URMC Compliance Office
Guidance for Use of Modifier 59
Distinct Procedural Service

Modifier 59 Distinct Procedural Service: use **Modifier 59** 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 the E/M services, that are not normally reported together but are appropriate under the circumstances. Modifier 59 should never be used routinely and never when another modifier will describe the circumstances better. Modifier 59 should not be appended to an E/M service.

URMC follows CPT/Medicare's guidance on the use of Modifier 59. Modifier 59 may be appropriate to indicate that one of the following special circumstances exists:

- *The service was performed at a different site on the body.* This may mean that a separate incision was required to perform the service but could also mean that the procedure was performed to address a separate lesion or separate injury. Not all services that require a separate incision will qualify for use of modifier 59.
- *The service was performed at a different session on the same date.* Occasionally services that are typically bundled may be performed at separate sessions on the same date. Modifier 59 is appropriate to indicate that the services were not performed during the same session.
- *The decision to perform a more extensive procedure was based on the results of a less extensive or diagnostic procedure.* This must be clearly documented in the record.

Modifier 59 Examples

- Closed treatment of a distal radial fracture with manipulation (25605) includes subsequent application of a long arm cast (29065). However, if the cast is applied to the other arm, both codes may be billed using modifier 59 to indicate that there was a different site. 25605, 29065-59.

- Endovenous ablation therapy of incompetent vein of the extremity by radiotherapy (36475) includes all imaging guidance and monitoring performed at that session. If injection of contrast for extremity venography (36005) was performed by the same provider earlier in the day, modifier 59 should be added to that code to indicate that it was performed at a different session. 36475, 36005-59.

- A patient with a breast mass has a needle biopsy (19100). Documentation indicates that frozen section showed adenocarcinoma and the decision was made at that time to perform simple mastectomy (19303) at the same session. The biopsy can be coded using modifier 59 to indicate that the decision to perform the mastectomy was based on the results of the biopsy. 19303, 19100-59.

- A patient undergoes posterior arthrodesis of the spine at T4, T5, and T6. Code 22614 is an add-on code for each additional segment after the first. No modifier is needed to indicate that different segments were treated as there are no bundling issues. 22600, 22614, 22614

Modifiers should never be added to claims unless the documentation has been reviewed and the use of the modifier is appropriate based on the documentation.

References

Proper Use of Modifier 59
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0715.pdf

NCCI Edits
http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage

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