Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Polish Your Modifier 59 Knowledge and Master CCI Edits in 5 Steps

The OIG is telling your carriers to crack down on incorrect unbundling

The National Correct Coding Initiative (NCCI) has been at it again with updated edits for this quarter. CCI Vol. 12.0 introduces a startling 59,080 new column 1/column 2 edits and 465 new mutually exclusive edits--and many of these code bundles could warrant a modifier 59 to optimize reimbursement.

But watch out--in a recent sampling, the **U.S. Office of Inspector General** (OIG) found over $59 million in overpayments to providers due to the misuse of modifier 59 (Distinct procedural service). This leaves your carrier no choice but to scrutinize your practice's CCI savvy and modifier 59 usages like never before.

How it works: There are two types of **CCI edits** : "column 1/column 2" and "mutually exclusive." A column 1/column 2 CCI edit is where one code (in column 1) comprehensively includes another code (in column 2), so you can't bill both under normal circumstances.

Example: An orthopedic surgeon wants to perform spinal decompression in addition to an anthrodesis. However, NCCI considers code 63047 (Laminectomy, facetectomy and foraminotomy [unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s)]...) a component of 22630 (Anthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace [other than for decompression], single interspace; lumbar), notes **Denise Paige, CPC**, coding and billing manager for **Beach Orthopedic Associates** and president of the **AAPC Long Beach Chapter** in Long Beach, CA. In this case you can actually see that both codes' descriptors include "laminectomy."

Mutually exclusive CCI edits are procedures that wouldn't normally be billed on the same day. For example, 50547 (Laparoscopy, surgical; donor nephrectomy [including cold preservation], from living donor) and 50546 (Laparoscopy surgical; nephrectomy, including partial ureterectomy) would not normally happen to the same patient on the same day.

The good news: In the right cases, you may be able to override these bundles with the proper application of a modifier. Here's how:

1. Use 59 only when the services are separate and distinct.

Modifier 59 isn't just a ticket to increase your reimbursement. Use it to "...identify procedures/services that are not normally reported together but are appropriate under the circumstances," states the **Centers for Medicare & Medicaid Services** (CMS) in an article on its Web site.

These situations may include a different session or different patient encounter, a different procedure or surgery, a different site or organ system, or a separate incision/excision, not ordinarily encountered or performed on the same day by the same physician.

To read the full CMS article, visit www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf.

2. Know when NOT to use 59.

This modifier does not automatically unbundle all CCI edits. The edits have a column that notes with a "1" or "0" whether a modifier is "allowed" or "not allowed." You're in the clear to unbundle the separate and distinct procedures if the edits list a "1"--but you're out of luck if you try to do this when you see a "0."

Next step: Don't put in modifier 59 on autopilot when you see a "1." The edits still don't specify which modifier to use, or if a modifier even qualifies for your situation, Paige says.

You may also have to use an anatomical modifier such as RT (Right) or LT (Left), Paige says. This might be appropriate if a patient had a total ethmoidectomy on the right side, but a partial ethemoidectomy on the left side. You would report 31255 (Nasal/sinus endoscopy, surgical; with ethmoidectomy, total [anterior and posterior]) with RT and 31254 (...with ethmoidectomy, partial [anterior]) with LT.

Careful: RT and LT don't always pay, so check with your payer to see which modifiers they prefer for certain CCI edits. You may have to resort to reporting 31255, 31254-59 instead, with the reasoning of two separate sites.

3. Append 59 to the correct code in the bundle.

If you think it doesn't matter to which code you apply the modifier, think again. The OIG has instructed CMS to "...ensure that the carriers' claims processing systems only pay claims with modifier 59 when the modifier is billed to the correct code."

Do this: You should always put the modifier on the column 2 code, advises **Rick Gawenda, PT**, director of physical medicine and rehabilitation at **Detroit Receiving Hospital** in Detroit, MI. "If you put it on the column 1 code, you'll only get paid for the column 1 code."

Example: A physician excises 1.5 cm benign lesion on the patient's leg and repairs an unrelated 8 cm laceration on his arm in the same visit. But the laceration repair, 12004 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 7.6 cm to 12.5 cm), and the neoplasm excision, 11402 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs; excised diameter 1.1-2.0 cm), are bundled, and you must separate them with 59. In this case, the column 2 code is 12004, so you would add the modifier to that code.

You may also use your ICD-9 codes to further support the separate sites. In the example above you would code 216.7 and 880.03 with the procedures.

4. Include time in the documentation to argue your case.

Fortunately, to justify a modifier 59, good documentation doesn't mean a novel's worth of extra notes. Along with the usual documentation, the physician should record the time of day he or she did the procedure and use words like "after" or "followed by," Gawenda suggests. Or mention the separate sites if it applies.

The documentation could also benefit from having the physician record diagnoses, Paige recommends. Diagnoses help indicate the medical necessity of the procedure(s) and justify a modifier.

Tip: If you code for a multi-specialty practice, check for patients who've had multiple treatments the same day--because the procedures could be bundled.

5. Audit your practice's 59 usage--before your carrier audits you.

You may think your claims are a-okay if you're following NCCI and Medicare guidelines, but it never hurts to see your stats. Without a self-audit, you may not realize that your facility's modifier 59 usage is above average. And these high numbers will wave a red flag at your carrier--especially after the latest OIG report.

Best bet: Keep track of how often your practice unbundles codes with modifier 59, and review the stats every quarter. If you find that you're appending 59 a bit loosely, meet with your colleagues and discuss possible reasons for the high usage. Remember, some practices may report 59 more often than others, such as those that perform many bilateral procedures.

Final word: Don't get confused with the different versions of CCI edits. The NCCI usually comes out with new edits every

quarter, but remember that private practices are always one CCI version ahead of all other settings, Gawenda reminds. This means that hospital settings will use CCI version 11.3 until the first of April before adhering to CCI 12.0. Private practices should have been using CCI 12.0 since Jan.1.