American Society of Anesthesiologists®

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Modifier 59 – Distinct Procedural Service: Know When to Use it and When Not to Use It

Modifier 59 – Distinct Procedural Service – is one of the most potent modifiers within the CPT® code set. It is used on claims to indicate that two procedures reported during the same encounter are separate and distinct from each other and eligible for separate and unreduced payment. It is a modifier of last resort in that, it is not to be used unless there is no other modifier that accurately explains the specific scenario.

Because it is such a powerful modifier, it is important that modifier 59 be used properly -- and that your documentation supports its use in the event of audit. The Centers for Medicare and Medicaid Services (CMS) recently released an article that describes both correct and incorrect use of modifier 59. If you are reporting this modifier, please take the time to review the CMS memo to ensure that you are using the modifier when you should – and not using it when you should not.

You can view the CMS article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1418.pdf

Physician anesthesiologists may use modifier 59 when reporting a post-op pain procedure separately from an anesthesia service. The modifier may also be applicable when reporting diagnostic transesophageal echocardiography (TEE) separately from anesthesia. In both these circumstances, the modifier overrides National Correct Coding Initiative (NCCI) edits that pair anesthesia with the other services. Medicare Administrative Contractors follow the NCCI when processing claims for services provided to Medicare beneficiaries. Many private payers follow the NCCI as well.

The NCCI (effective 1/2014) addresses post-op pain procedures as follows:

> Under certain circumstances an anesthesia practitioner may separately report an epidural or peripheral nerve block injection (bolus, intermittent bolus, or continuous infusion) for postoperative pain management when the surgeon requests assistance with postoperative pain management.

Notice: The foregoing information is being provided specifically to you based on the facts and details you provided. This information or advice is not necessarily applicable if the facts you provided are incomplete or inaccurate. The ASA has used its best efforts to provide accurate coding and billing advice, but this advice should not be construed as representing ASA policy (unless otherwise stated), making clinical recommendations, dictating payment policy, or substituting for the judgment of a physician.

An epidural injection (CPT code 623XX) for postoperative pain management may be reported separately with an anesthesia 0XXXX code only if the mode of intraoperative anesthesia is general anesthesia and the adequacy of the intraoperative anesthesia is not dependent on the epidural injection. A peripheral nerve block injection (CPT codes 64XXX)for postoperative pain management may be reported separately with an anesthesia 0XXXX code only if the mode of intraoperative anesthesia is general anesthesia, subarachnoid injection, or epidural injection, and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block injection. An epidural or peripheral nerve block injection (code numbers as identified above) administered preoperatively or intraoperatively is not separately reportable for postoperative pain management if the mode of anesthesia for the procedure is monitored anesthesia care (MAC), moderate conscious sedation, regional anesthesia by peripheral nerve block, or other type of anesthesia not identified above. If an epidural or peripheral nerve block injection (code numbers as identified above) for postoperative pain management is reported separately on the same date of service as an anesthesia 0XXXX code, modifier 59 may be appended to the epidural or peripheral nerve block injection code (code numbers as identified above) to indicate that it was administered for postoperative pain management. An epidural or peripheral nerve block injection (code numbers as identified above) for postoperative pain management in patients receiving general anesthesia, spinal (subarachnoid injection) anesthesia, or regional anesthesia by epidural injection as described above may be administered preoperatively, intraoperatively, or postoperatively.

The NCCI limits reporting TEE separately from anesthesia to instances in which the TEE is done for diagnostic purposes. Per the NCCI manual (as revised 1/2014) TEE as described by CPT codes 93312-93317 is not separately reportable from an anesthesia service when the TEE is used for monitoring. NCCI does state, "However, when performed for diagnostic purposes with documentation including a formal report, this service may be considered a significant, separately identifiable, and separately reportable service."

When CMS and its contractors that process claims see instances of improper coding, they often issue what they term "provider education" on the issue(s). This recent CMS article may or may not be a result of such an observation but nonetheless, it is information you should know and use when submitting your claims.

Resources:

National Correct Coding Initiative Policy Manual, http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/

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