Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Procedures Are Bundled? In Some Cases You Can Still Bill Them Together

Interpret CCI properly to know when you can report both.

When your physician performs two medically necessary procedures during the same session but the Correct Coding Initiative (CCI) bundles the procedures together, you might be inclined to simply write off the bundled portion. However, in some cases, the bundled procedure can be separately billable--if you know when you're allowed to separate CCI edits. A firm knowledge of what constitutes a \"separately identifiable procedure,\" along with the specifics of modifier 59, are essential for your coding.

The problem: Modifier 59 (Distinct procedural service) is one of the most misunderstood modifiers.

Avoid problems -- and get your claims paid -- by following these proven tips.

Tip 1: Know When to Use A Modifier, Such As 59

The Office of Inspector General (OIG) and many payers, including Medicare, continually review physicians' modifier 59 use. In fact, according to a 2005 review by the OIG and an independent contractor, 40 percent of code pairs studied did not meet program requirements for proper modifier 59 use. In addition, the study found that physicians did not adequately document in 25 percent of the billed code pair cases.

There are circumstances when you can -- and should -- use modifier 59, however. For instance, you may use modifier 59 to identify procedures that are distinctly separate from another procedure provided by your neurologist on the same day. In addition, you may append 59 to your claim when your physician:

- sees a patient during a different session
- treats a different site or organ system
- makes a separate incision/excision
- tends to a different lesion
- treats a separate injury.

Example: Your physician performs a maxillary nerve injection (64400) and trigger point injection on two muscles (20552). He addresses the maxillary nerve, also known as V1 of the trigeminal nerve, for trigeminal neuralgia (350.1) and injects trigger points in the left multifidus muscle at L5 (vertebral level) and left latissimus dorsi muscle at L1, both for myofascial pain (729.1). The CCI bundles 20552 (column 2 code) into the 64400 (column 1 code).

Since your doctor performed the injections in different anatomic locations, you are clear to bypass the bundling edit by appending modifier 59 to 20552.

You should also make sure that the ICD-9 diagnosis codes are correctly linked to the corresponding CPT® codes.

Important: You should never use modifier 59 for E/M services. If you're reporting a separately identifiable E/M service with another procedure on the same day, you'll turn to modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

Tip 2: CCI Limits the Codes You Can Report Separately

If you are unsure whether two procedures are subject to bundling edits, check the CCI edits. The CCI edits list two codes

as \"mutually exclusive\" of one another or pair them together (\"bundle\" them). If you see reference to \"column 1\" and \"column 2\" codes, CCI bundles the procedures and normally you would not report them together.

Unbundling is not automatic: Be aware that you can't automatically override a CCI edit with modifier 59 just because documentation supports a separate site, incision, or patient meeting.

Here's why: Before appending modifier 59, check the modifier indicator for the bundled code pair. You'll find the modifier indicator in Column F of the CCI Excel spreadsheet, which you can download from www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp. A modifier indicator of \"0\" means that you cannot unbundle the edit combination under any circumstances.

Alternately, a \"1\" indicator opens the possibility for you to override an edit using a modifier if you can verify that the procedures are distinct from one another. **Example:** Your doctor performs a motor nerve conduction with F-wave study and a motor nerve conduction without F-wave study on a different nerve or nerve branch during the same session. Because the physician performed the studies on different nerves, you can separately report both of the diagnostic studies. Report the first nerve conduction study with 95903 (Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study) and 95900 (...without F-wave study) for the second. Append modifier 59 to 95900.

This tells the payer you're legitimately overriding the CCI edit because your neurologist performed a separate procedure, and you should be paid for both.

How it works: Attach modifier 59 to the procedure code in column 2 (95900 in this example). If you break a CCI edit or bill for a separate procedure as outlined by the CPT®, append 59 to the \"separate procedure\" code found in column 2.

Pitfall: For mutually exclusive code pairs, don't assume that the higher-paying code is the one to which you should attach modifier 59. Check the CCI edits to see which code is listed in column 2.

Tip 3: Always Prove Necessity With Documentation

When you're trying to decide whether you should append modifier 59, use a logical approach. Ask: Did the second procedure require a separate approach or site?

Important: Never use modifier 59 just to get paid for a procedure. Make sure there is documentation supporting a separate and distinct procedure before adding modifier 59.

In addition, CPT® instructions dictate that if a more specific modifier describes the situation, you should not use modifier 59. Because the modifier has the potential to bypass CCI edits, coders use this modifier too often.

Modifier 59 should be the modifier of last resort and only used when the procedure was clearly distinct and different from that of the other procedure. There are also other modifiers that could be considered before using the 59 (58, 78, 79, etc.).

For tips on how to differentiate modifier 59 from other potentially applicable modifiers, see our chart on page 204.