MODIFIER 59

Policy # 05

Implementation Date: 1/1/02
Revision Dates: 7/1/05, 5/9/08, 9/24/14

Description

59 Distinct Procedural Service

Payment of some codes is allowed when appended with a modifier 59, without review of documentation. Multiple procedure reductions or other coding logic/rules may still apply. Other code combinations that occur when there is a National Correct Coding Initiative (NCCI), National Correct Coding Policy Manual for Part B Medicare Carriers, an internal claims system edit, or per Coding Policy will automatically deny regardless of the 59 modifier billed. Upon appeal, consideration will be given the denied code combination(s) based on the definition and criteria as defined below:

Commercial Plan Policy

Upon appeal, a code combination in which a 59 modifier is used will be reviewed against documentation to see if the use of the modifier is appropriate. If another modifier better describes the unique service or procedure performed it should be used instead of modifier 59. Additionally the code(s) must meet one or more of the following criteria to be eligible for payment:

- Be performed at a separate site, and/or
- Be performed on a separate organ system, and/or
- Be performed at a separate session on the same date of service, and/or
- Be a separate incision, excision, lesion, or injury, and/or
    - If separate incisions are used there will need to be a medically necessary indication, and it should be for a different anatomic site. If multiple incisions are necessary to complete a procedure in the same area the 59 modifier is not appropriate.
- Be a distinct and separate service/procedure, and

If the code(s) do not meet the above listed criteria the code will remain denied.

SelectHealth Advantage (Medicare/CMS)

SelectHealth Advantage **will follow CMS guidelines**.

SelectHealth Community Care (Medicaid)

SelectHealth Community Care **will follow the commercial plan policy.**

Applicable Codes

Modifier 59	**Distinct Procedural Service:** Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/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. Notes: 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.

Sources

1. Current Procedural Terminology (CPT®), (2014) – American Medical Association.
2. ICD-9-CM Coding Guidelines. (2013, January 1). Retrieved July 8, 2014, from https://www.encoderpro.com/epro/physicianDoc/pdf/i9v1/i9_guidelines.pdf
3. NCCI. (2014, January 1). General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services Chapter 1. Retrieved September 17, 2014.
4. CPT® Assistant March 2012, pp. 4−7, *Modifies 25 and 5*.