



USING MODIFIER 59 OR MODIFIER 76

Wisconsin Physicians Service (WPS) Medicare has a large number of claims denying for incorrect Modifier 59 usage. WPS Medicare researched these denied claims and found that Modifier 76 would be the appropriate modifier to use for several of the denials.

In an effort to help providers determine appropriate modifier usages, WPS Medicare has developed a series of Modifier Fact Sheets. The fact sheets are located at http://www.wpsmedicare.com/mac/education/b_modifiers.shtml on the Jurisdiction 5 (J5) Website.

Modifier 59

Modifier 59 is defined as “Distinct Procedural Service identifies procedures/services not normally reported together, but appropriately billable under the circumstances.”

Appropriate Usage:

- Documentation indicates two separate procedures performed on the same day by the same physician
- Represented by a different session or patient encounter, different procedure or surgery, different site, or separate injury (or area of injury)
- Use Modifier 59 with the secondary, additional, or lesser procedure of combinations listed in Correct Coding Initiative (CCI) edits
- Use Modifier 59 when there is **NO** other appropriate modifier

Inappropriate Usage:

- Code combination not appearing in the CCI edits
- Submission of Evaluation & Management (E/M) Codes
- Submission of weekly radiation therapy management codes (CPT 77427)
- Medicare Physician Fee Schedule Database (MPFSDB) lists the procedure code with a modifier indicator of “0”
- Documentation does not support the separate and distinct status
- The exact same procedure code was performed twice on the same day
- If a valid modifier exists to identify the services

Additional Information:

- CCI listings can be found at the following Website address:
<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>
- Medicare considers two physicians in the same group with the same specialty performing services on the same day as the same physician.

Modifier 76

Modifier 76 represents a repeat procedure by the same physician and indicates when it is necessary to report a procedure repeated subsequent to the original procedure.

Appropriate Usage:

- On a procedure code that cannot be quantity billed



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- When reporting each service on a separate line, using a quantity of one and appending 76 to the subsequent procedures
- When the **same** physician performs the services

Inappropriate Usage:

- Appending to a surgical procedure code
- Appending to each line of service
- Repeat services due to equipment or other technical failure
- For services repeated for quality control purposes

Additional Information:

- Medicare considers two physicians in the same group with the same specialty performing services on the same day the same physician
- For all procedure codes that cannot be quantity billed, always use a quantity of "1"
- To avoid denials please bill all services performed on one day on the same claim
- For repeat clinical diagnostic laboratory test, use modifier 91 if the service cannot be quantity billed.