

Provider Education

Medicare Part B



Use of Modifiers with National CCI Edits

Each year, Medicare contractors are required to update their coding system to reflect changes made in the Current Procedure Terminology (CPT) as well as changes to CMS and locally designated codes.

Effective January 1, 2008 the code description for Modifier 59 has been revised. When programs such as the National Correct Coding Initiative (CCI) are developed, CMS recognizes that there will be exceptions to the basic rules. In order to identify when a coding combination meets the exception criteria, modifiers are used.

Modifier 59 is frequently used incorrectly. Modifier 59 is now defined as:

A Distinct Procedural Service: Under certain circumstances it may be necessary to indicate 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/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 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 individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if a more descriptive modifier is not available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

Physicians and their billing staff often call the Medicare Customer Service Line requesting coding information. Supplying the right Healthcare Common Procedure Coding System (HCPCS) codes and Correct Coding Initiative (CCI) modifiers for specific claims is beyond the scope of the Medicare Customer Service Representatives (CSRs) work. HCPCS contains more than 12,000 codes, 7,000 of which describe physician procedures from all specialties and require specialized training to be able to describe. Therefore, the responsibility to supply the correct code on the Medicare claim lies with the practitioner or the provider. Customer Service Representatives can provide you with the rules, but not the codes that meet your individual circumstances. However, there is a great deal of information available on the CMS National Correct Coding website to assist you with proper coding and billing at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

The CCI edits always consist of pairs of HCPCS codes, and are arranged in two tables. One is the Column 1/Column 2 Correct Coding Edits table, and the other is known as the Mutually Exclusive Edits table. There are many modifiers, as indicated below, available to help you identify when services should be paid separately.

E1 Upper left, eyelid	T3 Left Foot, fourth digit
E2 Lower left, eyelid	T4 Left Foot, fifth digit
E3 Upper right, eyelid	T5 Right Foot, great toe
E4 Lower right, eyelid	T6 Right Foot, second digit

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FA Left Hand, thumb	T7 Right Foot, third digit
F1 Left Hand, second digit	T8 Right Foot, fourth digit
F2 Left Hand, third digit	T9 Right Foot, fifth digit
F3 Left Hand, fourth digit	LT Procedure on left side of body
F4 Left Hand, fifth digit	RT Procedure on right side of body
F5 Right Hand, thumb	25 Separate & identifiable services
F6 Right Hand, second digit	59 Distinct procedural service
F7 Right Hand, third digit	78 Return to operating room
F8 Right Hand, fourth digit	79 Unrelated procedure
F9 Right Hand, fifth digit	LC Left Circumflex Coronary Artery
TA Left Foot, great toe	LD Left Anterior Descending Coronary Disease
T1 Left Foot, second digit	RC Right Coronary Artery
T2 Left Foot, third digit	

The addition of this modifier indicates to the carriers that the procedure or service represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different anatomical site or organ system, separate incision/excision, different lesion, or different injury or area of injury (in extensive injuries).

If none of the anatomical or surgical modifiers can be used appropriately to describe the reason for the exception, then the modifier 59 can be attached. The placement of the modifier goes on the COLUMN 2 codes that meet the exception criteria. Do not bill the modifier on the column 1 code.

Often we find that providers, once they receive a denial stating the service is included with another procedure, use the modifier 59 every time they bill that service. The NCCI edits are not the only reason that codes are “bundled” and denied. Program coverage such as global surgery, radiation therapy, and even physician payment reform may result in bundling denials. One of the primary misuses of the modifier 59 is for providers to bill it on every procedure billed, assuming it will bypass the bundling edits. Indiscriminate use of the modifiers can lead to further review of a provider claims.

The NCCI file formats also include a correct coding modifier indicator for the correct coding edits table. This indicator determines whether a modifier is allowed with the code combinations. An indicator of 1 allows the procedure to bypass the editing and pay. An indicator of 0 does not allow a procedure code to bypass the edits, resulting in a denial.

Become familiar with these programs, make sure that you are billing the modifiers correctly, and fully document the conditions in the medical record that support the use of the modifiers. Please remember that modifier 59, and the global surgery modifiers, are “exceptions” to the normal rules. By using them incorrectly, or placing them on every service, you are telling Medicare that everything you do is an exception to the rule.

Remember, inappropriate or indiscriminate use of the CCI modifiers (including modifier 59) could be considered fraudulent or abusive.

12/28/2007

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