Modifier 59 – Distinct Procedural Service

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Related Policies

Code Edit Policy & Guidelines
   Modifier 25 - Significant, Separately Identifiable
      Evaluation and Management Service by the
      Same Physician on the Same Day of the Other
      Procedure
   Modifier 51 - Multiple Procedures

INSTRUCTIONS FOR USE

Reimbursement policies are intended to supplement certain standard benefit plans. Please note, the terms of an individual’s particular benefit plan document (Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document) may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual’s benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual’s benefit plan document always supersedes the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy. Proprietary information of Cigna. Copyright ©2021 Cigna.

Overview

Modifier 59 (Distinct Procedural Service) is used to indicate that procedural services not generally reported together are appropriate to reimburse separately. Modifier 59 should only be used if another modifier is not more appropriate.

This policy applies to the Center for Medicare and Medicaid Services (CMS) 1500 claim forms or its electronic equivalents.

Reimbursement Policy

Cigna will recognize two procedural services, not generally reported together, when performed on the same patient, on the same date by the same health care professional if:

- modifier 59 and the four X modifiers that were developed by CMS as a subset of modifier 59, are appended to the separate / distinct procedural service, and
- the Current Procedural Terminology (CPT®) or Health Care Procedure Coding System (HCPCS) code is not an Evaluation and Management (E/M) service (e.g., CPT 99202-99499)*, and
- a more descriptive and appropriate modifier is not available, and
- the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI), or a Cigna defined edit allows a modifier override, unless another industry standard edit applies and
- Clinical documentation is maintained by the provider supporting that the services/procedures are independent of each other and is available to Cigna upon request.
Cigna does not reimburse for:

- Arthroscopic debridement procedures that are considered incidental to a more complex arthroscopic procedure when billed with or without a modifier on the same date of service by the same provider on a CMS 1500 claim form.
- If modifier 59 and one of the four X modifiers is used on the same claim line.
- If modifier 59 or X modifiers are appended to E/M CPT® or HCPCS professional codes.

Documentation Requirements:

- For a select group of codes consistent with NCCI edits, Cigna requires documentation to be submitted with the initial claim
- Modifier 59 or the appropriate –X modifiers must be appended to the procedure code for which separate payment is requested.
- The documentation should substantiate the two procedures were separate and distinct from each other.

See the link to the Modifier 59 Code Pair List on page 4 which details what codes/edits require clinical documentation to be submitted with the claim.

NOTE: Both the supporting documentation and Modifier 59 (or –X modifier) appended to the denied code must be present with the initial claim submission or separate reimbursement will not be allowed.

If recognized, reimbursement for the separate / distinct procedural service is allowed at 100% of the fee schedule or other allowed amount.

When appropriate, multiple procedure reduction rules apply.

*To indicate an Evaluation and Management service is significant and separately identifiable, Modifier 25 should be used rather than modifier 59. Refer to the Modifier 25 Policy for more information.

General Background

Procedural Services

Procedural services rendered by the same healthcare professional on the same date cannot always be clearly identified by reporting CPT or HCPCS procedure codes alone. Modifier 59 is used to indicate that procedural services not generally reported together are appropriate to reimburse separately in the presenting clinical scenario.

The modifier indicates that in this specific circumstance, the procedural service stands alone as separate and distinct and is not a component of another reported procedural service.

Modifier 59 language states if another modifier is appropriate, it should be used rather than modifier 59. Use modifier 59 only if another more descriptive modifier is not available and modifier 59 better explains the circumstances.

Clinical indications for using modifier 59 are procedural services performed:

- on different anatomic sites or organ systems;
- different procedure or surgery;
- different sessions or patient encounters on the same date of service;
- through separate incisions or excisions;
- on independent lesions; and/or
- on separate injuries (or area of injury, in extensive injuries) in the case of multiple traumas

*
In August 2014, CMS announced the creation of four HCPCS (-X) modifiers that are defined as subsets of Modifier 59. Modifier 59 is problematic in that it can be used in a wide variety of circumstances. CMS hopes that more precise coding options coupled with increased education will reduce the errors associated with the utilization of Modifier 59 today.

The HCPCS modifiers are:

- XE – Separate Encounter. A Service that is distinct because it occurred during a separate encounter
- XS – Separate Structure. A Service that is distinct because it was performed on a separate organ/structure
- XP – Separate Practitioner. A Service that is distinct because it was performed by a different practitioner
- XU – Unusual Non-Overlapping Service. The Use of a service that is distinct because it does not overlap usual components of the main service.

Note: Neither Modifier -59 nor the –X modifiers should be utilized to bypass an NCCI edit, a Cigna defined edit or other industry standard edit unless the designated criteria for the use of the modifier is met.

As always, healthcare professionals should maintain operative reports or other supporting documentation and submit to Cigna as required or upon request.

Separate Procedures

Some CPT codes include the term “separate procedure” in their descriptions. These services are commonly considered a component of a more complex or comprehensive procedural service and, under most circumstances, should not be reported in addition to the more comprehensive procedural service.

When a “separate procedure” is distinct from a more comprehensive procedural service performed by the same physician on the same date of service, that “separate procedure” code may be appended with modifier 59 if submitted in addition to the more comprehensive procedural service. Appending modifier 59 or one of the –X modifiers serves to identify the “separate procedure” as independent from the comprehensive procedure under the presenting clinical circumstances.

A “separate procedure” code may also be reported alone when unassociated with another procedural service. In this case, it is not necessary to append modifier 59.

Generally, an open surgical procedure and closed surgical procedure in the same anatomic site will not be separately reimbursed.

If modifier 59 or one of the –X modifiers is appended to the disallowed code in a NCCI or Cigna defined edit code pair,* supporting documentation is required for consideration of separate reimbursement. The documentation must explain the unusual clinical scenario and/or reason one procedural service is separate / distinct from another.

NCCI

“The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices”.1

“The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported”.2
Reimbursement Policy: M59

Documentation Requirement for Modifier 59 Select NCCI Code Pairs

Cigna requires supporting documentation to be sent on initial claim submission for consideration of separate reimbursement for a select set of NCCI edits associated with modifier 59. The documentation must satisfy the modifier criteria as indicated in the General Background section of this policy. Use the below web address to identify the Modifier 59 NCCI code pair edits that require supporting clinical documentation.

3 Centers for Medicare and Medicaid, National Correct Coding Initiatives, FAQ 3372, “What is the mutually exclusive edit table”

http://home.healthcare.cigna.com/chchome/CRUntranet/admin_guidelines/modifiers_and_reimburse/Mod_59_Code_List.xls

Key Requirements of the Modifier 59 Documentation Requirement Include:

- Append modifier 59 or the appropriate –X modifiers to the denied code as identified on the edit list
- Submit supporting clinical documentation with the initial claim which substantiates the service being paid separately
- If the claim is being submitted electronically, follow the electronic claim submission directions as outlined below.

Claims should continue to be submitted electronically to Cigna, even if supporting documentation is required. Indicate in the PWK (Claim Supplemental Information) segment of Loop 2300 of the electronic claim that the documentation will be sent through another channel. The indicators on the electronic claim includes the delivery method (PWK02) for sending the attachment (e.g., fax, mail), as well as the description code (PWK01) for the type of attachment (e.g., physician report, operative notes). The attachment indicators or a text reference to an attachment should not be placed in the NTE (Claim Note) segment of Loop 2300 of the electronic claim. Cigna will not recognize that attachments were sent if the indicator or other attachment reference is sent in the NTE segment of Loop 2300 of the electronic claim. Please work with your electronic data interchange (EDI) vendor to be sure the appropriate fields on the electronic claim are completed. Supporting documentation can be either faxed to Cigna at 1. 859.410.2422 or sent by mail to the Cigna address on the back of the patient’s ID card.

Global Anesthesia and Nerve Block Edits:

Documentation supporting the use of the Modifier 59 or the appropriate –X modifiers should be submitted identifying that the peripheral nerve block was rendered ONLY for post-operative pain management and is unrelated to the anesthesia provided for the surgery itself.

Recommended documents that typically include this type of information are the Operative Report and the Anesthesia Record.

Postoperative pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesia practitioner unless separate services are required that cannot be rendered by the surgeon. Under certain circumstances an anesthesia practitioner may separately report a peripheral nerve block injection for postoperative pain management when the surgeon requests assistance with postoperative pain management.

CPT code 64450 (Peripheral nerve blocks introduction/injection of anesthetic agent (nerve block) may be reported by the anesthesia practitioner on the date of surgery if performed for postoperative pain management only if the operative anesthesia is general anesthesia, subarachnoid injection, or epidural injection and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block. Peripheral nerve block codes should not be reported separately on the same date of service as a surgical procedure if used as the primary anesthetic technique or as a supplement to the primary anesthetic technique. Modifier 59 or the appropriate –X modifier must be utilized to indicate that a peripheral nerve block injection was performed for
postoperative pain management, rather than intraoperative anesthesia. A procedure note should be included in
the medical record.

**Neuropsychological Testing Edits:**

Documentation that clearly identifies what test is being administered and who is administering the test as well as
who is interpreting the test results and preparing the written report.

**Recommended documents that typically include this type of information are** the Test Interpretation
Reports and Office Notes

Neuropsychological testing can be administered by a physician/psychologist or by a technician. In addition, there
are some tests that can be administered via computer. The test interpretation and written report is typically
completed by a qualified physician or psychologist.

In determining the correct coding for neuropsychological testing, it is important to determine how each test was
administered.

For reimbursement of code 96118, the physician or psychologist must administer the test and provide the test
interpretation and written report.

For reimbursement of code 96119, a technician administers the test and the physician or psychologist provides
the test interpretation and written report.

For reimbursement of code 96120, the test is administered via computer and the physician or psychologist
provides the test interpretation and written report.

**Modifier 59 Exception Scenario for Code Pair 96118 and 96119:** In the event the physician or psychologist
administers one or more tests and, in addition one or more different tests are administered by a technician,
reporting both code 96118 and 96119 with Modifier 59 or the specific –X modifier appended is appropriate. In
this situation, the physician or psychologist integrates the individual test interpretations and written reports for all
of the tests administered into a comprehensive report. Both codes 96118 and 96119 will be considered for
separate reimbursement under these circumstances.

**Modifier 59 Exception Scenario for Code Pair 96118 and 96120:** In the event the physician or psychologist
administers one or more tests and, in addition one or more different tests are administered via computer,
reporting both code 96118 and 96120 with Modifier 59 or the specific –X modifier appended is appropriate. In
this situation, the physician or psychologist integrates the individual test interpretations and written reports for all
of the tests administered into a comprehensive report. Both codes 96118 and 96120 will be considered for
separate reimbursement under these circumstances.

**Modifier 59 Exception Scenario for code pair 96119 and 96120:** In the event the technician administers one
or more tests and, in addition one or more different tests are administered via computer, reporting both code
96119 and 96120 with Modifier 59 or the specific –X modifier appended is appropriate. In this situation, the
physician or psychologist integrates the individual test interpretations and written reports for all of the tests
administered into a comprehensive report. Both codes 96119 and 96120 will be considered for separate
reimbursement under these circumstances.

**Pulmonary Artery Catheter Edits:**

Documentation that clearly identifies the insertion site and purpose of each catheter.

**Recommended documents that typically include this type of information are the** Operative/Procedure
Report, Progress Notes
When placing a pulmonary artery catheter (e.g. Swan-Ganz CPT code 93503), access to the central venous circulation is included. CPT code 93503 (insertion and placement of flow directed catheter (e.g., Swan-Ganz) should not be reported with CPT codes 36555-36556 (insertion of non-tunneled centrally inserted central venous catheter) or CPT codes 36568-36569 (insertion of peripherally inserted central venous catheter) for the insertion of a single catheter. In addition, if a physician does not complete the insertion of one type of catheter and subsequently inserts another during the same patient encounter, only the completed procedure may be reported.

**Modifier 59 Exception Scenario:** Cigna will allow separate reimbursement for CPT code 36556 when billed with CPT code 93503 when there is a specific indication or need for a separate and distinct central venous catheter introduced via a separate skin insertion site. One site is used for the measurement of cardiovascular function, the other dedicated to the administration of medications or fluids. Cigna will consider separate reimbursement for CPT code 36556 and CPT code 93503 if 1) Modifier 59 or the appropriate –X modifier is appended to CPT code 36556 and 2) supporting documentation that meets the exception scenario outlined above is submitted with the initial claim.

**Coding/Billing Information**

Arthroscopic debridement procedures that are considered incidental to a more complex arthroscopic procedure when billed with or without a modifier on the same date of service by the same provider on a CMS 1500 will not be reimbursed.

**Arthroscopic procedures considered to be more complex procedure when billed with debridement procedures.**

<table>
<thead>
<tr>
<th>CPT Codes®</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>29806</td>
<td>Arthroscopy, shoulder, surgical; capsulorrhaphy</td>
</tr>
<tr>
<td>29807</td>
<td>Arthroscopy, shoulder, surgical; repair of SLAP lesion</td>
</tr>
<tr>
<td>29819</td>
<td>Arthroscopy, shoulder, surgical; with removal of loose body or foreign body</td>
</tr>
<tr>
<td>29820</td>
<td>Arthroscopy, shoulder, surgical; synovectomy, partial</td>
</tr>
<tr>
<td>29821</td>
<td>Arthroscopy, shoulder, surgical; synovectomy, complete</td>
</tr>
<tr>
<td>29824</td>
<td>Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)</td>
</tr>
<tr>
<td>29825</td>
<td>Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation</td>
</tr>
<tr>
<td>29827</td>
<td>Arthroscopy, shoulder, surgical; with rotator cuff repair</td>
</tr>
<tr>
<td>29828</td>
<td>Arthroscopy, shoulder, surgical; biceps tenodesis</td>
</tr>
<tr>
<td>29834</td>
<td>Arthroscopy, elbow, surgical; with removal of loose body or foreign body</td>
</tr>
<tr>
<td>29835</td>
<td>Arthroscopy, elbow, surgical; synovectomy, partial</td>
</tr>
<tr>
<td>29836</td>
<td>Arthroscopy, elbow, surgical; synovectomy, complete</td>
</tr>
<tr>
<td>29837</td>
<td>Arthroscopy, elbow, surgical; debridement, limited</td>
</tr>
<tr>
<td>29840</td>
<td>Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)</td>
</tr>
<tr>
<td>29843</td>
<td>Arthroscopy, wrist, surgical; for infection, lavage and drainage</td>
</tr>
<tr>
<td>29844</td>
<td>Arthroscopy, wrist, surgical; synovectomy, partial</td>
</tr>
<tr>
<td>29845</td>
<td>Arthroscopy, wrist, surgical; synovectomy, complete</td>
</tr>
<tr>
<td>29847</td>
<td>Arthroscopy, wrist, surgical; internal fixation for fracture or instability</td>
</tr>
<tr>
<td>29860</td>
<td>Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)</td>
</tr>
<tr>
<td>29861</td>
<td>Arthroscopy, hip, surgical; with removal of loose body or foreign body</td>
</tr>
<tr>
<td>29863</td>
<td>Arthroscopy, hip, surgical; with synovectomy</td>
</tr>
<tr>
<td>29894</td>
<td>Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body</td>
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<tr>
<td>29895</td>
<td>Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial</td>
</tr>
<tr>
<td>29898</td>
<td>Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive</td>
</tr>
<tr>
<td>29899</td>
<td>Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis</td>
</tr>
</tbody>
</table>
29914 Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)
29915 Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)
29916 Arthroscopy, hip, surgical; with labral repair

Not Separately Reimbursed: Debridement procedures that are considered incidental to a more complex arthroscopic procedure.

<table>
<thead>
<tr>
<th>CPT Codes®</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23700</td>
<td>Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)</td>
</tr>
<tr>
<td>29805</td>
<td>Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)</td>
</tr>
<tr>
<td>29822</td>
<td>Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])</td>
</tr>
<tr>
<td>29823</td>
<td>Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])</td>
</tr>
<tr>
<td>29837</td>
<td>Arthroscopy, elbow, surgical; debridement, limited</td>
</tr>
<tr>
<td>29838</td>
<td>Arthroscopy, elbow, surgical; debridement, extensive</td>
</tr>
<tr>
<td>29846</td>
<td>Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement</td>
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<tr>
<td>29862</td>
<td>Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum</td>
</tr>
<tr>
<td>29897</td>
<td>Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited</td>
</tr>
<tr>
<td>29898</td>
<td>Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive</td>
</tr>
</tbody>
</table>

References

1. CMS, NCCI, FAQ 3517 “How should Modifier -59 be reported under the CCI”
2. CMS, NCCI Manual, Chapter 2, Anesthesia Code Edits
5. Medicare Claims Processing Manual, Chapter 23, Fee Schedule Administration and Coding Requirements, Publication 100-04
6. CMS Transmittal 1422, Specific Modifiers for Distinct Procedural Services, Pub 100-20, August 15, 2014
7. Optum 360° Understanding Modifiers 2018 (West Valley City, UT: Optum 360, LLC, ©2020)

Policy History/Update

<table>
<thead>
<tr>
<th>Date</th>
<th>Change/Update</th>
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<tr>
<td>05/16/2021</td>
<td>Effective 05/16/2021 Arthroscopic debridement procedures that are considered incidental to a more complex arthroscopic procedure when billed with or without a</td>
</tr>
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modifier on the same date of service by the same provider on a CMS 1500 will not be reimbursed.

<table>
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<th>Date</th>
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<tr>
<td>03/11/2021</td>
<td>Notification: Effective 05/16/2021 Arthroscopic debridement procedures that are considered incidental to a more complex arthroscopic procedure when billed with or without a modifier on the same date of service by the same provider on a CMS 1500 will not be reimbursed. Revisions and wording clarification updated</td>
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<tr>
<td>11/13/2018</td>
<td>Updated template and references. Took out “New” for the X modifiers no longer new.</td>
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<tr>
<td>06/06/2017</td>
<td>Policy template updated</td>
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<td>09/19/2016</td>
<td>Policy template updated</td>
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<tr>
<td>02/16/2015</td>
<td>Effective date for Cigna acceptance of CMS four new HCPCS modifiers (-X).</td>
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<tr>
<td>11/18/2014</td>
<td>Notification date for acceptance of CMS four new HCPCS modifiers (-X) on February 16, 2015.</td>
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<tr>
<td>08/19/2013</td>
<td>Effective date for Global Anesthesia and Nerve Block NCCI edits documentation requirement.</td>
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<tr>
<td>05/20/2013</td>
<td>Notification date for adding Global Anesthesia and Nerve Block NCCI Edit documentation Requirement. Old language for two types of NCCI edits-mutually exclusive edits removed. Policy updated to 2013 template.</td>
</tr>
<tr>
<td>06/18/2010</td>
<td>Updated policy with more detail about NCCI edits and documentation requirements</td>
</tr>
<tr>
<td>03/04/2010</td>
<td>Update to edit combinations and revision to policy requirement language</td>
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<tr>
<td>08/06/2009</td>
<td>Effective date for former Great-West Healthcare.</td>
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<td>05/06/2009</td>
<td>Notification for former Great-West Healthcare.</td>
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<tr>
<td>04/20/2009</td>
<td>Effective date of policy revision with NCCI Mutually Exclusive edits listing requiring supporting documentation.</td>
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<tr>
<td>04/15/2009</td>
<td>Addition of NCCI Mutually Exclusive edit code list for CIGNA HealthCare.</td>
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<tr>
<td>01/29/2009</td>
<td>Notification for CIGNA HealthCare that documentation will be required for a specified code set of NCCI Mutually Exclusive edits.</td>
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<td>02/18/2008</td>
<td>Update to CIGNA HealthCare policy.</td>
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