Optum Learning:

Understanding Modifiers

2016

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stated, it is not advisable to report modifier 59 routinely or when another modifier can more accurately describe the unique circumstances involved with the procedure or service being performed.

Modifier Alert: On August 15, 2014, the Centers for Medicare and Medicaid Services (CMS) issued Transmittal 1422 announcing the establishment of four new HCPCS Level II modifiers, collectively referred to as X{EPSU} modifiers, to identify and define specific subsets of modifier 59 Distinct Procedural Service, as listed below:

- 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

CMS has indicated that, at least for now, it will continue to recognize modifier 59 only when a more descriptive modifier is not available and may, in many instances, selectively require one of the more specific X{EPSU} modifiers when reporting certain combinations of codes at high risk for inappropriate billing. As an example, there may be certain NCCI procedure-to-procedure pairings identified as payable only with modifier XE Separate Encounter but not payable with modifier 59 or any other X{EPSU} modifiers.

Since these new modifiers are more descriptive, specific versions of modifier 59, it is inappropriate to report both modifier 59 and one of the X{EPSU} modifiers on the same line item. As earlier stated, CMS will initially accept either modifier 59 OR one of the more selective X{EPSU} modifiers since using both in combination would create an additional burden for both reporting and editing purposes.

CMS is encouraging providers to begin using these new modifiers, as appropriate, whenever possible. Note that while national edits may not be in place, these modifiers are still considered active and valid; therefore, CMS contractors are permitted to begin requiring the use of these modifiers in place of the more general modifier 59 as necessitated by local integrity and program needs.

Example:

An arch aortogram and bilateral selective common carotid angiograms are performed by femoral approach. Results demonstrate a 70 percent stenosis of the right carotid and 95 percent stenosis of the left carotid. The catheter placement is reported with code 36222-50 since the code definition describes the service as “unilateral.”

Injection codes are reported with 36216 and 36215-59 with modifier 59, signifying a different arterial family.

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QUICK TIP

Hospital ASC and Outpatient Coders

Medicare's instructions for modifiers 78 and 79 in hospital ASC or hospital outpatient facilities include in the definition procedures requiring a "return to the operating room on the same day." Use modifier 78 for a procedure related to the initial procedure on the same day and modifier 79 for a procedure on the same day that is unrelated to the initial procedure.

QUICK TIP

Hospital ASC and Outpatient Coders

Medicare's instructions for modifiers 76 and 77 in hospital ASC or hospital outpatient facilities include in the definition, procedures "repeated in a separate operative session return to the operating room on the same day." Use modifier 78 for a procedure related to the initial procedure on the same day and modifier 79 for a procedure on the same day that is unrelated to the initial procedure.

Modifier 79

- Modifier 79 reports a service/procedure performed by the provider as unrelated to the original service or procedure. When this modifier is used, a different diagnosis code from what was reported with the original procedure should be reported. Failure to use modifier 79 when appropriate may result in a denial of the subsequent surgery.
- Documentation must clearly indicate that the procedure is unrelated to the prior surgical procedure.
- It is important that each line item include the necessary modifier when appropriate. For example, if the provider has performed two unrelated surgical procedures that fall in the postoperative period of another surgery the individual performed, modifier 79 is applied to both surgery codes, not simply the first.
- CPT codes for use with modifier 79 (unless limited by the payer) are 10021–69990, 70010–79999, 90281–99199, and 99500–99607, when appropriate.

Modifier 79: Clinical Examples of Appropriate Use

Example #1:

A patient, having had a femoral-popliteal graft performed one week previously, presents to his physician with symptoms of acute renal failure. He is admitted for care but does not respond to the prescribed treatment. His physician discusses the possibility of hemodialysis with the patient and his family. They agree that it is a viable option. The same surgeon inserts a cannula for hemodialysis.

Submit CPT code 36810-79, since the insertion of the cannula for hemodialysis was not related to the femoral-popliteal graft that was performed earlier.

Example #2:

A patient is 60 days postoperative for an excision of a tumor of the upper left arm (CPT code 24077). He presents to the same general surgeon complaining of a persistent pain across his abdomen. The pain has increased in severity, and the patient is now complaining of nausea. After an examination the patient undergoes emergency surgery for a ruptured appendix.

CPT code 44960-79 is submitted.

REPEAT PROCEDURES AND SERVICES MODIFIERS 76 AND 77

Both modifiers 76 and 77 signify a procedure or service that needed to be repeated, the distinction between the two codes being whether the procedure or service was performed by the same physician or other qualified health care professional or by a different physician or other qualified health professional. These modifiers are not reportable with E/M services. The modifiers are listed below with their official definition and an example of appropriate use.

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Implementing a compliance program before a federal or state investigation takes place may positively influence federal auditors when they are deciding on appropriate sanctions. However, the burden is on the provider to demonstrate the operational effectiveness of the compliance program. Overall, the OIG believes that an effective compliance program is a sound investment as it can significantly reduce the risk of unlawful or improper conduct.

Section 6401 of the Affordable Care Act has since mandated that, as a condition of enrollment in the Medicare and Medicaid programs, providers establish a compliance program stating that "on or after the date of implementation determined by the secretary [of DHHS] under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, *as a condition of enrollment in the program* under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category." It further states that "the secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category." At the time of printing, a timeline for implementation had not yet been established.

Modifiers and Compliance: A Quick Self-Test

A cardiology practice in the Midwest was audited and fined by the federal government for inaccurate coding and lack of medical record documentation. An ophthalmology practice in the Northwest underwent an audit by a state Medicaid program and was found to have duplicate billings, unbundling of services, and inappropriate use of ophthalmological codes. A multispecialty practice in the West succumbed to federal auditors and was charged with abusive billing practices, which included the inappropriate use of modifiers.

With federal and state activities to uncover health care fraud and abuse reaching a fever pitch, many physician offices and billing services have implemented internal controls to ensure appropriate billing practices, including internal investigations of the use of modifiers. Here's a quick checklist to follow in setting up these controls. The list is not all-inclusive, but it can help practices remain compliant when reporting modifiers.

An answer of yes to the following questions is essential for fraud and abuse compliance:

- Is all pertinent documentation reviewed prior to appending a CPT or HCPCS Level II code with a modifier?
- Are the activities of your billing office or service monitored with respect to modifier usage (e.g., are denials and requests for more information received and reviewed) and if a billing service is used, do monthly reports detail all claims submitted?
- Are all billings performed by the billing office or service cross-checked to ensure that all claims submitted with modifiers are accurate, and is each modifier reported appropriate to the clinical situation or circumstance noted in the patient's chart?

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