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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Protect Modifier 59 Payments Using These Strategies

Find out 2 ways the OIG says coders are making big mistakes

Now is not the time to be lax in how you report modifier 59. Carriers are still scrutinizing your separate and distinct service submissions. But you can prevent paybacks by avoiding the following pitfalls that will land your claims in the **Office of Inspector General** (OIG) error rates.

Note: In a November 2005 study, the **HHS Office of Inspector General** cast a spotlight on the 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 claims sample.

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 the 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,- an article posted on the OIG Web site www.oig.hhs.gov/oei/reports/oei-03-02-00771.pdf.

Example: If your cardiologist catheterizes the left and right common carotid arteries, you will report 36216 (Selective catheter placement, arterial system; initial second-order thoracic or brachiocephalic branch, within a vascular family) for the right common carotid (RCC) and 36215 (Selective catheter placement, arterial system; each first-order thoracic or brachiocephalic branch, within a vascular family) for the left common carotid (LCC). If you don't put modifier 59 on 36215, your payers will assume that both codes apply to the same vascular family.

Keep in mind: In cardiology, you-ll find several situations in which you-ll need modifier 59 to facilitate proper reimbursement that -seem to be in direct conflict with several generic modifier 59 rules-of-thumb,- says **Jim Collins, CPC, ACS-CA, CHCC**, founder of **The Cardiology Coalition** in Matthews, N.C.

For instance, the National Correct Coding Initiative (NCCI) bundles -several diagnostic radiological supervision and interpretation codes into codes for interventional procedures. Cardiologists frequently perform these interventional procedures during the same operative session as the diagnostic study, through the same access site, and the same vessel.- You can also apply this concept to both peripheral vascular and coronary procedures.

Put 59 on the Secondary Code

Go back and re-read the cath example above. See how you needed to attach modifier 59 to the secondary code (36215)? NCCI publishes a list of comprehensive/component -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 NCCI 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.

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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.

Close call: Your modifier 59 payment was almost restricted to adhering to the -59 on the 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. Such an edit would have rejected payment for the following stent claim:

A cardiologist codes a chart as 37215 (Transcatheter placement of intravascular stent[s], cervical carotid artery, percutaneous; with distal embolic protection), 37184 (Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection[s]; initial vessel), and 36216 (Selective catheter placement, arterial system; initial second-order thoracic or brachiocephalic branch, within a vascular family). Your cardiologist's documentation shows that he performed the thrombectomy in a different vessel from the stent. You submit the procedure as:

- 37215-59
- 37184
- 36216.

The error? First, the claim incorrectly appends modifier 59 to the comprehensive or column-1 code (37215) instead of the component or column-2 code (37184).

You should also append modifier 59 to the catheter placement code (36216). -The reason is that the cardiologist performed the thrombectomy in a different vessel,- Collins says. -Adding modifier 59 to this code will bypass NCCI edits that bundle 37215 into 36216.-

Action: -If you notice that you have put modifier 59 on the wrong code(s), resubmit the claim,- says **Barbara J. Cobuzzi, MBA**, **CPC, CPC-H, CHBME,** president of **CRN Healthcare Solutions**, a coding and reimbursement consulting firm in Tinton Falls, N.J. In the event of an audit, payers should look positively on your proactive stance, she adds.

Your corrected claim should look like this:

- 37215
- 37184-59
- 36216-59.

Bonus: 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.

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