Codify
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Internal Medicine Coding Alert

Green Light 59 Appendage When Claim Meets 2 Criteria

These examples teach you to properly code this often-misused modifier

There's no better time than now to use caution when reporting modifier 59--the Office of Inspector General just upped the stakes for incorrect reporting.

In a recent study, the OIG found a 40 percent error rate in its sample of claims involving modifier 59 (Distinct procedural service). "Some coders may incorrectly overuse modifier 59 in an effort to get claims paid," says **John L. Inase BA, RHIT, CPC, CTR**, health information specialist and coding auditor at the Naval Medical Center in San Diego.

But the fact remains that you should only assign the modifier "when circumstances, the medical record and documentation justify its use," Inase says. Expect carriers to request that supporting information both pre- and postpayment. CMS' Part B carriers and Recovery Audit Contractors will step up their audits of modifier 59 submissions, based on the OIG's call for action.

Strategy: Use the following two scenarios to make sure your modifier 59 claims pass the litmus test.

Verify That Notes Support Separate Session/Site

You can confidently submit modifier 59 claims when your documentation supports a distinct procedural service. For the OIG's audited claims using modifier 59, 15 percent had procedures that 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."

Best bet: 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 internist is performing lesion biopsy and destruction, confirm that he's treating multiple lesions and not just multiple procedures on the same lesion. And when appropriate, you should make sure you use separate ICD-9 codes for the diagnoses behind the separate procedures, she says.

Example 1: Documentation shows that an internist destroys a common wart on a patient's hand and biopsies a lesion on the patient's back. Should you report both procedures?

Usually, lesion destruction includes biopsy. The National Correct Coding Initiative edits show 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) as the column 1 or comprehensive code and 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) as the column 2 or component code.

Exception: You should report both the biopsy (11100) and the destruction (17000) if "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." The documentation in example 1 shows that the internist biopsied and destroyed different lesions, so the claim meets the modifier 59 test for a separate session/site.

Therefore, you should report both the biopsy and the destruction. Append modifier 59 to the component code, 11100. Link the procedures to the appropriate ICD-9 codes, such as 17000 to 702.0 (Actinic keratosis) and 11100-59 to the pathology report's biopsy diagnosis. If the lesion turns out to be malignant, use 173.5 (Malignant neoplasm of skin;

trunk). Or if the report concludes that the lesion is benign, assign 216.5 (Benign neoplasm of skin; trunk).

Attach Modifier to Component Code

When you are appending modifier 59 to break an NCCI edit, you'll pass carrier audits with flying colors as long as you always append the modifier to the secondary code, as demonstrated in the previous example. 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."

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.

Example 2: An internist codes a chart as 11719 (Trimming of nondystrophic nails, any number) and 11720 (Debridement of nail[s] by any method[s]; one to five). Documentation shows that the physician trimmed and debrided different nails--trimming of the left-foot fifth-digit nail (T4) and debriding of the right-foot great toenail (T5). To which code should you append modifier 59?

You should append modifier 59 to the component code, which in the above case is the debridement code, 11720. So the claim should look like this:

• 11719-T4
• 11720-59-T5.

Problem: 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.

In fact, your modifier 59 payment was almost restricted to adhering to the "59 on second code" guideline. The OIG encouraged carriers to pay claims only when modifier 59 is attached to the secondary code, not the primary, but CMS responded that it lacks the technical ability to put in place such an edit.

Note: To read the OIG's modifier 59 report, visit http://oig.hhs.gov/w-new.html and scroll down to "Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits." You can further test your modifier 59 skills with examples from the CMS "Modifier 59 Article" available from www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf.