



POLICY INFORMATION			
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PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROFESSIONAL	FACILITY	DME	AMBULATORY SURGERY	LAB	OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMERCIAL	BLUE MEDICARE ADVANTAGE	ACA QHP¹	SMALL GROUP ACA	JAA²	FEP³	DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.



Description/Application

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when you should not report certain HCPCS or CPT codes together in all or most situations.

These edits allow the following:

- For NCCI PTP edits with a Correct Coding Modifier Indicator (CCMI) of “0,” do not report the codes together by the same provider for the same patient on the same date of service (DOS). If you do report the codes together on the same DOS, the Column 1 code is eligible for payment and Medicare denies the Column 2 code.
- For NCCI PTP edits that have a CCMI of “1,” report the codes together only in limited circumstances by using NCCI PTP-associated modifiers.

Refer to Chapter 1 of the [Medicare NCCI Policy Manual](#) for general information about the NCCI program, NCCI PTP edits, CCMIs, and NCCI PTP-associated modifiers. One purpose of NCCI PTP edits is to prevent payment for codes that report overlapping services except where the services are “separate and distinct.”

Modifier 59 is an important NCCI PTP-associated modifier that physicians and providers often use incorrectly. This fact sheet will help you use this modifier correctly.

Policy

Definition of Modifiers 59, XE, XP, XS, & XU

The CPT Manual defines modifier 59 as:

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 (Evaluation/Management) services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, which 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

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.

- XE – “Separate Encounter, a service that is distinct because it occurred during a separate encounter.” Only use XE to describe separate encounters on the same DOS.
- 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.”



Do not use modifiers 59, XE, XS, XP, XU, and other NCCI PTP-associated modifiers, to bypass an NCCI PTP edit unless the proper criteria for use of the modifiers are met. Medical documentation must support the use of the modifier.

Modifiers XE, XS, XP, and XU are valid modifiers. These modifiers give greater reporting specificity in situations where you used modifier 59 previously. Use these modifiers instead of modifier 59 whenever possible. Only use modifier 59 if no other more specific modifier is appropriate.

Appropriate & Inappropriate Use of These Modifiers

1. Using modifiers 59 or XS properly for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on:
 - Different organs
 - Different anatomic regions
 - In limited situations on different, non-contiguous lesions in different anatomic regions of the same organ
 - Are performed at different anatomic sites.
 - Are not ordinarily performed or encountered on the same day.
 - Cannot be described by 1 of the more specific anatomic NCCI PTP-associated modifiers – that is, RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI.

See examples 1, 2, and 3 below.

From an NCCI program perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. We created NCCI edits to prevent the inappropriate billing of lesions and sites that are not considered separate and distinct.

Treatment of contiguous structures in the same organ or anatomic region does not generally constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue distal to and including the skin overlying the distal interphalangeal joint on the same toe or finger constitutes treatment of a single anatomic site. **See example 4 below.**
- Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site. **See example 5 below.**

2. Only use modifiers 59 or XE if no other modifier more properly describes the relationship of the 2 procedure codes.

Another common use of modifiers 59 or XE is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures performed during different patient encounters on the same day that can't be described by 1 of the more specific NCCI PTP-associated modifiers – in other words, 24, 25, 27, 57, 58, 78, 79, or 91. **See example 7 below.**



3. Do not use modifiers 59 or XU just because the code descriptors of the 2 codes are different.

One of the common misuses of modifier 59 relates to the part of the definition of modifier 59 allowing its use to describe a “different procedure or surgery.” The code descriptors of the 2 codes of a code pair edit describe different procedures, even though they may overlap.

Do not report the 2 codes together if they’re performed at the same anatomic site and same patient encounter, because they aren’t considered “separate and distinct.” Do not use modifiers 59 or XU to bypass a PTP edit based on the 2 codes being “different procedures.” **See example 8 below.**

However, if you perform 2 procedures at separate anatomic sites or at separate patient encounters on the same DOS, you may use modifiers 59, XE, or XS to show that they’re different procedures on that DOS.

Also, there may be limited circumstances sometimes identified in the Medicare NCCI Policy Manual when you may report the 2 codes of an edit pair together with modifiers 59, XE, or XS when performed at the same patient encounter or at the same anatomic site.

4. Other specific proper uses of modifiers 59, XE, or XU

There are 3 other limited situations where you may report 2 services as separate and distinct because they’re separated in time and describe non-overlapping services even though they may occur during the same encounter.

- A. Using modifiers 59 or XE properly for 2 services described by timed codes provided during the same encounter only when they’re performed one after another. There is an appropriate use for modifier 59 that’s applicable only to codes for which the unit of service is a measure of time (2 examples are: per 15 minutes or per hour).

If you provide 2 timed services in separate and distinct time periods and aren’t mingled with each other (in other words, you complete 1 service before the next service begins), you may use modifiers 59 or XE to identify the services. **See example 9 below.**

- B. Using modifiers 59 or XU properly for a diagnostic procedure which is performed before a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When you perform a diagnostic procedure before a surgical procedure or nonsurgical therapeutic procedure and it is the basis on which you decide to perform the surgical procedure or non-surgical therapeutic procedure, you may consider that diagnostic procedure to be a separate and distinct procedure if it:
 - a Occurs before the therapeutic procedure and is not mingled with services the therapeutic intervention requires.
 - b Clearly provides the information needed to decide whether to proceed with the therapeutic procedure.
 - c Does not constitute a service that would have otherwise been required during the therapeutic intervention. **See example 10 below.**



If the diagnostic procedure is an inherent component of the surgical procedure, do not report it separately.

- C. Using modifiers 59 or XU properly for a diagnostic procedure which occurs after a completed therapeutic procedure only when the diagnostic procedure isn't a common, expected, or necessary follow-up to the therapeutic procedure.

When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, you may consider that diagnostic procedure to be a separate and distinct procedure if it:

- a Occurs after the completion of the therapeutic procedure and is not mingled with or otherwise mixed with services that the therapeutic intervention requires.
- b Does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, do not report it separately.

Use of modifiers 59, XE, XS, XP, XU do not require a different diagnosis for each HCPCS or CPT coded procedure. On the other hand, different diagnoses are not adequate criteria for use of modifiers 59, XE, XS, XP, XU. The HCPCS or CPT codes remain bundled unless you perform the procedures at different anatomic sites or separate patient encounters or meet 1 of the other 3 scenarios described by A, B, or C above.

Examples of Appropriate and Inappropriate Use of Modifiers 59, XE, XS, XP, XU

Example 1: Column 1 Code/Column 2 Code - 11102/17000

- CPT Code 11102 - Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette); single lesion
- CPT Code 17000 - Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), premalignant lesions (e.g., actinic keratoses); first lesion

You may report modifiers 59 or XS with either the Column 1 or Column 2 code if you did the procedures at different anatomic sites on the same side of the body and a specific anatomic modifier isn't applicable. If you did the procedures on different sides of the body, use modifiers RT and LT or another pair of anatomic modifiers. Do not use modifiers 59 or XS.

The use of modifier 59 or XS is appropriate for different anatomic sites during the same encounter only when procedures (which aren't ordinarily performed or encountered on the same day) are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Example 2: Column 1 Code/Column 2 Code - 47370/76942

- CPT Code 47370 - Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
- CPT Code 76942 - Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization)



device), imaging supervision and interpretation

Do not report CPT code 76942 with or without modifiers 59, XE, XS, XP, XU if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure 47370. Only report 76942 with modifiers 59, XE, XS, XP, XU if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

Example 3: Column 1 Code/Column 2 Code - 93453/76000

- CPT Code 93453 - Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
- CPT Code 76000 - Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time

Do not report CPT code 76000 with or without modifiers 59, XE, XS, XP, XU for fluoroscopy in conjunction with a cardiac catheterization procedure. You may report 76000 with modifiers 59, XE, XS, XP, XU if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

Example 4: Column 1 Code/Column 2 Code - 11055/11720

- CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
- CPT Code 11720 - Debridement of nail(s) by any method(s); 1 to 5

Do not report CPT codes 11720 and 11055 together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Do not use modifiers 59, XE, XS, XP, XU if you debride a nail on the same toe on which you pare a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint.

You may report modifier 59 or XS with code 11720 if you debride 1 to 5 nails and you pare a hyperkeratotic lesion on a toe other than 1 with a debrided toenail or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which you debride a nail.

Example 5: Column 1 Code/Column 2 Code - 67210/67220

- CPT Code 67210 - Destruction of localized lesion of retina (e.g., macular edema, tumors), 1 or more sessions; photocoagulation
- CPT Code 67220 - Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation (e.g., laser), 1 or more sessions

Do not report CPT code 67220 with or without modifier 59, XE, XS, XP, XU if you perform both procedures during the same operative session because the retina and choroid are contiguous structures of the same organ.



Example 6: Column 1 Code/Column 2 Code - 29827/29820

- CPT Code 29827 - Arthroscopy, shoulder, surgical; with rotator cuff repair
- CPT Code 29820 - Arthroscopy, shoulder, surgical; synovectomy, partial MLN Fact Sheet MLN Fact Sheet

Don't report CPT code 29820 with or without modifiers 59, XE, XS, XP, XU if you perform both procedures on the same shoulder during the same operative session. If you perform the procedures on different shoulders, use modifiers RT and LT, not modifiers 59, XE, XS, XP, XU.

Example 7: Column 1 Code/Column 2 Code - 93015/93040

- CPT Code 93015 - Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation, and report
- CPT Code 93040 - Rhythm ECG, 1-3 leads; with interpretation and report

You may report modifiers 59 or XE if you interpret and report the rhythm ECG at a different encounter than the cardiovascular stress test. If you interpret and report a rhythm ECG during the cardiovascular stress test encounter, do not report 93040 with or without modifier 59. You may report modifiers 59 or XE when you interpret and report the procedures in different encounters on the same day.

Example 8: Column 1 Code/Column 2 Code - 34833/34820

- CPT Code - 34833 - Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)
- CPT Code - 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

CPT code 34833 is followed by a CPT Manual instruction that states, "(Do not report 34833 in conjunction with 33364, 33953, 33954, 33959, 33962, 33969, 33984, 34820 when performed on the same side)."

Although the CPT code descriptors for 34833 and 34820 describe different procedures, do not report them together for the same side. Do not add modifiers 59, XE, XS, XP, XU to either code to report 2 procedures for the same side of the body. If you performed 2 procedures on different sides of the body, you may report them with modifiers LT and RT as appropriate. However, modifiers 59, XE, XS, XP, XU are inappropriate if the basis for their use is that the narrative description of the 2 codes is different.

Example 9: Column 1 Code/Column 2 Code - 97140/97750



- CPT Code 97140 - Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
- CPT Code 97750 - Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes

You may report modifier 59 if you perform 2 procedures in distinctly different 15-minute time blocks. For example, you may report modifier 59 if you perform 1 service during the initial 15 minutes of therapy and you perform the other service during the second 15 minutes of therapy.

As another example, you may report modifier 59 if you split the therapy time blocks by performing manual therapy for 10 minutes, followed by 15 minutes of physical performance test, followed by another 5 minutes of manual therapy. Do not report CPT code 97750 with modifier 59 if you perform 2 procedures during

the same time block. You may report modifier 59 when you perform 2 timed procedures in 2 different blocks of time on the same day.

Example 10: Column 1 Code/Column 2 Code - 37220/75710

- CPT Code 37220 - Revascularization, endovascular, open, or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- CPT Code 75710 - Angiography, extremity, unilateral, radiological supervision, and interpretation

You may report modifier 59 or XU with CPT code 75710 if you have not already performed a diagnostic angiography and you base the decision to perform the revascularization on the result of the diagnostic angiography.

The CPT Manual defines additional circumstances under which you may report diagnostic angiography with an interventional vascular procedure on the same artery. You may report modifier 59 or XU for a diagnostic procedure performed before a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

Coding

Modifier	Description
59	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.
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner



XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

References and Resources

Current Procedural Terminology Manual
Centers for Medicare and Medicaid Services

Related Documents

N/A

Revision History

Date	Summary of Revisions
06/01/2024	New Policy
06/1/2025	Annual review, no changes were made.