Contents

What's new in INCISIVE MD?

This release supports the new Medicare substitution HCPCS modifiers XE, XP, XS, and XU for modifier 59. We provided in early January the Medicare and Illinois Workers Compensation 2015 contract terms along with the CCI Edits Version 21.0 update.

Who should read these release notes?

If you are an INCISIVE MD user ...

Read this entire document for revised features and changes to INCISIVE MD.

If you are the clinic technical contact ...

No action is required because when the user logs into INCISIVE MD it will auto-detect if any necessary updates are needed and install them into the user's local profile. For clinics using terminal services or in a managed information technology (IT) environment, please contact INCISIVE Support for instructions on manually updating users' profiles.

Modifier 59 Substitution Modifiers XE, XP, XS, and XU

The primary purpose of this release is to support the Centers for Medicare and Medicaid Services (CMS) new substitution modifiers XE, XP, XS, and XU for modifier 59. The change is effective 1 January 2015 and was announced in CMS Transmittal 1422 (Change Request 8863) and distributed to providers in a MLN Matters article MM8863.

We have provided a contract term option that allows customers to choose whether they wish to use these new substitution modifiers instead of reporting modifier 59. For the Medicare 2015 contract term, this option will be set to use these substitution modifiers. Customers may set their Medicare 2015 contract term to continue to report only modifier 59.

Additionally, we have mapped the post-operative coding CCI Edit resolution reasons to each of these new substitution modifiers so that users will see no change in the way they determine if modifier 59 or one of the new substitution modifiers is appropriate when coding their cases. We think this will significantly aid customers in their compliance efforts by providing a clear and consistent manner in which these modifiers are chosen.

Table 1. New Modifier 59 Substitution Modifiers

Modifier	Title	Definition
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 Practioner	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

CrossCurrent, Inc.
516 SE Morrison St, Ste 800
Portland, Oregon 97214-2348

Purpose of the new modifier 59 substitution modifiers

Modifier 59 is the most reported modifier to Medicare and "is associated with considerable abuse and high levels of manual audit activity" because it can be used to bypass National Correct Coding Initiative (CCI) edits. The purpose of these new substitution modifiers is to provide better reporting of the circumstances when a distinct procedure is being performed; these circumstances include documenting a different encounter with the patient, a different physician providing service, procedures being done at different anatomical sites or because of a separate incisions, and so forth.

Substitution of modifier 59 for XS for Orthopedic, Spine, and Neurosurgeons

We did an analysis and have determined that 90% of the time, our customers will be substituting modifier 59 with modifier XS when reporting a distinct procedure because of a different anatomical site, structure, or incision.

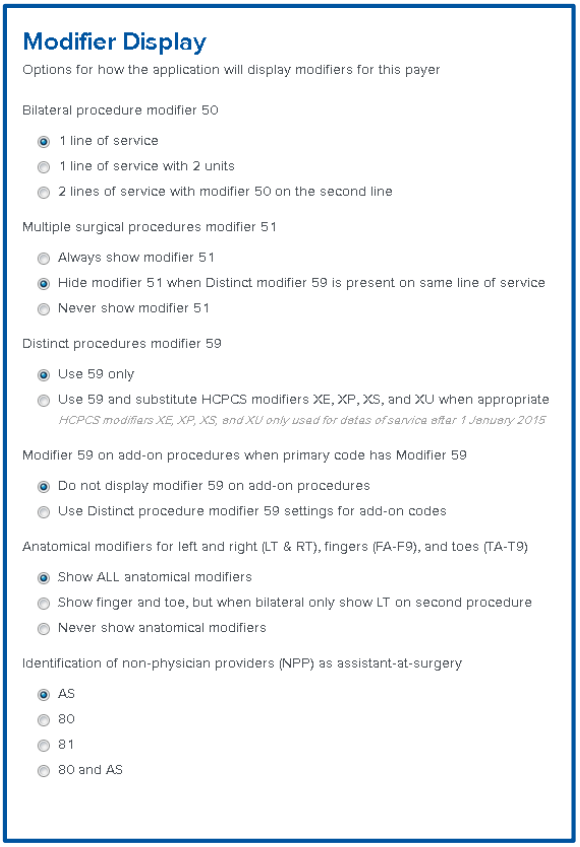
Revised Contract Term Modifier Display Settings

With this release, we have revised the Contract Term dialog to split out the modifier display rules from the financial adjustment percentages. We have rewritten the existing settings to make them more understandable when setting up a new contract term and have added two additional settings:

- Whether to use the new substitution modifiers XE, XP, XS, and XU instead of Modifier 59
- The ability to add Modifier 59 automatically to add-on procedures when the associated primary procedure has a modifier 59 appended to it

Modifier Display

The picture to the right shows the revised modifier display settings for contract terms. Existing contracts will have their settings retained and the new options for **Distinct procedures modifier 59** will be set to "Use 59 only" and the **Modifier 59 on add-on procedures when primary code has modifier 59** will be set to "Do not display modifier 59 on add-on procedures".



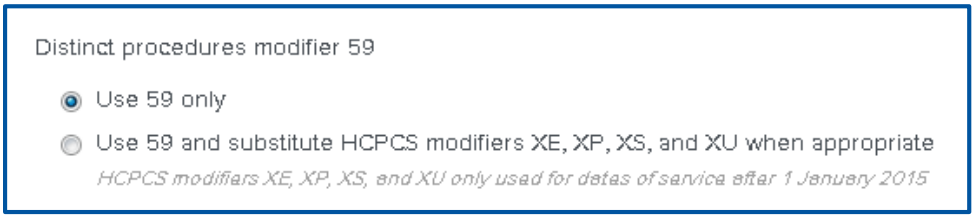
Modifier Adjustments

We have changed the layout of the modifier adjustments to be more readable, the percentages are now on the left-side for easy review and data entry. The order of the modifiers has been slightly changed in that modifier AS is

now at the bottom to be closer with the other assistant-at-surgery modifiers. Existing contracts will have their settings retained and customers do not need to take any action from this update.

Modifier 59 Contract Settings

Users can choose between only reporting modifier 59 or to substitute modifier 59 with XE, XP, XS, or XU when appropriate. The substitution will only occur for surgeries with dates of service after 1 January 2015.



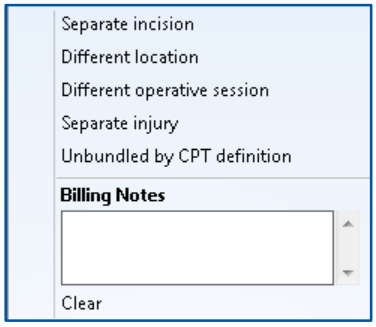
Default Settings for Modifier 59 with this Release

We have set all existing contracts except the Medicare 2015 contract term to continue to use modifier 59. If customers have commercial payers or Medicare Advantage plans that have directed them to use the new substitution modifiers, then they will need to change their contract term **Modifier Display** > **Distinct procedures modifier 59** setting to "Use 59 and substitute HCPCS modifiers XE, XP, XS, and XU when appropriate".

Medicare 2015 Contract Term

With this release, we have revised the Medicare 2015 contract term **Modifier Display** > **Distinct procedures modifier 59** setting to "Use 59 and substitute HCPCS modifiers XE, XP, XS, and XU when appropriate". If customers have been directed by their compliance departments to not report these new substitution modifiers, they will need to set their Medicare 2015 contract term **Modifier Display** > **Distinct procedures modifier 59** setting to "Use 59 only".

Modifiers XE, XP, XS, and XU Mapping to CCI Edit Resolution Reasons



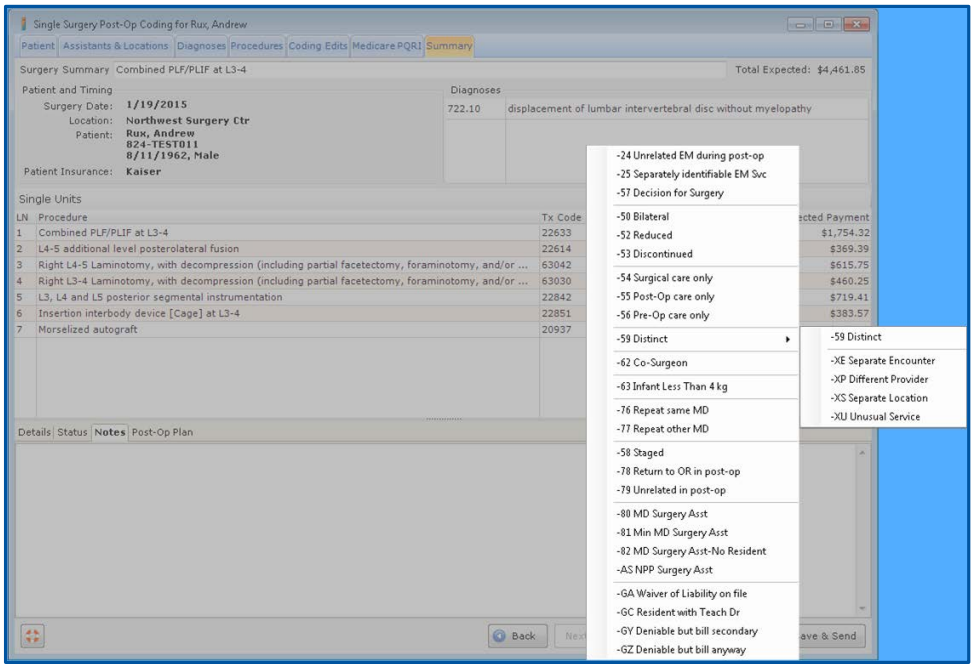
Given the limited guidance provided by CMS when they announced the use of the new substitution HCPCS modifiers XE, XP, XS and XU, we have assigned each of the standard AMA CPT Codebook distinct procedure reasons shown in the post-operative **Coding Edits** tab > distinct **Resolution** reasons drop down list to one of these new substitution modifiers. This mapping between the distinct **Resolution** reasons and the HCPCS substitution modifier is listed on the next page. If a user selects more than one resolution reason or enters **Billing Notes**, modifier 59 will be used given the ambiguity of the situation.

Table 2. Mapping of Modifier 59 Substitution modifiers

AMA CPT Codebook Modifier 59 Distinct Procedure Reasons	Substitution Modifier
Separate Incision	XS
Different Location	XS
Different Operative Session	XE
Separate Injury	XS
Unbundled by CPT Definition	XU

Manually Assigning Modifiers XE, XP, XS, and XU

If a contract term **Modifier Display** > **Distinct procedures modifier 59** option is set to "Use 59 and substitute HCPCS modifiers XE, XP, XS, and XU when appropriate" then users have the ability to manually assign modifier 59 or one of the new substitution modifiers to a line of service. While coding a surgery, users can manually append modifiers to procedures on the **Summary** tab by *left*-clicking in the **Procedures** grid > **Modifiers** column and selecting the appropriate distinct modifier from the pop-up menus; see the picture below.



Changing CCI Edit Resolution Reasons for Modifiers XE, XP, XS, and XU

As Medicare provides more guidance about the appropriate use of these new substitution modifiers for modifier 59, customers will need to provide us with feedback if they need to change the matching between the **CCI Edit** > **Resolution** reasons and the substitution modifiers. Given the limited guidance provided, we have set this matching within the software and users are unable to make changes. The feedback we will need is whether this matching should be changed or if the matching needs to be different between payers who adopt these new modifier 59 substitutions.

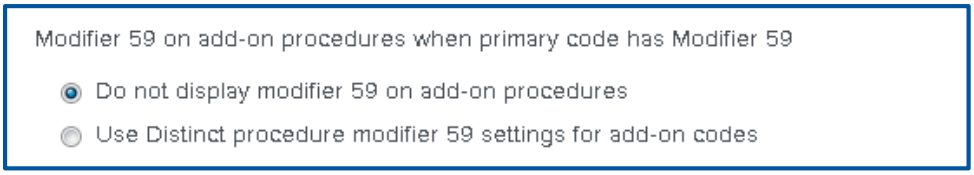
Regence Append Parent Procedure Modifiers to Add-ons

The Oregon Blue Cross and Blue Shield affiliate has listed on their Provider Coding Toolkit website a rule that add-on codes should have the same modifiers as with the associated primary code; see below:

Add-on codes

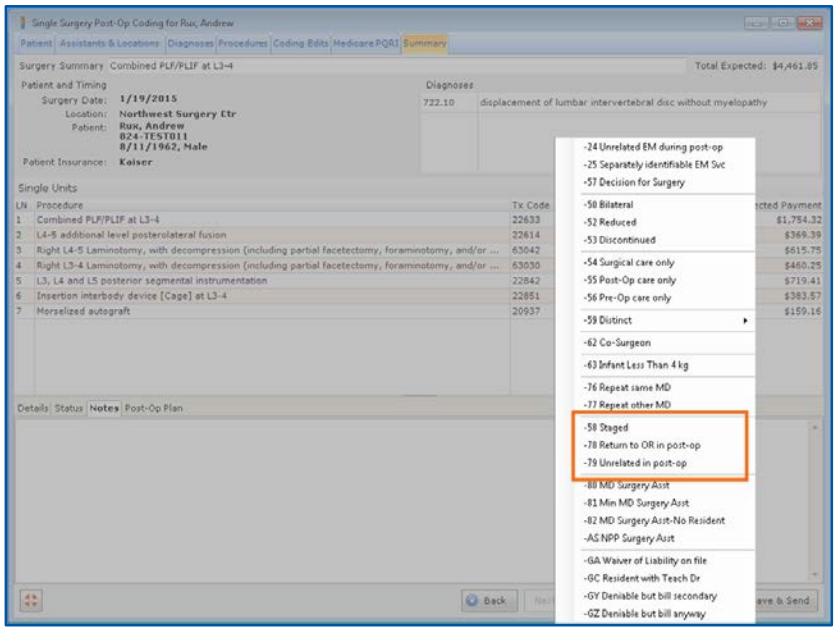
Some services are reported as add-on codes, which describe work done in addition to primary procedures. Add-on codes are not stand-alone codes, and must always be reported with primary procedures. We will deny reimbursement for an add-on code as a correct coding edit when its primary code is denied as part of an NCCI or correct code edit code pair. When correct coding indicates the use of a modifier is appropriate for the primary code, that modifier must be appended to both the primary code and add-on code.

We have interpreted this rule as requiring modifier 59 on the add-on procedure code when the primary procedure has modifier 59. We have included a new **Modifier Display** option to include reporting Modifier 59 on add-on codes.



Global Window Modifiers 58, 78, and 79

Given the wording of this Regence rule, we would also recommend that the global window modifiers 58, 78, and 79 also be reported on add-on codes when the primary code has these modifiers. The user can manually append these global window modifiers to the add-on procedure on the **Summary** tab by *left*-clicking in the procedure grid **Modifiers** column and selecting the appropriate global window modifier from the pop-up menu; see the picture below for how the manual modifier menu displays.



Customer Feedback on this Modifiers on Add-ons Option

We will work with our Oregon and Washington customers to revise how we have implemented this rule if their feedback and experience indicates that we should also include the global window modifiers along with modifier 59 to be appended to add-on procedure codes when the associated primary code has these modifiers. Moreover, we would recommend customers should verify with their local BCBS affiliate whether or not this rule is also applicable to their claims given the similarities and cross-processing of claims between BCBS affiliates.

Example Coding with New Modifier 59 options

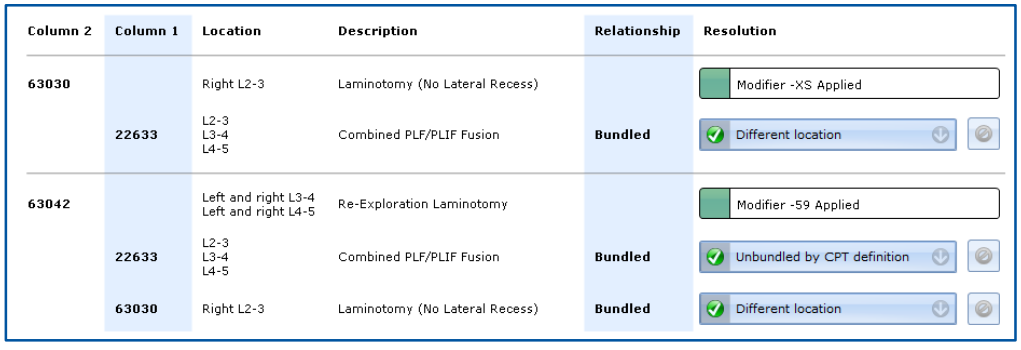
Given these new options for modifier 59, customers have a greater ability to use INCISIVE MD to code their cases in a consistent manner and have the software determine the best way to report the case for their payers' preferences. The vignette below is an example 2-level spine fusion case with two different decompression techniques. While procedure and location information is the same for all three payers, given the options selected for modifiers 51 and 59, INCISIVE MD will display different modifiers for each of these payers. This example is to demonstrate how a single case can be reported differently depending on the rules and preferences of each payer.

Vignette

Patient had a prior two level decompression 4 years ago and now presents with recurrent leg pain with radiographic studies confirming neurogenic claudication and lumbar stenosis. Given the indications, patient elects to proceed with lumbar posterolateral and interbody fusion from L2-3 to L4-5 with redo decompression and fixation and surgery is planned for 19 January 2015. The surgeon plans to perform an L2-3 Laminotomy, Bilateral Redo Laminectomies at L3-4 and L4-5, L2-3 to L4-5 posterolateral fusion, L3-4 and L4-5 posterior lumbar interbody fusion with PEEK cages, and posterior instrumentation from L2 to L5.

CCI Edits

In this example case, there are three sets of CCI Edit pairs for CPT codes 63030, 63042, and 22633. The picture below shows the edits and typical resolution reasons for each of the edits based upon AMA CPT Codebook guidelines.



Column 2	Column 1	Location	Description	Relationship	Resolution
63030		Right L2-3	Laminotomy (No Lateral Recess)		Modifier -XS Applied
	22633	L2-3 L3-4 L4-5	Combined PLF/PLIF Fusion	Bundled	Different location
63042		Left and right L3-4 Left and right L4-5	Re-Exploration Laminotomy		Modifier -59 Applied
	22633	L2-3 L3-4 L4-5	Combined PLF/PLIF Fusion	Bundled	Unbundled by CPT definition
	63030	Right L2-3	Laminotomy (No Lateral Recess)	Bundled	Different location

Medicare Coding

For the Medicare 2015 contact term, the modifier 59 options are to use the substitution modifiers and to not report modifier 59 on add-on codes. Additionally, modifier 51 is set

to not display per instructions from most Medicare carriers. With these options, INCISIVE MD will list the procedures and modifiers on the post-operative coding **Summary** tab > **Procedures** grid as shown below. The Bilateral L3-4 and L4-5 Redo Laminectomies are reported as CPT 63042 -59 -50 and 63044 -50 because more than one distinct reason (**Unbundled by CPT definition** and **Different Location**) was chosen for the CCI Edit pairs. Moreover, the Right L2-3 Laminotomy is reported as 63030 -XS because the distinct reason was **Different Location**.

Coding 1. Medicare

LN	Procedure	Tx Code	Modifiers	Units	722.10	722.52	Expected Payment
1	Bilateral L3-4 Laminotomy, with decompression (including partial facetectomy, foramin...	63042	59 50	1	☑		$1,847.25
2	Bilateral L4-5 additional level laminotomy, with decompression (including partial facet...	63044	50	1	☑		$1,147.50
3	Combined PLF/PLIF at L3-4	22633		1		☑	$877.16
4	Additional level Combined PLF/PLIF at L4-5	22634		1		☑	$467.47
5	L2-3 additional level posterolateral fusion	22614		1		☑	$369.39
6	Right L2-3 Laminotomy, with decompression (including partial facetectomy, foraminoto...	63030	XS	1	☑		$460.25
7	L2, L3, L4 and L5 posterior segmental instrumentation	22842		1		☑	$719.41
8	Insertion interbody device [Cage] at L3-4	22851		1		☑	$383.57

Note: See the paragraph below regarding the Medicare non-payment for Redo Lami (CPT 63042) at the same level of the posterolateral interbody fusion (22633).

Oregon Workers Compensation Coding

Oregon Workers Compensation does not use CCI Edits and so this case would be shown using only AMA CPT Codebook guidelines for determining which modifiers to display.

Coding 2. Oregon Workers Compensation

LN	Procedure	Tx Code	Modifiers	Units	722.10	722.52	Expected Payment
1	Bilateral L3-4 Laminotomy, with decompression (including partial facetectomy, foramin...	63042	50	1	☑		$4,553.98
2	Bilateral L4-5 additional level laminotomy, with decompression (including partial facet...	63044	50	1	☑		$918.00
3	Combined PLF/PLIF at L3-4	22633	51	1		☑	$2,138.86
4	Additional level Combined PLF/PLIF at L4-5	22634		1		☑	$1,244.14
5	L2-3 additional level posterolateral fusion	22614		1		☑	$980.51
6	Right L2-3 Laminotomy, with decompression (including partial facetectomy, foraminoto...	63030	51	1	☑		$1,129.86
7	L2, L3, L4 and L5 posterior segmental instrumentation	22842		1		☑	$1,914.25
8	Insertion interbody device [Cage] at L3-4	22851		1		☑	$1,024.73

Regence of Oregon Coding

Regence is the Blue Cross affiliate in Oregon and they have a payer rule that add-on codes should have the same modifiers as the parent procedure, which is contrary to guidelines in the NCCI Manual. So notice in the picture below that CPT 63044 also has modifier 59 listed. Additionally, this contract term is set to only report modifier 59 and so the software would display the procedure and modifiers for this case as show below.

Coding 3. Regence Oregon

LN	Procedure	Tx Code	Modifiers	Units	722.10	722.52	Expected Payment
1	Bilateral L3-4 Laminotomy, with decompression (including partial facetectomy, foramin...	63042	59 50	1	☑		$3,953.92
2	Bilateral L4-5 additional level laminotomy, with decompression (including partial facet...	63044	59 50	1	☑		$459.00
3	Combined PLF/PLIF at L3-4	22633	51	1		☑	$1,877.50
4	Additional level Combined PLF/PLIF at L4-5	22634		1		☑	$1,000.59
5	L2-3 additional level posterolateral fusion	22614		1		☑	$790.65
6	Right L2-3 Laminotomy, with decompression (including partial facetectomy, foraminoto...	63030	59 51	1	☑		$985.13
7	L2, L3, L4 and L5 posterior segmental instrumentation	22842		1		☑	$1,539.86
8	Insertion interbody device [Cage] at L3-4	22851		1		☑	$821.01

CCI Policy for Non-payment of Lumbar Fusion with Decompression

While we were testing this release, it came to our attention that CMS revised the CCI Edit manual for 2015 to include a new bundling policy for CPT 63042 and 63047 with 22630 and 22633 at the same interspace level; see the new policy statement below. This is a significant change, in that most of the lumbar interbody fusion cases coded within INCISIVE MD report both CPT 22633 and 63047 at the same interspace. Given this policy, the non-payment of CPT 63047 will approximate a 15% reduction in overall payment for the case. This policy change is effective 1/1/2015 and we will be revising INCISIVE MD to account for this change in the future release.

24. CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy...; lumbar) or 63047 (laminectomy...; lumbar) with CPT codes 22630 or 22633 (arthrodesis; lumbar) when performed at the same interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047.

We want to caution our customers, given the way the CCI Edits are set up for these procedure codes, the only way for this policy guideline to be enforced is through manual review of operative notes, that is, from either a request for additional information when adjudicating the claim, a post-payment RAC audit, or other Medicare take-back program. This is because the CCI Edits still allow modifier 59 to be reported since these procedures could be done at different interspace levels.

Medicare 2015 Contract Term

We provided to customers in early January the Medicare 2015 contact term that had a slight increase in the conversation factor to $35.7547 along with changes in the RVU values. There were usual small increases and decreases between RVU values between CPT codes. For orthopedic spine and neurosurgeons, there were three significant RVU changes in Total Facility RVUs:

- 11.43% decrease for a revision cervical total disc arthroplasty (CPT 22861) from 63.15 to 55.93
- 22.48% increase for a excision of cranial lesion (CPT 61615) from 65.08 to 97.65
- 41.05% increase for an extensive craniotomy with recontouring (CPT 61559) from 50.40 to 71.09

Illinois Workers Compensation 2015 Contract Term Update

The annual 2015 Illinois Workers Compensation Commission medical fee schedule update for professional services has been included with this release. The fee schedule changes are effective 1 January 2015 and include a 1.70% increase for this year. No changes in the administrative rules were posted to the Commission website as of 12 January 2015 and we made only one change for this contract term. We have added checking the overall reported units for each procedure against the Medicare Medically Unlikely Edits (MUE) limits. When the MUE limits apply, INCISIVE MD will set the units to the MUE cap and create a billing note what the software did to the reported units.

National Correct Coding Initiative (CCI) Edits Version 21.0

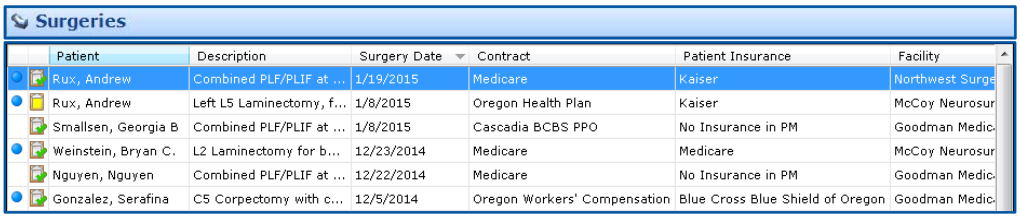
We updated the application in early January for the first quarter of 2015. For this revision, 68,213 new pairs were added; 19,693 pairs were deleted, and 16 pairs had their status indicator changed. As with any new revision at the beginning of the year, a significant portion of the newly added CCI edits were for the new 2015 CPT and HCPCS codes. In our review of the changes and this revision, we did not notice any significant changes for orthopedic, spine, and neurosurgeons.

Cervical and Thoracic Locations for CPT 63655

At customer request, we have added thoracic and cervical interspace locations to the Laminectomy for neurostimulator implantation (CPT 63655).

Surgery Last Saved but not Sent Icon

We have changed the color of the **Surgeries** list **Saved but not Sent** icon from red to blue. We made this change because several new users of INCISIVE MD called us concern what the little red dot meant and were concerned since it was red that something was wrong with the surgery. To ease this anxiety about something being wrong with the surgery, we changed the color of the icon; see the picture on the next page.



How do I contact Support?

During normal business hours, 8:00 am to 5:00 pm Pacific Time, you may contact INCISIVE Support at (503) 546-5323 or by email at support@crosscurrentinc.com. Our INCISIVE MD support website also offers resources to help answer basic questions about the software.