Modifier 59 and CCI

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Modifier 59

- **Modifier 59 Distinct Procedural Service:** Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from 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. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/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 physician. 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. **Note:** This modifier is not used to report the treatment of a problem that requires a return to the operating room (see modifier 78).

59: The Modifier of Last Resort

- What Else Can Be Used Instead of Modifier 59?
  - 50 Bilateral Service
  - 58 Staged or Related Service by Same Physician
  - 76 Repeat Procedure by the Same Physician
  - 77 Repeat Procedure by Another Physician
  - 78 Return to the Operating Room for a Related Procedure
  - 79 Unrelated Procedure During the Postoperative Period
  - 91 Repeat Clinical Diagnostic Laboratory Test
  - Level II (HCPS/National) Modifiers, ex. Lt, Rt, E1

Modifier 50 Bilateral Procedure

- Used when the same procedure is performed on bilateral anatomy
- Reimbursement is usually 150% of the fee schedule
- Some payers want it appended to a single code. Other payers want it appended to a second line of the same code:

  20610-50 vs. 20610, 20610-50
- Does not break a global period

Modifier 50 vs. 59 Example

- Scenario 1: Patient has osteoarthritis of both knees and undergoes bilateral knee injections:

  20610-50

  If payment for 20610 is $100, then payment for 20610-50 would be $150

- Scenario 2: Patient has multi-joint osteoarthritis and undergoes a right knee joint injection and also a left hip joint:

  20610 (Rt Knee Injection)

  20610-59 (Lt Hip Injection)

  If payment for 20610 is $100, payment for the above would be $100 for 20610 and $50 for 20610-59 due to multiple surgery rules

Modifier 58 Staged or Related Procedure

- Procedure was planned at time of initial procedure (staged)
- More extensive than the original procedure
- Therapy following a diagnostic procedure
- Will break a global period
- Starts a new global period
- Do not use for Noridian on same day as original surgery
- Does not require a return to the operating room

Modifier 58 vs. 59 Example: Staged at time of original procedure

- Scenario 1: Patient undergoes complex aneurysm repair but doctor cannot place pressure monitor until brain has refilled the cranium, so the monitor is placed later in the day

  61697 Aneurysm repair

  61107-58 Twist Drill for implanting pressure monitor

- Scenario 2: Patient sustains a traumatic brain injury and requires a ventricular catheter to drain fluid in one area of the brain and a pressure monitor in another area

  61107 Twist Drill for Ventricular Catheter

  61107-59 Twist Drill for ICP and Licox Monitor

  This was **not** a staged procedure as both procedures were performed at the same operative session

Modifier 58 vs. 59 Example: Staged at time of original procedure

- Scenario 3: A patient underwent a lumpectomy for breast cancer and on postoperative day two underwent placement of a radiotherapy afterloading balloon catheter

  19160 Mastectomy, partial (lumpectomy)

  19296-58 Placement of radiotherapy balloon catheter on separate date from partial mastectomy

- Scenario 4: A patient underwent a lumpectomy for breast cancer and at the same operative session underwent placement of a radiotherapy balloon catheter

  19160 Mastectomy, partial (lumpectomy)

  19297 Placement of radiotherapy balloon catheter concurrent with partial mastectomy

  This was <u>not</u> a staged procedure as both procedures were performed at the same operative session

Modifier 58 vs. 59 Example: More Extensive than the original procedure

- Scenario 1: A diabetic suffers from peripheral vascular disease such that the large toe of her left foot has become gangrenous and must be amputated. The patient's gangrene continues to progress and a week later the patient required amputation of her left foot.

  28820 Amputation, toe

  28805-58 Amputation, foot

(I would also consider 28820-TA and 28805-58-LT)

Modifier 58 vs. 59 Example: More Extensive than the original procedure

- Scenario 2: A diabetic suffers from bilateral peripheral vascular disease such that the large toe of her left foot and all of her right foot have become gangrenous and both must be amputated. Both amputations are performed at the same surgical session.

  28805 Amputation, foot

  22820-59 Amputation Toe

  (For Medicare, 28805-RT and 28820-TA)

- Scenario 3: Patient was driving his motorcycle when a car pulled in front of him. Patient's motorcycle went into a long skid causing the patient to sustain a severe, contaminated injury to the tissues of his left thigh. Patient was taken to the operating room for initial debridement of the wound. The patients wound continued to evolve and the patient needed a second, additional debridement two days later.

  11043 Debridement, skin, subcutaneous tissue, and muscle

  11043-58 Debridement, skin, subcutaneous tissue, and muscle

Modifier 58 vs. 59 Example: Therapy following a diagnostic procedure

- Scenario 1: A woman is referred to a surgeon for a suspicious breast lump. The surgeon performs an incisional biopsy which proves to be cancer. Two days later the surgeon performs a mastectomy.

  19101 Open, incisional biopsy of breast

  19240-58 Mastectomy, modified radical

- Scenario 2: A patient is admitted to the hospital with abdominal pain, fever, and dehydration. A CT scan demonstrates a large abnormality in the transverse colon. A colorectal surgeon is asked to see the patient and performs a colonoscopy which demonstrates a large abscess. The surgeon takes the patient to surgery later in the day for resection of the transverse colon.

  44140 Colectomy, partial; with anastomosis

  45378-58 Colonoscopy, diagnostic

Modifier 58 vs. 59 Example: Therapy following a diagnostic procedure

- Scenario 3: While undergoing destruction of an actinic keratosis, the dermatologist notices a separate lesion very suspicious for malignant melanoma. The dermatologist biopsies this lesion.

  11100 Biopsy of skin, subcutaneous tissue… single lesion

  17000-59 Destrucion of premalignant lesion

  This is not a staged procedure as the biopsy and destruction were performed on separate lesions

- Scenario 4: A patient presents for surgery to remove metastatic implants within the abdominal cavity. The patient's cancer diagnosis has been well established. The physician spends significant time performing laser removal of tumor implants. One large implant appears to be invading the colon. The physician takes a biopsy of this lesion and then performs a partial colectomy to remove the lesion.

  44140 Colectomy, partial; with anastomosis

  The biopsy is not billed because the patient has already been diagnosed and the decision to perform the colectomy is based on the invasive nature of the tumor and is not predicated on the biopsy results.

Modifier 58: Which code gets the modifier?

- When two codes are billed on the **same date** of service, the modifier is appended to the **smaller** of the two codes. (Except for Noridian who prefers -59 in place of -58 when both procedures are performed on the same day.)
- When two codes are billed on **separate dates** of service, the modifier is appended to the code that occurs on the **later** date.

Modifier 76 Repeat Procedure by the Same Physician

- What is the difference between 76 and 59?
  - 76 is the same procedure repeated at the same location on the same day
  - 59 indicates that something is different: location, lesion, injury
- Modifier 76 is used only on the same day and does not break a global period

Modifier 76 vs. 59 Example

- Scenario 1: A mother takes her four year old to the Emergency Department for an unrelenting nose bleed. The doctor cauterizes and packs the area of bleeding. Later in the day, while playing actively, the child dislodges the packing and the bleeding restarts. The patient returns to the ED and the doctor recauterizes and packs the area of bleeding.

  30903 Control of nasal hemorrhage, anterior, complex

  30903-76 Control of nasal hemorrhage, anterior, complex

- Scenario 2: A patient with melanoma presents with new lesions on her back and thigh. The doctor removes both lesions. The excised diameter of the back lesion is 2.7cm and the excised diameter of the thigh lesion is 2.2 cm.

  11603 Excision of malignant lesion, trunk, arms, legs 2.1-3.0 cm

  Put in notes field on claim: "2.7 cm lesion on back"

  11603-59 Excision of malignant lesion, trunk, arms, legs 2.1-3.0 cm

  Put in notes field on claim: "2.2 cm lesion on leg"

  Even though the procedure code billed is the same, the second is not a repeat procedure of the first because it is performed on a separate lesion.

Nebraska Medicare

- The claims processing software for our Nebraska Medicare Carrier, Blue Shield of Kansas, has difficulty recognizing Modifier 59 when it is used with two of the same CPT codes on the same date of service.

- We have received verbal instruction from our Carrier to append Modifier 76 and Modifier 59 for this occurrence. Modifier 76 will correct the claims processing glitch and Modifier 59 will correctly report that the second procedure was actually performed in a separate location, lesion, or injury.

Using Units vs. 76 or 59

- Some codes allow billing in multiple units. Examples would be supplies, drug codes, x-rays, even spinal fusion codes.
- Plus to billing units: less lines to key
- Minus to billing units: Not all claims processing software recognizes units
- Minus: The billing price of the CPT code appears skewed
- Minus: It is difficult to tell if all units were reimbursed

Modifier 77 Repeat Procedure by Another Physician

- Modifier 77 is similar to Modifier 76, except that the repeat procedure is not performed by the same physician who performed the earlier procedure. For example, if the pediatric patient with the nose bleed was treated in a large Emergency Department, the child could be treated by a different ED physician the second time.

Modifier 78 Return to the OR

- Per September 1997 CPT Assistant:

  Modifier -78 is used to report the performance of another related procedure during the postoperative period. Although both the -58 and -78 modifiers use the words "related procedure," they mean slightly different things. When using the -78 Modifier remember that the procedure requires a return to the OR and are **directly associated with the performance of the initial operation.**

  An example of this includes a postoperative complication and hemorrhage from/in the operative site that requires the patient to return to the operating room for treatment.

Difference between 58 and 78?

- The descriptions for both modifiers contain the term "related." For -58, related refers to the patient's underlying reason for surgery: illness, injury, or condition. For -78 "related" refers to the initial surgery. In other words for -58 the patient's underlying problem necessitates the second surgery.

- For -58, for staged procedures, the surgical treatment requires sequential procedures to treat the problem. For the more extensive procedures, the initial procedure was not entirely successful in treating the problem and a more extensive procedure was necessary. For diagnostic followed by therapy, the establishment of the diagnosis was needed in order for the treatment to be determined.

Difference between 58 and 78

- For -78, "related" refers to the initial procedure. This most often would be a complication. In other words, the need to return to the OR is directly related to a result of the initial surgery. For example, a patient wouldn't need to return to the OR for the control of postoperative bleeding, if the patient hadn't first had surgery. The patient wouldn't need to return to the OR for repair of an intestinal anastomosis leak, if the patient hadn't first undergone the intestinal anastomosis.

- In the earlier example of the patient who had a gangrenous toe removed and the gangrene continued to progress to the point that the foot had to be removed, the patient would most likely have needed the foot removed whether the toe had been removed or not. So for this patient, the second surgery (amputation) would necessitate Modifier 58. However, if the patient's sutures did not hold and the patient began bleeding to where a return to the OR was needed to control the bleeding, this second surgery (control of postoperative bleeding) would necessitate Modifier 78.

Payment Differences 58 and 78

- Modifier 58 starts a new global period
- No reduction in payment is received by appending 58
- Modifier 78 does not start a new global period
- Modifier 78 is paid at the intra-operative percentage in the Medicare Fee Schedule

Modifier 78 vs. 59 Example

- Scenario 1: A patient with a history of multiple previous abdominal surgeries presents with a small bowel obstruction and undergoes a small bowel resection. Later in the day, bloody fluid begins to flow from the patient's abdominal drain. The patient returns to the OR and undergoes surgery to control bleeding at the site of the earlier surgery.

  44120 Resection of Small Intestine with anastomosis

  49002-78 Reopening of recent laparotomy

- Scenario 2: A trauma patient presents to the ED with a ruptured spleen and is taken emergently to the OR for a splenectomy. After the splenectomy, the surgeon does not see any other areas of hemorrhage and closes the patient. Later in the day, the patient's condition deteriorates and the patient is returned to the OR where it is discovered that an injured area of the patients colon has started to bleed. The surgeon performs a partial colectomy.

  44140 Colectomy, partial with anastomosis

  38100-59 Splenectomy, total (Separate Procedure)

  An argument for Modifier 79 instead of 59 could be made for this one, but due to the "Separate Procedure" noted in the splenectomy code, the -59 seems most appropriate to explain that the procedures were separate.

Modifier 79 Unrelated Procedure During the Operative Period

- Modifier 79 is used to indicate that a second procedure performed in the global period of an initial procedure, is unrelated to the initial period.
- A common occurrence of this is bilateral problems. It is not uncommon for patients to experience Carpal Tunnel Syndrome in both wrists, cataracts in both eyes, or stenosis in both carotid arteries. However, since patients don't always have these illnesses in both sides, they are considered separate illnesses. Patients frequently have surgery on one side and then surgery on the other side a few months later. The second surgery is billed with Modifier 79 to indicate that it is unrelated to the first surgery.
- It is less common to see Modifier 79 used on the same day as the first surgery.
- Modifier 79 starts a new global period for the second surgery.

Modifier 79 vs. 59 Example

- Scenario 1: A patient undergoes surgery for Carpal Tunnel on the right wrist and 6 weeks later undergoes surgery for Carpal Tunnel on the left wrist

  64721 Neuroplasty, median nerve at carpal tunnel

  64721-79 Neuroplasty, median nerve at carpal tunnel

- Scenario 2: A patient is in an mva and sustains a large scalp laceration and on the opposite side of the head, experiences a subdural hematoma. The physician repairs the scalp laceration, moves to the opposite side of the head and performs a craniotomy to drain the hematoma

  61312 Craniotomy for Subdural Hematoma

  12032-59 Layered closure of scalp wound, 2.6-7.5cm

  Although the scalp laceration and hematoma are separate injuries and therefore unrelated to each other, the repair of a scalp laceration is inherent in the craniotomy procedure since a surgical laceration is created to access the skull. Therefore, -59 is more descriptive in this case to say that the injury laceration is in a separate location from the surgical laceration.

Modifier 91: Repeat Clinical Laboratory Test

- Per the Microbiology section of CPT 2006:

  For multiple specimens/sites use modifier 59. For repeat laboratory tests performed on the same day, use modifier 91.

- Modifier 91 is used when the same test is run multiple times for the same patient on the same day for separate results. An example would be for a diabetic patient who has serial glucoses drawn after administration of insulin.

Modifier 91: Repeat Clinical Laboratory Test

- Modifier 91 is not used when there is a problem running a test and it is repeated.
- Modifier 91 is not used when the test results seem abnormal and the test is re-run for confirmation purposes.
- Modifier 91 is not used when the description of the test provides for a series of results, for example a glucose tolerance test.

Modifier 91: Repeat Clinical Laboratory Test

- Modifier 59 is used when tests are performed on separate specimens or from separate anatomical sites. For example, this would be for separate tumors removed from a patient or for specimens obtained at separate wounds or even separate parts of a wound.

Modifier 91 vs. 59 Example

- Scenario 1: An elderly patient with problems with hypokalemia presents to the clinic with a low potasium level determined by a serum potassium test. The patient is treated with a potassium replacement IV solution. The patient is monitored and two more serum potassium are run.

  84132 Potassium, serum

  84132-91 Potassium, serum

  84132-91 Potassium, serum

- Scenario 2: The lab receives two containers for a patient. Container A is labeled "skin biopsy, right cheek" and Container B is labeled "skin biopsy, left forehead." Both specimens undergo gross and microscopic examination by the pathologist with results sent to the surgeon.

  88305 Level IV Surgical Pathology, gross and microscopic

  88305-59 Level IV Surgical Pathology, gross and microscopic

Level II Modifiers

- Some Level II modifiers indicate anatomical location, such as specific fingers or toes
- Some payers recognize them for radiology tests, but not for surgical procedures.

Level II Modifiers vs. 59 Example

- Scenario 1: A patient with coronary artery disease had a stent placed in the left anterior descending coronary artery and a second stent placed in the left circumflex coronary artery.

  92980-LD Transcatheter placement of intracoronary stent(s), single vessel

  92981-LC Transcatheter placement of intracoronary stent(s), each additional vessel

- Scenario 2: An elderly patient was seen for right knee pain and sent for an x-ray of the knee which demonstrated arthritis. While walking to his car, the patient stumbled, fell hard onto his right knee, heard a cracking sound, and experienced greatly increased pain. The patient returned to the clinic and the physician sent the patient for a three view x-ray of the knee.

  73562 Radiologic exam of knee, three views

  73560-59 Radiologic exam of knee, one or two views

Did anyone notice something about the dates of the service and Modifier 59?

Modifier 59 only works on the same day as another procedure and does not break a global period.

CCI: The Correct Coding Initiative

- **From the CMS Website**

The CMS developed the Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS will e-mail an updated version of the CCI Coding Policy Manual to the ROs for distribution to the carriers. The Coding Policy Manual should be utilized by carriers as a general reference tool that explains the rationale for CCI edits.

Carriers implemented CCI edits within their claim processing systems for dates of service on or after January 1, 1996.The CCI edits are incorporated within the outpatient code editor (OCE).

The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, CCI edits check for mutually exclusive code pairs. These edits were implemented to ensure that only appropriate codes are grouped and priced. The unit-of-service edits determine the maximum allowed number of services for each HCPCS code.

CCI is Medicare Only

- CCI is a product that is owned by Medicare and does not necessarily apply to all insurances.
- Most insurance payers have their own bundling edits which they consider to be proprietary and do not publish.

What is different about Modifier 59 in terms of CCI?

- Per CCI 11.3
- One of the misuses of modifier -59 is related to the portion of the definition of modifier -59 allowing its use to describe "different procedure or surgery". The code descriptors of the two codes of a code pair edit usually represent different procedures or surgeries. The edit indicates that the two procedure/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier -59 for such an edit based on the two codes being different procedures/surgeries. However, if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier -59 may be appended to indicate that they are different procedures/surgeries on that date of service.

How do you tell if something is "bundled" in CCI?

- Read the CCI Chapter Policies – These are rules that always apply and frequently do not show as an edit, but will cause a denial.
- Look on the CMS website: www.cms.gov
- Look in the Encoder

What is a Mutually Exclusive Edit?

- Two procedures that if performed at the same anatomical location, don't make sense
  - A vaginal hysterectomy reported with an abdominal hysterectomy
  - Provision of a DTaP vaccine and a DT vaccine

Can Mutually Exclusive Edits be bypassed?

- Many times yes, because the procedures that bundle may be performed at a different anatomical site or at a different session. In this context, the performance of both procedures makes sense.

- However some edits cannot be bypassed in any circumstances.

What are Column 1/Column 2 Edits?

- Many procedures require multiple steps to complete. Frequently separate codes exist to describe the separate steps of a larger procedure. These codes exist to describe when these lesser procedures are performed alone and not as part of the larger procedure. For example, when performing a craniotomy to evacuate a subdural hematoma, burr holes are frequently drilled as part of creating a skull flap. The procedure for creating the burr holes is bundled into the procedure for the craniotomy.

More on Column1/Column 2

- The main intention of CCI is to prevent component code billing when a single code exists to describe the entire service.

- CCI will apply the edits to physicians of the same specialty, in the same group practice as if they are the same physician. In other words, if Partner A performs a procedure on a patient in the morning and Partner B performs another procedure in the afternoon, CCI will apply the edits to both physicians as if only one of them performed both procedures.

Can Column 1/Column 2 edits be bypassed.

- Similarly to Mutually Exlusive edits, sometimes Column1/Column 2 edits can also be bypassed.

- Also similarly, some Column1/Column 2 edits can never by bypassed.

How can I tell if an edit can be bypassed?

- Both CCI on the CMS wedsite and in the Encoder Pro provide indications as to whether an edit can be bypassed
  - CMS Key
    0=not allowed
    1=allowed
    9=not applicable
  - Encoder Pro simply states "Allowed" or "Not Allowed"

A fatal CCI misunderstanding

Just because an edit can by bypassed does not mean it should be bypassed.

How do I know if an edit should be bypassed

- Review the CCI rules for Modifier 59
- We have provided flow sheets to help out
- Remember that Modifier 59 is the modifier of "last resort" so make sure to ask if a different modifier is more descriptive

If something is always bundled, can I bill it anyway?

- No.

- Medicare publishes their rules with the expectation that providers will follow them. If something is not supposed to be billed to Medicare, and is billed to Medicare, then Medicare may consider it a false claim. False claims may be subject to up to a fine of $11,000 per claim.

Scenario 1

A patient with osteoarthritis in multiple joints undergoes aspiration and then injection of her right knee followed by an injection into her left hip.

Scenario 1 Answer

- 20610 (Right Knee)
- 20610-59 (Left Hip)

- The code includes both aspiration and injection, so only one occurrence is allowed for the right knee
- Modifier 59 indicates that the second injection was done in a separate joint

Scenario 2

A patient with recurrent malignant melanoma has a 3.2cm by 2.0cm lesion (including margins) removed from his trunk. The doctor performs an adjacent tissue transfer to correct the defect.

Scenario 2 Answer

- 14000

- Code 11604 was also performed, but is bundled. It does not meet criteria for a modifier

Scenario 3

A patient with malignant melanoma has a 3.1 cm x 3.1 cm lesion removed from his trunk with repair of the defect by adjacent tissue transfer. The patient has a second lesion removed from his arm with an excised diameter of 3.3. The second lesion is repaired with an intermediate closure.

Scenario 3 Answer

- 14000 for the trunk lesion
- 11604-59 for the arm lesion
- 12032-59 for the arm lesion

- 11604 was also performed on the trunk lesion but is bundled.
- Modifier 59 indicates that the two codes were performed on a separate lesion.

Scenario 4

A patient undergoes a Roux-en-Y gastric bypass. Ten days postoperatively, the patient's wound dehisces and the patient is returned to surgery for secondary closure.

Scenario 4 Answer

- 43846
- 13160-78

- The would dehiscence is related to the earlier surgery, not the patient's underlying condition. Therefore the modifier is 78 and not 58.

Scenario 5

A patient undergoes a fine needle aspiration with imaging guidance of a suspicious area in her breast. The aspirate is positive for breast cancer and the patient undergoes a partial mastectomy two days later.

Scenario 5 Answer

- 10022
- 19160

- Although the lumpectomy could be considered a therapeutic procedure based on the results of a diagnostic procedure, the fine needle aspiration code does not have a global period, so no modifier is needed for the lumpectomy.

Scenario 6

A patient notices blood in his stool and undergoes a colonoscopy. The Gastroenterologist discovers that the bleeding is emanating from an AV malformation and applies cautery to control the bleeding. The physician also notices a polyp which she removes by snare technique.

Scenario 6 Answer

- 45382
- 45385-59

- If control of bleeding is performed at the same site and same operative session as a procedure, it is not separately billable. In this case the biopsy did not cause the bleeding and was done at a site separate from the procedure. If the biopsy had caused bleeding which then needed cauterization, 45382 would not have been separately billable as it would have been part of the biopsy procedure and not separate from it.

Scenario 7

A patient's lab reveals elevated liver enzymes with no obvious cause. An abdominal CT is suspicious for a blockage in the common bile duct. The patient is taken to the endoscopy suite and first undergoes an EGD. The EGD scope is removed and an ERCP scope is inserted and an ERCP is performed.

Scenario 7 Answer

- 43260

- Although 43235 was also performed, it was done as part of the ERCP and therefore does not meet the criteria for a modifier to bypass the CCI edit.

Resources

- CMS's website
  - Our Carrier: http://www.kansasmedicare.com/Part_B/index.htm
  - Medicare: http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage
- Creighton's Helpline – 280-5846
- Creighton's Billing Compliance Office
  - Janine Pufall: 280-3507
  - Julie Leu: 280-2017