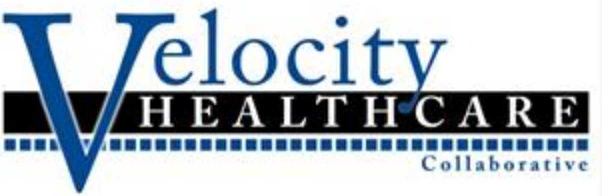
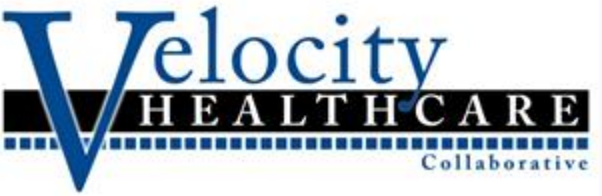


Facility NCCI Edits

Lamon Willis

Agenda

- History of NCCI Edits
- Purpose and Design
- Fragmenting and Unbundling
- Standards of Medical and Surgical Practice
- NCCI Edit Files
- Modifier Not Allowed
- Modifier 25
- Modifier 27
- Modifier 59
- Anatomical Modifiers
- Other HCPCS Level II Modifiers



History of NCCI Edits

Origins

- 1994 - AdminaStar Federal, the Indiana Medicare carrier, is awarded contract to define correct coding practices that would serve as the basis for national Medicare.
- They reviewed the Current Procedural Terminology (CPT) codes to develop two main concepts:
  1) Comprehensive and component code combinations
  2) Mutually exclusive coding combinations

Origins

- January 1, 1996 - The National Correct Coding Initiative (NCCI) edits were officially adopted and implemented in 1996. The edits were procedure to procedure (PTP) for physicians only.
- August 2000 – NCCI PTP edits were applied to hospital services under the outpatient prospective payment system (OPPS).

Origins

- 2006 – NCCI PTP edits are applied to additional therapy services billed to Medicare FIs.
- January 1, 2007 – Medically Unlikely Edits (MUEs) for physicians, outpatient hospital, and DME services are implemented.

Origins

- October 1, 2010 – Impacts of Affordable Care Act
  - State Medicaid Programs must implement NCCI
  - CMS issued instructions to States on September 1, 2010
  - March 1, 2011, Secretary of Department of Health and Human Services (DHHS) reported to Congress regarding Medicaid NCCI implementation

NCCI Edits for All?

- While the NCCI edits are not mandatory for all commercial payers to utilize, many of them take advantage of the opportunity to do so and may alter their use to make their edits proprietary and undisclosed.
  - Humana
  - Cigna
  - Aetna
  - Anthem
  - UHC
  - BCBS

NCCI Edits for All?

Percentage of edited claim lines reduced to $0 by undisclosed edits

	Aetna	Anthem	CIGNA	HCSC	Humana	Regence	UHC	Medicare
2009	10.40%	28.00%	13.80%		12.90%		12.70%	42.90%
2010	10.80%	11.90%	13.90%	39.70%	8.90%		9.90%	26.30%
2011	9.41%	18.87%	13.33%	13.33%	10.81%	3.81%	7.04%	11.54%

Purpose and Design

Purpose and Design

- Purpose
  - Promote correct coding
  - Reduce paid claim error rates
- Basis for Edits
  - CMS coding guidelines and payment policies
  - National specialty society coding policies with slight variations
  - Medicaid

Types of NCCI Edits

Edits focus on services provided by same provider/facility to the same beneficiary on the same date of service billed with HCPCS/CPT codes

Two types of edits:

- Procedure-to-procedure (PTP)
- Medically Unlikely Edits (MUE)

PTP Edits

- Pairs of HCPCS/CPT codes which should NOT be reported together
- Referred to as an "NCCI" or "NCCI PTP" edit
- Example – It would not be appropriate to bill both of the following on the same date:
  - Vaginal hysterectomy
  - Abdominal hysterectomy

MUEs

- Units of Service (UOS) edit
- Unlikely that provider/facility would report more UOS
  - Example
    - Billing 4 units of service for a cataract extraction (each unit of service represents 1 eye)
  - There are only 2 eyes.

Fragmenting and Unbundling

Multiple Vs. Single Code

Don't report multiple CPT codes when a single comprehensive CPT code describes the service

- CPT 58262 Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
- CPT 58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
    - These codes would not be reported together and are an example of "fragmenting" or "unbundling" of services

Multiple Vs. Single Code

Don't fragment a procedure into component parts

- CPT 46606 Anoscopy; with biopsy, single or multiple
  - CPT 46600 Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
  - CPT 45100 Biopsy of anorectal wall, anal approach (eg, congenital megacolon)
    - It would be improper to report CPT codes 46600 and 45100 when the comprehensive procedure is 46606.
    - CPT 45100 is not intended to be used with an endoscopic procedure

Downcoding

Don't report a less comprehensive code than required

- CPT 19302 Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
  - CPT 19301 Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
  - CPT 38745 Axillary lymphadenectomy; complete
  - Reporting 19301 and 38745 together instead of 19302 is downcoding.

Upcoding

Don’t report a code in which all services in the descriptor are not performed

- CPT 38740 Axillary lymphadenectomy; superficial
- CPT 38745 Axillary lymphadenectomy; complete
  - CPT 38745 would not be reported if the provider only excises superficial lymph nodes below the axillary vein but not deep beneath the layers of the muscle

Units of Service

Don't report units of service by criteria that differs from the CPT code description

- For example, some therapy codes are reported in 15-minute increments (e.g., CPT codes 97110-97124).
- Others are reported per session (e.g., CPT codes 92507, 92508).
  - CPT code 92507 or 92508 should be reported with one unit of service on a single date of service.
- A physician should not report a "per session" code using 15-minute increments.

Standards of Medical and Surgical Practice

Integral Services

Don’t separately report integral services

- CPT 36000 introduction of needle or intracatheter into a vein
  - This code is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein.
  - CPT code 36000 is not separately reportable with these types of nuclear medicine procedures.
- However, CPT code 36000 may be reported alone if the only service provided is the introduction of a needle into a vein.

Integral Services

Don't separately report integral services

- Other integral services do not have specific CPT codes.
  - For example, wound irrigation is integral to the treatment of all wounds and does not have a HCPCS/CPT code.
- Services integral to CPT code defined procedures are included in those procedures based on the standards of medical/surgical practice. It is inappropriate to separately report services that are integral to another procedure with that procedure.

Integral Services

- Cleansing, shaving, prepping of skin
- Draping and positioning of patient
- Insertion of IV access for medication administration
- Insertion of urinary catheter
- Sedative administration by MD performing a procedure
- Surgical cultures
- Local, topical, regional anesthesia by physician performing procedure
- Surgical approach
- Insertion/removal of drains, suction devices, pumps into same site
- Surgical closure and dressings
- Surgical supplies, except where CMS policy permits

General Principles

There are several general principles that can be applied to the edits as follows:

1. The component service is an accepted standard of care when performing the comprehensive service.
2. The component service is usually necessary to complete the comprehensive service.
3. The component service is not a separately distinguishable procedure when performed with the comprehensive service

General Principles - Examples

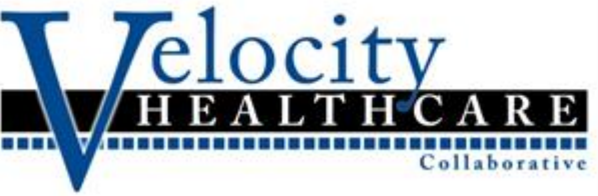
Medical:

1. Since interpretation of cardiac rhythm is an integral component of the interpretation of an electrocardiogram, a rhythm strip is not separately reportable.
2. Since determination of ankle/brachial indices requires both upper and lower extremity doppler studies, an upper extremity doppler study is not separately reportable.
3. Since a cardiac stress test includes multiple electrocardiograms, an electrocardiogram is not separately reportable.

General Principles - Examples

Surgical:

1. Since a myringotomy requires access to the tympanic membrane through the external auditory canal, removal of impacted cerumen from the external auditory canal is not separately reportable.
2. Since a colectomy requires exposure of the colon, the laparotomy and adhesiolysis to expose the colon are not separately reportable.



Medical/Surgical Package

What's In A Package?

Most medical and surgical procedures include:

- Pre-procedure work
- Intra-procedure work
- Post-procedure work

- When multiple procedures are performed there is often overlap of pre- and post-procedure work
  - Payment methodologies for surgical procedures account for the overlap.

Package Principles

- Airway Access
  - Airway access is necessary for general anesthesia and is not separately reportable
  - CPT 31500 Intubation, endotracheal, emergency procedure, would not be reported separately
  - Visualization of the airway is a component of 31500
    - Don’t report endoscopy, laryngoscopy, bronchoscopy as they are all diagnostic and therapeutic

Package Principles

- Vascular Access
  - Intravenous access (e.g., CPT codes 36000, 36400, 36410) is not separately reportable when performed with many types of procedures such as:
    - surgical procedures,
    - anesthesia procedures,
    - radiological procedures requiring intravenous contrast,
    - nuclear medicine procedures requiring intravenous radiopharmaceutical

Package Principles

- Vascular Access
  - Saline and heparin "lock" services are necessary for maintaining vascular access and are not separately reportable
  - Global surgical packages include the administration of fluids and drugs during the operative procedure
- **Note:** If a procedure requires more invasive access such as central venous or pulmonary artery, the more invasive service is separately reportable if it is not typical of the procedure and the service is not already included Global surgical packages include the administration of fluids and drugs during the operative procedure

Package Principles

- Cardiopulmonary Monitoring
  - Required when various types of surgical procedures are performed and anesthesia is administered
  - Since it is integral, they are not separately reportable
  - Examples include:
    - Cardiac monitoring – 93000-93010, 93040-93042
    - Pulse oximetry – 94760-94761
    - Ventilation management

Package Principles

- Exposure/Exploration of Surgical Field
  - Exposure and exploration of the surgical field is integral to an operative procedure and is not separately reportable.
    - For example, an exploratory laparotomy (CPT code 49000) is not separately reportable with an intra-abdominal procedure.
  - If exploration results in additional procedures, the additional procedures may generally be reported separately.
  - If exploration of the surgical field results in additional procedures other than the primary procedure, the additional procedures may generally be reported separately.

Package Principles

- Exposure/Exploration of Surgical Field
  - A procedure designated by the CPT code descriptor as a "separate procedure" is not separately reportable if performed in a region anatomically related to the other procedure(s) through the same skin incision, orifice, or surgical approach.

Package Principles

- Surgical Access through Diseased Tissue
  - Debridement of tissue in the surgical field of another musculoskeletal procedure is not separately reportable
    - For example, debridement of muscle and/or bone (CPT codes 11043-11044, 11046-11047) associated with excision of a tumor of bone is not separately reportable

Package Principles

- Surgical Access through Diseased Tissue
    - Similarly, debridement of tissue (e.g., CPT codes 11042, 11045, 11720-11721, 97597, 97598) superficial to, but in the surgical field, of a musculoskeletal procedure is not separately reportable.
  - This rule does not apply for debridement of open fracture or dislocations

Package Principles

- Failed Procedures
  - If a procedure utilizing one approach fails and is converted to a procedure utilizing a different approach, only the completed procedure may be reported.
    - For example, if a laparoscopic hysterectomy is converted to an open hysterectomy, only the open hysterectomy procedure code may be reported.

Package Principles

- Failed Procedures
  - If a laparoscopic procedure fails and is converted to an open procedure, the physician should not report a diagnostic laparoscopy in lieu of the failed laparoscopic procedure.
    - For example, if a laparoscopic cholecystectomy is converted to an open cholecystectomy, the physician should not report the failed laparoscopic cholecystectomy nor a diagnostic laparoscopy.

Package Principles

- Treatment of Complications of Primary Procedure
  - Not separately reportable if:
    1) It represents usual and necessary care in the operating room during the procedure or
    2) If it occurs postoperatively and does not require return to the operating room
  - Control of postoperative hemorrhage is also not separately reportable unless the patient must be returned to the operating room for treatment.

NCCI Edit Files

NCCI Edit Files

- How to use the NCCI edit tools - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf
- NCCI Policy Manual for Medicare Services - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/NCCI-Policy-Manual-2018.zip

NCCI Edit Files

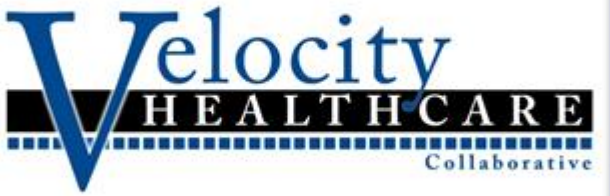
- Facility Outpatient MUE Tables - https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Coding/NationalCorrectCodInitEd/downloads/2018-04-01-MCR-MUE-Outpatient-Services.zip

NCCI Edit Files

- NCCI Edit Excel Files:
  - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

Related Links

Hospital PTP Edits v24.0 effective January 1, 2018 (492,215 records) 0001M/80050 – 27894/G0471
Hospital PTP Edits v24.0 effective January 1, 2018 (491,890 records) 28001/0213T - 49999/49570
Hospital PTP Edits v24.0 effective January 1, 2018 (365,778 records) 50010/0213T - 79999/36000
Hospital PTP Edits v24.0 effective January 1, 2018 (140,660 records) 80003/80002 –R0075/R0070
Practitioner PTP Edits v24.0 effective January 1, 2018 (511,599 records) 0001M/36591 – 25931/G0471
Practitioner PTP Edits v24.0 effective January 1, 2018 (507,927 records) 26010/01810 – 36909/J2001
Practitioner PTP Edits v24.0 effective January 1, 2018 (474,903 records) 37140/0213T – 60650/G0471
Practitioner PTP Edits v24.0 effective January 1, 2018 (514,837 records) : 61000/0213T – R0075/R0070
Hospital PTP Edits v24.1 effective April 1, 2018 (492,229 records) 0001M/80050 – 27894/G0471
Hospital PTP Edits v24.1 effective April 1, 2018 (492,084 records) 28001/0213T - 49999/49570
Hospital PTP Edits v24.1 effective April 1, 2018 (365,312 records) 50010/0213T - 79999/36000
Hospital PTP Edits v24.1 effective April 1, 2018 (141,123 records) 80003/80002 –R0075/R0070
Practitioner PTP Edits v24.1 effective April 1, 2018 (537,183 records) 0001M/36591 – 25931/G0471
Practitioner PTP Edits v24.1 effective April 1, 2018 (482,358 records) 26010/01810 – 36909/J2001
Practitioner PTP Edits v24.1 effective April 1, 2018 (523,111 records) 37140/0213T – 60650/G0471
Practitioner PTP Edits v24.1 effective April 1, 2018 (466,820 records) 61000/0213T – R0075/R0070



Modifier Not Allowed

Which Code Do I Remove?

- Example:
  - 94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device
  - 94644 Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour

Which Code Do I Remove?

- Both 94640 and 94644 hit the CCI edits and a “0” which means that a modifier is not allowed for use.
- How do you know which code to remove?
  - You need to consult the National Correct Coding Initiative (NCCI) Edit Manual

Which Code Do I Remove?

- Chapter 11 Section J – Pulmonary Services
  - "CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes."

Which Code Do I Remove?

- Chapter 11 Section J – Pulmonary Services
  - “CPT code 94640 shall only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered.”
- CPT code 94640 has a Medical Unlikely Edit (MUE) of “2”.

Which Code Do I Remove?

- Chapter 11 Section J – Pulmonary Services
  - "If inhalation drugs are administered in a continuous treatment or a series of "back-to-back" continuous treatments exceeding one hour, CPT codes 94644 (continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour) and 94645 (...; each additional hour) may be reported instead of 94640."

Which Code Do I Remove?

- Chapter 11 Section J – Pulmonary Services
  - "CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) and CPT code 94664 (demonstration and/or evaluation of patient utilization of an aerosol generator...) generally should not be reported for the same patient encounter."

Which Code Do I Remove?

- Chapter 11 Section J – Pulmonary Services
  - "The demonstration and/or evaluation described by CPT code 94664 is included in CPT code 94640 if it utilizes the same device (e.g., aerosol generator) that is used in the performance of CPT code 94640. If performed at separate patient encounters on the same date of service, the two services may be reported separately."

3M Encoder Edits

Nosology Messages/Edits

3M Nosology Edits

Code R079 should not be used as a principal diagnosis if a related definitive diagnosis has been established.

References:
ICD-10-CM Guidelines

NCCI Edits

You have coded 94664 in addition to the following code(s):
(99201--99205, 99211--99215, 99281--99285, 99304--99310, 99315, 99316, 99318, 99324--99328, 99334--99337, 99341--99345, 99347--99350, 99483, 99497, G0463)

The Medicare NCCI edits consider this separate reporting of codes that are components of the comprehensive procedure if billed for services provided to the same beneficiary by the same physician on the same day.

These codes will be rebundled by your Medicare payor and payment will be based on code 94664 only.

* If these codes represent a different session, surgery, site, lesion, or injury, then use of an appropriate modifier on the excluded code will differentiate the services provided and will notify the payor to bypass this edit.

Medicare Outpatient Code Editor

You have coded 94640 in addition to the following code(s):
(94664, 99201--99205, 99211--99215, 99281--99285, 99304--99310, 99315, 99316, 99318, 99324--99328, 99334--99337, 99341--99345, 99347--99350, 99483, 99497, G0463)

The Medicare NCCI edits consider this separate reporting of codes that are components of the comprehensive procedure if billed for services provided to the same beneficiary by the same physician on the same day.

These codes will be rebundled by your Medicare payor and payment will be based on code 94640 only.

* If these codes represent a different session, surgery, site, lesion, or injury, then use of an appropriate modifier on the excluded code will differentiate the services provided and will notify the payor to bypass this edit.

Medicare Outpatient Code Editor

3M Encoder Edits

Age: 45 Gender: Female Disch Date: 04/02/2018 LOS: 1

ICD-10 Summary

Code	Description
94640	**Pressurized/nonpressurized inhalation treatment** APC: 05791 - Pulmonary Treatment **Edit: 3340 - 3M- This comprehensive code is paired with another CPT component code to trigger OCE edit 0040** **LCD Edit: 11 - Failed medical necessity.** REV: 9999 - No Rev Code Status: S - Procedure or service, not discounted when multiple.
94664	**Demo&/eval of pt utiliz aersl gen/neb/inhlr/ip** APC: 19996 - Payment status not determined - criteria not met for payment or packaging **Edit: 0040 - OCE- NCCI Edit - Code 2 of a code pair with 94640 that would be allowed if an appropriate NCCI modifier were present. (LIR)** **Edit: 3340 - 3M- This comprehensive code is paired with another CPT component code to trigger OCE edit 0040** **LCD Edit: 11 - Failed medical necessity.** REV: 9999 - No Rev Code Status: Q1 - STV-Packaged codes
99282	**Emergency department visit low/moder severity** APC: 05022 - Level 2 Type A ED Visits **Edit: 0021 - OCE- Medical visit on same day as a type T or S procedure without modifier -25 (significant separate E&M service). (RTP)** **Edit: 0040 - OCE- NCCI Edit - Code 2 of a code pair with 94664,94640 that would be allowed if an appropriate NCCI modifier were present. (LIR)** REV: 9999 - No Rev Code Status: V - Clinic or emergency department visit.

Dx Reason for Visit

Code	Description
R079	**Chest pain, unspecified**

Diagnosis Code Detail

Code	Description
R079	Primary **Chest pain, unspecified**

3M Encoder Edits

Estimated Reimbursement -- APC - Payment at Risk

Total	$296.41
CMS	$236.17
Copay	$60.24
Tot Adj Wt	3.96
OPPS	$296.41
APC1	05791 94640 Tot $177.62 H $141.52 C $36.10 U 1 W 2.37 P1.00 RISK1
APC2	05022 99282 Tot $118.79 H $94.65 C $24.14 U 1 W 1.59 P1.00 RISK2
APC3	19996 94664 Error APC
Status	Inlier Payment with Line Item Reject/Denial

Claim Type (APC-Payment at Risk)

01	Single day procedure claim (Status = S and/or T, without V)

APC Overall Claim Disposition

4	Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w only pre-payment edits.

APC Bill Type

13X	Hospital Outpatient

APC Condition Code

9999	No/Unknown Condition Code

Modifier 25

Use in the Hospital Setting

- Modifier -25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

Use in the Hospital Setting

- Under the Medicare Outpatient Prospective Payment System (OPPS) and use of Ambulatory Payment Classifications (APCs), modifier -25 is only appended to Evaluation and Management (E&M) visit codes which have a status indicator of "V."

Use in the Hospital Setting

- The following code range is applicable for use with modifier -25:
  - 0359T, 0360T, 0362T, 90945, 92002-92004, 99201, 992014, 95250,99281-99285, 99460, 99463, 99495-99496, G0101, G0175, G0245, G0246, G0248, G0249, G0379, G0380-G0384, G0402, G0463

Use in the Hospital Setting

- Modifier used on an E/M code when it is reported with a procedure code that has a outpatient payment status indicator (OPSI) of "S" or "T."
- However, this does not preclude the provider from reporting this modifier with E/M codes that are assigned to an OPSI other than the "S" or "T" as long as the procedure meets the definition of "significant, separately identifiable E/M service" (Medicare Claims Processing Manual, chapter 4, section 20.6, Integrated Outpatient Code Editor, v17.1.)

Modifier 27

Multiple E/M Encounters

- Modifier -27 Multiple Outpatient Hospital E/M Encounters on the Same Date
- Under the Medicare Outpatient Prospective Payment System (OPPS) and use of Ambulatory Payment Classifications (APCs), modifier -27 is only appended to Evaluation and Management (E&M) visit codes which have a status indicator of "V."

Multiple E/M Encounters

- The following code range is applicable for use with modifier -27:
  - 90945, 92002-92014, 99201-99285, 99431, G0101, G0175, G0245, G0246, G0248, G0249, G0379 G0380-G0384, G0402, and G0463

Multiple E/M Encounters

- Hospitals use this modifier on the second and subsequent E/M code when more than one E/M service is provided to indicate that the E/M service is a separate and distinct E/M encounter from the service previously provided on the same day in the same or different hospital setting.
  - (Medicare Claims Processing Manual, chapter 4, section 20.6, Integrated OCE (IOCE) CMS Specifications V17.1)

Modifier 59

Modifier 59

- Distinct procedural service
  - Indicates a procedure or service was distinct or independent from other services performed on the same day
- Most widely used modifier
  - Considerable abuse and high level of manual audit
  - May lead to civil fraud and abuse cases

Modifier 59

- Identifies procedures/services that are not normally reported together, but are appropriate under the circumstances
- Represents a different
  - Session or patient encounter
  - Procedure or surgery
  - Site or organ system
  - Separate incision/excision
  - Separate lesion/injury

Modifier 59 Misuse

- 2015 CERT Report
  - Part A claims
    - Reviewed 20,279 claims
    - $260 Billion paid
    - $28.7 Billion projected in errors
  - Part B claims
    - Reviewed 18,317
    - $90.4 Billion in payment made
    - $11.5 Billion projected in errors

NCCI/PTP Example

1	Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
214884	17000	11000		19980401	*	1	Standards of medical / surgical practice
214885	17000	11001		19960101	19960101	9	Standards of medical / surgical practice
214886	17000	11040		19980401	20101231	1	Standards of medical / surgical practice
214887	17000	11041		19980401	20101231	1	Standards of medical / surgical practice
214888	17000	11042		19980401	*	1	Standards of medical / surgical practice
214889	17000	11051		19960101	19970101	1	Mutually exclusive procedures
214890	17000	11052		19960101	19970101	1	Mutually exclusive procedures

Modifier 59

- Indicator
- 1 Code pairs may be submitted separately
  - if performed in a different session or patient encounter,
  - different procedure or surgery,
  - different site or organ system,
  - separate incision/excision,
  - separate lesion or separate injury not ordinarily encountered or performed on same day by the same physician
- Documentation must be maintained in the medical records

Modifier 59

- Indicator
- 0 These code pairs will not be reimbursed if submitted for the same date of service
- 9 Not subject to CCI edits

Modifier 59

Standard of Medical Surgical Practice

Date of Service	Treatment	CPT and MOD
1/23/2016	Resection, diaphragm with complex repair (eg, prosthetic material, local muscle flap	39561
1/23/2016	Insertion of temporary indwelling bladder catheter, simple	51702

Modifier 59

Mutually Exclusive

Date of Service	Treatment	CPT and MOD
1/23/2016	Destruction (eg. Laser surgery, electrosurgery, eg, actinic keratosis) first lesion	17000
1/23/2016	Paring or cutting of benign hyperkeratotic lesion (eg. Corn or callus) 2 to 4 lesion	11056

Modifier 59

- CPT codes in column I and the CPT codes in column II
  - Either CPT or CMS has instructions that identify appropriate methodology for code submission and usually the column II codes is included in or cannot be reported with the column I code.

Modifier 59

Date of Service	Treatment	CPT and MOD
4/23/2016	Destruction, premalignant lesions; first lesion	17000
4/23/2016	Biopsy of skin, subcutaneous tissue and/or mucous membrane, unless otherwise listed; single lesion	11100

- Is it appropriate to report these together?

Modifier 59

- Answer

  - Modifier 59 may be reported with code 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used, not modifier 59.

Modifier 59

- Answer
  - Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Anatomical Modifiers

Common Anatomic Modifiers

- E1-E4: Associated with eyelid
- FA, F1-F9: Associated with fingers
- LT, RT: Left side, right side (used to identify procedures performed on the LT/RT side of the body)
- LC, LD, LM, RC, RI: Associated with coronary arteries
- TA, T1-T9: Associated with toes

Payer Requirements

- Many payers require the use of anatomical modifiers for reimbursement.
  - Humana and BCBS both consider the claim incomplete if anatomical modifiers are absent from appropriate CPT codes.
- Anatomical modifiers can be used for diagnostic and therapeutic services.
- LT/RT are the most commonly used anatomical modifiers.

Other HCPCS Level II Modifiers

EPO Stimulating Agents

- The Erythropoiesis (EPO) Stimulating Agents (ESAs) stimulate the bone marrow to make more red blood cells and are United States Food and Drug Administration (FDA) approved for use in reducing the need for blood transfusion in patients with specific clinical indications.

EPO Stimulating Agents

- All non-ESRD claims billing HCPCS J0881 Injection, darbepoetin alfa, 1 mcg (non-ESRD use) and J0885 Injection, epoetin alfa, (for non-ESRD use), 1000 units must report one of the following modifiers:
  - EA Erythropoetic stimulating agent (ESA) administered to treat anemia due to anticancer chemotherapy

EPO Stimulating Agents

- EB Erythropoetic stimulating agent (ESA) administered to treat anemia due to anticancer radiotherapy
- EC Erythropoetic stimulating agent (ESA) administered to treat anemia **not** due to anticancer radiotherapy or anticancer chemotherapy

EPO Stimulating Agents

- ESAs administered for more than one of the indicated therapies are to be billed as separate line items:
  - ESAs for chemo-induced anemia, (EA modifier) are reported as separate line items (J0881EA)
  - ESAs for radio-induced anemia (EB modifier) are reported as separate line items (J0885EB)
  - ESAs for non-chemo/radio induced anemia (EC modifier) are reported as separate line items (J0881EC)