Editor’s note: The following questions were submitted to HCPro after the June 23 audio conference, “Modifier -59: Manage Pre- and Post-Payment Audits to Reduce Denials.” For more information or to order the audio conference on demand, please visit www.hcmarketplace.com/prod-7725.html.

The lab receives a bronchial washing and a bronchial brushing. It uses a thin-layer preparation technique to perform the bronchial washing and make a direct smear of the brushing. Because the preparations being evaluated are from two distinct specimens, the lab would report the directly prepared smear and the cellular enhancement preparation as separate services: 88112 and 88104-59.

The narratives for these codes state “If multiple services (i.e., separate specimens from different anatomic sites) are reported, modifier -59 should be used to indicate that different levels of service were provided for different specimens from different anatomic sites.” The example does not state that these were from different sites, so I do not understand how a -59 modifier could be used on the 88104 when we are to bill “to the highest level of specificity.” Can you please clarify?

You might be reading too much into the definition. It’s true the anatomic site is the same, but they are distinct specimens (washing instead of brushing). In this case, you can’t use modifier -91 (repeat procedure) because it’s not the same procedure being performed a second time. Since different tests and specimens were run, -59 is appropriate.

I’m the laboratory manager and need some guidance. Medicare is denying a claim which I am told is due to “charge bumping” on a patient of ours who had a BUN (84520), creatinine (82565), potassium (84132), and a liver profile (80076) ordered by a physician. Could you please explain the conflict? I think this possibly has to do with unbundling charges, yet I’m not sure.

You will need to check your charges to see whether the codes you list above code out higher than 80053 (comprehensive metabolic panel) would. You don’t have all the tests for 80053, but it’s so close, and if the separate charges/payments exceed 80053, I think that’s why the payer is denying the claim.

A patient had two coronary stents inserted in the morning—one in the RC vessel and the other in the LD vessel. Later that day, the patient returns to the cath lab and has the LD stent angioplastied. I was going to use -76 on the angioplasty, but there is not an angioplasty on the claim due to the hierarchy rules. Is modifier -59 more appropriate?

Modifier -59 would be appropriate. Do not use modifier -76 because you are not repeating a procedure.

We performed an IVC filter placement and the legs of the filter did not deploy, requiring filter retrieval and placement of a different filter from a competitive vendor. Should we apply a -59 modifier to the filter retrieval? Is it appropriate to charge for the filter retrieval since the device malfunctioned?

For the IVC, you should only code the successful procedure and should not code failed procedures.
Code 90804 (individual psychotherapy, insight oriented, behavior modifying, and/or supportive, in an office or outpatient facility, 20–30 minutes face to face with the patient) is mutually exclusive to code 90853 (group psychotherapy). However, a modifier is allowed to differentiate between the services provided. Which modifier should we assign?

These two edit against one another because you cannot bill individual psychotherapy and group psychotherapy for the same encounter. Make sure the group therapy for a different therapy session than those you are billing for individual psychotherapy when using modifier -59. Also, frequency and medical necessity might limit you here as well.

Can you please explain the difference between these two examples?

Example 1: Three wound cultures are initiated from three anatomical sites on the same day. In this case, CPT code 87070 (culture, bacterial; any other source except urine, blood, or stool, with isolation and presumptive ID of isolates) is reported three times:

- 87070
- 87070-59
- 87070-59

Example 2: An ED patient has a troponin run in the morning and after treatment has a second troponin; the second would be billed with a modifier -91.

In example 1, separate wound cultures were drawn at different anatomic sites, so this is not a repeated exam. Instead, you are culturing to see what each wound’s diagnosis would be.

In example 2, the troponin is repeated to determine whether the patient’s cardiac status has changed since the earlier test.

Think about modifier -91 this way: If a general test (e.g., blood or urine) is performed, time elapses, and a second test is performed to determine whether the patient’s condition changed, that’s when you would use modifier -91.

Editor’s note: Susan E. Garrison, CHCA, PCS, FCS, CPC, CPC-H, CCS-P, CHC, CPAR, executive vice president of healthcare consulting services at Magnus Confidential in Atlanta, answered the questions above. Garrison has more than 25 years of experience in healthcare management, including the areas of documentation, coding, billing, and reimbursement for outpatient hospital and physician services.

We are a laboratory performing histology 88305 (level IV—surgical pathology, gross and microscopic examination). Can we bill using modifier -59? Also, what modifier should we use for code 88112 (cytopathology, selective cellular enhancement technique with interpretation [e.g., liquid-based slide preparation method], except cervical or vaginal)?

If you are performing a level IV surgical pathology (88305) on more than one specimen from the same patient, the unit of service for this code is the number of specimens requiring individual exam and pathologic diagnosis. Use modifier -59 to indicate tests that were provided for different specimens.

If a single specimen is tested, you should only report the code that describes the highest level of specificity within a group of related codes if the tests are performed on a specimen with the same end result. For example, within the code range of 88104–88112, you should only report one code. If multiple tests are performed on multiple specimens, you should use modifier -59.
Editor's note: **Peggy S. Blue, MPH, CPC, CCS-P**, instructor for Medicare Boot Camp®–Physician Services Version and Certified Coder Boot Camp® at HCPro, Inc., in Marblehead, MA, answered the question above. Blue has more than 20 years of experience in the health insurance industry. Prior to joining HCPro, she oversaw the development, implementation, dissemination, and reporting of information related to Medicare professional services training efforts at Highmark Medicare Services in Pennsylvania.