Navigating NCCI and its Modifiers

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Disclaimer

- This PowerPoint presentation is an educational tool to provide basic information for coding. The information is the sole view of the author and was put together based on experience, research and expertise in the coding profession. It is not intended to be an exhaustive review and should not be considered a substitution for Coding Guidelines. The presenter does not accept any responsibility or liability with regard to errors, omissions, misinterpretation or misuse by the audience.

Objectives

- The presentation will educate on the National Correct Coding Initiative to ensure proper use of modifier 59 and X{EPSU} modifiers.
- It will also guide you through the steps to find the NCCI edits on the CMS website in order to equip you with the resources necessary for proper modifier usage.

What is NCCI?

- NCCI – National Correct Coding Initiative

  - NCCI Policy

  - NCCI Edits

    - Practitioner

    - Hospital

Automated prepayment edits

Why was it developed?

CMS developed the NCCI to prevent inappropriate payment of services that should not be reported together.

What is MUE?

- Medically Unlikely Edits are also prepayment edits which define the maximum number of units allowable under most circumstances for a single HCPCS/CPT code on a date of service.

How often is it updated?

- NCCI edits are updated quarterly
- NCCI policy is updated annually
- MUE tables are updated quarterly

- NCCI edits were implemented with DOS January 1, 1996
- MUEs were implemented January 1, 2007

History

- Prior to April 1, 2012, NCCI PTP edits were placed into either the “Column One/Column Two Correct Coding Edit Table” or the “Mutually Exclusive Edit Table”.

- On April 1, 2012, the edits in the “Mutually Exclusive Edit Table” were moved to the “Column One/Column Two Correct Coding Edit Table” so that all the NCCI PTP edits are currently contained in this single table.

  Combining the two tables simplifies researching NCCI PTP edits and online use of NCCI tables.

How do I use NCCI?

- Look up the code pair on the NCCI table
  - Column 1
  - Column 2

Indicators

- “0” a modifier is not allowed and the code in the second column is either a component of the code in the first column or is mutually exclusive to the code in the first column.
- “1” a modifier, such as 59, is allowed if appropriate
- “9” codes can be billed together without a modifier

Sample

Column 1	Column 2	* = in existence prior to 1996	Effective Date	Deletion Date * = no data	Modifier 0= not allowed 1= allowed 9 = N/A	PTP Edit Rationale
29880	29877		20030301	*	0	Misuse of column two code with column one code
29880	G0289		20120101	*	1	HCPCS/CPT procedure code definition

- **29880** *Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed*
- **29877** *Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)*
- **G0289** *Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee*

Sample

Column 1	Column 2	* = in existence prior to 1996	Effective Date	Deletion Date * = no data	Modifier 0= not allowed 1= allowed 9 = N/A	PTP Edit Rationale
11055	11720		19980401	*	1	Mutually exclusive procedures

- **11055** *Paring or cutting of benign hyperkeratotic lesion (eg. Corn or callus); single lesion*
- **11720** *Debridement of nail(s) by any method(s); 1-5*

Modifiers

- Anatomic modifiers:

  E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI

- Global surgery modifiers:

  24, 25, 57, 58, 78, 79

- Other modifiers:

  27, 59, 91, XE, XS, XP, XU

Modifier 59 or X{EPSU}

- CPT® states:

  "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 Article

- “Treatment of the nail, nail bed, and adjacent soft tissue on the same toe or finger constitutes treatment of a single anatomic site.”
- “Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site.”
- “Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site.”

Separate Procedure

- A procedure designated by the CPT code descriptor as a “separate procedure” is not separately reportable if performed in a region anatomically related to the other procedure(s) through the same skin incision, orifice, or surgical approach.

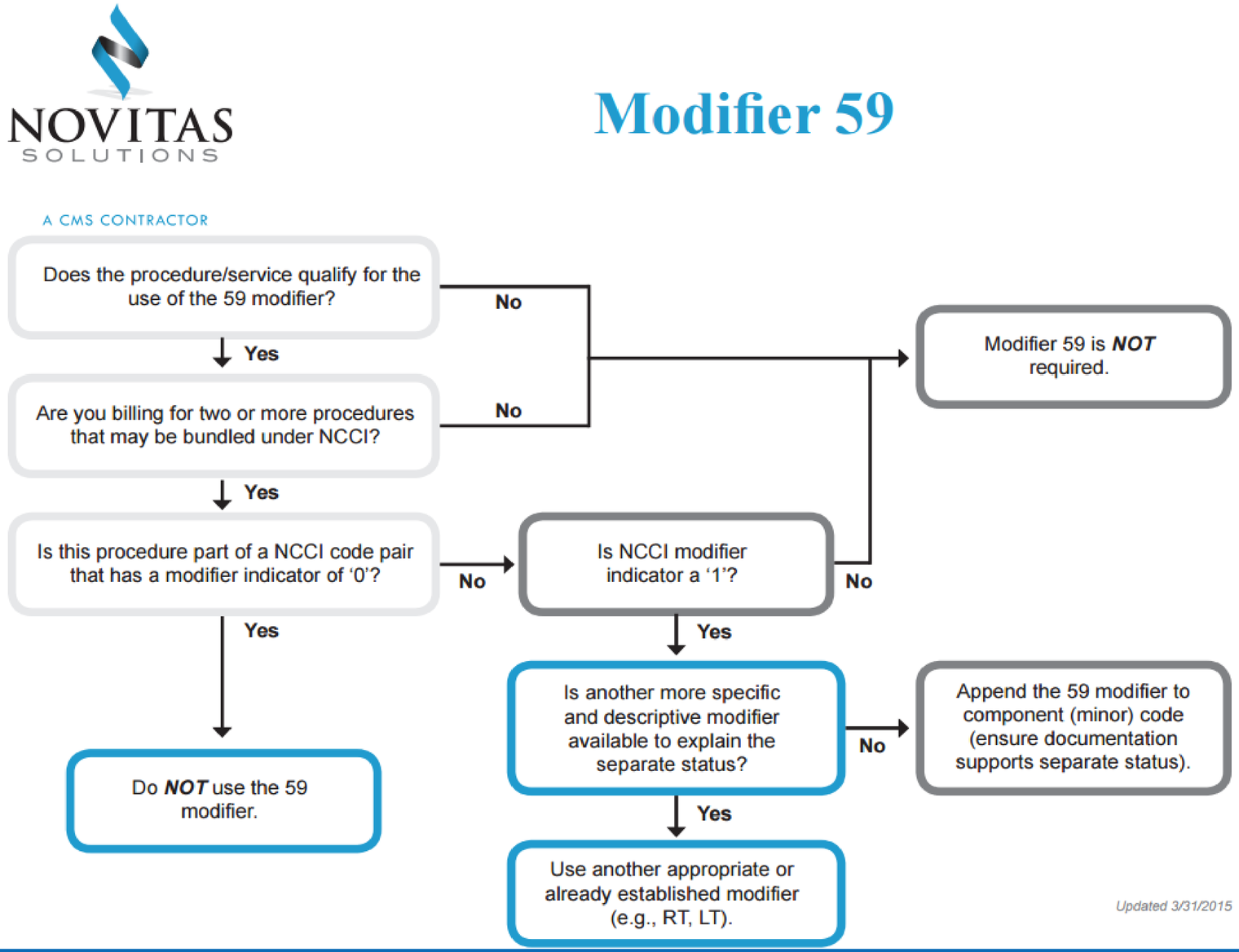
49000 Exploratory laparotomy, exploratory celiotomy with or without biopsy(s)(separate procedure)

Test Your Knowledge

A physician performs and documents for both a Arthroscopic rotator cuff repair (29827) and an arthroscopic limited debridement in the shoulder (29822). 29827 is the column 1 code and 29822 is the column 2 code. The indicator is “1” with the PTP Edit Rationale of “Standards of medical / surgical practice”

29827 and 29822 can only be coded together when they are performed on contralateral shoulders. The appropriate modifier usage would be RT and LT, not 59.

Modifier 59 Flow Chart



Modifier X{EPSU}

- **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
- **XU Unusual Non-Overlapping Service**: The use of a service that is distinct because it does not overlap usual components of the main service

Louisiana Medicaid

DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid

MOLINA Medicaid Solutions

New Healthcare Common Procedure Coding System (HCPCS) Modifiers:
XE, XP, XS and XU

Four new HCPCS modifiers have been established to provide greater reporting specificity than modifier -59 on claims with dates of service on or after January 1, 2015. They are:

- 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

Modifier -59 will remain a valid modifier. Use of the new XE, XP, XS and XU modifiers is currently optional. However, providers may choose to use them to specify more clearly the clinical situations in which modifier -59 is now reported.

These modifiers may be used for clinical situations in which two HCPCS/CPT codes are reported by the same provider on the same date of service and that are currently indicated by appending modifier -59 "Distinct Procedural Service" to a HCPCS/CPT code.

These modifiers should not be used unless the proper criteria for use of the modifier are met. Documentation in the medical record must support the use of any modifier that is used.

Provider use of these modifiers will be monitored for abuse and when appropriate, referred to Program Integrity for detailed review and potential recovery of overpayments.

For questions related to this information as it pertains to Legacy Medicaid claims processing, please contact Molina Medicaid Solutions Provider Services at (800) 473-2783 or (225) 924-5040.

United Healthcare

The Centers for Medicare and Medicaid Services (CMS) has created four new healthcare common procedure coding system (HCPCS) modifiers to selectively identify subsets of modifier 59 (distinct procedural services) for use, effective Jan. 1, 2015. They are:

- **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 physician.
- **XS Separate Structure:** A service that is distinct because it was performed on a separate organ/structure.
- **XU Unusual Non-Overlapping Service:** A service that is distinct because it does not overlap usual components of the main service.

These modifiers, collectively referred to as X {EPSU} modifiers, define specific subsets of modifier 59. Like CMS, UnitedHealthcare will continue to recognize modifier 59; however, current procedural terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. In addition, the X {EPSU} modifiers are more selective versions of modifier 59 so it would be incorrect to include both modifiers on the same line.

CMS will continue to recognize modifier 59 but may selectively require a more specific X {EPSU} modifier for billing certain codes at high risk for incorrect billing. For example, a particular national correct coding initiative (NCCI) procedure to procedure code pair edit may be identified as payable only with the XE separate encounter modifier but not the 59 or other X {EPSU} modifiers.

UnitedHealthcare will recognize these new modifiers, effective for dates of service on and after Jan. 1, 2015. Please reference the following table to find out when the new modifiers will be considered in administering the UnitedHealthcare's reimbursement policies.

Policy	X{EPSU} Modifiers considered in lieu of Modifier 59	Effective for claims with dates of service Jan. 1, 2015 processed on or after these dates:
Anesthesia	XE and XU	Feb. 15, 2015
Bilateral	XS	Jan. 1, 2015
CCI Editing	XE, XP, XS, and XU	Jan. 1, 2015
Laboratory Services	XE, XP, XS, and XU	Feb. 15, 2015
Maximum Frequency Per Day	XE, XS, and XU	Jan. 1, 2015
Obstetrical	XE, XS, and XU	Feb. 15, 2015
Pediatric and Neonatal Critical & Intensive Care Services	XE, XS and XU	New policy becomes effective March 1, 2015 DOS
Procedure to Modifier	XE, XP, XS, and XU	Feb. 15, 2015
Professional-Technical Component	XE, XP, XS, and XU	Feb. 15, 2015
Radiology Multiple Imaging Reduction	XE	Jan. 1, 2015
Rebundling	XE, XP, XS, and XU	Feb. 15, 2015

Humana

Commercial and Medicare Advantage Payment Policy

In addition to this policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

Humana plans accept HCPCS *modifiers -XE, -XP, -XS,* and *-XU*. Each of these modifiers should only be used to accurately describe the service that occurred. Until CMS determines when these modifiers must be used in place of *modifier -59*, Humana will accept either *modifier -59* or one of these modifiers accurately appended to a service code.

Blue Cross

Modifiers XE, XP, XS and XU

The primary purpose of modifier 59 is to report two or more procedures that are being performed at different anatomic sites or for different patient encounters by the same provider on the same date of service.

- According to the Centers for Medicare & Medicaid Services (CMS), "The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter."
- Modifier 59 should not be used to bypass an edit unless the proper criteria for its use are met and the documentation in the patient's medical record clearly supports this criteria and the use of modifier 59.

CMS has established four new HCPCS modifiers to define specific subsets for modifier 59. For professional claims, Blue Cross will allow the same incidental and mutually exclusive edit overrides for the new 2015 modifiers XE, XP, XS and XU as it does for modifier 59.

- 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.

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.

NCCI Policy Manual

- Arranged by Chapters corresponding to a separate section of the CPT® manual.
- Includes a chapter for general correct coding policies – Chapter 1
- Addresses HCPCS Level 2 codes in Chapter 12
- Addresses Category III CPT codes in Chapter 13

Integral Components

- Cleansing, shaving and prepping of skin
- Draping and positioning of patient
- Insertion of IV access for medication administration
- Insertion of urinary catheter
- Wound irrigation
- Surgical closure and dressings
- Lysis of adhesions

THIS IS NOT AN ALL INCLUSIVE LIST

NCCI Guidelines

- A physician should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services.
- A physician should not fragment a procedure into component parts.
- A physician should not unbundle a bilateral procedure code into two unilateral procedure codes.
- A physician should not unbundle services that are integral to a more comprehensive procedure.

Test Your Knowledge

The provider performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpino-oophorectomy

A. 58262 *Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)*

B. 58260 *Vaginal hysterectomy, for uterus 250 g or less*

C. 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)*

D. Both B and C

(Hint 58720 is a column 2 code to 58260 with an indicator of "0")

(58260 and 58720 are both column 2 codes to 58262)

Test Your Knowledge

A physician performs a bilateral mammography.

A. 77065-RT and 77065-LT *Mammography; unilateral with anatomic modifier*

B. 77065-50 *Mammography; unilateral with bilateral modifier*

C. 77065 x 2 *Mammography; unilateral with a quantity of two*

D. 77066 *Mammography; bilateral*

NCCI Guidelines

- More extensive procedures
  - Not separately reportable if performed at the same patient encounter on the same anatomic site.
    - A “partial” procedure is not separately reportable with a “complete” or “total” procedure.
    - A “unilateral” procedure is not separately reportable with a “bilateral” procedure.
    - A “single” procedure is not separately reportable with a “multiple” procedure.
    - A “with” procedure is not separately reportable with a “without” procedure.

General Principles

- The component service is an accepted standard of care when performing the comprehensive service.
- The component service is usually necessary to complete the comprehensive service.
- The component service is not a separately distinguishable procedure when performed with the comprehensive service.

Approach

Multiple approaches to the same procedure are mutually exclusive of one another and should not be reported separately.

- both a vaginal hysterectomy and abdominal hysterectomy should not be reported separately.

- Scope converted to open. Only code for the successful procedure

Biopsy

- If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

- If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination.

- If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

Arthroscopy

- Update for 2017
- Shoulder arthroscopy procedures include limited debridement (29822) even if limited debridement is performed in a different area of the same shoulder than the other procedure.
- Extensive debridement (29823) is also included with 3 exceptions if the debridement is performed in a different area of the same shoulder
  - 29824 arthroscopic claviculectomy
  - 29827 arthroscopic rotator cuff repair
  - 29828 arthroscopic biceps tenodesis

Complications

- Treatment of a complication of a primary surgical procedure is not separately reportable:
  - if it represents usual and necessary care in the operating room during the procedure or
  - if it occurs postoperatively and does not require return to the operating room.

During Operation

- The administration of fluids and drugs during the operative procedure is included in the global surgical package.
  - CPT codes 96360-96376 should not be reported separately.
    - OPPS considers 96360-96376 inclusive and not separately reportable.
- Cardiopulmonary monitoring is integral to the procedure
  - (e.g. 93000-93010, 93040-93042, 94760-94761, 94770)

Nuclear Medicine

- CPT code 36000 *introduction of needle or intracatheter into a vein* is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT code 36000 is not separately reportable with these types of nuclear medicine procedures. However, CPT code 36000 may be reported alone if the only service provided is the introduction of a needle into a vein.) Other integral services do not have specific CPT codes.

Radiology

- 2017 Update
  - “When *a* comparative *imaging* study *is* performed *to assess potential complications or completeness of a procedure*(e.g., post-reduction, post-intubation, post-catheter placement, etc.), the *professional component of the* CPT code for the *post-procedure imaging study is not separately payable and should not be reported. The technical component of the CPT code for the post-procedure imaging study may be reported.”*

Family Codes

- CPT® codes followed by one or more indented CPT® codes

```
CPT code 70120    Radiologic examination, mastoids; less than
                  three views per side
CPT code 70130        complete, minimum of three views per side
```

Evaluation and Management

- Same day as a major surgery (90 day global)
  - Modifier 57
- Same day as a minor surgery (0 or 10 day global)
  - Modifier 25
  - Diagnosis code
  - New patient status
- Unrelated E/M during a post operative period
  - Modifier 24

Software Edit Pitfalls

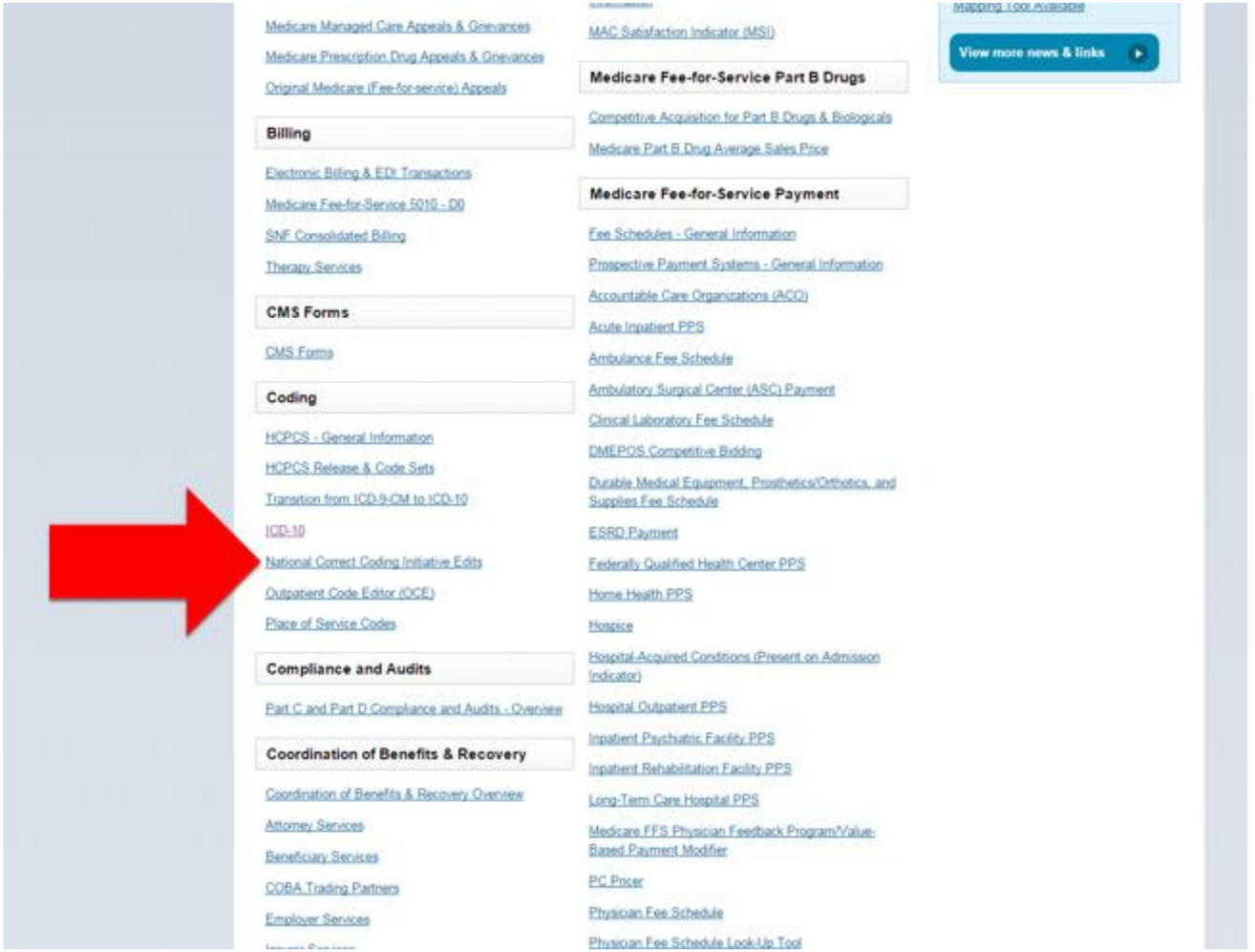
Steps

- NCCI Manual
  - www.cms.gov -> Medicare -> National Coding Initiative Edits -> NCCI Policy Manual for Medicare Services – Effective January 1, 2015 -> Choose the Chapter you would like to read.

- NCCI Edits
  - www.cms.gov -> Medicare -> National Coding Initiative Edits -> PTP Coding Edits -> Choose hospital or physician and code range you are reviewing.

Click on the Medicare tab

Scroll down to the Coding section
Click on National Correct Coding Initiative Edits



Guidelines – Scroll down and click on the NCCI Policy Manual for the current year

Downloads

How to Use The National Correct Coding Initiative (NCCI) Tools [PDF, 1MB]

R1386CP [PDF, 167KB]

MM5824 [PDF, 69KB]

NCCI Policy Manual for Medicare Services - Effective January 1, 2014 [ZIP, 749KB]

NCCI Policy Manual for Medicare Services - Effective January 1, 2015 [ZIP, 1MB]

NCCI Policy Manual for Medicare Services - Effective January 1, 2016 [ZIP, 761KB]

NCCI Policy Manual for Medicare Services - Effective January 1, 2017 [ZIP, 770KB]

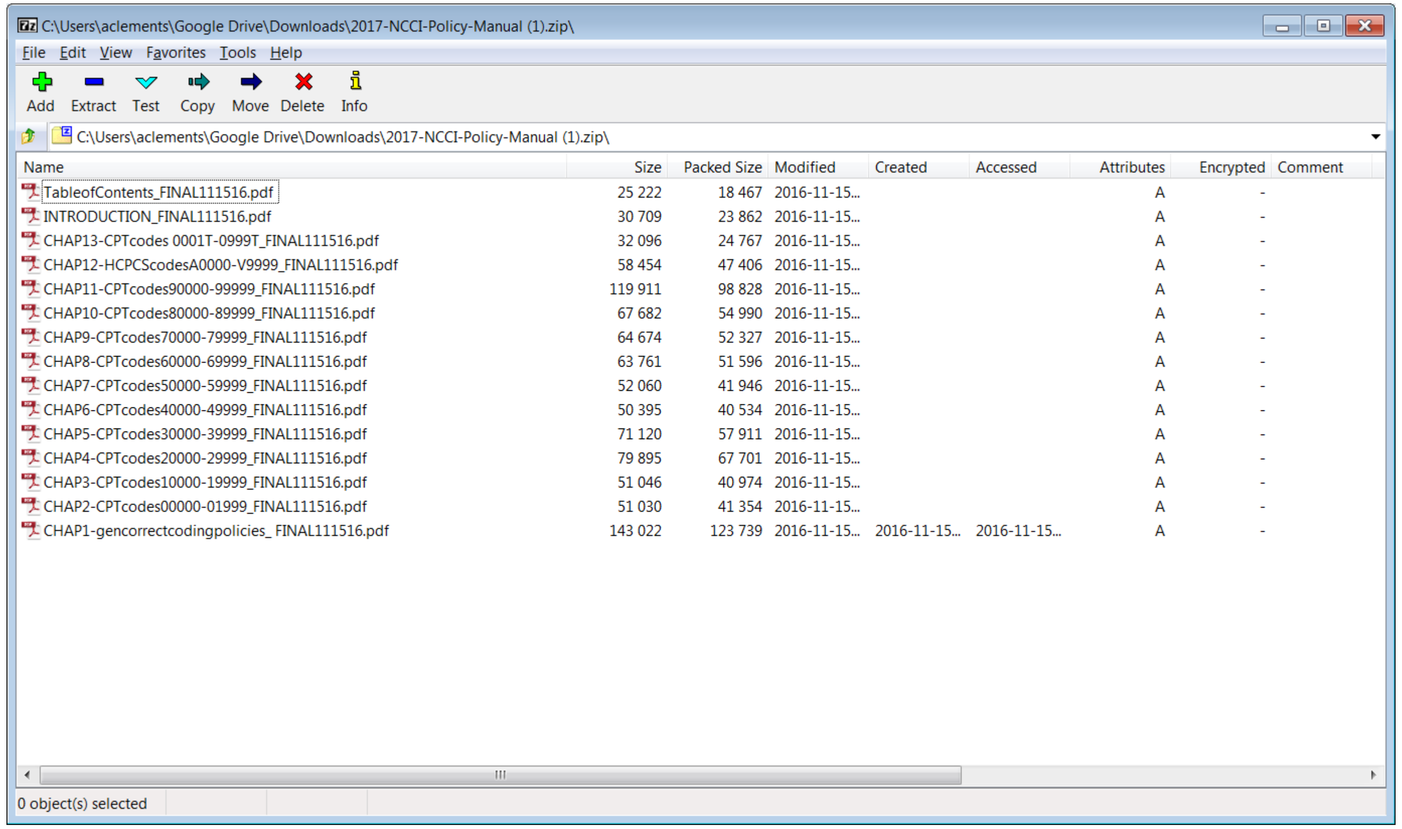
Correspondence Language Manual for Medicare Services - Effective April 1, 2015 [PDF, 322KB]

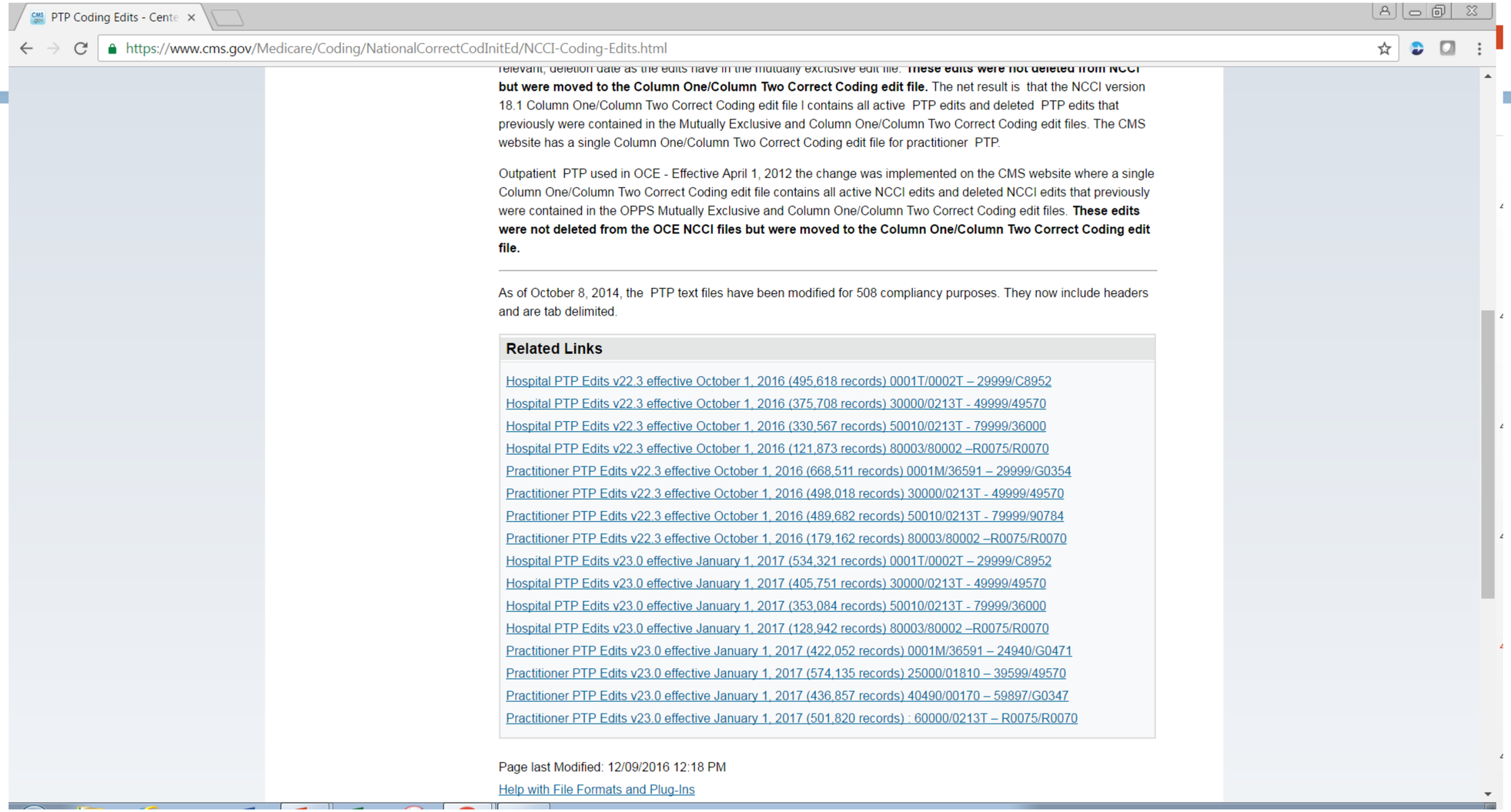
Correspondence Language Manual for Medicare Services – Effective April 1, 2016 [PDF, 195KB]

Chapter 23 - Fee Schedule Administration and Coding Requirements [PDF, 1MB]

Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service – Updated 11/16/16 [PDF, 106KB]

Click on the manual to open the zip file.




PTP Coding Edits - Cente
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html
relevant, deletion date as the edits have in the mutually exclusive edit file. **These edits were not deleted from NCCI but were moved to the Column One/Column Two Correct Coding edit file.** The net result is that the NCCI version 18.1 Column One/Column Two Correct Coding edit file I contains all active PTP edits and deleted PTP edits that previously were contained in the Mutually Exclusive and Column One/Column Two Correct Coding edit files. The CMS website has a single Column One/Column Two Correct Coding edit file for practitioner PTP.
Outpatient PTP used in OCE - Effective April 1, 2012 the change was implemented on the CMS website where a single Column One/Column Two Correct Coding edit file contains all active NCCI edits and deleted NCCI edits that previously were contained in the OPPS Mutually Exclusive and Column One/Column Two Correct Coding edit files. **These edits were not deleted from the OCE NCCI files but were moved to the Column One/Column Two Correct Coding edit file.**
As of October 8, 2014, the PTP text files have been modified for 508 compliancy purposes. They now include headers and are tab delimited.
Related Links
Hospital PTP Edits v22.3 effective October 1, 2016 (495,618 records) 0001T/0002T – 29999/C8952
Hospital PTP Edits v22.3 effective October 1, 2016 (375,708 records) 30000/0213T - 49999/49570
Hospital PTP Edits v22.3 effective October 1, 2016 (330,567 records) 50010/0213T - 79999/36000
Hospital PTP Edits v22.3 effective October 1, 2016 (121,873 records) 80003/80002 –R0075/R0070
Practitioner PTP Edits v22.3 effective October 1, 2016 (668,511 records) 0001M/36591 – 29999/G0354
Practitioner PTP Edits v22.3 effective October 1, 2016 (498,018 records) 30000/0213T - 49999/49570
Practitioner PTP Edits v22.3 effective October 1, 2016 (489,682 records) 50010/0213T - 79999/90784
Practitioner PTP Edits v22.3 effective October 1, 2016 (179,162 records) 80003/80002 –R0075/R0070
Hospital PTP Edits v23.0 effective January 1, 2017 (534,321 records) 0001T/0002T – 29999/C8952
Hospital PTP Edits v23.0 effective January 1, 2017 (405,751 records) 30000/0213T - 49999/49570
Hospital PTP Edits v23.0 effective January 1, 2017 (353,084 records) 50010/0213T - 79999/36000
Hospital PTP Edits v23.0 effective January 1, 2017 (128,942 records) 80003/80002 –R0075/R0070
Practitioner PTP Edits v23.0 effective January 1, 2017 (422,052 records) 0001M/36591 – 24940/G0471
Practitioner PTP Edits v23.0 effective January 1, 2017 (574,135 records) 25000/01810 – 39599/49570
Practitioner PTP Edits v23.0 effective January 1, 2017 (436,857 records) 40490/00170 – 59897/G0347
Practitioner PTP Edits v23.0 effective January 1, 2017 (501,820 records) : 60000/0213T – R0075/R0070
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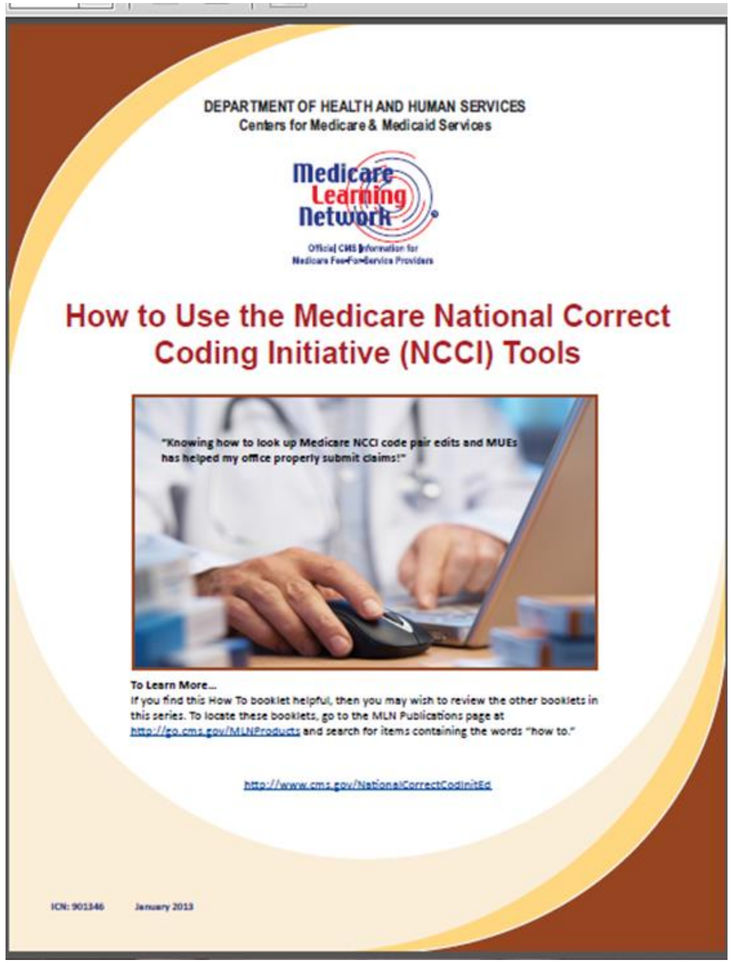
Help with File Formats and Plug-Ins

Summary

- A HCPCS/CPT® code may be reported if and only if all services described by the code are performed.
- A physician should not report multiple codes corresponding to component services if a single comprehensive code describes the services performed.
- HCPCS/CPT® code(s) corresponding to component service(s) of other more comprehensive HCPCS/CPT code(s) should not be reported separately.
- If the HCPCS/CPT® codes do not correctly describe the procedure(s) performed, they physician should NOT report the code that most closely describes the procedure(s) performed.

RESOURCES

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network

Official CMS Information for Medicare Fee-For-Service Providers

How to Use the Medicare National Correct Coding Initiative (NCCI) Tools

To Learn More…
If you find this How To booklet helpful, then you may wish to review the other booklets in this series. To locate these booklets, go to the MLN Publications page at http://go.cms.gov/MLNProducts and search for items containing the words "how to."

http://www.cms.gov/NationalCorrectCodInitEd

ICN: 901346 January 2013

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf

MODIFIER 59 ARTICLE

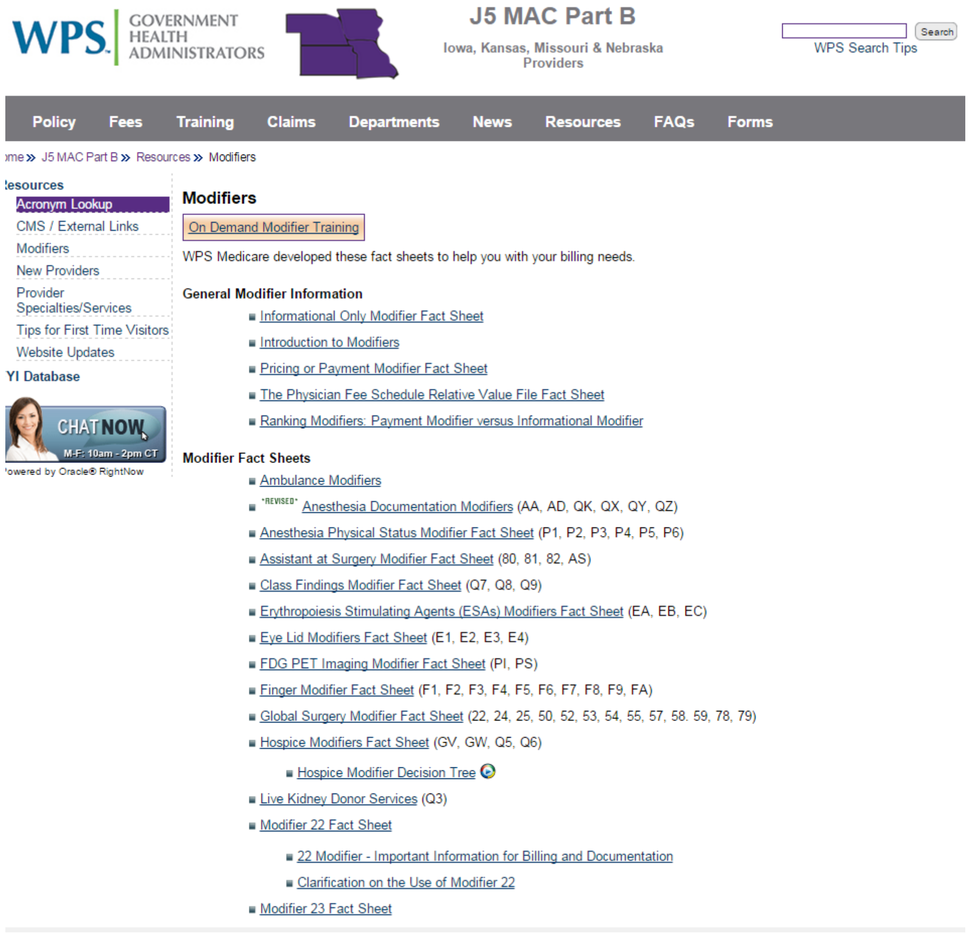
The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations. For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of "0," the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied. For PTP edits that have a CCMI of "1," the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the *National Correct Coding Initiative Policy Manual for Medicare Services*, Chapter 1, for general information about the NCCI program, PTP edits, CCMIs, and NCCI-associated modifiers.) One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct." Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

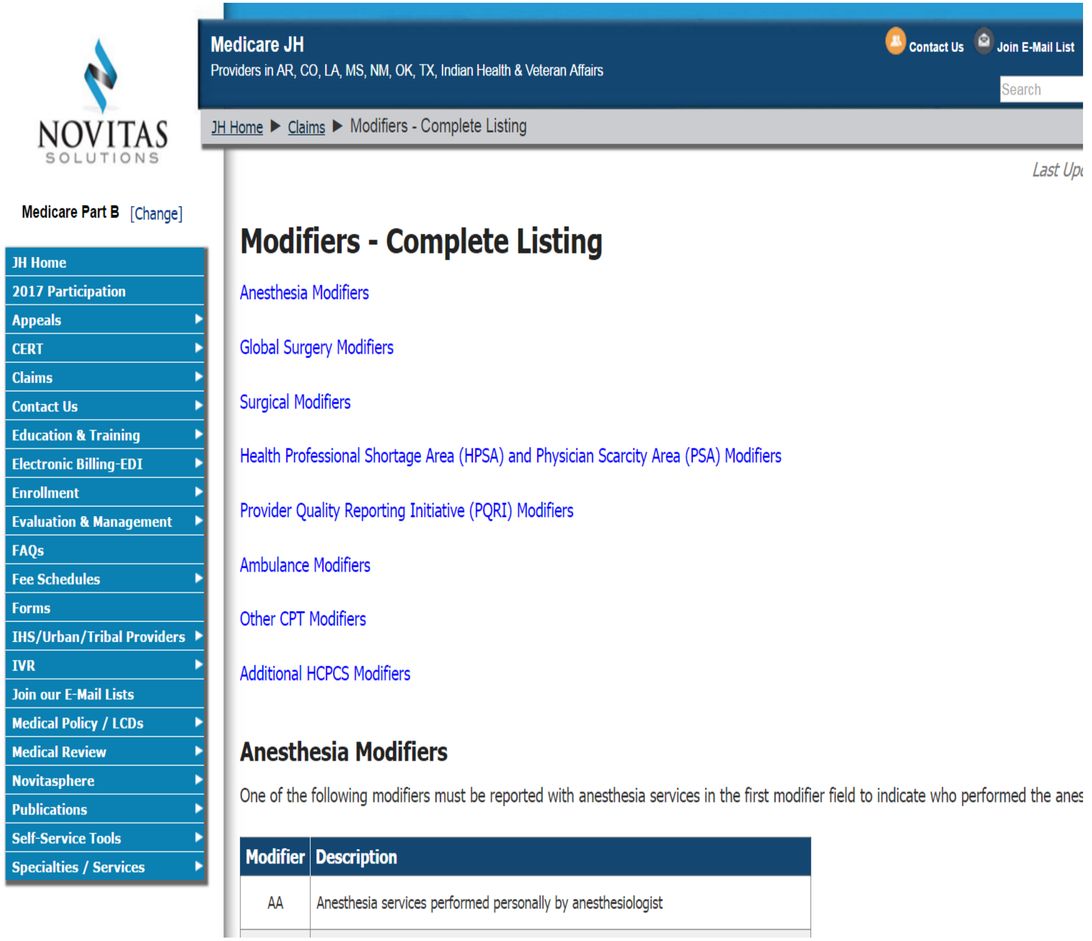
The *CPT Manual* defines modifier 59 as follows:

> "**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. 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."

Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

Check Your Local MAC





Questions

Thank you!

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