

Payment Policy: Distinct Procedural Service: Modifier 59

Reference Number: CC.PP.014

Product Types: ALL

Effective Date: 01/01/2013

Last Review Date: 11/14/2025

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Policy Overview

The misuse of modifiers that override the Center for Medicare and Medicaid (CMS) National Correct Coding Initiative (NCCI) edits represent challenges for payers. Medicare's Procedure-to-Procedure (PTP) modifications are elements of the NCCI, and they define CPT and/or HCPCs codes that, in most or all cases, should not be reported together. The Correct Coding Modifier Indicator (CCMI) for modifications related to NCCI PTP is either "0" or "1". For services reported on the same date of service and whether they are due, each of these CCMI has a rule. Modifier 59 is one of the modifiers that can be used to bypass the NCCI Edits.

In 2005, the Office of Inspector General (OIG) published the results of a randomized study of carriers on the appropriate use of Modifier 59. The purpose of the OIG Review was to determine whether modifier 59 is being improperly used to bypass Medicare's National Correct Coding Initiative (CCI) edits and the extent to which Medicare carriers are monitoring modifier 59 utilization. The outcome of the study revealed that a high percentage of providers were using Modifier 59 inappropriately, resulting in millions of dollars in improper payments. Furthermore, most carriers did not review Modifier 59, but those who did found that providers were using the modifier incorrectly.

This outcome prompted the OIG to make a recommendation to CMS to encourage carriers to conduct pre- and post-payment reviews of the use of Modifier 59.

To comply with OIG and CMS guidance, the Health Plan conducts prepayment clinical claims review on all procedures billed with Modifier 59. A clinician reviews the information billed on the claim, along with the member and provider's claims history, to determine whether it is likely that Modifier 59 was used correctly for the clinical circumstances. The Health Plan uses CPT and CMS guidelines to determine whether or not the modifier was used correctly.

This policy applies to the use of Modifier 59, which should only be appended to procedure codes when used to indicate that two or more services were performed at 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.

Reimbursement

Claims Reimbursement Edit

Code auditing software flags all claims billed with Modifier 59 for prepayment clinical validation. Clinical validation occurs prior to claims payment. Once a claim has been clinically validated, it is either released for payment or denied for incorrect modifier use.

Rationale for Edit

The CPT Manual defines Modifier 59 as follows: “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 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. 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. Modifier 59 should not be appended to an E/M service.

Appeals/Reconsiderations

In the event that claims documentation is insufficient to support billing Modifier 59, the provider will receive a denial determination on the explanation of payment (EOP). The provider may submit an appeal/reconsideration request according to provider manual guidelines. All pertinent medical records for the date of service and procedures billed should be submitted. **Medical records should not be submitted** on first time claims, as first time claim review consists only of a review of the information documented on the claim and in the member/provider history. Medical records should only be submitted if the provider receives a denial and wishes to request a reconsideration or appeal.

Examples

Here are several instances of both proper and improper use of Modifier 59:

- CPT 11720, Debridement of nail(s) by any method(s); 1 to 5, **is denied when reported with** CPT 11055, Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion.
 - Modifier 59 is appropriate if the debridement is performed at a separate site or at separate patient encounters.
 - It would be considered incorrect coding to report the debridement with codes 11055-11057 for removal of hyperkeratotic skin adjacent to nails needing debridement.
- This is also true when reporting CPT 11719, Trimming of nondystrophic nails, any number with CPT 11720, Debridement of nail(s) by any method(s); one to five.
 - Modifier 59 is only appropriate if the trimming and the debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters.
- CPT Code 97112, Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities, **is denied when reported with** 98942, Chiropractic manipulative treatment (CMT); spinal, 5 regions.

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- Modifier 59 is only appropriate if 97112 is performed in a different region than where the CMT is performed. Frequently, providers merely mention that there are “different procedures” documented in their notes. This does not support the utilization of Modifier 59, nor payment when billed.

Documentation Requirements

- The diagnosis codes on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- To avoid incorrect denials providers should code all applicable diagnoses and services and use applicable anatomical modifiers designating the areas of the body treated.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only.

Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Modifier	Descriptor
59	Distinct Procedural Service

References

American Medical Association (AMA), Current Procedural Terminology (CPT®) Professional Edition, 2025

HCPCS Level II, 2025, Centers for Medicare & Medicaid Services

Centers for Disease Control and Prevention (CDC), *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*, 2025

Department of Health and Human Services, Office of Inspector General, November 2005 OEI-03-02-00771

<https://www.cms.gov/medicare/coding-billing/ncci-medicare>

<https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf>

Revision History

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02/07/2017	Converted to corporate template, conducted annual review and added modifier table.
02/24/2018	Updated Policy, updated resources, verified modifier and conducted review.
04/01/2019	Conducted review, verified modifier, updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual Review completed; no major updates required
12/01/2022	Annual Review completed; no major updates required
11/08/2023	Annual Review completed; reviewed policy and updated dates
02/08/2024	Annual Review completed; updated policy overview, examples and references for clarification and updated links as well as dates.
12/02/2024	Annual Review completed; no major updates required
11/14/2025	Annual Review completed; Validated policy content, references and links; Added revision date

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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