July 29, 2021

Provider Memorandum

Details Matter: Billing Guidance for Modifiers 25/59

Molina Healthcare of Illinois (Molina) aligns with the Centers for Medicare & Medicaid Services (CMS) on National Correct Coding Initiative (NCCI) guidance for the use of modifiers 25 and 59. When properly used, these modifiers indicate that the services provided are separate and distinct during this episode of care, and **may** qualify for separate reimbursement.

Modifiers

Appropriate modifiers must be billed in order to reflect services provided and for claims to pay correctly. Molina may request documentation such as medical records, operative reports, or office notes to verify services provided.

Modifier 59 is an important NCCI-associated modifier that is often used incorrectly. Sometimes modifier 59 (which is rather wide-ranging) overrides NCCI rules, and sometimes it does not.

Modifier 59, **Distinct Procedural Services**—must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was **not** part of the comprehensive service. Medical records **must** reflect appropriate use of the modifier.

Modifier 59 **cannot** be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

Read the NCCI Modifier 59 Article online at the CMS website.

The AMA's Current Procedural Terminology (CPT) specifies that modifier 59 is used to identify procedures/services, other than Evaluation and Management (E/M) services, that are not normally reported together but are appropriate under the circumstances. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

Documentation **must** support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used **instead of** modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should

modifier 59 be used. **Note**: Modifier 59 should **not** be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

Modifier 25, **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**—must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was **not** part of the comprehensive service. Medical records **must** reflect appropriate use of the modifier.

Modifier 25 is used with Evaluation and Management (E/M) codes and **cannot** be billed with surgical codes.

Read the NCCI Modifier 25 explanation online at the CMS website.

The AMA's Current Procedural Terminology (CPT) specifies that modifier 25 indicates that a significant, separately identifiable Evaluation and Management (E/M) service was provided by the same physician or other qualified health care professional on the same day of the procedure or other service.

Modifier 25 may be added to an E/M CPT code to indicate that the E/M service is significant and separately identifiable from other services reported on the same date of service. The E/M service may be related to the same or different diagnosis as the other procedure(s).

What Causes Bundling?

NCCI edits are designed to promote correct coding and prevent improper payments by bundling component codes into a more inclusive code. Component services that are billed separately from the more inclusive code will be denied, unless an exception applies. For example, closure of a surgical opening is part of the surgery. But if the closure is a complex procedure that involves an extensive amount of time and skill, then you may be able to unbundle those services. Unbundling means that two or more codes that are normally incidental to another can be billed separately.

Final Determination

You should include modifier 25 or 59 on the claim if you think the services should be unbundled. Molina makes the final determination, but you can take the next step if you don't agree.

If you have submitted a claim with unbundled services that was denied, and you believe that the services should **not** be bundled, your first step should be to file a claim dispute.

File the dispute via Molina's Availity Provider Portal or fax to (855) 502-4962. **Always** include supporting documentation. A Claims Dispute Request form is **required** when submitting a claim dispute via fax. Find this form on the Frequently Used Forms page of the website, under the Contracting & Provider Forms header.

Questions?

We're here to help. Contact your Provider Network Manager or email the Provider Network Management team at MHILProviderNetworkManagement@MolinaHealthcare.com. For help identifying your Provider Network Manager, visit Molina's Service Area page at MolinaHealthcare.com.

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