
Ask the Contractor Teleconference (ACT) – MINUTES
“Use of the Modifier 59”
December 18, 2007

Wisconsin Physician’s Service – Medicare
Chairperson: Aileen Sigler

The Central Region ACT, “Use of the Modifier 59” teleconference was called to order by Aileen Sigler, Medicare Outreach Analyst – Omaha Office, at 1:00 PM Central Time.

Aileen began the teleconference by introducing herself. She was joined by other Outreach Analysts and members of the Provider Education staff. The introductions were followed by a brief description of the information available on the WPS Medicare website. Participants were encouraged to sign up for the WPS and CMS electronic mailing lists.

The introductory discussion was followed by a review of the presentation and handouts that had been e-mailed to the registered teleconference participants prior to the call.

At the conclusion of the presentation, the line was opened up for questions from the audience.

OPEN QUESTION AND ANSWER SESSION

Q1. Who should place the 59 modifier on the claim, medical records staff or coders?

A1. The information that the modifier is appropriate will come from the physician. The person responsible for taking that information and putting it on the claim form in your facility would be the correct person.

Q2. If a patient comes in through the emergency department for lab, x-rays and infusions, does the modifier 59 go on every claim? Our clearinghouse states they must have a modifier or the claim will reject.

A2. It is never advisable to regularly use a blanket code on every claim as a standard of practice. You can not add a code simply to bypass edits, it must be appropriate for the services provided on that claim and documented in the medical record.

TELECONFERENCE DETAILS

The teleconference ended at approximately 1:31 PM Central Time.

The references included in this presentation are for informational purposes only. The current Medicare regulations will prevail.

There were 138 participants on 52 lines for the teleconference.