

Health Information Compliance Alert

Coding CMS HAS ITS EYE ON CCI SKIRTERS

If your coders use the 59 modifier as a cure-all for overriding the Correct Coding Initiative bundling rules, the Centers for Medicare & Medicaid Services could give you the big 86.

Coders can use the 59 modifier ("distinct procedural service") under certain circumstances to receive separate payment for services that normally would be bundled together, explains consultant Quin Buechner with ProActive Consultants in Cumberland, WI. The modifier "essentially overrides the automatic bundling of CCI," he says. However, you can't just tack that modifier on willynilly. There must be a solid reason why the normal rules shouldn't apply to the particular case at hand.

And in some cases, you can't bill separately no matter what. Coders should check CCI before they even think about using modifier 59, urges consultant Robyn Lee with Lee-Brooks Consulting in Chicago. Look up the "comprehensive code," or the base code, for the primary service in question. To the right of that, you'll find a list of the codes CCI bundles into the comprehensive code. If CCI marks a code in this list with a "0" superscript, you can't bill it separately from the comprehensive code under any circumstance, Lee instructs. A "1" superscript indicates that you might have a chance for separate reimbursement.

Show Proof of a Separate Service

"Under certain circumstances, the provider may need to indicate that a procedure or service was distinct or independent from the other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances," the CPT Manual explains.

The key words here are "distinct and independent" — it must be a "separately identifiable service," urges Lee. For example, say a cardiologist places a stent in a patient, and the patient then develops a heart block that necessitates pacing wires. Under normal circumstances, the physician wouldn't be able to bill separately for the pacing wires, since they're considered part of the "global procedure" of placing the stent, Lee notes. But in this case, the heart block mandates the pacing wires — and that heart block is a separate diagnosis from the reason for the stent. Since the diagnoses are separately identifiable, the physician can bill for the pacing wires using the 59 modifier, she explains.

But for this to fly, the medical record must show evidence of that separately identifiable procedure. In the case above, "the note would have to reflect the fact that the patient's heart rate went way down and they had to put in pacing wires," Lee says.

That's why this modifier can be used only in specific cases. If you use 59 every time you submit a pair of codes that normally shouldn't be billed separately, "that's going to hit the computers sooner or later," making it look as though you're trying to circumvent CCI on a regular basis, Buechner warns.

And when that happens, you'll have to answer some pretty tough questions from the feds. "Medicare gets really angry if you keep making this mistake," Lee adds.