Eli's Rehab Report

OIG Spotlight: Make Sure You Can Withstand Modifier 59 Scrutiny

Double-check NCCI edits before you append 59--here's what to look for

The Office of Inspector General (OIG) has homed in on modifier 59 use, and the results aren't pretty.

If you want to stay off the audit radar screen, documentation for your physiatry modifier 59 claims will be key.

Bad news: The OIG found a 40 percent error rate for modifier 59 (Distinct procedural service) in its sample of claims, so you can expect a lot more prepayment and postpayment audits.

Of the claims with modifier 59 that the OIG audited, 15 percent didn't represent a distinct service because "they were performed at the same session, same anatomical site, and/or through the same incision," the OIG says. Another 25 percent of modifier 59 claims lacked enough documentation to support one or both of the services.

Good news: You can tighten up your modifier 59 know-how with the following best practices from our experts.

Use 59 as a Last Resort

Increase your modifier 59 accuracy rate by using it only when absolutely necessary. If you overuse this modifier, you may indicate routine unbundling of services to insurers, and they can initiate a review based on this suspicion, coding experts say. Your documentation must clearly identify the medical necessity and separate nature of the unbundled service.

CPT guidelines indicate "that the 59 modifier is only used if no more descriptive modifier is available and [its use] best explains the circumstances," according to the July 1999 CPT Assistant.

In other words, 59 "is the modifier of last resort," says **Marcella Bucknam, CPC, CCS-P, CPC-H, HIM** program coordinator at Clarkson College in Omaha, Neb.

Coding example: Your therapist performs active wound care (97597-97598) and also re-examines a patient for a problem unrelated to the wound, such as for a fall.

You can report the re-evaluation with 97002 (Physical therapy re-evaluation), and the wound care with the appropriate code.

You would need to append modifier 59 to 97002 because the National Correct Coding Initiative bundles 97002 into 97597 (Removal of devitalized tissue from wound[s], selective debridement, without anesthesia [e.g., high-pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps], with or without topical application[s], wound assessment, and instruction[s] for ongoing care, may include use of a whirlpool, per session; total wound[s] surface area less than or equal to 20 square centimeters) and 97598 (... total wound[s] surface area greater than 20 square centimeters).

Watch Out for Specialty Snags

Remember that the need for modifier 59 is provider-specific, not discipline-specific. For example, suppose a patient has speech language pathology (SLP) treatment at your clinic and the provider bills one unit of 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual).

The patient then goes to PT, and the PT bills three units of 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility).

The CMS billing system does not recognize modifiers GN (Outpatient speech language service), GO (Outpatient occupational therapy service) and GP (Outpatient physical therapy service) for the purpose of bypassing the NCCI. If the coder does not append modifier 59 to 97110, the payer will deny those three units because therapeutic exercise is considered a component of speech treatment.

Keep in mind: This scenario is true if you're billing both services under the same provider identification number, such as an outpatient facility. If you're billing for individual providers under their own names and IDs, you should remember that NCCI does bundle these two codes together.

Get Your Documentation in Ship Shape

Be sure that the PT's documentation supports the need for a formal re-evaluation and the fact that the therapist performed the two services at separate and distinct times.

You should be able to separate the therapist's documentation into two stand-alone notes. Both the main procedure and the secondary procedure (which has 59 appended to it) documentation should include enough detailed information about the patient's condition and the therapist's services to stand on their own if you removed the other service from the notes.

"We use modifier 59 if--and only if--we perform two procedures that are typically bundled in the NCCI edits," says **Elisabeth Janeway**, CPC, president of Carolina Healthcare Consultants in Winston-Salem, N.C. "If the two codes appear to the insurance company that they are bundled, but should be paid because they are separately identifiable procedures, we would append the 59 modifier to the second code to correctly bypass the edit."

Some insurers have grown so suspicious of modifier 59 misuse that several of them, such as the North Dakota Medicaid program, handle all modifier 59 claims by hand.

For tips on modifier 59 documentation, see "Not Positive You've Got 59 Down Pat? Test Yourself" included with this issue.

You Can Append 59 More Than Once

In rare cases, PT coders say, they have to append modifier 59 more than once on the same claim form.

Example: The therapist spends 30 minutes training a stroke patient on cognitive skills to help improve her attention and memory. Immediately afterward, the therapist spends 15 minutes teaching the patient how to use her new wheelchair.

The patient takes an hour break and then meets with the therapist and two other patients for group therapy, during which they work on arm-strengthening exercises together. You should report the following codes:

• 97150--Therapeutic procedure(s), group (2 or more individuals)

• 97532-59 x 2 units--Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes

• 97542-59--Wheelchair management (e.g., assessment, fitting, training), each 15 minutes.

Because the NCCI bundles both 97532 and 97542 into 97150, you should append modifier 59 to both 97532 and 97542. Here, modifier 59 tells the payer that the procedures were not components of one another but were performed in separate time "sessions."

Codify
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