

Payment Policy: Distinct Procedural Service : Modifier 59

Reference Number: CC.PP.014

Product Types: ALL

Effective Date: 01/01/2013

Last Review Date:02/24/2018

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

The misuse of modifiers that override the Center for Medicare and Medicaid (CMS) National Correct Coding Initiative (NCCI) edits represents challenges for payers. In 2005, the Office of Inspector General (OIG) published the results of a randomized study of carriers on the appropriate use of Modifier 59. The objective of the study was to determine 1) if modifier 59 was being used correctly to bypass Medicare's NCCI edits; and 2) to what extent Medicare carriers are reviewing the use of modifier 59. The outcome of the study revealed that a high percentage of carriers were using the modifier 59 inappropriately, resulting in millions of dollars in improper payments. Furthermore, most carriers did not review modifier 59, but those who did, found that providers were using the modifier incorrectly.

This outcome prompted the OIG to make a recommendation to CMS to encourage carriers to conduct prepayment and post payment reviews of the use of Modifier 59.

To comply with the OIG and CMS guidance, the Health Plan will conduct prepayment clinical claims review on all procedures billed with the modifier 59. A registered nurse will review the information billed on the claim along with the member and provider's claims history to determine whether or not it is likely that the modifier 59 was used correctly for procedures performed on the date of service. The Health Plan, and its vendors, will use nationally published guidelines from CPT and CMS when determining whether or not the modifier was used correctly.

The policy applies to the use of modifier 59, which should only be appended to procedure codes when used to indicate that two or more procedures are performed at 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.

Modifier 59 should only be reported with CPT codes 00100-01999, 10021-69990, 70010-79999, 80047-89399, 90281-99199 and 99500-99607.

Reimbursement

Claims Reimbursement Edit

The Health Plan's clinical code auditing software will flag all provider claims billed with the modifier 59 for prepayment clinical validation. Clinical validation occurs prior to claims payment. Once a claim has been clinically validated, it is either released for payment or denied for incorrect use of the modifier.

Rationale for Edit

The CPT Manual defines modifier 59 as follows: “Modifier 59: 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. Modifier 59 should not be appended to an E/M service.

Pre-payment Clinical Claims Review

The Health plan will conduct a *prepayment* clinical *claims* review of all claims billed with Modifier 59 in accordance with the documentation requirements listed below.

Appeals/Reconsiderations

In the event the claims documentation is insufficient to support billing modifier 59; the provider will receive a denial determination on their explanation of payment (EOP). The provider may submit an appeal or reconsideration request according to the guidelines outlined in the provider manual. Please submit all pertinent medical records for the date of service and procedures billed. ***Medical records should not be submitted*** on the first time claims submission as first time claim review consists only of a review of the information documented on the claim and in the member/provider history. Medical records should only be submitted once the provider receives a denial and wishes to request a reconsideration or appeal.

Utilization

Examples

The following are some examples of appropriate use, as well as incorrect use of modifier 59:

- **NCCI denies CPT Code 11720 when reported with 11055.**
CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion.
CPT Code 11720 – Debridement of nail(s) by any method(s); one to five.
Modifier 59 is appropriate if the debridement is performed at a separate site or at separate patient encounters. It would be considered incorrect coding to report the debridement with codes 11055-11057 for removal of hyperkeratotic skin adjacent to nails needing debridement. Same is true when reporting CPT Code 11719 – Trimming of nondystrophic nails, any number with CPT Code 11720 – Debridement of nail(s) by any method(s); one to five. 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.
- **NCCI denies CPT Code 97112 when reported with 98942.**
CPT Code 98942 – Chiropractic manipulative treatment (CMT); spinal, five regions.

PAYMENT POLICY

Modifier 59

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. Modifier 59 is only appropriate if the physical therapy service 97112 is performed in a different region than where the CMT is performed. Providers commonly submit their notes and only indicate that these are ‘different procedures’ which would not support the use of modifier 59.

Documentation Requirements

- 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 use all applicable anatomical modifiers designating which areas of the body were treated.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Modifier	Descriptor
-59	Distinct Procedural Service

Related Documents or Resources

1. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.
2. Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications.
3. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.

PAYMENT POLICY

Modifier 59

4. Department of Health and Human Services, Office of Inspector General, November 2005 OEI-03-02-00771
5. Optum 360Learning. (2016) *Understanding Modifiers*. Comprehensive instruction to effective modifier application.

References

1. *Current Procedural Terminology (CPT®)*, 2017
2. *HCPCS Level II*, 2017
3. *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM), 2017
4. *ICD-10-CM Official Draft Code Set*, 2017

Revision History	
02/07/2017	Converted to corporate template, conducted annual review and added modifier table.
02/24/2018	Updated Policy, updated resources, verified modifier and conducted review.

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

PAYMENT POLICY

Modifier 59



Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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