



Unraveling the Mystery of Modifier -59

At last! Clarity on the new “X” modifier use. Not.

BY HARRY GOLDSMITH, DPM

Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

In 2012, the HHS Office of Inspector General (OIG) published a “Compendium of Unimplemented Recommendations” that included the following recommendations: 1) encourage Medicare’s payment contractors to conduct pre-payment and post-payment reviews of the use of service code modifier-59 and 2) ensure that the payment contractors’ claims processing systems pay claims with modifier -59 only when the modifier is billed with the correct service code. The report noted that the OIG estimated that \$27 million was improperly paid in fiscal year 2003 (that’s right, 2003) because modifier-59 was attached to the wrong service codes on claims, while an additional \$59 million was improperly paid because the use of the “-59” modifier was also found to not meet certain CCI requirements.

It should be noted that in 1996 Medicare altered modifier “-59” use to fit its editing program, the National Correct Coding Initiative (NCCI or just CCI), which had been developed by CMS to “promote correct coding by providers and to prevent Medicare payment for improperly coded services.” That adoption of the “-59” modifier for use under the CCI was a unilateral move away from more universal CPT definition and use requirements by commercial payers.

And that is where the initial confusion regarding the “-59” modifier began. If there is any confusion regarding the modifier, CMS started it.

As the OIG pointed out, Medicare does not automatically detect misuses of modifier “-59” before paying the claims. By definition provided by the OIG, *the modifier “-59” is to be used to indicate that the provider performed a distinct procedure or service for a beneficiary along with another procedure or service that generally would not be billed together on the same date of service.* Appropriately appended modifier “-59” allows payment for both procedure codes by permitting bypassing Correct Coding Initiative (CCI) edits. The 2003 fiscal year review noted that providers had an error rate of 40% or more when the “-59” modifier was audited.

In April of 2008, CMS published an *MLN Matters* article to educate physicians on how to bill modifier “-59” appropriately. Apparently, physicians were not educated enough, since in 2011, CMS began the process of exploring alternative solutions to ensure correct coding. CMS issued a transmittal (#1422) on August 15, 2014 entitled “Specific Modifiers for Distinct Procedural Services.” This was our introduction to Medicare’s unilateral development of 4 modifiers to eliminate any confusion surrounding the “-59” modifier. These 4 modifiers are defined as subsets of the “-59” modifier. In other words, CMS unbundled the “-59” modifier for us ironically at a time CMS complains of the “-59” modifier abuse in unbun-

dling procedures. Those new HCPCS modifiers—collectively referred to as -X {EPSU}—are:

XE Separate Encounter: A service that is distinct because it occurred during a separate encounter.

XS Separate Structure: A service that is distinct because it was performed on a separate organ/structure.

XP Separate Practitioner: A service that is distinct because it was performed by a different practitioner.

XU Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

NOTE: Coders are never to use a “-59” modifier and one of the X modifiers appended to the same procedure or service code.

NOTE: Coders have the option to continue using modifier “-59” in any instance in which it was correctly used prior to January 1, 2015.

If you actually compare it to the Modifier “-59” CPT definition:

Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier -59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or

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surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier -59. Only if no more descriptive modifier is available and the use of modifier -59 best explains the circumstances should modifier -59 be used.

You might not see a whole lot of difference because there isn't. The one problem in the "XS" modifier definition is the use of phrase "performed on a separate organ/structure" versus the "-59" modifier use of phrase "[performed on] a different site or organ system." The American Podiatric Medical Association asked if procedures involving two lesions on the skin would be limited to only being payable because both are within the same organ system—the skin. Also, if two distinct procedures for two distinct pathologies at two distinct areas (e.g., base and head) of the same metatarsal are performed, would only one procedure be payable? CMS promised clarification. As of mid-February 2015 (the time of this writing), there has been no clarification from CMS.

What we are getting are individual "clarifications" from some of the Medicare Administrative Contractors (MACs—i.e., Medicare carriers). Novitas Solutions (Medicare) suggested and posted on its website the following examples of -X{ESPU} to "clarify" their use versus "-59" modifier use:

Example 1

CPT 17000—Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), all benign or pre-malignant lesions (e.g., actinic keratosis) other than skin tags or cutaneous vascular proliferative lesions; first lesion

CPT 11100—Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Modifier -59 may be reported with

CPT 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier does not apply.

If the procedures are performed on different sides of the body, modifiers RT and LT, or another pair of anatomic modifiers should be used.

Modifier -59 is reported for different anatomic sites during the same encounter only when procedures, not ordinarily performed or encountered on the same day, are performed on different organs, different anatom-

LT) for CPT 47370 and hammertoe correction (CPT 28285-TA) for CPT 76942 in the above. These codes are unrelated to each other. Novitas Solutions' suggestion for "XU" modifier would be appropriate.

Example 3

Treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site.

CPT 11055—Paring or cutting of benign hyperkeratotic lesion (e.g.,

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ic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Novitas Solutions' suggestion: Beginning January 1, 2015, modifier XU may be more appropriate.

Example 2

CPT 47370—Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency

CPT 76942—Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Modifier -59 should not be reported with CPT 76942 if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure.

Modifier -59 may be reported with CPT 76942 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

Novitas Solutions' suggestion: Beginning January 1, 2015, modifier XU may be more appropriate.

NOTE: *Since most people don't walk on their livers, consider replacing hallux valgus repair (CPT 28296-*

corn or callus); single lesion

CPT 11720—Debridement of nail(s) by any method(s); one to five

Modifier -59 should not be reported with CPT 11720 if a nail is debrided on the same toe from which a hyperkeratotic lesion has been removed.

Modifier -59 may be reported with CPT 11720 if multiple nails are debrided and a corn that is on the same foot but that is not adjacent to a debrided toenail is pared.

Novitas Solutions' suggestion: Beginning January 1, 2015, modifier XS may be more appropriate.

Novitas goes on to say in an attempt to clarify: The definition of different anatomic sites includes: different organs, or different lesions in the same organ.

NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered separate and distinct. Therefore, modifier -59 should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit.

The treatment of *contiguous* structures in the same organ or anatomic region does not constitute treatment of different anatomic sites

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[emphasis added by author].

Novitas goes on to include within its lists of examples the following suggestions/comments:

Modifier -59 should not be reported when one procedure is used in conjunction or as a part of another procedure.

Modifier -59 may be reported when one procedure is performed and is unrelated to the other procedure performed.

Novitas Solutions' suggestion: Beginning January 1, 2015, modifier XU may be more appropriate.

Modifier -59 should not be reported if both procedures are performed during the same operative session and the structures are contiguous structures of the same organ.

Novitas Solutions' suggestion: Beginning January 1, 2015, modifier XU may be more appropriate if the structures in question are not contiguous structures of the same organ.

Common misuses of modifier -59 are related to the portion of its definition used to describe a different procedure or surgery. The description of the edit usually represents different procedures, even though they may be overlapping. The edit indicates that the two procedures should not be reported together if performed at the same anatomic site and same patient encounter, as those procedures would not be considered separate and distinct.

Modifier -59 may be reported if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date to indicate they are different procedures on that date of service.

Novitas Solutions' suggestion: Beginning January 1, 2015, modifiers XE or XS may be more appropriate.

There are many examples (other than on the foot and ankle) listed by Novitas Solutions in this "clarification". You can find all the examples

and solutions from Novitas Solutions, or as they put it, "suggestions." Keep in mind that these suggestions are Novitas Solutions' suggestions and may not represent your Medicare contractor's policy or CMS.

To read Novitas Solutions' solution in toto, go to http://www.novitas-solutions.com/webcenter/faces/oracle/webcenter/page/scopedMD/sad60252a_5537_4c5d_9350_ca405e36e159/Page133.jspx?contentId=00087124&_adf.ctrl-state=1re9sisp2_4&_afLoop=

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Treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site.

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Conclusion

After reading Novitas Solutions' solutions to clarify not only the "-59" modifier (which can still be used if appropriate), but also the new X modifiers, one cannot help but wonder what CMS was thinking when it thought it was going to "unconfuse" providers and coders by unbundling the "-59" modifier into 4 subset X modifiers. I don't see a lot of difference between the "-59" modifier and these new modifiers (except there are more of them to abuse). I can't figure out how going to four X modifiers is going to reduce confusion or overuse. I assume in 3-5 years, the OIG will do another report that shows that the overutilization of the "-59" modifier is now parceled out to the 4 subset modifiers.

Thanks, CMS. What next, the elimination of the global periods for 10- and 90-day procedures?

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.