

New Modifier 59 Coding Revisions

BY RIVA LEE ASBELL

The Centers for Medicare and Medicaid Services (CMS) has issued new coding requirements for modifier 59 that explain the proper use of X subsets. The X subsets are 4 newly established modifiers that can (and should) be used to define specific subsets of modifier 59.¹ Per the requirements, an X subset should be appended, when applicable, to a claim whenever modifier 59 is used. These requirements are effective January 1, 2015; the implementation date is January 5, 2015 (Table 1).

Modifier 59 is defined in the Current Procedural Terminology (CPT) handbook as follows:

59 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 [evaluation/management] 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 no more descriptive modifier is 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.

THE BASICS OF MODIFIER 59 AND THE NCCI

What does not appear in CPT is the most common usage of modifier 59, namely breaking of the code pair edits ("bundles") of CPT codes that should not be billed together. The codes may be for surgical procedures, diagnostic tests, or office visits. Full instructions appearing in a document published by CMS, known as the National Correct Coding Initiative (NCCI), may be accessed on the CMS website. The NCCI issues updates quarterly. The NCCI focuses on aiding CMS in its goals of decreasing fraud and abuse and reducing the number of overpayments erroneously made to providers.

An example of bundling: When coding for vitrectomy with removal of an epiretinal membrane (67041) at the same time as a vitrectomy for removal of internal limiting membrane for repair of macular hole (67042),

TABLE 1. THE NEW X SUBSETS FOR MODIFIER 59

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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 Nonoverlapping Service: A service that is distinct because it does not overlap usual components of the main service

only 67042 is billed because those 2 codes are bundled. The provider is paid for the highest paying procedure according to Medicare's fee schedule, but only if the correct code is chosen. Note that if you chose the wrong code, you are paid for the lesser code.

Unfortunately, many are not familiar with NCCI rules. Therefore, some may think that if 2 or more procedures that have CPT codes are performed, and the codes are bundled, then the 59 modifier may be applied, thus engendering payment for both procedures.

The Office of the Inspector General has identified excessive use of modifier 59 as a red flag for misuse or abuse of coding procedures and has subjected some physicians to Medicare audits due to excessive use of the modifier. To avoid audits, modifier 59 should not be used to break bundles injudiciously. A physician or biller may not agree with the logic behind the bundle, but regular use of this modifier often triggers audits.

WHAT IS UNBUNDLING?

Unbundling of services is defined as the intentional fragmenting of procedures into component codes resulting in unwarranted reimbursement. Unbundling may be intentional or unintentional, but the principal objective of the NCCI and CMS is to eliminate the practice in either case.

The NCCI also requires physicians to consider anatomic sites when determining if a code should be unbundled:

One of the common 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 edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and [in] same patient encounter. The provider cannot use modifier 59 for such an edit based on the two codes being different procedures/surgeries. From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site.²

Table 2 lists examples of how codes can be incorrectly unbundled by applying modifier 59 to bundled code pairs.

TABLE 2. EXAMPLES OF INCORRECTLY UNBUNDLED CODES

- Reporting multiple CPT codes in place of a single comprehensive code that describes the procedure.
- Fragmenting a single service into component parts and coding each component as if it were a separate procedure.
- Breaking out bilateral procedures when a single code is appropriate.
- Separating a surgical approach from the major surgical procedure. Even if 2 approaches are used, only the most comprehensive approach and associated CPT code should be reported.
- Reporting units of service incorrectly.

Upcoding and Downcoding: Physicians should avoid upcoding and downcoding. Upcoding occurs when a code is reported and all services described in the code were not performed. Downcoding occurs when the physician fails to report the most comprehensive code, choosing a less comprehensive code plus other codes that are not included in the less comprehensive code.

CLINICAL EXAMPLES

Here are some clinical examples using modifier 59 in instances in which the new X subsets may apply. The CMS has stated that Medicare Administrative Contractors (MACs) will accept modifier 59 without an X subset after January 1, 2015. It is recommended that legitimate usage of modifier 59 be continued without the X subset and that the X subset be used when required by a MAC or under unusual circumstances.

XE Separate Encounter: A Service That is Distinct Because It Occurred During A Separate Encounter

Here are some possible scenarios in which 59-XE may be appended to a second claim or a second line entry on a claim. It applies to different providers in the same group or the same provider as long as the 2 visits are for unrelated problems. Medicare considers all physicians in the same practice to be the same physician unless they have different taxonomy codes. All ophthalmologists are specialty 18.

An example: A patient is examined in a multispecialty practice for cataract follow-up and later that day gets hit in the eye and experiences floaters, resulting in a subsequent examination by the practice's retina specialist for

possible retinal detachment. Ordinarily, Medicare does not pay for multiple visits by different physicians in the same practice on the same day. In this case, modifier 59-XE should be used.

Another example of an appropriate time to use modifier 59-XE: During cataract surgery, an intraocular lens (IOL) is dropped into the posterior vitreous. The anterior segment surgeon closes the eye and requests the services of the retina specialist in the same practice who later that day performs a vitrectomy with retrieval and suture fixation of the IOL. Without the modifier 59-XE, the computer processing the claims may interpret the 2 encounters on the same date of service as a single session. (Note: This example may also qualify for use of 59-XP. See below for further explanation.)

XS Separate Structure: A Service That is Distinct Because It Was Performed On A Separate Organ Structure

Procedures performed in the anterior segment and posterior segment during the same session often are regarded as surgery on different organ structures because surgeries performed on each segment are usually technically unrelated. According to the NCCI manual, “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.” However, also according to the manual, “treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site.” These 2 statements from the NCCI manual might seem contradictory. Although the manual does not specifically state that the anterior and posterior segments are different anatomic sites, payment usually reflects that concept.

The case of a trauma-induced retinal tear in an eye repaired with vitrectomy with focal endolaser serves as an adequate scenario to illustrate proper use of 59-XS. In this case, an IOL was found on the macula encased in the lens capsule and surrounded by lens remnants. The IOL was raised into the anterior vitreous, and lens fragments and posterior capsule remnants were removed from the haptics. Using different incisions 2 mm posterior to the limbus, under a scleral flap, the haptics were externalized and then sutured to the scleral flap bed. The CPT coding for this encounter should be 67039-LT (vitrectomy with endolaser) + 67121-59-XS (removal of implanted material; posterior segment) + 66825-LT (repositioning of intraocular lens prosthesis, requiring an incision). (Note that code 66682 [McCannel suture] is bundled with code 66825.)

XP Separate Practitioner: A Service That Is Distinct Because It Was Performed By A Different Practitioner

To decide whether the 59-XP modifier is required, a determination must be made as to whether the surgeon performed a completely different operation and whether the surgeon is part of the same group or is in a different group. If the procedure is a separate operation and the surgeon is from a different practice (and is not acting as an assistant and is not participating in either cosurgery or team surgery), then no modifier is needed.

For example, in the case of trauma to the eye resulting in a ruptured globe and a retinal detachment, an anterior segment surgeon performs removal of an IOL and repair of the scleral laceration with repositioning of iris prolapse. A retina surgeon then repairs the retinal detachment. If the surgeons are in the same practice, modifier 59-XP or modifier 59-XS should be appended to the code to indicate that the 2 procedures are distinct because different surgeons (even though they are from the same practice) performed them.

XU Unusual Nonoverlapping Service: A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

An example of when to use modifier code 59-XU is in the case of a trauma-induced retinal tear that requires the removal of an IOL from the posterior chamber. The retrieval of an IOL (67121) performed in conjunction with another posterior segment procedure such as retinal detachment repair and stripping of epiretinal membranes (67113) is not included in the work Relative Value Units, or RVUs, of the vitrectomy.

It is important to remember that proper use of modifier 59-XU remains less clear than use of modifiers 59-XE, 59-XS, and 59-XP. If these modifiers are able to adequately describe the procedure, the person coding the procedure should use them to avoid potential issues with use of 59-XU.

MORE INFORMATION

More information about the NCCI can be found on the CMS website at CMS.gov/Medicare/Coding/NationalCorrectCodInitEd. ■

Riva Lee Asbell is the principal of Riva Lee Asbell Associates, an ophthalmic reimbursement consulting firm in Fort Lauderdale, Florida. Ms. Asbell may be reached at rivalee@rivaleeasbell.com.



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1. Centers of Medicare and Medicaid Services. MLN Matters Newsletter. <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf>. Accessed 17 November 2014.

2. National Correct Coding Initiative Policy Manual for Medicare Services. Revision Date: January 1, 2014.