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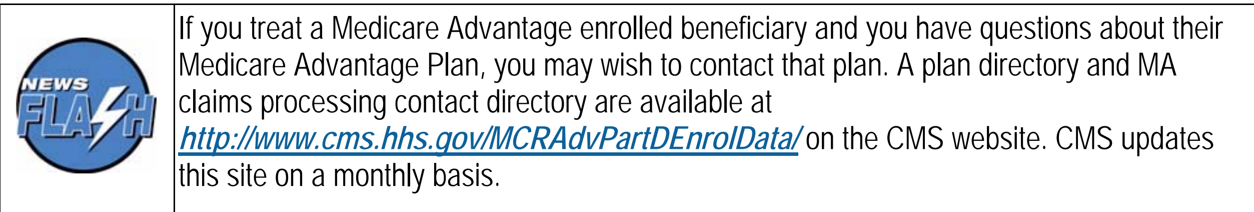
Information for Medicare Fee-for-Service Health Care Professionals



If you treat a Medicare Advantage enrolled beneficiary and you have questions about their Medicare Advantage Plan, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/ on the CMS website. CMS updates this site on a monthly basis.

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Related CR Transmittal #: N/A | Implementation Date: N/A

Proper Use of Modifier "-59"

Provider Types Affected

Physicians and providers submitting claims to Medicare carriers, or 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.

Background

Under certain circumstances, a physician may need to indicate that a procedure or service was distinct or independent from other services, and modifier "-59" may be appropriate depending on the circumstances. Modifier "-59" is used to identify procedures/services that are not normally reported together, and this include the following procedures/services that are not ordinarily encountered or performed on the same day by the same physician:

- A different
    - Session or patient encounter,

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  - Procedure or surgery,
  - Site or organ system; or
- A separate
  - Incision/excision,
  - Lesion, or
  - Injury (or area of injury in extensive injuries).

When another already established modifier is appropriate, it should be used rather than modifier "-59". Modifier "-59" is an important National Correct Coding Initiative (NCCI) associated modifier that is often used incorrectly, and it should only be used if no more descriptive modifier is available or when its use best explains the circumstances.

For the NCCI, the primary purpose of modifier "-59" is to indicate that two or more procedures are performed at different anatomic sites or during different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes.

NCCI edits define when two procedure Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes may not be reported together except under special circumstances.

If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at:

- Different anatomic sites, or
- Different patient encounters.

Medicare carrier and MAC Part B claim processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit.

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

One of the misuses of modifier "-59" is related to the portion of the definition of modifier "-59" allowing its use to describe "different procedure or surgery." The code descriptors of the two codes of a code pair edit usually represent different procedures or surgeries. The related NCCI edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. **The provider cannot use modifier "-59" for such an edit based on the two codes being different procedures/surgeries.** However, if the **two procedures/surgeries are**

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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/surgeries on that date of service.

Use of modifier "-59" to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier "-59". The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, **it does not include treatment of contiguous structures of the same organ**. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitute a single anatomic site.

EXAMPLES OF MODIFIER "-59" USAGE

Following are some examples developed to help guide physicians and providers on the proper use of Modifier "-59":

Example 1: 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

Policy: Mutually exclusive procedures

Modifier "-59" is:

- Only appropriate if procedures are performed for lesions anatomically separate from one another or if procedures are performed at separate patient encounters.
- Don't report CPT codes 11055-11057 for removal of hyperkeratotic skin adjacent to nails needing debridement.

Example 2: Column 1 Code/Column 2 Code 11719/11720

- CPT Code 11719 – Trimming of nondystrophic nails, any number
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

Policy: Mutually exclusive procedures

Modifier "-59" is only appropriate if the trimming and the debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters

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Example 3: Column 1 Code/Column 2 Code 17000/11100

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

Policy: HCPCS/CPT coding manual instruction/guideline

Modifier "-59" is only appropriate if procedures are performed on separate lesions or at separate patient encounters.

Example 4: Column 1 Code/Column 2 Code 38221/38220

- CPT code 38221 - Bone marrow; biopsy, needle or trocar
- CPT code 38220 - Bone marrow; aspiration only

Policy: Standards of medical/surgical practice

Use of "-59" modifier should be uncommon but appropriate for these circumstances:

- Different sites - contralateral iliac crests; iliac crest and sternum;
- Different incisions - same iliac crest; or
- Different encounters.

Example 5: Column 1 Code/Column 2 Code 45385/45380

- CPT Code 45385 - Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- CPT Code 45380 - Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

Policy: More extensive procedure

Modifier "-59" is only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.

Example 6: 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 (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation

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Policy: HCPCS/CPT coding manual instruction/guideline

Modifier "-59" is only appropriate if the ultrasonic guidance service 76942 is performed for a procedure done unrelated to the surgical laparoscopic ablation procedure.

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

Policy: More extensive procedure

Modifier "-59" is only appropriate if the rhythm ECG service 93040 is performed unrelated to the cardiovascular stress test procedure at a different patient encounter.

Example 8: Column 1 Code/Column 2 Code 93529/76000

- CPT Code 93529 – Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
- CPT Code 76000 – Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

Policy: Standards of medical/surgical practice

Modifier "-59" is only appropriate if the fluoroscopy service 76000 is performed for a procedure done unrelated to the cardiac catheterization procedure.

Example 9: Column 1 Code/Column 2 Code 95903/95900

- CPT Code 95903 – Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study
- CPT Code 95900 - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Policy: More extensive procedure

Modifier "-59" is only appropriate if the two procedures are actually performed on different nerves or in separate patient encounters.

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Example 10: 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

Policy: Mutually exclusive procedures

Modifier "-59" is only appropriate if the two procedures are performed in distinctly different 15 minute intervals. **The two codes cannot be reported together if performed during the same 15 minute time interval.**

Example 11: Column 1 Code/Column 2 Code 98942/97112

- CPT Code 98942 – Chiropractic manipulative treatment (CMT); spinal, five regions
- CPT Code 97112 – Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Policy: Standards of medical/surgical practice

Modifier "-59" is only appropriate if the physical therapy service 97112 is performed in a different region than the CMT and the provider is eligible to report physical therapy codes under the Medicare program.

Additional Information

If you have any questions, please contact your Medicare carrier or MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

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