## I'm not a robot



Physical therapists often grapple with the complexity of their billing process, especially when it comes to the usage of the 59 modifier. This essential tool in the billing toolkit has left many therapists perplexed, leading to improper usage and subsequent claim denials. This comprehensive guide aims to demystify the modifier 59, explaining its proper application in physical therapy and providing practical examples for better understanding. The 59 modifier is primarily designed for surgical procedures or services that are not usually reported together but are appropriate under certain circumstances CMS refers to this as a "separate" or "distinct procedural service." However, the modifier setablished modifier se two completely separate and distinct services are provided in the same treatment period. The National Correct Coding Initiative (NCCI) has identified certain procedures that therapists commonly perform together, dubbed "edit pairs." If a therapist bills a Current Procedural Terminology (CPT) code linked to one of these pairs, they are generally reimbursed for only one of the codes. In such scenarios, the modifier 59 can be employed to indicate that both services were provided independently, warranting separate payment. NCCI edit pairs, also known as National Correct Coding Initiative edit pairs, are a set of coding rules developed by the Centers for Medicare and Medicaid Services (CMS) The intent of NCCI edit pairs is to prevent improper payments and ensure accurate coding and billing practices. In physical therapy the most common NCCI edit pair involves CPT code 97140. For this code, NCCI indicates that 97530, 95851, 95852, 97018, and 97750 are all linked services when billed in combination with 97140. So, if you bill any of these codes with 97140, youll receive payment for only 97140. Medicare actually uses this example on their site for therapists regarding appropriate use of modifier 59. Consider a therapist providing 15 minutes of manual therapy (CPT code 97140) and 15 minutes of therapists regarding appropriate use of modifier 59. Consider a therapist providing 15 minutes of therapists regarding appropriate use of modifier 59. Consider a therapist providing 15 minutes of therapists regarding appropriate use of modifier 59. Consider a therapist providing 15 minutes of therapists regarding appropriate use of modifier 59. Consider a therapist providing 15 minutes of manual therapy (CPT code 97140) and 15 minutes of therapists regarding appropriate use of modifier 59. Consider a therapist providing 15 minutes of manual therapy (CPT code 97140) and 15 min the modifier 59 to code 97530, the therapist indicates that both services were provided separately, thus qualifying for separate reimbursement for each procedure.97530 Therapeutic ActivitiesAnother instance could be when a patient requires a re-evaluation during the same visit due to lack of progress. The 59 modifier can be used to bill for both the re-evaluation and the therapeutic exercise. Despite its utility, the 59 modifier should not be used indiscriminately. It is not a tool to guarantee increased payment and should not be appended without sufficient proof of necessity. Using the 59 modifier without adequate justification can lead to audits and penalties. Moreover, routine use of the 59 modifier with re-evaluation codes can raise red flags with payers. Commercial payers, following the lead of CMS, have adopted front-end claim edit policies for claims containing modifiers 59. These policies have led to a slew of denials, especially for 97530 and 97140. When faced with such denials, therapists should appeal the decision and provide evidence supporting the correct usage of the 59 modifier. To avoid NCCI edit pairs altogether, therapists can provide interventions other than therapeutic activities (97110) and/or neuromuscular reeducation (97112). However, therapists must ensure that the intervention delivered aligns with the intervention del time by eliminating the need for manual checks. The 59 modifier, although complex, is a crucial component of physical therapy billing. By understanding its intent and proper usage, therapists can maximize their revenue while maintaining compliance with billing regulations. Remember, the key is to make judicious use of the 59 modifier, ensuring that it reflects the actual services provided and that your documentation supports its usage. Finally, keep abreast of policy changes from CMS and commercial payers. Stay informed, stay compliant, and ensure that you receive the payment you deserve for the services you provide. How can financial brands set themselves apart through visual storytelling? Our experts explainhow.Learn MoreThe Motorsport Images Collections captures events from 1895 to todays most recentcoverage. Discover The Collection Curated, compelling, and worth your time. Explore our latest gallery of Editors Picks. Browse Editors storytelling? Our experts explainhow.Learn MoreThe Motorsport Images Collections captures events from 1895 to todays most recentcoverage. Discover The Collection Curated, compelling, and worth your time. Explore our latest gallery of Editors Picks. Browse Editors' Favorites How can financial brands set themselves apart through visual storytelling? Our experts explainhow.Learn MoreThe Motorsport Images Collections captures events from 1895 to todays most recentcoverage. Discover The Collection Curated, compelling, and worth your time. Explore our latest gallery of Editors Picks. Browse Editors purpose, even commercially. Adapt remix, transform, and build upon the material for any purpose, even commercially. The license terms. Attribution You must give appropriate credit, provide a link to the license, and indicate if changes were made. You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use. ShareAlike If you remix, transform, or build upon the material, you must distribute your contributions under the same license as the original. No additional restrictions You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits. You do not have to comply with the license for elements of the material in the public domain or where your use is permitted by an applicable exception or limitation. No warranties are given. The license may not give you all of the permissions necessary for your intended use. For example, other rights such as publicity privacy, or moral rights may limit how you use the material. In the realm of medical coding, the 59 modifier holds significant importance. It's a tool that, when used correctly, ensures accurate billing and compliance issues, and even audits. This article aims to demystify the 59 modifier usage. It will provide a comprehensive guide on its application in various clinical scenarios. We will also discuss common misconceptions about the 59 modifier and how to avoid them. Through detailed examples, we'll illustrate the correct application of the 59 modifier. By the end, you'll have a clear understanding of when to use this crucial tool in medical student, a healthcare professional, or a billing specialist, this guide is for you. Let's dive in. Understanding the 59 modifier is a tool in medical student, a healthcare professional, or a billing specialist, this guide is for you. Let's dive in. Understanding the 59 modifier is a tool in medical student, a healthcare professional, or a billing specialist, this guide is for you. Let's dive in. Understanding the 59 modifier is a tool in medical student, a healthcare professional, or a billing specialist, this guide is for you. Let's dive in. Understanding the 59 modifier is a tool in medical student. coding that indicates separate and distinct procedures. Its use ensures that each service is recognized for reimbursement. This modifier is crucial for coding services that might otherwise be bundled together. In practice, the 59 modifier is crucial for coding services that might otherwise be bundled together. In practice, the 59 modifier is crucial for coding services that might otherwise be bundled together. In practice, the 59 modifier is crucial for coding services that might otherwise be bundled together. In practice, the 59 modifier is crucial for coding services that might otherwise be bundled together. In practice, the 59 modifier is crucial for coding services that might otherwise be bundled together. it, services could be mistakenly viewed as overlapping, reducing reimbursement. Medical coders must decide when the 59 modifier is truly necessary. This decision rests on clearly distinguishing the services performed. Incorrect usage can trigger audits or denials of claims, which can disrupt billing and payments. Understanding the 59 modifier also involves recognizing its role in the overall coding system. This insight aids in maintaining compliance with federal guidelines. It also helps in safeguarding against financial losses due to incorrect claims processing. With this knowledge, healthcare professionals can use the 59 modifier effectively. It becomes a valuable tool, enabling precise billing that reflects the care provided. Definition and PurposeThe 59 modifier is defined as a "distinct procedural services." It signifies that a particular procedure is distinct from other services that might seem related. It highlights the need for separate reimbursement. Without this modifier, services may be mistakenly bundled, affecting payment accuracy. Using the 59 modifier correctly ensures that healthcare providers receive appropriate compensation. Accurate application supports financial stability in clinical settings. The Correct Coding Initiative (CCI) and Modifier 59The Correct Coding Initiative (CCI) is a critical element in modifier use. It sets national coding standards to prevent improper payment. CCI ensures that the combination of services is appropriately billed. Modifier is essential for signaling that procedures are distinct. Coders must use the 59 modifier with care, adhering to CCI guidelines. Proper use prevents incorrect billing and ensures compliance. This attention to detail safeguards against audits and enhances reimbursement accuracy. When to Apply the 59 modifier Applying the 59 modifier requires a thorough assessment of the procedures in question. It's essential to recognize situations where services are truly independent. This determination is crucial for correct billing. The modifier is utilized when multiple services are truly independent. Proper application demands careful documentation of each service. Complex cases often necessity for separate coding. Medical practitioners must be aware of specific guidelines for using the 59 modifier. These include understanding payer-specific policies that can affect reimbursement. Adherence to guidelines protects against denied claims. Ensuring compliance involves a collaborative approach between clinicians and coders. Effective communication clarifies when the modifier is justified. This teamwork results in consistent and accurate modifier usage. Separate and Distinct Services Recognizing when services are separate is the heart of using the 59 modifier. This modifier signifies when services are truly distinct and deserve separate coding. Examples include different anatomical sites or sessions. Successful application relies on precise documentation. Recording the distinct nature of the procedures is essential. Without clear documentation, the modifier may be misapplied. This distinction prevents errors in billing. Coders must ensure that each service is necessary and unrelated to others. Proper use of the 59 modifier can lead to its misuse. Often, there's a belief that it can be used liberally. This misunderstanding can result in overuse, increasing audit risks. Some assume the 59 modifier is a quick fix for claim denials. This false belief can lead to incorrect application. Instead, coders should understand the specific scenarios for its use. To avoid pitfalls, education is vital. Coders should engage in continuous learning and stay updated on guidelines. This proactive approach helps mitigate errors and ensures compliant coding. Modifier 59 Examples in PracticeUnderstanding the 59 modifier appropriately. Observing these cases enhances comprehension and application skills. Consider a scenario where a patient receives procedures on distinct anatomic sites. Here, the 59 modifier would be warranted, as each site requires individual consideration. This separation validates separate coding and billing. Another example is when services are performed in distinct operational sessions. If a patient has procedures on the same day at different times, they may warrant the modifier. This ensures that each service is recognized independently. Modifier 59 Example Situations: Procedures on separate anatomical sites Distinct identification by examining these examples, medical students and coders grasp the correct uses and nuances of the 59 modifier. This understanding facilitates accurate billing and compliance. CPT Code Procedure/Service Use of Modifier 59 97110 Therapeutic exercises Use modifier 59 if performed separately from other procedures like manual therapy (97140) on the same day. 97140 Manual therapy techniques Modifier 59 when injections are performed at different anatomical sites or on separate encounters. 99214 Office visit (Level 4) Modifier 59 may be used if additional procedures are performed in a separate context (e.g., new problem or separate location). 20550 Injection, tendon sheath, ligament Use modifier 59 when injections are given to different anatomical sites or multiple blood draws in one session. 11042 Debridement of superficial wound Modifier 59 used if debridement is performed at separate sites or at different locations or multiple limbs. 43235 Upper GI endoscopy Modifier 59 used when separate procedures (e.g., biopsy) are performed in different sites during the same session. 31500 Intubation is done at a different sites during the same session. 31500 Intubation is done at a different sites during the same session. the same surgery. Step-by-Step Application ScenariosApplying the 59 modifier correctly entails following a step-by-step process. Begin by analyzing whether procedures are distinct. Determine if they occur on different sites or at separate times. Next, review medical records for detailed documentation. Its crucial to have a comprehensive account of each service. This step ensures that the services can justify distinct coding. Assess payer-specific guidelines and policies. These rules may vary, impacting how and when modifier application. Discuss complex cases with experienced coders. This collaboration provides insight and reinforces the proper use of the modifier in complex clinical scenarios. This methodical approach supports accuracy and compliance in medical coding practices. Documentation and Compliance Proper documentation is essential when using the 59 modifier. It serves as the foundation for accurate coding and billing. Without it, claims may be denied or questioned. Ensure that medical records provide a detailed account. This includes the rationale for separate procedures. Clear and complete documentation supports the distinct nature of services. Compliance is another critical factor. Following established coding guidelines protects against audits. It also improves accuracy and reduces the risk of claims denial. Supporting Medical Documentation must clearly indicate why services are distinct. This involves noting any separate anatomic sites or times. The explanation should be explicit and tied to the patient's care. The record should include justification for each procedure. Describe how each service stands on its own. This supports the decision to use the 59 modifier. Detailed notes are essential for auditing purposes. They demonstrate that services meet the criteria for separate reimbursement. This careful documentation plays a vital role in achieving compliance. Impact on Billing and Audits Modifier 59 has significant implications for billing. Correct usage ensures appropriate compensation for distinct procedures. Incorrect application, however, may lead to denial of claims. Billing integrity relies on proper modifier use. It is fundamental for minimizing errors and denials. Ensuring thorough documentation is key to preventing billing issues. Audits scrutinize modifier use closely. Errors can lead to penalties or payment recoveries. Adhering to guidelines mitigates risks associated with audits, protecting the healthcare provider's financial interests. Tips for Mastering Modifier 59 UsageMastering the 59 modifier requires diligence and practice. Begin by thoroughly understanding its role. Knowing when and why to apply it is crucial. Stay informed on coding guidelines and payer-specific rules. These steps ensure you remain compliant and up-to-date. Leverage technology to aid your learning. Electronic health records often have features to guide correct modifier usage. Practicing within these systems can boost your proficiency. Strategies for Medical Students Medical Students Medical students can benefit from hands-on learning. Start by working with mentors or supervisors in coding sessions. This provides real-world insights into modifier application. Simulate coding scenarios for practice. This helps reinforce understanding through practical examples. It also aids in grasping complex coding concepts. Attend workshops or webinars focused on coding. These educational opportunities offer valuable insights. They also provide the chance to ask questions and clarify doubts. Ensuring Accurate Coding Practices Accuracy in coding is paramount for medical billing success. Double-check each entry to ensure precision. Avoid assumptions about which modifier to use. Develop a habit of cross-referencing coding books and online databases. Consistent reference checking helps avoid errors. Encourage open communication in clinical settings. Discuss coding decisions with peers and supervisors. Collaboration can lead to improved accuracy and shared knowledge. Conclusion and Further Resources Understanding the 59 modifier is key to effective medical billing. Proper use ensures accurate documentation and billing compliance. Continually updating your knowledge is crucial for success. Seek out additional resources like coding seminars and industry publications. They provide valuable insights and examples. This ongoing education supports your mastery of the 59 modifier 51 (multiple procedures) and modifier 59 (distinct procedural service) can be used together in specific circumstances. However, it's essential to ensure that each modifier 59 and 76 be used together? Modifier 59 can be used with modifier 59 can be used with modifier 59 can be used together? situations. Ensure that documentation supports the distinct nature of the services are distinct and should be reimbursement? Yes, proper use of modifier 59 can positively impact reimbursement. It indicates that services are distinct and should be reimbursed separately, helping avoid bundling errors. What is the difference between modifier 59 and 78? Modifier 59 denotes a distinct procedural service, while modifier 78 indicates a return to the operating room for a related procedure during the post-operative period. Understanding these differences is crucial for accurate coding. What is the difference between modifier 91 and 59? Modifier 91 is used to report repeat clinical diagnostic laboratory tests, whereas modifier 59 is for distinct procedural services. Each modifier 59 is used for distinct procedural services, while modifier 59 is a significant, separately identifiable evaluation and management service provided by the same physician on the same day. Recognizing these distinctions is essential for accurate billing. Modifier 59 vs 51 Modifier article's usefulness and help improve its SEO by addressing common questions related to the 59 modifier. You can place this section at the end of your article or integrate it into existing sections where relevant. Let me know if you need further assistance! MeSH Heading Physical Therapy Specialty Tree Number(s) H02.010.625 Unique IDD026761 RDF Unique Identifier Annotationuse for the specialty only; use MUSCULOSKELETAL MANIPULATIONS or PHYSICAL THERAPY MODALITIES to prevent, correct, and alleviate movement dysfunction of anatomic or physiological origin. Entry Term(s) Physiotherapy Specialty NLM Classification # WB 460 Previous Indexing Physical THERAPY (SPECIALTY) 2002-2011, see PHYSICAL THERAPY 1963-2001 History Note2012 (1963) Date Established 2002/01/01 Date of Entry 2001/07/25 Revision Date 2016/07/01 Physical therapy billing success depends heavily on how modifiers are properly utilized as it allows timely reimbursement and compliance with payer requirements. The biller mainly uses three essential modifiers: Modifier 59 (Distinct Procedural Service), Modifier GP (Outpatient Physical Therapy Services), and Modifier KX (Threshold Exceeded with Medical Necessity). In fact, the usage of such modifiers follows specific purposes that might trigger claim denials, audits, or recoupments when improperly applied. This blog demonstrates correct implementation strategies for Modifiers 59, GP, and KX in physical therapy billing which will provide modifier helps prevent improper billing of services during interactions with the National Correct Coding Initiative (NCCI) edit processes. When to Use Modifier 59 should be applied when: Distinct Procedural Services: Two medical services that typically do not combine into a single billing are performed during separate and distinct time intervals on the same day. For example, if physical therapist can use Modifier 59 on the therapeutic activities service (CPT code 97140) on the same day. Different Anatomical Sites: When services treat different anatomical regions which typically should not be billed together, Modifier 59 allows providers to demonstrate service independence. Documentation is imperative: Detailed Session Notes: Every separate procedure requires clear documentation of its time, anatomical location, and the rationale for each distinct service. Justification for Distinct Services: A clinical statement should explain the differences between separate services and describe their role in patient treatment planning. Common Errors to Avoid Overuse of Modifier 59: Applying Modifier 59 indiscriminately can raise red flags with payers. Ensure documentation supports the necessity of using Modifier 59 for each instance. Lack of Supporting Documentation: Failure to adequately document the distinct nature of services can lead to claim denials during audits. Modifier GP: Services Delivered Under an Outpatient treatment plan require the use of Modifier GP as an indicator. This modifier GN). Insurance providers who include Medicare need this Modifier GP to correctly process claims. When to Use Modifier GP Physicians must use Modifier GP on all CPT procedure codes when treating patients with physical therapy care plans. Services are provided across multiple locations which include private practices, hospital outpatient departments, and rehabilitation facilities. When performing therapeutic exercises (CPT code 97110) as a physical therapy care plans. Services are provided across multiple locations which include private practices, hospital outpatients with physical therapy care plans. service falls under physical therapy. Documentation Requirements To ensure compliance when using Modifier GP: Established Plan of Care: An established Plan of Care must contain physical therapy services with a signing approval from qualified healthcare providers. Consistent Documentation: Medical claims using Modifier GP should have physical therapy interventions that match those documented in the established plan of care. Common Errors to Avoid Omitting Modifier GP: The absence of to claim rejections. Always verify that the correct modifier aligns with the therapy discipline. Modifier KX: Threshold Exceeded but Services Medically Necessary The healthcare provider uses Modifier KX: Threshold Exceeded but Services Medically Necessary The healthcare provider uses Modifier KX: Threshold Exceeded but Services Medically Necessary The healthcare provider uses Modifier KX: Threshold Exceeded but Services Medically Necessary The healthcare provider uses Modifier KX: Threshold Exceeded but Services Medically Necessary The healthcare provider uses Modifier KX: Threshold Exceeded but Services Medically Necessary The healthcare provider uses Modifier KX: Threshold Exceeded but Services Medically Necessary The healthcare provider uses Modifier KX: Threshold Exceeded but Services Medically Necessary The healthcare provider uses Modifier KX: Threshold Exceeded but Services Medically Necessary The healthcare provider uses Modifier KX: Threshold Exceeded but Services Medically Necessary Threshold Exceeded but Services Medically Necessar thresholds for 2025 consist of \$2,230 for physical therapy and speech-language pathology combined services separately. When to Use Modifier KX when: Exceeding Therapy is justified as medically necessary. Medical Necessity Documentation: There is clear documentation supporting the need for continued therapy beyond the threshold amount. Documentation supporting the need for continued therapy beyond the threshold amount. Documentation supporting the need for continued therapy beyond the threshold amount. therapy care for the patient's health condition and functional recovery. Progress Reports: Therapy progress updates must display patient treatment outcomes and therapy service necessity at each evaluation point. Common Errors to Avoid Premature Application of KX: Using Modifier KX before the patient reaches the therapy threshold can lead to claim issues. Monitor the patient's therapy costs to determine the appropriate timing. Insufficient Documentation: Inadequate documentation of medical necessity will lead to denied claims and potential audits. Best Practices for Modifier Usage in Physical Therapy Billing Regular Staff Training: Conduct ongoing education sessions for billing and clinical staff to stay updated on modifier guidelines and payer policies. Internal Audits: Implement routine audits of claims to ensure correct modifier application and identify areas for improvement. Utilize Billing Software: Practice medical billing software that can flag incorrect modifier use and suggest compliant alternatives before claims are submitted. Conclusion Physical therapy billing depends on correct modifier 59 distinguishes unrelated procedures, while Modifier GP identifies physical therapy services under formal plans of care, and Modifier KX confirms services past the annual therapy limits are medically essential. To apply these modifiers effectively one must follow proper documentation and train their staff and use supporting technology. Moreover, physical therapy providers can build more efficient revenue cycles, minimize audit risks, and protect their patients' continuous healthcare services by following best practices and payer-specific requirements. FAQs Q1.Can Modifiers 59, GP, and KX be used together on the same line? Yes, if clinically justified, multiple modifiers 59 as Medicare? Not alwaysprivate payers may have their own guidelines, so review their specific modifier GP apply to occupational therapy, and GN for speech therapy services? No, Modifier GP is specific to physical therapy; GO is used for occupational therapy or speech therapy or speech therapy services? No, Modifier GP apply to occupational therapy or speech therapy or speech therapy or speech therapy or speech therapy. the improper use of Modifier 59 will trigger audits and generate claim denials due to improper unbundling. In a PTs paradise, the billing process wouldn't exist. Therapists would simply provide treatment and receive payment accordingly, no explanationor codingrequired. In the real world, though, claims and the codes and modifiers you submit with those claims are your ticket to getting paid. And in many situations, one little modifier 59. Not sure of the rules governing proper use of this much talked-about modifier? Youre not alone. After all, the CPT Manual doesnt offer the most helpful guidance. So today, Im going to unshroud the mystery surrounding modifier 59 related denials, be sure to check out this billing FAQ.) {{inline-form}}1. When youre billing for two services that form a National Correct Coding Initiative (NCCI) edit pairand you provided those services separately and independently of one another. According to the above-cited CPT document, Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. Holy gobbledygook. Part of the reason that definition isnt super relatable to those in the therapy world is that modifier 59 applies mainly to surgical procedures (hence, all the references to incisions, excisions, and lesions). However, there are instances in which its appropriate to use modifier 59 in conjunction with rehab therapy services. Recognizing those instances, though, requires you to recognize NCCI edit pairs. To make a long story short, edit pairsalso called linked servicesare sets of procedures that therapists commonly perform together. (For a full list of edit pairs, along with guidance as to which ones are modifier 59-eligible, check out this blog post.) If you submit a claim containing both of the services was essentially built into the other. But what iffor whatever reasonyou actually didnt perform those services together? Thats where modifier 59 to one of the CPT codes in an edit pair, it signals to the payer that you also should receive separate payment for each procedure. Here are a couple of specific examples from compliance Group: Therapists often use modifier 59 to bill for two timed code procedures [that] are performed sequentially in the same encounter. For instance, if you billed CPT codes 97140 (Manual Therapy) and 97530 (Therapeutic Activities) and you provided those services during separate and distinct 15-minute intervalsthen, as Ambury explains, it would be appropriate to add the 59 modifier to the claim submitted for that date of service. Therapists also can use modifier 59 to signify that a diagnostic procedure was the basis for performing a linked therapeutic procedure. For example, if a current patient presents with a new diagnosis for which he or she is currently receiving treatment from the diagnosis. To signify that you finished the re-evaluation (97164/97168) before beginning treatmentthus making the diagnostic procedure separate from the linked therapeutic procedure was not an inherent part of the treatment procedure (Conversely, if the diagnostic procedure was an inherent part of treatment, you would not bill for the two procedures separately.) Finally and I cannot emphasize this point enoughyou should not routinely use the 59 modifier in conjunction with re-evaluation codes, because doing so could throw up a red flag to your payers. 2. When the payer recognizes NCCI edits. Speaking of payers, keep in mind that while Medicare adheres to NCCI edits, not all commercial insurances follow suitat least not completely. As explained here, Private payers use a combination of NCCI/CCI edits and proprietary edits to determine covered services in accordance with payer benefit plans. Payer payment policies frequently draw from CPT, NCCI/CCI and Medicare as well as applying payer-specific proprietary edits. Thus, to prevent denials for improper modifier 59 use, be sure to check the list of edit pairs for each individual carrier. When it comes to telling your patients stories, codes and modifiers can only say so much. Its on you to fill in the plot holes with detailed, defensible documentation. After all, your documentation justifies your billing decisions and if your ever faced with an audit, your notes will be your main source of proof that those decisions were the right ones. That means you should never:append modifier 59 simply because you know it will guarantee more payment.skimp on your document tionor intentionally document vaguely or misleadingly. 4. When there is one point on which its amore descriptive modifier available. At the beginning of this post, I kind of threw the CPT Manual under the bus for lack of claritybut there is one point on which its amore descriptive modifier available. At the beginning of this post, I kind of threw the CPT Manual under the bus for lack of claritybut there is one point on which its amore descriptive modifier available. At the beginning of this post, I kind of threw the CPT Manual under the bus for lack of claritybut there is one point on which its amore descriptive modifier available. At the beginning of this post, I kind of threw the CPT Manual under the bus for lack of claritybut there is one point on which its amore descriptive modifier available. At the beginning of this post, I kind of threw the CPT Manual under the bus for lack of claritybut there is one point on which its amore descriptive modifier available. At the beginning of this post, I kind of threw the CPT Manual under the bus for lack of claritybut there is one point on which its amore descriptive modifier available. At the beginning of this post, I kind of the clarity but the bit less murky: clinicians, coders, and billers should only use modifier 59 as a last resort (i.e., when theres not a better option). As the CPT Manual states, ...when another already established modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Now, youve probably heard talk about the new modifiers XE, XP, XS, and XUare intended to bypass a CCI edit by denoting a distinct encounter, anatomical structure practitioner, or unusual service. However, even though these modifiers went into effect January 1, 2015, the APTA has stated that therapists do not need to start using them in place of modifiers issued by CMS, and the answer at this time is no, Gayle Lee, JD, APTA senior director of health finance and quality, is quoted as saying in the article. As of February, 2015, PTs are being instructed that therapists may be required to use the new modifiers in the future, so they should keep an eyeor an earout for further instruction regarding modifier 59 usage. So, while PTs probably will never live in the billing-free utopia they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they ear are the ones that most accurately represent the treatments they earlied the treatments the treatment the treatments the treatment the treat deserve. Modifier 59 is an extremely useful modifier, but it should be used only when necessary. Incorrect use of the modifier can result in claim denial by Medicare and commercial payers. NCCI has identified certain services that therapists commonly perform together as edit pairs. These pair with other CPT codes to create modifier 59-eligible codes sets. Navigating Edit Pairs: Identifying Modifier 59-Eligible Services Modifier 59, which is frequently misused by physical therapists. Misusing this modifier can lead to bundled claims and claim denials. To avoid these issues, it is important to understand the definition of modifier 59 and when it should be used. In a nutshell, modifier 59 in physical therapy billing is a way to indicate that two procedures that would normally be billed together on the same date of service are actually separate and distinct services. This is accomplished by using the code pair edits established by NCCI. These edits identify sets of procedures that should never be billed together, and they are designed to prevent duplicate payments. Strategic Usage: Proper Application of Modifier 59To use this modifier correctly, a therapist must know the appropriate pairs of CPT codes and which ones are eligible to be billed separately. This is also known as recognizing edit pairs. For example, if a Level 3 established patient visit (CPT code 99213) is billed with psychological testing (CPT code 96101), the therapist must apply modifier is frequently used is for re-evaluation and treatment services. However, it is important to remember that re-evaluation is a part of the treatment process and cannot be billed separately. To ensure that you are billing for both services correctly, you must document that the re-evaluation was necessary and that it led to a change in the plan of care. Beyond Pairing: Distinguishing Anatomical Sites and Encounters This modifier may be used to distinguish procedures performed on different anatomical sites or during different patient encounters. However, it should be used to bypass NCCI or payer edits or to guarantee more payment. Modifiers in Action Effective Utilization of Modifier 59 Modifier 59 in physical therapy billing is a powerful tool in the physical therapy world. But, if it is misused, it can raise red flags for payers and trigger denials. Payers look at a combination of CPT, NCCI, and proprietary edits when determining what services they will cover. This includes Medicare as well as commercial insurances. So, therapists should only use modifier 59 when the documentation supports characterizing those services as separate and distinct. One of the most common mistakes made by PTs is using modifier 59 improperly. This is often due to confusion about how and when the modifier should be used. A key concept to remember is that the 59 modifier is only used when two procedures are performed in the same treatment session. If the procedures are done in different session, both treatments can be billed. But, if they are done in the same session, then you must add modifier 59 to the 97140 code on the claim form. In addition, if two codes are part of an edit pair, then the 59 modifier must be appended to only one of the procedures. The NCCI has identified procedures that therapists commonly perform together and labeled them as an edit pair. For example, 97140 Manual therapy techniques, one or more regions (each for 15 minutes) links to 97530 Therapeutic activities, direct one-on-one patient contact by the provider, each 15 minutes. These code pairs are not meant to be billed separately. They are part of an edit pair and should only be billed if the documentation clearly supports that they were performed in distinct times. blocks. This is also true of re-evaluation and discharge codes, as these are part of an edit pair as well. However, some therapists routinely append a 59 to re-evaluation and discharge codes just because they know it will guarantee more payment. However, this is a big mistake that can easily trigger a payer audit. For any pt billing assitance contact our company. Documentation Shield: Supporting Modifier 59 UsageModifier 59 used when no other modifier better describes the relationship between the two codes. The list of CPT code pairs that constitute an NCCI edit is regularly updated, and you should be familiar with these prior to billing. You should also be aware of which codes can never be billed together and which ones may be billed together if the correct modifier is used. A useful resource for this is the latest fact sheet on Modifier 59. Using the correct modifier is critical to avoiding claim denials from payers. This is especially true with the Centers for Medicare and Medi Modifier 59 is one of the most commonly used modifiers in physical therapy, and it can be a red flag for CMS and commercial payers when not used properly. The most common use of this modifier is to indicate that a diagnostic procedure was the basis for performing a linked therapeutic procedure. For example, if a patient was brought into the clinic with a new diagnosis, it would be appropriate to complete a re-evaluation to ensure that the treatment plan was appropriate. The re-evaluation should be billed with a diagnostic code, and the linked treatment should be billed with a treatment code. Modifier 59 can be added to the re-evaluation and the linked treatment were performed separately from each other. To support the use of this modifier, you will need detailed documentation in the patients medical record to demonstrate that the two procedures were truly separate and distinct from each other. This includes documentation that clearly demonstrates that the 15-minute timed services were provided in distinctly different increments and that they were not overlapping. The documentation should also be clear in demonstrating that no other modifier was able to adequately describe the relationship between the two services. Summarizing Modifier 59 in Physical Therapy BillingIf you use modifier 59 inappropriately, it can raise red flags with the US Centers for Medicare and Medicaid Services and even trigger an audit. Thankfully, there are ways to avoid misusing this modifier in a physical therapy setting. First, you must recognize the instances when its appropriate. The key is knowing which codes form an NCCI pair edit. (For more on this topic, check out our blog post on NCCI Modifier Pairs.) Once you know which pairs to look out for, you can understand when the 59 modifier may be used to indicate separate and distinct services. However, there must be documentation supporting the characterization of those services as separate and distinct. This means different times, separate patient encounters, and/or different body parts. The 59 modifier is available, it should be utilized before appending the 59 modifier to the claim. The 59 modifier should only be applied if no more descriptive modifier better explains the circumstances and documentation. Likewise, you should never use the 59 modifier better explains the circumstances and documentation modifier such as GO, GP, or CQ. This will help you distinguish re-evaluation services from the other treatment provided on the same day. For more tips for your PT clinic, click here. Finally, if youre using the 59 modifier to unbundle NCCI edits for a surgical procedure, its important to remember that this is only applicable if the surgeon knew that the initial procedure would lead to another more extensive operation before performing the original one. For example, if the surgeon did a biopsy and found cancer, then the doctor will need to do an additional surgery. The 59 modifier is an excellent tool for separating and identifying unique physical therapy services, but only if its used properly. When you apply it improperly, it can cause a red flag to be raised by the US Centers for Medicare and Medicaid Services or even by a private payer. By understanding when and how to use the 59 modifier, you can ensure that your billing and documentation align with CMS guidelines. Whether youre a therapy billing newbie or a seasoned vet, knowing the ins and outs of modifier 59 and when its appropriate to bill with this last resort modifiercan be difficult and just plain confusing. With CMSs recent release of new eval and re-eval CPT codes, your confusion may be intensifying. But, dont let this weighty topic keep you up at night. Instead, look to the information below to fine-tune your billing and documentation efforts. Proper Use of Modifier 59 isnt some across-the-board free pass to higher reimbursement. There are hard and fast rules about its application. Essentially, if you want to avoid a potential claims audit, modifier 59 should be the exceptionnot the rule. So, when can you use it? Here are the criteria for proper modifier 59 use: You must perform services that are considered separate and distinct. According to this WebPT Blog post, 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 is used to identify procedures [and/or] services that are not normally reported together, but are appropriate under the circumstances. You must bill for services that form edit pairs. So if you, the PT, bill two codes that are considered a linked pair, youll receive payment for only one of those codes. That is, of course, unless you determine that you performed the services separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which case you can affix modifier be to the claim and receive separately and independently of one anotherin which can be to the claim and receive separately and independently of one another anoth said, modifier 59 shouldnt be your go-to option for securing separate payment for linked services. Instead, as the CPT manual states, when another already established modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. To that end, CMS created a new set of modifiersXE, XP, XS, and XUfor providers to use in place of modifier 59, when appropriate. However, therapists should hold off on using these new modifiers until further notice. CCI Edit Pairs for the New PT and OT Evaluation CodesAs of July 1, 2020, the new PT and OT evaluation codes 97161 to 97163 for PTs and 97165 to 97168 for PTs and OTs can bill for evaluative services in conjunction with other therapy services without needing to apply modifier 59 for Medicare, anyway. Some commercial payers may have their own modifier 59), we recommend appealing the denial.Looking for the most common NCCI edit pairs for rehab therapists? Download your free copy of this chart to see which commonly used code pairs still require modifier 59.2021 ChangesIf youve been keeping tabs on the NCCI edit pairs for a while now, then you may notice that there are several prior NCCI edit pairs missing in 2021. Thats because CMSat the behest of the APTAhas agreed to accept these pairs without needing to affix modifier. In other words, you can perform the following services and receive payment for themwithout needing to affix modifier 59:97110 with 9716497113 with 9716497116 with 9716497110 w 9716497150 with 9716497530 with 9716497530 with 9716497530 with 9716497163 with 9716497167 wit the comment section below. One of the primary reasons medical providers depend on certified coders is that coders know how to maximize practice revenues. Thats because certified coders understand how and when to use modifiers and there are a lotto indicate anything from laterality (e.g., right [RT] and left [LT]), to separate and distinct procedures. With the latter. Im of course referring to the very real guestions regarding modifier 59. A physical therapist isnt a certified coder, and vet, when it comes to guestions about the 59 modifiers cause as much confusion for PTs or wreak as much havoc on their payments. as this mysterious modifier. In this post, Ill demystify modifier 59 by detailing how and when physical therapists should use it. Heres what PTs need to know about the proper use of modifier 59.1. Most of the guidelines on Modifier 59 are predominantly intended for surgical procedures. The Current Procedural Terminology (CPT) Manual defines modifier 59 as the following: Under certain circumstances, the physician may need to indicate that a procedure or services performed on the same day. Modifier 59 is used to identify procedures [and/or] services that are not normally reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different site or organ system, separate incision/excision, or separate incision/excision, or separate incision/excision, separate incision/excision, or separate incision/excision, or separate incision/excision, separate incision/excision excision excisio modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier 59 be used." If you think that definition is not only dense but also ill-fitting for rehab therapy providers, then youre correct on both counts. In short, Modifier 59 is meant for a distinct procedural service not normally performed at the same time as another but if a more descriptive modifier 59 is intended mainly for surgical procedures, and thats reflected in the CPT Manuals definition. Dont let that mislead you on the importance of modifier 59 for rehab therapists, though; you may encounter the 59 modifier 59 is used in conjunction with edit pairs. So, how does modifier 59 come into play in the therapy setting? If youre providing two wholly separate and distinct services during the same treatment period, it might be modifier 59 time! The National Correct Coding Initiative (NCCI) has identified procedures that therapists commonly perform together and labeled these edit pairs. Thus, if you bill a CPT code that is linked to one of these pairs, youll receive payment for only one of the codes. Its your responsibility as the therapist to determine whether youre providing linked services or wholly separate services. This, in turn, will determine whether modifier 59 is appropriate. As Brooke Andrus explains in this blog post, When you append modifier 59 to one of the CPT codes in an edit pair, it signals to the payer that each service performed in the pair was done separately and independently of one another meaning that you also should receive separate payment for each procedure.3. In 2021, CMS agreed to reimburse several former NCCI edit pairs without modifier 59. According to the APTA, this change is, expected to reduce the use of code modifiers that were creating confusion and sparking claim denials, which is a big win for everyone involved. Thus, providers can perform the following services and receive reimbursementwithout affixing a modifier:97110 with 9716497113 with 9716497116 with 9716497110 wit 9711697530 with 9716499281-99285 with 9716497163 with 9716497167 with 9716497140 with 9716497140 with 97163097530 with 9716497163 with 9716497140 with 9716497140 with 9716497140 with 9716497164 with 9716497140 with 9716497 Denials for 97530 and 97140, CMS is looking for appropriate documentation to reflect the use of these modifier 59. Too often, PTs receive denied claims or insufficient payments because of improper modifier 59 use. Thats why we developed a feature (aptly named Built-In NCCI Edits) that will check your codes against the Medicare NCCI rules as you add services to be billed for each visit. Once youve turned on this feature, it will notify you of any NCCI edit pairs entered for the same date of service. If your documentation justifies billing both codes, you can acknowledge this, and WebPT immediately adds modifier 59 to the appropriate code. Pretty nifty, right? Activating Built-In NCCI Edits within WebPTTo activate this feature, please follow the steps below. Note that youll need to complete these steps for each insurance plan. We recommend applying this to commercial and government plans only (i.e. no workmans compensation, legal/lien, and auto liability policies). Select Display Insurance, located on the left side of the WebPT Dashboard. Click Edit on the individual insurance for which you want to activate the feature. Once the insurance editing screen opens, check Apply CCI edits; then, select Save. If youre not yet a WebPT Member, you can see this functionality and an array of other awesome features in our free, live online demonstration. 5. Modifier 59 isnt your billing-free card. You should apply modifier 59 to denote when you have provided a typically bundled service wholly separate from its counterpart. Thats it. You should not be modifier 59 to denote when you have provided a typically bundled service wholly separate from its counterpart. That it. You should not be modifier 59 to denote when you have provided a typically bundled service wholly separate from its counterpart. vaguely or misleadingly. Additionally, do not routinely use modifier 59 in conjunction with re-evaluation codes because doing so could raise a red flag to your payers. As WebPT billing expert John Wallace laid out in How to Handle Modifier 59 Denials for 97530 and 97140, overuse of modifiers 59 and 25 led private payers like Anthem, Aetna, and Humana to adopt front-end claim edit policies for any claims with those modifiers. While the policies have been updated, the change caused several denials for providers using those claimseven in cases where the modifiers were correctly affixed. As Wallace notes, if youve used modifier 59 appropriately and had your claim denied, you should appeal the decisionassuming your documentation demonstrates proper use. Ideally, your documentation should include: Interventions that apply to each CPT code and are grouped appropriately; One-on-one and total treatment time in minutes for therapy and therapeutic activities; The body part involved in an intervention; and A version of the statement The manual therapy interventions were performed at a separate and distinct time from the therapeutic activities interventions. There you have it: the five things you, as a PT, need to know on modifier 59. Of course, rules are always changingso check back here in the future for updates!