



Proper Use of Modifiers 59 & –X{EPSU}

Introduction

This fact sheet educates physicians and other providers on proper use of modifiers 59 and –X{EPSU} and gives information on:

- Definition of modifiers 59, XE, XP, XS, and XU
- Appropriate and inappropriate use of these modifiers
- Examples of appropriate and inappropriate use

Background

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when you shouldn't report certain HCPCS or CPT codes together either in all situations or in most situations. These edits allow the following:

- For NCCI PTP-associated edits that have a Correct Coding Modifier Indicator (CCMI) of "0," never report the codes together by the same provider for the same beneficiary on the same date of service. If you do report the codes together on the same date of service, the Column One code is eligible for payment and Medicare denies the Column Two code.
- For NCCI PTP-associated edits that have a CCMI of "1," you may report the codes together only in defined circumstances by using specific NCCI PTP-associated modifiers.

Refer to the National Correct Coding Initiative Policy Manual for Medicare Services, [Chapter 1](#), for general information about the NCCI program, NCCI PTP-associated edits, CCMI, and NCCI PTP-associated modifiers.

One purpose of NCCI PTP-associated 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 providers often use incorrectly.

This fact sheet will help you use this modifier correctly.

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

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 (Evaluation/Management) 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. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.”

Don't use modifiers 59, -X{EPSU} 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 satisfy the required criteria.

Effective January 1, 2015, 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.)

CMS allows the modifiers 59 or -X{ESPU} on Column One or Column Two codes (see the related transmittal at [CR11168](#)).

We define these modifiers as follows:

- 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 date of service.
- 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”

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 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**

Modifiers 59 or –XS are for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that:

- Are performed at different anatomic sites,
- Aren't ordinarily performed or encountered on the same day, and
- Can't be described by one 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 aren't considered separate and distinct. The treatment of contiguous structures in the same organ or anatomic region doesn't 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 that are performed during different patient encounters on the same day and that can't be described by one of the more specific NCCI PTP-associated modifiers – that is, 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7 below.)

3. Don't 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. Don't 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.” Don't 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 date of service, you may use modifiers 59 or –X{ES} to show that they're different procedures on that date of service. Also, there may be limited circumstances sometimes identified in the [National Correct Coding Initiative Policy Manual](#) for Medicare services when you may report the 2 codes of an edit pair together with modifiers 59 or –X{ES} when performed at the same patient encounter or at the same anatomic site.

4. Other specific proper uses of modifiers 59 or -XE

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 are performed one after another.** There's an appropriate use for modifier 59 that's applicable only to codes for which the unit of service is a measure of time (two examples are: per 15 minutes or per hour). If you provide 2 timed services in time periods that are separate and distinct and aren't mingled with each other (that is, you complete one 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 a diagnostic procedure is performed before a surgical procedure or non-surgical therapeutic procedure and is the basis on which you decide to perform the surgical procedure, you may consider that diagnostic procedure to be a separate and distinct procedure as long as it:
- Occurs before the therapeutic procedure and isn't mingled with services the therapeutic intervention requires;
 - Provides clearly the information needed to decide whether to proceed with the therapeutic procedure; and
 - Doesn't 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, don't 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 as long as it:
- Occurs after the completion of the therapeutic procedure and isn't mingled with or otherwise mixed with services that the therapeutic intervention requires, and
 - Doesn't 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, don't report it separately.

Use of modifiers 59 or –X{EPSU} don't require a different diagnosis for each HCPCS or CPT coded procedure. On the other hand, different diagnoses aren't adequate criteria for use of modifiers 59 or –X{EPSU}. The HCPCS or CPT codes remain bundled unless you perform the procedures at different anatomic sites or separate patient encounters or meet one of the other 3 scenarios described by A, B, or C above.

Examples of Appropriate & Inappropriate Use

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

- CPT Code - 11102 - Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion
- CPT Code - 17000 - Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, 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. Don't 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 (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Don't report CPT code 76942 with or without modifiers 59 or -X{EPSU} if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure 47370. Only report 76942 with modifiers 59 or -X{EPSU} 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

Don't report CPT code 76000 with or without modifiers 59 or -X{EPSU} for fluoroscopy in conjunction with a cardiac catheterization procedure. You may report modifier 59 or -XU with code 76000 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 (eg, corn or callus); single lesion
- CPT Code - 11720 - Debridement of nail(s) by any method(s); 1 to 5

Don't 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. Don't use modifiers 59 or -X{EPSU} 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 (eg, macular edema, tumors), 1 or more sessions; photocoagulation
- CPT Code - 67220 - Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

Don't report CPT code 67220 with or without modifier 59 or –X{EPSU} 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

Don't report CPT code 29820 with or without modifiers 59 or –X{EPSU} 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 or –X{EPSU}.

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, don't 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, don't report them together for the same side. Don't add modifiers 59 or –X{EPSU} 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 or –X{EPSU} 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 (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
- CPT Code - 97750 - Physical performance test or measurement (eg, 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. Don't report CPT code 97550 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 haven't 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.

Resources

- [National Correct Coding Initiative webpage](#)

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