

Provider Bulletin

Subject:	Modifier 51 and 59		
Plan:	Coordinated Care Option 1	Bulletin Date:	December 31, 2014
Bulletin Number:	14-015	Effective Date:	January 15, 2015

The purpose of this bulletin is to provide clarification regarding the usage of modifiers 51 and 59.

Effective January 15, 2015 claims with a modifier 51 and 59 on the same procedure will not be accepted. Claims received with this modifier combination will be denied for invalid modifier. Appealed claims for this denial will require medical documentation if modifier 59 is determined to be the most appropriate modifier for this situation.

Below is helpful information as to the usage of Modifier 51 and 59.

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.

Modifier 59, the distinct procedural service modifier, should **only** be reported if a more descriptive modifier (50, 51) is not available, and the use of modifier 59 best explains the circumstances. 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.

According to CPT, documentation **must** support a different session, a different procedure or surgery, different site or organ system, a separate incision/excision, 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.

If you have questions regarding this bulletin, please contact your Provider Representative at (561) 659-1002.

Please insert this bulletin into your Provider Handbook. The policies and procedures in this bulletin supersede any related policies and procedures within the handbook.