

Master the Use of Modifier 59 and CMS' X Modifiers

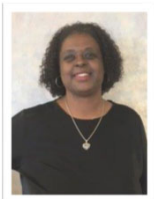
A WEBINAR PRESENTED ON OCTOBER 24, 2023

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Presented By



- **Corella Lumpkins, CHC, CPC, CPCO, CDEO, CPB, CPPM, CPC-I, CCS, CCS-P**, is the manager of coding compliance and provider education at Loudoun Medical Group PC. She has over 30 years of experience working in every area of the healthcare revenue cycle. She has a bachelor's degree in health science administration and has an extensive background in auditing, billing, coding, compliance, denials management, education, and practice management. Lumpkins works closely with providers and staff and is a certified instructor teaching both the Certified Professional Biller (CPB®) and CPC® curriculum. She is a mentor to her students and an active member and past president of AAPC's Leesburg, Virginia, local chapter.

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Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
 - Understand the background & meaning of modifier -59 and the four X modifiers
 - Identify combinations of procedures that would be appropriate or inappropriate for modifier 59/X modifier use, as well as other modifiers that may be more appropriate
 - Use documentation to support the use of modifier 59/X modifiers
 - Justify use of modifier 59/X modifiers when challenged

History of the – 59 Modifier & CMS “X-modifiers”



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AMA Current Definition – 59 MODIFIER

The American Medical Association (AMA) created the – 59 modifier in 1994

- 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, 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.

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How Did We Get Here.....

The American Medical Association (AMA) created the – 59 modifier in 1994

Created to identify these “distinct procedures” to ensure correct reimbursement

CMS, OIG & private payers have identified this modifier as widely over-used & misused.

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AMA Current Definition – 59 MODIFIER

The American Medical Association (AMA) later revised to current:

- The CPT Manual defines modifier 59 as:
 - “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.”

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CMS Current Definition – 59 MODIFIER

The Center of Medicare & Medicaid Services (CMS) created the – X modifiers in 2015

Here come the X's.....

- **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”

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CMS Current Definition – 59 /- X Modifiers

- “Don’t use modifiers 59, **XE**, **XS**, **XP**, or **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.**)
- **CMS allows the modifiers 59, XE, XS, XP, or XU on Column 1 or Column 2 codes**” (see the related transmittal at CR 11168 and MM11168).

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National Correct Coding Initiative (NCCI)



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What Is the National Correct Coding Initiative (NCCI)?

- **Definition:** CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment
 - Purpose: Applies to coding policies defined in the AMA, CPT Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice
- **Includes the following:**
 - Procedure to Procedure (PTP) Edit Pairs
 - Add-On-Codes (AOC)
 - Medically Unlikely Edits (MUEs)

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Procedure to Procedure (PTP) Code Edits



A PTP code pair is subject to automated prepayment edits when two services are performed:

By the same physician or provider
For the same beneficiary
On the same date of service



A modifier is appropriate to use when:

The modifiers associated with NCCI are allowed with the PTP code pair

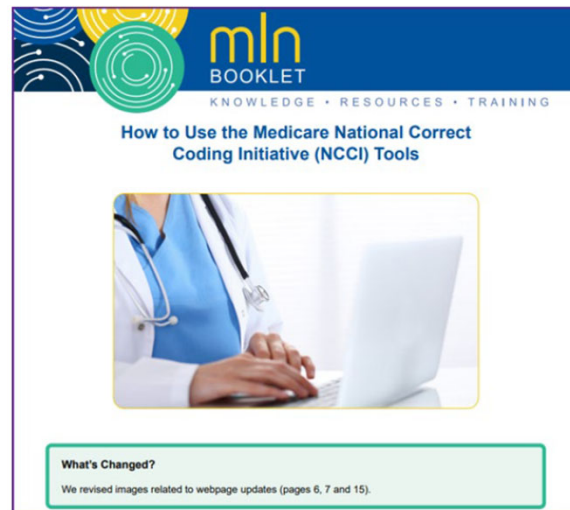


Documentation supporting the PTP code pair and the modifier is appropriate when:

A clinical circumstances that justifies the use of a modifier

National Correct Coding Initiative (NCCI)

- CMS has a step-by-step process on the Medicare National Correct Coding Initiative (NCCI)



NCCI PTP Example

Column 1 Code	Column 2 Code	Effective Date	Deletion Date * = no data	Modifier	PTP Rationale
20610	36591	20151001	*	0	CPT Manual or CMS manual coding instructions
20610	36600	20090401	*	1	Standards of medical/surgical practice
20610	61650	20160101	20160101	9	Misuse of column two code with column one

- Column 1 is the primary payable code
- Column 2 contains the secondary code:
 - May or may not be payable
- Column 3 effective date of the edit
- Column 4 deletion date
- Column 5 modifier is permitted:
 - Append modifier if applicable to the Column 1 or Column 2
- Column 6 underlying basis for each PTP edit

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Correct Coding Modifier Indicators (CCMI)

- Indicator 0:
 - Code pairs will not be reimbursed if submitted for the same date of service
 - Modifiers associated with NCCI are not allowed to be used with the PTP code pair
- Indicator 1:
 - Modifiers associated with NCCI are allowed with the PTP code pair when appropriate
- Indicator 9:
 - Not subject to NCCI edits for the PTP code pair
 - Edit for the code pair was deleted
- Documentation must be maintained in the medical record to support the use of NCCI modifier

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Top Common PTP Edits

PTP Edit	Definition
HCPCS/CPT Procedure code definition	Describes procedures with several components which may be performed independently or have their own HCPCS/CPT codes
Mutually exclusive procedures	Certain services or procedures would not reasonably be performed at the same session by the same provider on the same beneficiary
More extensive procedure	HCPCS/CPT codes corresponding to more extensive procedures always include HCPCS/CPT corresponding to less complex procedures
Standards of medical/surgical practice	Procedures that are typically necessary to complete a more comprehensive procedure have been assigned independent HCPCS/CPT code
Misuse of column two with a column one code	Physician or non-physician provider must have perform all of the services noted in the descriptor unless the descriptor states otherwise
Separate procedure definition	Separate procedure should not be reported when performed along with another procedure in anatomically-related region through same skin incision or surgical approach

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National Correct Coding Initiative (NCCI) Notes:

NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist.

Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

NCCI is updated quarterly and loaded into the all of our payers claims payment processing systems, billing clearinghouses and onto the NCCI website.

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Modifiers Used for NCCI PTP Edits

Definition: Indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code

- **Purpose:** Used to add information or change the description of service in order to improve accuracy or specificity

- **NCCI modifier categories:**
 - Anatomical 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**

59 / X - MODIFIERS OF LAST RESORT

Modifier 59 is defined as procedures or services that are not normally reported together, but are appropriate under the circumstances

Represents a different:

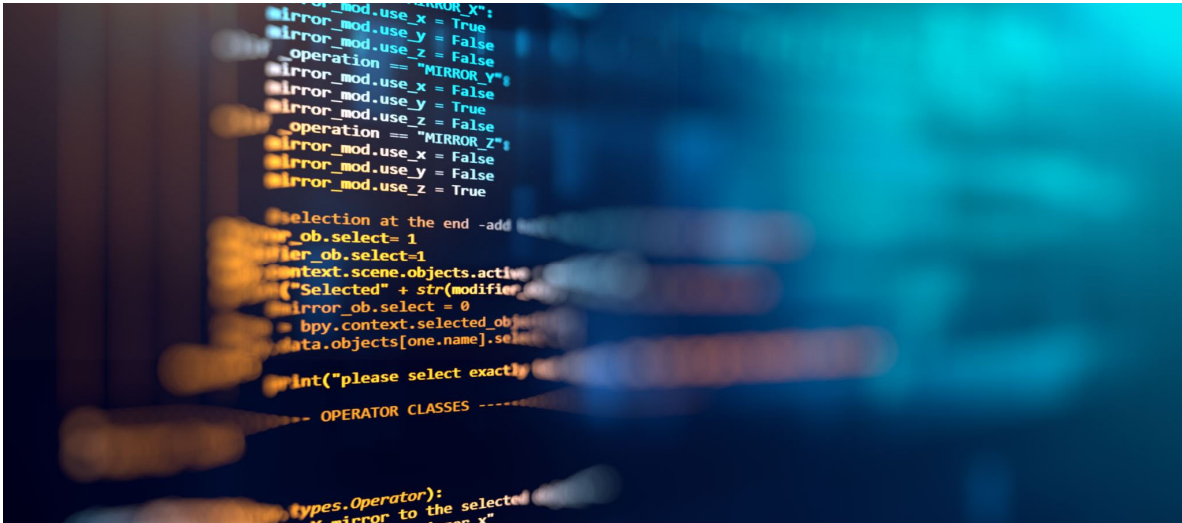
- Session or patient encounter
- Procedure or surgery
- Site or organ system
- Separate incision/excision
- Separate lesion/injury

HCPCS modifiers to define specific subsets of the 59 modifier:

- **XE -Separate Encounter**
- **XS -Separate Structure**
- **XP -Separate Practitioner**
- **XU -Unusual Non-Overlapping Service**

Modifier 59 should only be used if no other modifier can be used

Understanding the CMS “X” MODIFIERS



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-XE MODIFIER

The XE modifier is defined as a separate encounter:

- A service that is distinct because it occurred during a **separate encounter**
 - Should only be used to describe separate encounters on the same date of service
 - Documentation must support the time for each encounter

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- XE MODIFIER SCENARIO

- The physician performs a diagnostic nasal endoscopy (31231) at 10 a.m.
- Later that day the patient develops epistaxis and the physician uses complex techniques to control the nosebleed (30903)
- The diagnostic endoscopy is bundled with the control of epistaxis if they were done during the same encounter
- The XE modifier is appropriate since the procedures were done at different encounters

Column 1	Column 2	Effective Date	Deletion Date	Modifier	PTP Edit Rationale
31231	30903	19970401	N/A	1	Standard of medical/surgical practice

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- XE MODIFIER SCENARIO

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				
OPT/HCPCS	MODIFIER			
93015				
93000	XE			

- Patient presents for a scheduled stress test. Test is performed (93015) & patient left.
- Later patient returns, complaining of chest pain & EKG is done (93000).
- The XE modifier is appropriate since the procedures were done at different encounters

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- XS MODIFIER

The XS modifier is defined as a separate structure

A service that is distinct because it was performed on a **separate organ/structure** during the same encounter

Represents a procedure or surgery performed on a different:

- Anatomical site, organs or regions (non-contiguous areas)
- Separate orifices
- Separate incision/excision
- Separate lesion/injury

- XS MODIFIER SCENARIO

- The physician does a debridement of a hyperkeratotic lesion (**11055**) on the left foot second toe
- During the same encounter he performed a debridement of five toe nails (**11720**)
- The **XS** modifier is appropriate because the procedures are mutually exclusive and were performed on different structures

Column 1	Column 2	Effective Date	Deletion Date	Modifier	PTP Edit Rationale
11055	11720	19980401	N/A	1	Mutually exclusive procedures

- XS MODIFIER SCENARIO

- The physician does a debridement of a hyperkeratotic lesion (**11055**) on the left foot second toe
- During the same encounter he performed a debridement of five toe nails (**11720**)
- The **XS** modifier is appropriate because the procedures are mutually exclusive and were performed on different structures

Column 1	Column 2	Effective Date	Deletion Date	Modifier	PTP Edit Rationale
11055	11720	19980401	N/A	1	Mutually exclusive procedures

- XP MODIFIER

The XP modifier is defined as a separate practitioner:

A service that is distinct because it was performed by a different practitioner



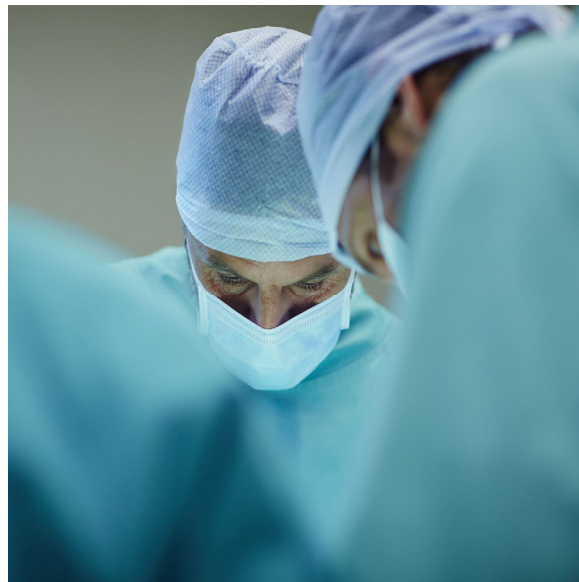
- XP MODIFIER SCENARIO

- A physical therapist and occupational therapist bill 97110 on the same day for a patient recovering from a stroke
- The services are distinct because the providers are practicing under different disciplines

- XU MODIFIER

Modifier XU is defined as an unusual non-overlapping service:

The use of a service that is distinct because it does not overlap usual components of the main service



- XU MODIFIER SCENARIO

Procedure codes **37220** and **75710** were performed on the same day

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

The **XU** modifier is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure

Column 1	Column 2	Effective Date	Deletion Date	Modifier	PTP Edit Rationale
37200	75710	20110104	N/A	1	Misuse of column two with a column one code

NCCI Notes

- **Bill all services performed on one day on the same claim**
- **Report each service on a separate line**
- **Consult other NCCI modifiers prior to using modifier 59:**
 - Append modifiers to either procedure
- **Do not append a modifier to bypass an NCCI edit:**
 - Documentation must substantiate the proper use of the modifier
- **More than one line with modifier 59 appended to the same procedure code requires submission of supportive documentation on the claim:**
 - Item 19 of the paper CMS 1500 (02/12) claim form
 - 2300 loop of the electronic equivalent
 - Failure to provide a narrative description may result in a duplicate denials

APPROPRIATE & INAPPROPRIATE USE

59 / X modifiers

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APPROPRIATE USE vs. INAPPROPRIATE USE

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 curettement), 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. 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.

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APPROPRIATE USE vs. INAPPROPRIATE USE

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
- Don't report CPT code 76942 with or without modifiers 59, XE, XS, XP, or 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, or XU if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

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APPROPRIATE USE vs. INAPPROPRIATE USE

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, XE, XS, XP, or XU for fluoroscopy in conjunction with a cardiac catheterization procedure.
- You may report 76000 with modifiers 59, XE, XS, XP, or XU if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

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APPROPRIATE USE vs. INAPPROPRIATE USE

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
- 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, XE, XS, XP, or 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.

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APPROPRIATE USE vs. INAPPROPRIATE USE

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

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APPROPRIATE USE vs. INAPPROPRIATE USE

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, XE, XS, XP, or 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, or XU.

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APPROPRIATE USE vs. INAPPROPRIATE USE

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.

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APPROPRIATE USE vs. INAPPROPRIATE USE

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, XE, XS, XP, or 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, or XU are inappropriate if the basis for their use is that the narrative description of the 2 codes is different.

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APPROPRIATE USE vs. INAPPROPRIATE USE

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.
- 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.

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APPROPRIATE USE vs. INAPPROPRIATE USE

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.**

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Medicare Administrative Carrier (MAC) Tools



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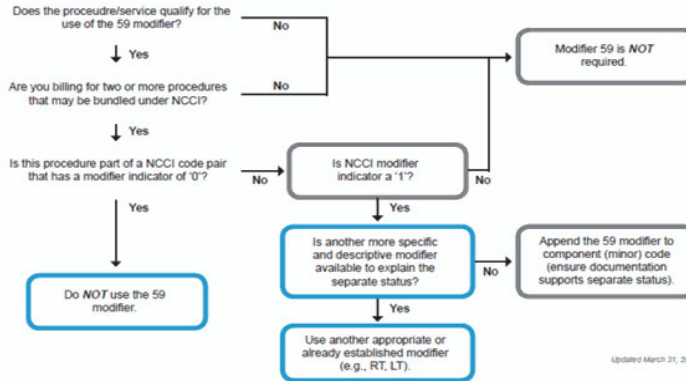
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MAC TOOLS: NOVITAS SOLUTIONS – 59 Decision Tree



A CMS CONTRACTOR

Modifier 59

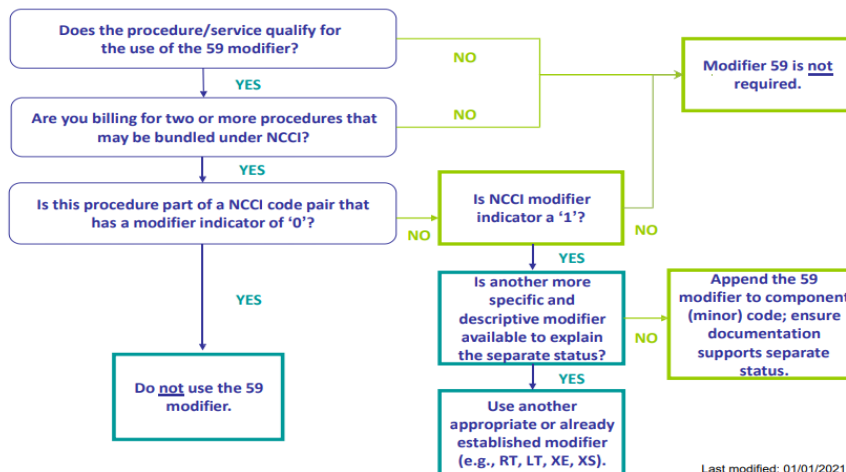


Updated March 31, 2013

MAC TOOLS: FCSO – 59 Decision Tree



Modifier 59



Last modified: 01/01/2021

Remember Modifier -51 (Multiple Surgery Reduction)

- Do not use -51 on procedures that are components of another procedure
- Do not use the -51 on the primary procedure, only on the secondary procedures (order procedures by RVU)
- Do not use -51 on procedures on “add-on” codes with a “+” sign indicated in the CPT Manual
- Reimbursement will be subject to multiple surgical reduction

Maximum Reimbursement

- List most resource intense first (**highest RVU value**)
- Next other procedure(s) + -51
(unless code is -51 exempt or an add-on code)
- Usual payment: 1st procedure 100%, 2nd 50%, 3rd 25%
- Medicare: 1st procedure paid 100%,
 - 2nd–5th paid 50%,
 - more than 5, priced *manually*

ALWAYS DO YOUR OWN RESEARCH:

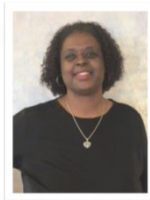
Weblink References:

- <https://www.cms.gov/national-correct-coding-initiative-ncci>
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- <https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf>
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- <https://medicare.fcso.com/wrapped/243924.pdf>

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Questions & Answers



**Corella Lumpkins, CHC, CPC, CPCO,
CDEO, CPB, CPPM, CPC-I, CCS, CCS-P**
Manager of Coding Coding Compliance and
Provider Education
Loudoun Medical Group PC

To Submit a Question: Go to the Q&A box located in the lower left area of your screen. Type your question in the lower text box, then press your “Enter” key.

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DecisionHealth, an HCPro brand, 5511 Virginia Way, Suite 150, Brentwood, TN 37027

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