

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**USE OF MODIFIER 59 TO BYPASS
MEDICARE'S NATIONAL
CORRECT CODING INITIATIVE
EDITS**



Daniel R. Levinson
Inspector General

November 2005
OEI-03-02-00771

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in the inspections generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid Fraud Control Units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.



E X E C U T I V E S U M M A R Y

OBJECTIVE

To determine (1) whether modifier 59 is being used inappropriately to bypass Medicare’s National Correct Coding Initiative (CCI) edits and (2) to what extent Medicare carriers are reviewing the use of modifier 59.

BACKGROUND

In January 1996, the Centers for Medicare & Medicaid Services (CMS) began the CCI. This initiative was developed to promote correct coding by providers and to prevent Medicare payment for improperly coded services. The initiative consists of automated edits that are part of the carriers’ claims processing systems.

Specifically, the CCI edits contain pairs of Healthcare Common Procedure Coding System codes (i.e., code pairs) that generally should not be billed together by a provider for a beneficiary on the same date of service. All code pairs are arranged in a column 1 and column 2 format. The column 2 code is generally not payable with the column 1 code. Throughout this report we will refer to the column 1 code as the primary code or service and the column 2 code as the secondary code or service.

Under certain circumstances, a provider may bill for two services in a CCI code pair and include a modifier on the claim that would bypass the edit and allow both services to be paid. A modifier is a two-digit code that further describes the service performed. Thirty-five modifiers can be used to bypass the CCI edits. Modifier 59 is one of these modifiers.

Modifier 59 is used to indicate that a provider performed a distinct procedure or service for a beneficiary on the same day as another procedure or service. It may represent a different session, different procedure or surgery, different anatomical site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries). Modifier 59 should be attached to the secondary, additional, or lesser service in the code pair.¹ According to CMS, this is the second code in a CCI code pair.² When modifier 59 is

¹ “Medicare Claims Processing Manual,” Chapter 23, section 20.9, http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf.

² National Correct Coding Initiative Frequently Asked Questions, <http://www.cms.hhs.gov/physicians/cciedits/>.

used, a provider's documentation must demonstrate that the service was distinct from other services performed that day.³

CMS provides carriers with guidance and instructions on the correct coding of claims, including the use of modifier 59, through manuals, transmittals, and CMS's Web site. Carriers, in turn, are required by CMS to educate providers concerning issues such as correct coding. Carriers are also responsible for developing their own prepayment and postpayment medical review strategies to identify billing errors.

We selected a stratified random sample of 350 code pairs for services that bypassed CCI edits using modifier 59 in fiscal year (FY) 2003. An independent contractor conducted a coding review of the medical records for these services to determine the appropriateness of the use of modifier 59. We performed separate analysis on our FY 2003 data to determine whether modifier 59 was billed with the primary or secondary code. We also surveyed each Medicare carrier to learn about their medical review activities, claims processing systems, and provider education activities related to modifier 59.

FINDINGS

Forty percent of code pairs billed with modifier 59 in FY 2003 did not meet program requirements, resulting in \$59 million in improper payments. Medicare allowed payments for 40 percent of code pairs that did not meet the following program requirements: (1) the services were not distinct from each other or (2) the services were not documented. Specifically, modifier 59 was used inappropriately with 15 percent of the code pairs because the services were not distinct from each other. Medicare allowed an estimated \$31 million for the secondary services in these code pairs. Secondary services are the services that CCI edits would deny. Most of these services were not distinct because they were performed at the same session, same anatomical site, and/or through the same incision as the primary service. Five code pairs represented 53 percent of the services that were not distinct. In addition to services that were not distinct, 25 percent of the code pairs billed with modifier 59 were not adequately documented. Medicare allowed an estimated \$28 million for these services. In most of these cases, either one or both of the services billed were not documented in the medical record, or the

³ "Medicare Claims Processing Manual," Chapter 12, section 30, http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf.

documentation indicated that another code should have been billed for one or both of the services performed. In the remaining cases, either the documentation was insufficient to make a determination, or the documentation was not provided.

Eleven percent of code pairs billed with modifier 59 in FY 2003 were paid when the modifier was billed with the incorrect code. Pursuant to the “Medicare Claims Processing Manual,” modifier 59 should be billed with the secondary, additional, or lesser service in a CCI code pair. However, our analysis of 3.4 million code pairs showed that 11 percent of the code pairs were paid when modifier 59 was attached to the primary code only. This billing error represented \$27 million in Medicare paid claims. Our analysis also indicated that 37 carriers paid for at least 10 percent of their claims billed with modifier 59 when the modifier was attached to the incorrect code.

Most carriers did not conduct reviews of modifier 59, but those carriers that did found providers who were using modifier 59 inappropriately. Between 2002 and 2004, 11 of 56 carriers conducted 1 or more reviews of the use of modifier 59. Ten carriers completed at least one review and one carrier’s only review was still in progress. All of the carriers that completed reviews found providers who were using modifier 59 inappropriately. One-third of 32 reviews completed found error rates of 40 percent or more for services billed with modifier 59.

RECOMMENDATIONS

The Centers for Medicare & Medicaid Services should encourage carriers to conduct prepayment and postpayment reviews of the use of modifier 59. Our inspection found that 40 percent of code pairs billed with modifier 59 did not meet program requirements. Carrier reviews also indicated that providers were using modifier 59 inappropriately. We recommend that CMS encourage carriers to conduct prepayment and postpayment reviews of the use of modifier 59. We believe carriers should use data analysis to determine how to best carry out these reviews. Because we found that a small number of code pairs made up more than half of the services that were not distinct in our sample, carriers may want to focus their initial analysis on these code pairs.

The Centers for Medicare & Medicaid Services should ensure that the carriers’ claims processing systems only pay claims with modifier 59 when the modifier is billed with the correct code. The

“Medicare Claims Processing Manual” states that modifier 59 should be billed with the secondary, additional, or lesser service in the CCI code pair. However, our analysis indicated that the majority of carriers paid for at least 10 percent of their claims billed with modifier 59 when the modifier was attached to the primary code only. This raises questions about how Medicare guidelines are being applied within the carriers’ claims processing systems.

AGENCY COMMENTS

CMS concurred with our recommendation to encourage carriers to conduct prepayment and postpayment reviews of the use of modifier 59. CMS stated it would inform its contractors of our study so they can consider our data when prioritizing their payment review strategies. After these reviews are completed, suspected fraud and abuse cases will be forwarded to the appropriate program safeguard contractor for further development.

CMS also concurred with our recommendation to ensure that carriers’ claims processing systems only pay claims when modifier 59 is billed with the secondary code. However, CMS reports that it is not able to implement an edit to ensure this correct coding at the present time. Instead, CMS will:

- Distribute this report to its contractors responsible for identifying improper payments and potential fraud, waste, and abuse.
- Share this report with the Recovery Audit Contractors that were implemented on a pilot basis under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- Issue a “Medlearn Matters” article to provide continuing education to physicians on how to bill modifier 59 appropriately.

The full text of CMS’s comments can be found in the “Agency Comments” section of this report.

OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate CMS’s multipronged approach to addressing the inappropriate billing and use of modifier 59 on Medicare claims. While CMS reports that it cannot implement a claims processing edit to ensure that claims with modifier 59 are billed with the correct code at this time, we hope CMS will consider implementing this type of edit in the future.

▶ T A B L E O F C O N T E N T S

EXECUTIVE SUMMARY i

INTRODUCTION 1

FINDINGS 9

 Forty percent of services did not meet requirements..... 9

 Modifier 59 billed with incorrect code 12

 Reviews found inappropriate use..... 13

RECOMMENDATIONS 14

APPENDIXES 16

 A: Description of Stratified Sample..... 16

 B: Estimates and Confidence Intervals..... 17

AGENCY COMMENTS 18

ACKNOWLEDGMENTS 20

OBJECTIVE

To determine (1) whether modifier 59 is being used inappropriately to bypass Medicare's National Correct Coding Initiative (CCI) edits and (2) to what extent Medicare carriers are reviewing the use of modifier 59.

BACKGROUND

The Medicare program provides coverage of health care services for the elderly and disabled. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program and contracts with carriers nationwide to process most Medicare Part B claims. Part B claims include those for physician, radiology, and laboratory services. Medicare paid approximately \$77 billion for Part B services in fiscal year (FY) 2003.

National Correct Coding Initiative

In January 1996, CMS put the CCI into effect. This initiative was developed to promote correct coding by providers and to prevent Medicare payments for improperly coded services. CMS developed the coding policies based on coding conventions defined in the American Medical Association's "Current Procedural Terminology (CPT) Manual," national and local policies and edits, coding guidelines developed by national societies, a review of current coding practices, and analysis of standard medical and surgical practices.⁴ CMS works with a contractor to continually review and refine the CCI edits with input from national medical societies, carriers, and providers.

CMS provides the CCI edit files to the carriers each quarter. The CCI edits are updated quarterly; however, the most current version contains all prior additions and deletions of edits. Previously, providers had to purchase the CCI edits; but as of September 2003, the CCI edits are available for providers to reference or download from CMS's Web site.⁵

National Correct Coding Initiative Edits

Medicare providers use the Healthcare Common Procedure Coding System (HCPCS) to code services provided to Medicare beneficiaries. The CCI edits contain pairs of HCPCS codes (i.e., code pairs) that

⁴ "National Correct Coding Policy Manual for Medicare Part B Carriers," Introduction, p. vi.

⁵ <http://www.cms.hhs.gov/physicians/cciedits/default.asp>.

generally should not be billed together by a provider for a beneficiary on the same date of service. All code pairs are arranged in a column 1 and column 2 format. The column 2 code is generally not payable with the column 1 code. Throughout this report we will refer to the column 1 code as the primary code or service and the column 2 code as the secondary code or service.

Modifier 59

Under certain circumstances, a provider may bill for two services in a CCI code pair and include a modifier on the claim. A modifier is a two-digit code that further describes the service performed. A modifier would allow the code pair to bypass the edit and both services would be paid. Each CCI code pair has a modifier indicator that determines whether a modifier can be used. Thirty-five modifiers can be used to bypass the CCI edits. Modifier 59 is one of these modifiers.

In FY 2003, Medicare allowed \$370 million for Part B services that bypassed the CCI edits using a modifier.⁶ Of this amount, \$245 million (66 percent) was allowed for services that bypassed the CCI edits using modifier 59.

Proper Use of Modifier 59

Pursuant to the “Medicare Claims Processing Manual”⁷ and the “CPT Manual 2003,”⁸ modifier 59 is used to indicate that a provider performed a distinct procedure or service for a beneficiary on the same day as another procedure or service. It may represent a:

- Different session,
- Different procedure or surgery,
- Different anatomical site or organ system,
- Separate incision or excision,
- Separate lesion, or
- Separate injury (or area of injury in extensive injuries).

Modifier 59 should not be used with the radiation treatment management code 77427 or with the evaluation and management

⁶ This figure represents the dollar amount paid for the secondary code in a code pair when a beneficiary had no more than two services on the same day by the same provider.

⁷ Chapter 23, section 20.9. http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf.

⁸ Appendix A, p. 404.

service codes 99201-99499. Modifier 59 should only be used if there is no other CCI modifier that best explains the circumstances.

The “Medicare Claims Processing Manual” further clarifies that modifier 59 should be attached to the secondary, additional, or lesser service in the code pair.⁹ According to CMS, this is the second code in a CCI code pair.¹⁰ The following example explains the proper use of modifier 59:

If an infusion procedure is performed, the routine placement of the intravenous catheter for that procedure should not be billed separately because it is considered a component of the infusion procedure. However, if a catheter is placed in a different site later in the day, modifier 59 should be attached to the code representing the placement of the catheter. This would indicate that two separate procedures were actually performed. In this case, both codes would be paid.¹¹

Documentation Requirements

Providers must maintain adequate documentation in the medical record to support the services billed. Section 1833(e) of the Social Security Act requires that providers furnish “such information as may be necessary in order to determine the amounts due” in order to receive Medicare payment. In addition, pursuant to the “Medicare Claims Processing Manual,” when modifier 59 is used, a provider’s documentation must demonstrate that the service was distinct from other services performed that day.¹² For example, to allow both a bone marrow biopsy procedure and a bone marrow aspiration procedure to be billed together, the medical record must indicate that the services were performed through separate incisions or at separate sessions.¹³ Other types of CCI code pairs must have documentation demonstrating that the services were

⁹ Chapter 23, section 20.9, http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf.

¹⁰ National Correct Coding Initiative Frequently Asked Questions, <http://www.cms.hhs.gov/physicians/cciedits/>.

¹¹ Adapted from, “National Correct Coding Policy Manual for Medicare Part B Carriers,” version 9.3, Chapter XI, p. 1.

¹² Chapter 12, section 30, http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf.

¹³ “National Correct Coding Policy Manual for Medicare Part B Carriers,” version 9.3, Chapter I, pp. 14-15.

performed sequentially¹⁴ or that a different level of service was provided to indicate that the services were distinct from each other.¹⁵

Carrier Guidance

CMS provides carriers with guidance and instructions on the correct coding of claims, including the use of modifier 59, through manuals, transmittals, and the CMS Web site. CMS's Web site contains the CCI edits as well as the "National Correct Coding Policy Manual for Medicare Part B Carriers" (NCCI policy manual), the "Medicare Claims Processing Manual," and responses to frequently asked questions concerning CCI. The NCCI policy manual contains a general policy chapter and 10 narrative chapters each corresponding to a separate section of the "CPT Manual." Most chapters contain some examples of circumstances when it is appropriate to use modifier 59 with certain code pairs or types of code pairs. This manual is updated each year in October.

Education for Providers

CMS requires carriers to educate providers concerning issues such as correct coding. Using data analysis, carriers develop their own strategies for conducting prepayment and postpayment medical review to identify errors. Carriers target individual providers who require education when claims review indicates billing problems. Depending on the level of error identified, carriers may address providers' coverage or coding-related problems through educational letters, telephone conferences, or face-to-face meetings. Carriers also use mass media and training seminars to give timely and accurate Medicare information to the provider community.

Clarification of the National Correct Coding Initiative Policy Manual

During the course of our inspection, we shared information with the CCI workgroup¹⁶ concerning CCI edits that were frequently bypassed using modifier 59. The workgroup addressed many of the issues concerning these code pairs when updating the October 2004 version of the NCCI policy manual.

¹⁴ "National Correct Coding Policy Manual for Medicare Part B Carriers," version 9.3, Chapter XI, p. 9.

¹⁵ Ibid., Chapter X, p. 3.

¹⁶ The workgroup consists of staff at CMS headquarters and at the CCI contractor.

METHODOLOGY

Sample Selection

We matched the CCI edits that were in effect in FY 2003 against 100 percent FY 2003 Part B claims data from CMS's National Claims History File. To determine if a code pair was active on a particular date of service and if the code pair allowed a modifier on that date, we used the CCI edits from version 9.3 (October 2003) as well as the modifier indicator change lists from version 8.3 (October 2002) through version 9.3.

We defined our population as code pairs that allowed a modifier and that bypassed the CCI edits because modifier 59 was present. The population consisted of approximately 3.4 million code pairs with \$227 million in payments for the secondary codes after we excluded the following services:

- Code pairs that had another valid CCI modifier in addition to modifier 59,¹⁷
- Services where a beneficiary had more than two services on the same day by the same provider,¹⁸
- Services represented by codes 99201-99499 or 77427 since modifier 59 should not be billed with these codes,
- Services rendered by three providers who were under investigation, and
- Services where the payment for the secondary service in the code pair was less than or equal to \$24.¹⁹

From the population, we selected a stratified random sample of 350 code pairs to send to an independent contractor for coding review. The strata definitions were based on the frequencies of code pairs in the population, the dollar amount of the secondary code in a code pair, and information received from members of the CCI workgroup. The details of our stratification are outlined in Appendix A.

¹⁷ These code pairs were excluded to be certain that the use of modifier 59 was the only reason CCI edits were bypassed.

¹⁸ No additional analysis was conducted to determine the effect this had on the types of services excluded from our population.

¹⁹ Excluding these services eliminated 25 percent of code pairs (1 million) and 6 percent of the dollars (\$15 million) from our population.

Medical Record Request

We sent our initial written request for medical records by Federal Express to all providers in our sample. The requests were sent to addresses found in CMS's Unique Provider Identification Number (UPIN) file. A number of requests were returned as undeliverable. We looked for alternate addresses in the UPIN file, searched the Internet, and contacted carriers to find correct address information. We continued to send requests to alternate addresses until we found a valid address or exhausted all possibilities. We were unable to locate six providers. We removed the services performed by these providers from subsequent data analysis.

We sent up to two follow-up requests by Federal Express to providers who did not respond to our first request. We were able to contact providers for 344 code pairs in our sample. Three of these providers were excluded from our data analysis because they were unable to provide the records for a valid reason or the records arrived too late to be included in our coding review. This left us with 341 CCI code pairs for analysis. Of these, six were considered undocumented because the provider did not send the records requested. The remaining 335 records were forwarded for coding review.

Medical Record Review

We sent 335 medical records to an independent contractor for coding review to determine whether modifier 59 was used inappropriately to bypass CCI edits. The records were reviewed by experienced certified coders. We asked the coders to determine whether both services in the code pairs were documented, whether another code should have been billed for one or both of these services, and whether the services were distinct from each other. For services that were not distinct, we asked the coders to describe why they were not distinct services. We provided the coders with a copy of the October 2003 version of the NCCI policy manual and instructed them to refer to it as well as the 2002 and 2003 CPT and HCPCS manuals in making their determinations. The coding review was conducted between October and December 2004.

Calculation of Improper Payments

We calculated the total amount paid for secondary services in CCI code pairs when the services were not distinct or the secondary services were not adequately documented. It is the secondary code in the code pair that would be denied by the CCI edits. We did not include the dollar amounts for code pairs when the coding review determined that only the

primary code was not documented²⁰ or that one or both services should have been coded differently.²¹ We totaled the allowed amounts for inappropriate services and weighted the estimates to reflect our stratified sample design. The point estimates and confidence intervals for these statistics are presented in Appendix B.

Claim Data Review

We performed separate analysis on the 3.4 million FY 2003 code pairs from which we selected our sample to determine whether modifier 59 was billed with the primary or secondary code in the CCI code pairs. This analysis enabled us to determine whether the carriers' claims processing systems handled claims according to the requirements in the "Medicare Claims Processing Manual." The manual instructs providers to bill modifier 59 with the secondary, additional, or lesser service in a CCI code pair.²² According to CMS, this is the second code in a CCI code pair.²³ We considered modifier 59 to be billed with the incorrect code when modifier 59 was billed with the primary code only. To calculate the amount paid when modifier 59 was billed with the primary code only, we totaled the payments for the secondary services in these code pairs.

The Centers for Medicare & Medicaid Services and Carrier Surveys

We conducted telephone surveys with CMS central office and each CMS regional office to determine what roles they have in ensuring the proper use of modifier 59. These surveys were conducted between January and May 2004.

We also surveyed all Medicare Part B carriers to determine the extent to which carriers review the use of modifier 59. We asked the carriers about their medical review activities, claims processing systems, and provider education and outreach activities.

We received 30 individual survey responses. The 30 responses represented all 56 carrier jurisdictions since some carriers handle operations for more than 1 State. If carrier operations differed from

²⁰ These payments were excluded because our estimates of improper payments were based on the allowances for the secondary code only.

²¹ Since we did not analyze whether these services were upcoded (billed at a higher level than the service actually performed) or downcoded, we did not calculate the amount Medicare allowed for the services.

²² Chapter 23, section 20.9, http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf.

²³ National Correct Coding Initiative Frequently Asked Questions, <http://www.cms.hhs.gov/physicians/cciedits/>.

I N T R O D U C T I O N

jurisdiction to jurisdiction, we instructed the carriers to complete more than one survey; otherwise, we instructed them to complete one survey. In our analysis, we applied the carrier's response to all of the applicable jurisdictions. Therefore, our total number of carriers is 56. We conducted the surveys from October through December 2004.

Standards

This inspection was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

► FINDINGS

Forty percent of code pairs billed with modifier 59 in FY 2003 did not meet program requirements, resulting in \$59 million in improper payments

Medicare allowed payments for 40 percent of code pairs that did not meet the following program requirements: (1) the services were not distinct from each other or (2) the services were not adequately

documented. We estimate that Medicare allowed \$59 million for these services in FY 2003. A summary of improper payments is presented in Table 1 below.

Table 1. Code Pairs That Did Not Meet Program Requirements		
Type of Error	Projected	
	Percentage of Code Pairs	Allowed Amount (Millions)
Services not distinct	15%	\$31
Services not adequately documented	25%	\$28
- Primary, secondary, or both services not documented	12%	\$16 ¹
- Different code should have been billed	7%	N/A ²
- Documentation insufficient to make a determination	5%	\$9
- Documentation not provided	1%	\$3
Total	40%	\$59

¹ Estimate includes allowed amounts for secondary services only.

² We did not estimate allowed amounts when one or both services should have been coded differently.

Source: Office of Inspector General analysis of medical records request and coding review results, 2005.

Fifteen percent of code pairs billed with modifier 59 were not distinct.

Modifier 59 was used inappropriately with 15 percent of the code pairs because the services were not distinct from each other. In most cases, services were not distinct because they were performed at the same session, same anatomical site, and/or through the same incision. Medicare allowed an estimated \$31 million for the secondary services in these code pairs. Secondary services are the services that CCI edits would deny.

Five code pairs represented over half of the services that were not distinct.

Just five code pairs made up 53 percent of the services that were not distinct, representing an estimated \$11 million in payments. We compared the percentage of services that were not distinct for these five code pairs to the percentage of services that were not distinct for all other code pairs in our population. Our comparison found a statistically significant difference between these two groups.²⁴

In our sample data, modifier 59 was used inappropriately most often with the CCI code pair for bone marrow biopsy (38221) and bone marrow aspiration (38220). This code pair represented 13 of our 62 sampled services that were not distinct from each other. In all of these cases, modifier 59 was inappropriate because the two services were not distinct since they were performed at the same session and through the same incision. Pursuant to the NCCI policy manual, these two procedures are only distinct when performed through different incisions or at different sessions.²⁵

A code pair for physical therapy (97140/97530) represented another eight of our sampled services that were not distinct from each other. In all of these cases, modifier 59 was not appropriate because the medical record did not document that the services were performed in different 15-minute time intervals. Pursuant to the “Medicare Claims Processing Manual,” time spent performing physical therapy services must be included in the medical record.²⁶ Without this documentation, these services cannot be considered distinct.

A cytopathology code pair (88108/88104) represented six of the services billed inappropriately with modifier 59 in our sample. In most of these cases, the documentation showed that the services were performed on the same specimen; therefore, pursuant to the NCCI policy manual, only one code should have been billed.²⁷

Two code pairs for chemotherapy and IV infusion (96410/90780 and 96408/90780) represented another six of our sampled services that were not distinct. In all of these cases, the documentation showed that two

²⁴ For the five code pairs, 29 percent of services were not distinct. For all other code pairs, 9 percent of services were not distinct. This difference is statistically significant at the 95 percent confidence level based on a chi-square test of independence ($p = .0016$).

²⁵ Version 9.3, Chapter I, pp. 14-15.

²⁶ Chapter 5, Section 20.2, http://www.cms.hhs.gov/manuals/104_claims/clm104c05.pdf.

²⁷ Version 9.3, Chapter X, p. 3.

F I N D I N G S

services were performed but did not indicate whether the supportive medication was administered sequentially to the chemotherapy. Pursuant to the NCCI policy manual, such documentation is needed to demonstrate that these services were performed at different sessions and, therefore, are both payable.²⁸

Services for an additional 28 code pair combinations in our sample were found to be not distinct. Each of these code pairs had one or two services that were not distinct.

Twenty-five percent of the code pairs billed with modifier 59 were not adequately documented. Modifier 59 was used inappropriately with 25 percent of the code pairs because the services were not adequately documented in the medical record. In most cases, either one or both of the services in a code pair was not documented or the documentation indicated that a different code should have been billed for one or both of the services. In the remaining cases, either the documentation was insufficient to make a determination or the documentation was not provided. Medicare allowed an estimated \$28 million for the secondary services in these code pairs.

One or both services not documented. For 12 percent of the code pairs, one or both of the services billed were not documented in the medical record. Specifically, in 4 percent of code pairs, the primary service was not documented. We did not calculate the amount Medicare allowed for these services. In the remaining 8 percent of these code pairs, either both services were not documented or the secondary service was not documented. Medicare allowed an estimated \$16 million for secondary services when these services were not documented. For example, one provider billed for two podiatry services. However, the medical record only showed that the patient visited the office to pick up medication. The record did not include documentation for either podiatry service billed.

Different code should have been billed. For 7 percent of the code pairs, another code should have been billed for one or both of the services performed. We did not analyze whether these services had been upcoded (billed at a higher level than the service actually performed) or downcoded. Therefore, we did not calculate the amount Medicare allowed for these services.

²⁸ Version 9.3, Chapter XI, p. 9.

F I N D I N G S

Documentation insufficient to make a determination. For 5 percent of the code pairs, the documentation provided was not sufficient to determine whether the services were distinct. In these cases, the documentation provided was not legible or did not sufficiently support the use of the code(s) billed. For example, a provider documented removal of polyps but not the specific technique for the removal. Therefore, the documentation was insufficient for the coder to determine the correct code for the procedure. Medicare allowed an estimated \$9 million for the secondary services in these code pairs.

Documentation not provided. Providers did not send us the requested records for 1 percent of the code pairs. These providers either did not send records for the beneficiary for the date of service we requested or did not send records for the beneficiary at all. Medicare allowed an estimated \$3 million for the secondary services in these code pairs.

Confidence intervals for these estimates are presented in Appendix B.

Eleven percent of code pairs billed with modifier 59 in FY 2003 were paid when the modifier was billed with the incorrect code

The “Medicare Claims Processing Manual” states that modifier 59 should be billed with the secondary, additional, or lesser service in a CCI code pair. According to CMS, this is the second code in a CCI code pair. However, our review of 3.4 million code pairs billed with modifier 59 in FY 2003 found that 11 percent of the code pairs were paid when modifier 59 was attached to the primary code only. This billing error represented \$27 million in Medicare paid claims.

In addition, another 13 percent of code pairs were paid when modifier 59 was billed with both the primary and secondary codes. The remaining 76 percent of code pairs were paid when modifier 59 was attached to the secondary code only.

For each carrier, we analyzed the paid claims for code pairs billed with modifier 59. Thirty-seven carriers paid for at least 10 percent of their code pairs when the modifier was attached to the primary code only. These carriers paid between 10 and 32 percent of code pairs billed with modifier 59 when modifier 59 was billed with the primary code only. Nineteen of the thirty-seven carriers paid between 10 and 15 percent, 16 carriers paid between 16 and 28 percent, and 2 carriers paid 32

F I N D I N G S

percent for code pairs billed with modifier 59 when modifier 59 was billed with the primary code only.

Most carriers did not conduct reviews of modifier 59, but those carriers that did found providers who were using modifier 59 inappropriately

Between 2002 and 2004, 11 of 56 carriers conducted 1 or more reviews of the use of modifier 59. Two carriers had conducted prepayment reviews of modifier 59,

eight had conducted postpayment reviews, and one conducted both types of reviews. Ten carriers completed at least one review and one carrier's only review was still in progress. All of the carriers that completed reviews reported that they found providers who were using modifier 59 inappropriately. Many carriers chose to focus on modifier 59 because they had identified vulnerabilities through analysis of claims data or through provider appeals and denials.

The 11 carriers conducted a total of 32 reviews of services billed with modifier 59. One-third of the 32 reviews conducted by the carriers found error rates of 40 percent or more among certain providers for services billed with modifier 59. Specifically, three of these reviews found error rates of nearly 100 percent among providers billing for bone marrow biopsy and bone marrow aspiration with modifier 59. As stated previously, this is the code pair that made up the highest number of services in our sample that were not distinct from each other. Another six reviews found error rates between 5 and 20 percent for services billed with modifier 59. Five reviews found no errors. We did not receive error rates for 10 reviews because either the reviews were still in progress or the error rate was not provided by the carrier.

Several carrier reviews resulted in the collection of overpayments. One carrier recovered over \$200,000 in improper payments. In addition, some carriers put certain providers' claims under review as a result of their findings. Carriers that conducted reviews and found inappropriate use of modifier 59 reported that they either educated individual providers on the proper use of the modifier or offered all providers education on modifier 59 through seminars and/or newsletter articles.

The Centers for Medicare & Medicaid Services should encourage carriers to conduct prepayment and postpayment reviews of the use of modifier 59. Our inspection found that 40 percent of code pairs billed with modifier 59 were inappropriate. Carrier reviews also indicated that providers were using modifier 59 inappropriately. We recommend that CMS encourage carriers to conduct prepayment and postpayment reviews of the use of modifier 59. We believe carriers should use data analysis to determine how to best carry out these reviews. Because we found that a small number of code pairs made up more than half of the services that were not distinct in our sample, carriers may want to focus their initial analysis on these code pairs.

The Centers for Medicare & Medicaid Services should ensure that the carriers' claims processing systems only pay claims with modifier 59 when the modifier is billed with the correct code. The "Medicare Claims Processing Manual" states that modifier 59 should be billed with the secondary, additional, or lesser service in the CCI code pair. However, our analysis indicated that the majority of carriers paid at least 10 percent of their claims billed with modifier 59 when the modifier was attached to the primary code only. This raises questions about how Medicare guidelines are being applied within carriers' claims processing systems.

AGENCY COMMENTS

CMS concurred with our recommendation to encourage carriers to conduct prepayment and postpayment reviews of the use of modifier 59. CMS stated it would inform its contractors of our study so they can consider our data when prioritizing their payment review strategies. After these reviews are completed, suspected fraud and abuse cases will be forwarded to the appropriate program safeguard contractor for further development.

CMS also concurred with our recommendation to ensure that carriers' claims processing systems only pay claims when modifier 59 is billed with the secondary code. However, CMS reports that it is not able to implement an edit to ensure this correct coding at the present time. Instead, CMS will:

R E C O M M E N D A T I O N S

- Distribute this report to its contractors responsible for identifying improper payments and potential fraud, waste, and abuse.
- Share this report with the Recovery Audit Contractors that were implemented on a pilot basis under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- Issue a “Medlearn Matters” article to provide continuing education to physicians on how to bill modifier 59 appropriately.

The full text of CMS’s comments can be found in the “Agency Comments” section of this report.

OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate CMS’s multipronged approach to addressing the inappropriate billing and use of modifier 59 on Medicare claims. While CMS reports that it cannot implement a claims processing edit to ensure that claims with modifier 59 are billed with the correct code at this time, we hope CMS will consider implementing this type of edit in the future.

► A P P E N D I X ~ A

Description of Stratified Sample					
Strata	Description of Code Pairs		Population of Code Pairs	Medicare Allowance for Secondary Code	Sample size
1- High frequency code pairs	17000/11100	Destroy benign, premalignant lesion/ Biopsy of skin lesion	1,214,267	\$ 65,981,193	75
	96410/90780	Chemotherapy infusion method/ IV infusion therapy, 1 hr			
	97140/97530	Manual therapy/ Therapeutic activities			
	96408/90780	Chemotherapy, push technique/ IV infusion therapy, 1 hr			
2- High frequency-debridement services	11055-56/ 11720-21	Trim skin lesion-Trim skin lesions, 2 to 4/ Debride nail, 1 to 5-Debride nail, 6 or more	623,654	\$ 21,373,167	50
	11719/11720	Trim nail(s)/ Debride nail, 1 to 5			
	11057/11721	Trim skin lesions, over 4/ Debride nail, 6 or more			
	11040/11721	Debride skin, partial/ Debride nail, 6 or more			
3- Potential high error rate and high frequency code pairs	88108/88104	Cytopathology, concentrate tech/ Cytopathology, fluids	74,942	\$4,554,038	40
	38221/38220	Bone marrow biopsy/ Bone marrow aspiration			
4- Potential high error rate and low frequency code pairs	Any combinations of the following codes: pathology codes: 88104-88112 (excluding 88108/88104), 88160-88162, 88173, 88174, 88180, 88271-88275, 88300-88365; urinary codes: 52000-52640; eye surgery codes: 65400-67228; extremity surgery codes: 23930-26952		41,741	\$ 5,327,770	35
5- High secondary code dollar amount	Allowance for secondary code was greater than or equal to \$200 (excluding code pairs in strata 3 and strata 4)		106,482	\$ 39,225,417	50
6- Remaining code pairs	All other code pairs not in strata 1 through 5		1,365,551	\$ 90,644,881	100
Total			3,426,637	\$227,106,466	350

Source: Office of Inspector General sample of FY 2003 CCI code pairs billed with modifier 59.

➤ **A P P E N D I X ~ B**

The table below contains statistical estimates presented in the Findings section of this report. Point estimates and confidence intervals were weighted based on the stratified random sample design and are reported at the 95 percent confidence interval.

Estimates and Confidence Intervals		
Statistic	Point Estimate	95% Confidence Interval
Total services that did not meet program requirements	40.22%	34.12% - 46.32%
	\$58,907,886	\$47,210,537 - \$70,605,236
Services that were not distinct	14.79%	10.42% - 19.16%
	\$30,616,030	\$21,456,650 - \$39,775,409
Services that were not adequately documented	25.43%	20.04% - 30.82%
	\$28,291,857	\$19,466,497 - \$37,117,217
Services where the primary, secondary, or both services were not documented	11.96%	7.94% - 15.98%
	\$16,368,134	\$9,589,143 - \$23,147,125
Services where a different code should have been billed	7.42%	4.28% - 10.56%
Services where the documentation was insufficient to make a determination ¹	4.67%	1.98% - 7.36%
	\$8,580,251	\$3,688,575 - \$13,471,928
Services where the documentation was not provided ¹	1.38%	0% - 2.77%
	\$3,343,472	\$0 - \$7,089,485
Services represented by five code pair combinations that were not distinct	53.36%	38.70% - 68.02%
	\$11,222,880	\$6,313,582 - \$16,132,177

¹ The relative precision for these estimates exceeds 50 percent.

Source: Office of Inspector General analysis of medical records request and coding review results, 2005.

▶ AGENCY COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 20 2005

TO: Daniel R. Levinson
Inspector General
Office of the Inspector General

FROM: Mark B. McClellan M.D., Ph.D. *mm*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General's Draft Report: "Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits," (OEI-03-02-00771)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report entitled, "Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits." We appreciate the OIG's efforts to examine this important issue.

The Centers for Medicare & Medicaid Services (CMS) implemented the National Correct Coding Initiative (NCCI) to promote correct coding of Medicare claims and to prevent Medicare payment for improperly coded services. This initiative consists of automated edits used to evaluate Medicare claims submission when a provider bills for two services that should only be billed once or with a modifier in certain circumstances. Under certain circumstances, a provider may bill for two services in a NCCI code pair and include modifier 59 on the claim. Modifier 59 is used to indicate that a provider performed a distinct procedure or service for a beneficiary on the same day as another procedure or service. This modifier would allow the code pair to bypass the edit and both services would be paid. The OIG report determines whether modifier 59 is being used inappropriately to bypass the NCCI edits and the extent to which Medicare carriers review the use of modifier 59.

OIG Recommendation:

CMS should encourage carriers to conduct pre-payment and post-payment reviews of the use of modifier 59.

CMS Response:

CMS concurs with this recommendation. We will inform our contractors of this study and ask that they include the information contained in this report as part of the data they consider when prioritizing their strategies. If potential fraud and abuse is suspected after medical records have

A G E N C Y C O M M E N T S

Page 2 – Daniel R. Levinson

been reviewed, these situations should be referred to the appropriate Program Safeguard Contractor for further development.

OIG Recommendation:

CMS should ensure that the carriers' claims processing systems only pay claims with modifier 59 when the modifier is billed with the correct code.

CMS Response:

CMS agrees with the OIG's recommendation, however, CMS is not able to implement an edit into the carriers' claims processing systems to address this issue at this time. Instead, as stated above, CMS will take steps to ensure that claims with modifier 59 are paid correctly. CMS will distribute this report to its Medicare contractors responsible for identifying improper payments and potential fraud, waste and/or abuse in the Medicare program for their consideration. CMS has also shared this report with the Recovery Audit Contractors that were implemented on a pilot basis under the Medicare Modernization Act of 2003 to identify and recover Medicare overpayments. Finally, CMS will issue a Medlearn Matters article to provide continuing education to physicians on how to bill appropriately when using modifier 59.

Thank you very much for your work on this report. The information it contains is very helpful to CMS efforts to ensure correct payment for Medicare services.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Robert A. Vito, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and Linda M. Ragone, Deputy Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

Tara Bernabe, *Team Leader*

Nancy J. Molyneaux, *Program Analyst*

Linda Frisch, *Program Specialist*

Doris Jackson, *Program Specialist*

Tricia Davis, *Director, Medicare & Medicaid Branch*

Barbara Tedesco, *Mathematical Statistician*

Kevin Farber, *Mathematical Statistician*

Scott Horning, *Program Analyst*

Steve Milas, *Program Analyst*

Michael P. Barrett, *Program Analyst*