to append to the subsequent (lesser-valued) procedure.

To summarize, modifier 51 is appended to a subsequent procedure that is considered a stand-alone code (not an add-on or exempt code) when the following conditions are met:

- Two or more code combinations are reported.
- By definition, the reported codes stand alone.
- Special rules do not have to be met to report the code combination.

Modifier 59

Modifier 59, the distinct procedural service modifier, is reported with a CPT code combination when a coding rule has to be met, when another, more specific modifier (multiple-51 or bilateral-50) will not explain the situation to the payer, or when the code combination is correct, but the payer has a reimbursement edit in place.

According to CPT, modifier 59 is used to support a different session, a different procedure or surgery, a different site or organ system, a separate incision or excision, a separate lesion, or a separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Of critical importance and differentiation is the following statement from CPT: “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.” Thus, if the bilateral or multiple procedure modifiers describe the situation, modifier 59 should not be used—even in cases of a different procedure, a different site, a separate incision, or a separate injury.

The following examples show when modifier 59 should be used because, according to CPT, a coding rule has to be met to report a code combination, modifiers 51 or 59 will not adequately explain the scenario, and the code combinations are reportable together under CPT rules, but Medicare has issued a payment edit (Correct Coding Initiative, or CCI).

For example, the surgeon documents a chondroplasty performed in the medial and patellofemoral compartments and a meniscal repair on the same knee, the chondroplasty must be performed in a different compartment than the meniscal repair. If the chondroplasty is performed in the same compartment as the repair, the chondroplasty is not separately reimbursable.

To meet a CPT coding rule

To report a chondroplasty during the same surgical session as a meniscal repair on the same knee, the chondroplasty must be performed in a different compartment than the meniscal repair. If the chondroplasty is performed in the same compartment as the repair, the chondroplasty is not separately reimbursable.

For example, the surgeon documents a chondroplasty performed in the medial and patellofemoral compartments and a meniscal repair in the medial compartment. Modifier 59 is appended to the chondroplasty code to tell the payer that the coding rule to report the chondroplasty (different site) was met (Table 4).

The goal in this case is to obtain reimbursement for the chondroplasty. Reimbursement is expected to be reduced unless a contractual agreement is in place that allows for full reimbursement.