Updates - Coding with Modifiers, Fifth Edition

Since the October 2013 publication of Coding with Modifiers, Fifth Edition, the Center for Medicare and Medicaid Services (CMS), the National Correct Coding Initiative (NCCI), and Medicare contractors have made changes to the guidelines for modifier 76 and modifier 59.

Modifier 76
The changes exclude modifier 76 when reporting a surgical procedure, reporting equipment failure, and appended to each line of service.

The examples in Coding with Modifiers, Fifth Edition do not indicate any particular insurance carrier, and examples are based on CPT® guidelines for modifier usage.

Modifier 59
Language changes regarding modifier 59, highlighted in red, were made in the National Correct Coding Initiative Policy Manual, Chapter 1:

1. If a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical or non-surgical therapeutic procedure is made, the two procedures may be reported with modifier 59 appended to the column two HCPCS/CPT code under appropriate circumstances. However, if the diagnostic procedure is an inherent component of the surgical or non-surgical therapeutic procedure, it cannot be reported separately.

2. If a diagnostic procedure follows a surgical procedure or non-surgical therapeutic procedure at the same patient encounter and the post-procedure diagnostic procedure is not an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, the two procedures may be reported with modifier 59 if appropriate.

3. If the same procedure is performed at different anatomic sites, it does not necessarily imply that a HCPCS/CPT code may be reported with more than one unit of service (UOS) for the procedure. Determining whether additional UOS may be reported depends upon the HCPCS/CPT code descriptor and the code’s UOS.