Dermatology Coding Alert

Adopt Simple Strategies to Protect Modifier 59 Payments

Don't be one of the 40 percent who use the modifier improperly

Get ready: Carriers will increasingly scrutinize your separate-and-distinct service submissions. But you can prevent paybacks if your documentation supports the dermatologist's services.

In a recent study, the Office of Inspector General (OIG) cast a spotlight on your use of modifier 59 (Distinct procedural service), and the results weren't pretty. The OIG found a 40 percent error rate for modifier 59 in its sample of claims and a 35 percent error rate for modifier 25.

Result: The OIG is encouraging CMS' Part B carriers and Recovery Audit Contractors to scrutinize your claims that use that modifier--and you can expect to see a lot more pre- and post-payment audits. To protect your claims, use these strategies.

Confirm Separate Region Before Using 59

Pull a sample of your modifier 59 submissions and verify that those claims properly represent a distinct procedural service. Fifteen percent of OIG's audited claims using modifier 59 had procedures that weren't distinct because "they were performed at the same session, same anatomical site, and/or through the same incision," says **Daniel R. Levinson**, inspector general, in "Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits."

Make sure the physician is working in a separate body area before you use modifier 59, says **Margie Scalley Vaught, CPC, CPC-H, PCE, CCS-P, MCS-P,** a coding consultant in Ellensburg, Wash. Or if your dermatologist is performing lesion biopsy and destruction, confirm that he's treating multiple lesions and not just multiple procedures on the same lesion.

You should also make sure you use separate ICD-9 codes for the diagnoses behind the separate procedures, she says.

Here's how: Suppose you pull a claim that contains modifier 59 on 17000 (Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], all benign or premalignant lesions [e.g., actinic keratoses] other than skin tags or cutaneous vascular proliferative lesions; first lesion) and 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion).

The National Correct Coding Initiative (NCCI) edits show 17000 as the column 1 or comprehensive code and 11100 as the column 2 or component code. This bundle makes the biopsy (11100) a component of the destruction (17000), unless "the procedures are performed on separate lesions or at separate patient encounters," according to the CMS in "Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service."

Documentation included in the notes shows that the dermatologist biopsied and destroyed different lesions, so your claim meets the first test. Your next step is to check to be sure you:

• appended modifier 59 to 11100 (the component or column 2 code), not to 17000 (the comprehensive or column 1 code)

• linked the procedures to appropriate diagnoses, such as 17000 to 702.0 (Actinic keratosis) and 11100 to 195.8 (Malignant neoplasm of other and ill-defined sites; other specified sites).

Put 59 on the Secondary Code

The checklist in the above lesion example includes attaching modifier 59 to the secondary code. NCCI publishes a "list of mutually exclusive codes that contains edits consisting of two codes (procedures) that cannot reasonably be performed together based on the code definitions or anatomic considerations," says **Laurie Green, CPC,** coding and compliance analyst at Group Health Cooperative in Seattle. "Each edit consists of a column 1 and column 2 code."

How bundles work: If a physician reports the two codes of an edit for the same beneficiary for the same date of service without an appropriate modifier, the carrier pays only the column 1 code, Green says. The carrier may allow payment for both codes if clinical circumstances justify appending a modifier to the column 2 code of a code pair edit.

Although attaching the modifier to the column 2 code may seem elementary, the OIG found numerous application errors. The study found that 11 percent of claims had modifier 59 attached to the primary code instead of the secondary code, and another 13 percent had modifier 59 attached to both primary and secondary codes.

Note: To read the OIG's modifier report, visit http://oig.hhs.gov/w-new.html. You can test your modifier 59 skills with examples from the CMS "Modifier 59 Article" available online at www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf.