PROVIDER*Update*

Health Net®

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New Review Policy for Modifier 59

The misuse of modifiers that override the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) edits creates challenges for managed care plans. According to a randomized study conducted by the Office of Inspector General (OIG), a high percentage of providers used modifier 59 inappropriately. As a result of this study, OIG recommended that CMS encourage managed care plans to conduct prepayment and post-payment reviews when modifier 59 is used. Accordingly, effective August 1, 2016, Health Net of Arizona, Inc. and Health Net Life Insurance Company (Health Net) are implementing a new modifier review policy where Health Net conducts prepayment clinical claims review on all procedures billed with modifier 59.

PREPAYMENT CLINICAL REVIEWS

Upon receipt of a claim using modifier 59, a Health Net registered nurse will review the information billed on the claim, along with the member's and provider's claims history, to determine whether modifier 59 was used correctly for procedures performed on the date of service. Health Net uses nationally published guidelines from the American Medical Association (AMA), CPT and CMS associated publications when determining whether the modifier was used correctly, including the use of claim documentation requirements as listed below:

- The diagnosis codes on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas, which would result in procedures being performed on multiple body areas and sites.
- To avoid incorrect denials, providers should assign to the claim all applicable diagnosis and procedure codes using all applicable anatomical modifiers designating which areas of the body were treated.

EDIT RATIONALE

Modifier 59 is used to identify procedures or services, other than evaluation and management (E&M) services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Modifier 59 should not be appended to an E&M service.

Health Net does not require documentation for modifier 59 at the time of claim submission; however, in the event the claim is audited, documentation may be required or should be submitted upon request of reconsideration or appeal.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- Advantage Platinum (HMO)
- Advantage Platinum (PPO, POS)
- Medicare Advantage (HMO)

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
HMO, PPO, POS, Medicare Advantage – 1-800-289-2818
Health Insurance Marketplace – 1-888-926-1870
www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax 1-800-937-6086

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PROVIDER APPEALS AND DISPUTE RESOLUTION REQUESTS

In the event claims documentation is insufficient to support billing modifier 59, Health Net will send the provider a denial determination on his or her Explanation of Payment (EOP). The provider may submit an appeal or reconsideration request according to the guidelines outlined in the provider operations manuals. Providers should submit all pertinent medical records for the date of service and procedures billed. Medical records should not be submitted on first-time claims submissions as first-time claim reviews consist only of a review of the information documented on the claim and in the member and provider history. Medical records should only be submitted once the provider receives a denial and wishes to request a reconsideration or appeal.

Details on Health Net's provider appeals and dispute resolution processes are available in the provider operations manuals on the Health Net provider website at provider.healthnet.com in the Provider Library under *Operations Manuals > Dispute Resolutions, Organization Determinations and Appeals > Provider Appeals and Dispute Resolutions > Overview.*

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center at:

Line of Business	Telephone Number	Email Address
HMO, PPO, POS, & MEDICARE ADVANTAGE	1-800-289-2818	AZ_InternetProviderInquiries@healthnet.com
HEALTH INSURANCE MARKETPLACE	1-888-926-1870	

Discover Helpful Tools to Support Your Office

The Provider Library online at provider.healthnet.com allows participating providers to quickly access pertinent information to assist in their everyday interaction with Health Net. The Provider Library includes operations manuals, communications (updates and letters), Online News articles, forms, Health Net contact information, and more.