Modifier 59 Reimbursement Policy					
Policy Number	0050	**Annual Approval Date**	04/2024	**Approved By**	Optum Reimbursement and Technology Committee Optum Quality and Improvement Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. Optum reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding Optum's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to Client enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This policy applies to all products, all network and non-network rehabilitation providers. This includes non-network authorized, and percent of charge contract providers.

Fee schedule/provider contract/client contract may supersede

Policy

Overview

This policy describes Optum requirements for the reimbursement of CPT codes appended by modifier -59

Reimbursement Guidelines

Modifier -59: Distinct Procedural Service

Description: 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.

Guidelines: Modifier -59 indicates that the procedure represents a distinct service from others reported on the same date of service. This modifier was developed explicitly for the purpose of identifying services not typically performed together. In the event that a more descriptive modifier is available, it should be used in preference to modifier -59. The documentation in the medical record should clearly support the separate and distinct procedures i.e., the location (different region), the procedural description (technique), and time.

Use of modifier -59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier -59. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

From a National Correct Coding Initiative (NCCI) program perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitutes a single anatomic site.

CMS has established the following four HCPCS modifiers (referred to collectively as –X{EPSU} modifiers) to define specific subsets of the -59 modifier:

- 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, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. Providers should utilize the more specific –X modifier when appropriate.

Background Information

A modifier provides the means by which the reporting health care practitioner can indicate that a CPT descriptor code (service or procedure), which has been performed, has been altered by a specific circumstance or in some way *without changing the definition of the CPT code*. Modifiers increase the specificity of certain CPT codes.

CPT code modifiers are comprised of two digits, either numeric (Level I; AMA) or alphabetic (Level II; CMS), and are listed after a procedural code by a hyphen. Modifiers are typically recorded in Section 24 (D) on the CMS-1500 form.

Modifiers have two different applications: (1) to identify circumstances that significantly alter a service or procedures where reimbursement will be affected; and (2) for informational purposes without impact on reimbursement. For the purposes of this policy, the applications of select Level I (AMA) and Level II (CMS) modifiers have been assessed for their impact on reimbursement determinations.

CPT coding modifiers are used to communicate that something is *atypical* about a particular claim. Circumstances where the use of a modifier include, if the service: (a) has been increased or decreased; (b) has both a professional and technical component; (c) only part of the service was performed; (d) an independent or adjunctive procedure was performed; (e) if unusual events occurred; and (f) is expected to be denied as not appropriate and/or necessary.

Resources

- American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services
- Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services

History / Updates

10/11/2007	New
10/2008	Annual review and update
02/2009	Annual review and update

04/2010	Annual review and update
04/2011	Annual review and update
04/2012	Annual review and update
04/2013	Annual review and update
04/2014	Annual review and update
04/2015	Annual review and update; added new CMS –X modifier detail
04/2016	Annual review and update
04/2017	Annual review and update
04/2018	Annual review and update
04/2019	Annual review and update
04/2020	Annual review and update
04/2021	Annual review and update
05/2022	Annual review and update
04/2023	Annual review and update
04/2024	Annual review and update