Payment Policy: Distinct Procedural Service: Modifier 59

Reference Number: LA.PP.014
Effective Date: 08/2020 **Coding Implications**
Last Review Date: 12/2024 **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 represent 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 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 OIG and CMS guidance, Louisiana Healthcare Connections conducts post~~re~~payment clinical claims review on a sampling of ~~all~~ procedures billed with modifier -59. A clinician ~~registered nurse~~ reviews the information billed on the claim, along with the member and provider's claims history, to determine whether or not it is likely that modifier -59 was used correctly for procedures performed on the date of service. The Health Plan and its vendors 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 were 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

Modifier 59 is not used to guarantee higher reimbursement.

~~**Claims Reimbursement Edit**~~

~~**Louisiana Healthcare Connection's code auditing software flags all provider claims billed with 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.

Post~~re~~payment Clinical Claims Review

Providers may be subject to a sampling of ~~Louisiana Healthcare Connection conducts a *prepayment* clinical claims review of all~~ claims review, billed with modifier -59. Post payment reviews modifier to procedure code combination using claim information. To ensure modifier 59 is not being overused. The patient's medical records must support the use of modifier 59. ~~in accordance with the documentation requirements listed below.~~

Appeals/Reconsiderations

In the event that 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:

CPT 11720, Debridement of nail(s) by any method(s); 1 to 5, is denied when reported with CPT 11055, Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion.

- **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.**

- **This is also true when reporting CPT 11719, Trimming of nondystrophic nails, any number with CPT 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. •**
- **CPT Code 97112, Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities, is denied when reported with 98942, Chiropractic manipulative treatment (CMT); spinal, 5 regions.**
  - **Modifier 59 is only appropriate if 97112 is performed in a different region than where the CMT is performed. Frequently, providers merely mention that there are "different procedures" documented in their notes. This does not support the utilization of Modifier 59, nor payment when billed.**

Documentation Requirements for Post-Payment Reviews

- **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 2024, 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 performed; separate from other services rendered on the same day by the same provider.

References

1. ***Current Procedural Terminology (CPT®), 2024***
2. ***HCPCS Level II*, 2024**
3. ***International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2024**
4. ***Department of Health and Human Services, Office of Inspector General, November 2005 OEI-03-02-00771***
5. ***Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) manuals and publications***
6. **https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf**

Revision History	Revision Date	Approval Date	Effective Date
Converted corporate to local policy.	08/15/2020		
Annual Review; Removed clinical and added payment policy in "Important Reminder" section	08/26/2022		
Annual Review; References updated	06/30/2023	9/13/2023	
Retire policy due to Modifiers 59 and 25	6/26/24		
Annual Review, updated examples, removed related documentation or references, this was a duplication of references Updated references as well as link and dates. Removed "registered nurse" and replace it with clinician; removed Pre-payment clinical validation, replaced sampling of post-payment review of claims.	12/2024		

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results.

Coverage decisions 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 LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. 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. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical 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.

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

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