Codify
BY AAPC

Dermatology Coding Alert

READER QUESTIONS: Modifier 59 Doesn't Override Payment Reduction

Question: When I remove one lesion and biopsy another with an uncertain nature, Medicare pays the removal at 100 percent and the biopsy at 50 percent. The carrier applies this payment reduction even though I use modifier 59 on the bundled procedure--the biopsy. Is there another way to code these encounters that would avoid the fee reduction?

Wyoming Subscriber

Answer: You are coding these claims correctly. Normally, a lesion removal includes a biopsy. To indicate that the biopsy occurred at a separate site from the lesion removal--and thus deserves separate payment--you must append modifier 59 (Distinct procedural service) to the otherwise bundled biopsy code.

Although same-session, separate-site lesion removals and biopsies deserve separate payment, modifier 59 does not exempt the claim from multiple-procedure payment rule reductions, which you probably associate with modifier 51 (Multiple procedures).

For claims containing more than one surgical procedure, "Medicare's allowance is 100 percent of the fee schedule for the procedure with the highest fee schedule amount and 50 percent of the fee schedule amount for the other procedures performed on the same day," according to CIGNA's Medicare Bulletin.

CMS bases the reduction on the fact that the fee schedule amount comprises relative value units for practice expense, professional services, and malpractice expense. Because Medicare believes that the physician incurs no increased practice expense or malpractice expense for the additional procedure, the carrier pays a 50 percent allowance for the professional services over and above the professional services for the first procedure.

Example: A dermatologist makes a full-thickness removal of a 0.4-cm malignant lesion including margins from a patient's arm and also biopsies a suspicious mole on the patient's other arm.

Because the biopsy occurs at a separate site from the excision, you should report both the lesion removal (11600, Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less) and the biopsy (11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion).

You attach modifier 59 to 11100 to inform the carrier that the encounter's circumstances warrant overriding the usual 11600-11100 edit.

Result: For the claim, Medicare nationally pays:

• 11600 at $153.48 (4.05 nonfacility total RVUs x the 2006 conversion factor of 37.8975)

• 11100-59 at $39.61 (50 percent reduction on $79.21 [2.09 RVUs x 37.8975]).