



**BlueCross BlueShield
of Florida**

An Independent Licensee of the
Blue Cross and Blue Shield Association

September 2008

Distinct Procedure (-59 Modifier) Policy

The following provides information on Blue Cross and Blue Shield of Florida's (BCBSF's) claims processing policy pertaining to modifier -59.

The *CPT Manual* defines modifier -59 as follows:

Modifier -59: Distinct Procedural Service

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. This may represent a different session or patient encounter, 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 physician.

However, when another already established modifier is appropriate, it should be used instead of modifier -59. Modifier -59 should only be used if no more descriptive modifier is available, and its use best explains the circumstances.

National Correct Coding Initiative (NCCI) edits define when two procedure codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at different anatomic sites or different patient encounters. Modifier -59 and other NCCI-associated modifiers should not be used to bypass an NCCI edit unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

BCBSF Policy

NCCI edits that do not allow the reporting of modifier -59 will not allow separate payment. In addition, BCBSF has identified the following coding situations where an edit will not be overridden by modifier -59. These situations are as follows:

- 94760 billed with any Anesthesia, Surgery, Radiology, Medicine or E/M service
- Q0091 billed with preventative E/M codes 99384-99387 and 99394-99397
- 63047 or 63048 billed with 22630 or 22632

Claims processed after October 16, 2008, regardless of service date(s), will process according to this policy. No retrospective claim payment changes are made for processing changes that are the result of new code editing rules.

If you have any questions regarding this bulletin, please contact your physician/provider relations specialist or call our Provider Contact Center at (800) 727-2227.