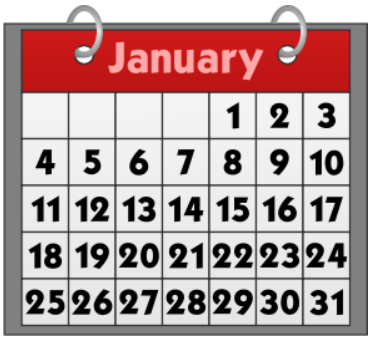

Medicare Part B Billing, Therapy and Modifier 59

January 1st, 2015 brought some changes to the modifiers used for outpatient services. It was the date that the Centers for Medicare and Medicaid Services (CMS) set to implement some changes to billing Modifier 59, a common modifier used in physical, occupational and speech therapy services in the skilled nursing facility setting. Let's spend a few minutes talking about what the modifiers are, why they are used and how the new changes will impact your therapy billing practice.

On August 15, 2014, CMS issued Transmittal 1422/ Change Request 8863 outlining four new Healthcare Common Procedure Coding System (HCPCS) modifiers that would be implemented on January 1, 2015, to help further define the current Modifier 59, a modifier used to define a "Distinct Procedural Service."

Therapists are among current health professionals that use Modifier 59 for Medicare Part B billing to indicate that a Current Procedural Terminology (CPT) code represents a service that was done separately and distinctly from another CPT code service. So in {plain} language, Modifier 59 is sometimes used to report that 2 therapy treatment interventions that were completed with the same patient on the same day, though not simultaneously, and should be billed individually vs bundled together.

Some Examples

These examples should ring a bell…for physical therapy – Gait Training CPT 97716 and Therapeutic/Functional Activity CPT 97530 conflict and for occupational therapy – ADL CPT 97535 and Therapeutic Activity CPT 97530 conflict. Therapists may have even been told that these codes "cannot be billed together." Some facilities discourage charging both of these codes in the same session as it can create "issues" for the billing office. In fact, these codes can be billed together, assuming they were performed at different times (one after another in the

same session OR at 2 different times of the day).

These codes are just a few in a long list of code combinations that are part of the National Correct Coding Initiative (NCCI), Procedure to Procedure code edits designed to prevent unbundling of codes that should be bundled together for payment resulting in overpayment (double-billing) to providers. Some edits as defined by NCCI are optional and by-passable – like the examples above- or as permanent and non-by-passable. Modifiers can be used to bypass edits when they are established by NCCI as optional edits.

Some other therapy code combinations that require Modifier 59 to enable the codes to be billed individually on the same day are:

- 97530 (Therapeutic Activity) and 97116 (Gait Training)
- 97530 (Therapeutic Activity) and 97535 (ADL)
- 97140 (Manual Therapy) and 97530 (Therapeutic Activity)
- 97542 (Wheelchair Mobility) and 97530 (Therapeutic Activity)
- 97542 (Wheelchair Mobility) and 97110 (Therapeutic Exercise)
- 97530 (Therapeutic Activity) and 97542 (Wheelchair Mobility)
- 97760 (Orthotic Training and Fitting) and 97710 (Therapeutic Exercises)
- 97526 (Dysphagia Treatment) and 97110 (Therapeutic Exercise)

An example of a “permanent and non-by-passable” code combination (codes that can’t be billed together, even with a modifier) is:

- 97001 (Physical Therapy Evaluation) and 97002 (Physical Therapy Re-Evaluation)

To make things even a bit more confusing, the codes used and the edits that go along with them are not discipline specific. This plays a tricky role in the skilled nursing facility setting, where PT, OT and Speech services are typically billed monthly and are all on the same billing claim (vs a private practice that would only bill for 1 discipline.) So for example, if PT provided gait training (97116) and OT provided therapeutic activity (97530), the billing claim would need Modifier 59

on the 97116 charge to allow for payment of both codes, otherwise, the NCCI edit would only allow payment for 1 code. Since PT and OT were provided at separate and distinct times, Modifier 59 is appropriate. The problem presents when the facility has to recognize the need for the code and apply it manually, as all discipline charges need to be reviewed at the end of each billable day to see if the edits are present. Therapists can not be expected to apply Modifier 59 to their daily charges as the charges for all disciplines will need to be entered and reviewed prior to determining if Modifier 59 is needed and where it needs to be applied. (If PT provided gait training in the morning and OT provided therapeutic activity in the afternoon, how would PT know to apply the Modifier 59 to their gait charge?)

Modifier 59 is the most widely used modifier, has multiple purposes, and is associated with considerable abuse leading to reviews, appeals and even civil fraud and abuse cases, per CMS in Transmittal 1422. CMS reports that 2013 data showed a possible $320-450 million projected error totals related to modifiers, particularly 59. CMS believes that adding more precise coding options to Modifier 59 will help reduce the errors associated with this overpayment.

So what are the new codes?

CMS has defined four new HCPCS modifiers to selectively identify subsets of Modifier 59:

• XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter **This may be appropriate for Therapy**
• 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 **This may be appropriate for Therapy**
• XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

These modifiers, collectively referred to as -X{EPSU} modifiers, define specific subsets of Modifier 59. CMS stated they will not stop recognizing Modifier 59 but notes that the modifier

should not be used when a more descriptive modifier above is available. CMS will continue to recognize Modifier 59 in many instances but may selectively require a more specific modifier for billing certain codes in the near future.

How will this change our practice?

On and after January 1st, CMS will initially accept either Modifier 59 or a more selective – X{EPSU} modifier as correct coding. CMS is encouraging providers to transition to the new modifiers even before the NCCI edits are put in place, and are informing Medicare contractors that they have the OK to start requiring the new modifiers as needed.

The APTA requested clarification from CMS on the new modifier use and reported that per CMS, therapists could "keep on using Modifier 59 in reimbursement claims to indicate that a HCPCS represents a service that is separate and distinct from another service to which it is paired under the Correct Coding Initiative (CCI) program."

So, the bottom line, **therapists can wait it out a bit**, as noted in Transmittal 1422 , and continue to use Modifier 59 until more specific edits are released requiring the above new codes, or begin to use the newer codes.

Some helpful resources: (click to follow links)

- CMS Memo on Modifier 59 Changes
- CMS MLN Article on Modifier 59 Changes (MM8863)
- NCCI Coding Edit Resources
- NCCI Coding Edits
- Physical Therapy Code/Edits
- Occupational Therapy Code/Edits
- Speech Therapy Code/Edits