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Proper Use of Modifier 59

Note: This article was revised on May 26, 2015, to provide a reference to MLN Matters® Article [SE1503](#) that advises physicians, providers and suppliers submitting bills to Medicare that additional guidance and education on the appropriate use of the new X modifiers will be introduced in a gradual, controlled fashion by CMS and that providers may continue to use Modifier -59 after January 1, 2015, in any instance in which it was correctly used before January 1, 2015. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians and providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of Modifier 59. The article only clarifies existing policy. Make sure that your billing staffs are aware of the proper use of Modifier 59.

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Background

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of “0,” the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the *National Correct Coding Initiative Policy Manual for Medicare Services*, Chapter 1, for general information about the NCCI program, PTP edits, CCMI, and NCCI-associated modifiers. This manual can be retrieved from the download section at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> on the Centers for Medicare & Medicaid Services (CMS) website.)

One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are “separate and distinct.” Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The *CPT Manual* defines modifier 59 as follows:

“Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than 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/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. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.”

Modifier 59 and other NCCI-associated modifiers **should NOT be used** to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

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- 1. Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.**

One of the common uses of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered on the same day, and that cannot be described by one of the more specific anatomic NCCI-associated modifiers – i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3.) From an NCCI perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. However, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct. Modifier 59 should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region **does not** constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue (See example 4.)
- Treatment of posterior segment structures in the eye (See example 5.)
- Arthroscopic treatment of structures in adjoining areas of the same shoulder (See example 6.)

- 2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.**

Another common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day and that cannot be described by one of the more specific NCCI-associated modifiers – i.e., 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7) As noted in the CPT definition, modifier 59 should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.

- 3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.**

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe a “different procedure or surgery.” The code descriptors of the two codes of a code pair edit usually represent different procedures, even though they may be overlapping. The edit indicates that the two

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procedures should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be “separate and distinct.” The provider should not use modifier 59 for such an edit based on the two codes being “different procedures.” (See example 8.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures on that date of service.

4. Other specific appropriate uses of modifier 59

There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter, i.e.:

A. Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services. (See example 9.)

B. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10.) If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

C. Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs

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after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 11.) If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

Use of Modifier 59 does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures are performed at different anatomic sites or separate patient encounters or meet one of the other three scenarios described above.

Examples of Modifier 59 Usage

Following are some examples developed to help guide physicians and providers on the proper use of Modifier 59 (**Please remember that Medicare policy is that Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.**):

Example 1: Column 1 Code / Column 2 Code - 17000/11100

- CPT Code 17000 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
- CPT Code 11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Modifier 59 may be reported with code 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used, not modifier 59.

Example 2: Column 1 Code/Column 2 Code 47370/76942

- CPT Code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- CPT Code 76942 – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

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CPT code 76942 should not be reported and Modifier 59 should not be used if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure. Code 76942 may be reported with modifier 59 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

Example 3: Column 1 Code/Column 2 Code 93453/76000

- CPT Code 93453 – Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed
- CPT Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

CPT code 76000 should not be reported and Modifier 59 should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure. Modifier 59 may be reported with code 76000 if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

Example 4: Column 1 Code / Column 2 Code - 11055/11720

- CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

CPT code 11720 should not be reported and Modifier 59 should not be used if a nail is debrided on the same toe from which a hyperkeratotic lesion has been removed. Modifier 59 may be reported with code 11720 if multiple nails are debrided and a corn that is on the same foot and that is not adjacent to a debrided toenail is pared.

Example 5: Column 1 Code / Column 2 code - 67210/67220

- CPT Code 67210 – Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
- CPT Code 67220 – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

CPT code 67220 should not be reported and Modifier 59 should not be used if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ.

Example 6: Column 1 Code / Column 2 Code - 29827/29820

- CPT Code 29827 – Arthroscopy, shoulder, surgical; with rotator cuff repair
- CPT Code 29820 – Arthroscopy, shoulder, surgical; synovectomy, partial

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CPT code 29820 should not be reported and Modifier 59 should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not Modifier 59.

Example 7: Column 1 Code / Column 2 Code - 93015/93040

- CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Modifier 59 may be reported if the rhythm ECG is performed at a different encounter than the cardiovascular stress test. If a rhythm ECG is performed during the cardiovascular stress test encounter, CPT code 93040 should not be reported and Modifier 59 should not be used.

In this case, the procedures are performed in different encounters on the same day.

Example 8: Column 1 Code/Column 2 code - 34833/34820

- CPT code 34833 - Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral
- CPT code 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral

CPT code 34833 is followed by a *CPT Manual* instruction that states: "(Do not report 34833 in addition to 34820)." Although the CPT code descriptors for 34833 and 34820 describe different procedures, they should not be reported together for the same side. Modifier 59 should not be appended to either code to report the two procedures for the same side of the body. If the two procedures were performed on different sides of the body, they may be reported with modifiers LT and RT as appropriate. **However, the use is inappropriate if the basis for its use is that the narrative description of the two codes is different.**

Example 9: Column 1 Code / Column 2 Code - 97140/97530

- CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute intervals. CPT code 97530 should not be reported and Modifier 59 should not be

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used if the two procedures are performed during the same 15 minute time interval. **In this case, the procedures are performed in different encounters on the same day.**

Example 10: Column 1 Code / Column 2 Code - 37220/75710

- CPT Code 37220 – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- CPT Code 75710 – Angiography, extremity, unilateral, radiological supervision and interpretation.

Modifier 59 may be reported with CPT code 75710 if a diagnostic angiography has not been previously performed and the decision to perform the revascularization is based on the result of the diagnostic angiography. The *CPT Manual* defines additional circumstances under which diagnostic angiography may be reported with an interventional vascular procedure on the same artery. **Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.**

Example 11: Column 1 Code / Column 2 Code - 32551/71020

- CPT Code 32551 – Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open
- CPT Code 71020 – Radiologic examination, chest, 2 views, frontal and lateral

Modifier 59 may be reported if, later in the day following the insertion of a chest tube, the patient develops a high fever and a chest x-ray is performed to rule out pneumonia. CPT code 71020 should not be reported and Modifier 59 should not be used for a chest x-ray that is performed following insertion of a chest tube in order to verify correct placement of the tube. **Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.**

Additional Information

The CMS webpage on the National Correct Coding Initiative Edits is available at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> on the CMS website.

The CPT Manual includes the definition of Modifier 59, as well as CPT codes used with Modifier 59. The manual is available at <http://www.ama-assn.org/ama> on the American Medical Association (AMA) website.

You may want to review MLN Matters® article [MM8863](#) that alerts providers that CMS is establishing four new HCPCS Modifiers to define subsets of Modifier 59, Distinct Procedural Services.

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