

UNDERSTANDING HOW TO CORRECTLY USE THE -59 MODIFIER IN CPT CODING

Healthcare providers currently use Current Procedural Terminology (CPT) codes to report medical and procedural services performed on patients to both Medicare Administrative Contractors (MACs) and commercial payors. While some CPT codes specifically define a distinct, single service, other CPT codes define procedures consisting of several related services that are typically performed together. An example is CPT code 58263, which describes a vaginal hysterectomy performed with removal of tubes and ovaries, and a repair of an enterocele. Because a single CPT code can commonly include a group of related procedures, CMS created the National Correct Coding Initiative (NCCI) to prevent inappropriate payment for services where a single code describes the entire procedure and additional codes should not be reported separately. A common example is pubovaginal sling and cystoscopy. CMS considers CPT code 57288 to be inclusive of both procedures and does not allow them to each be billed separately on the same claim (commonly referred to as “unbundling”).

There are, of course, exceptions to the unbundling rule. NCCI has created a process to allow for special circumstances where an NCCI edit pair can have each CPT code used separately. 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. NCCI has created policies to allow for the use of surgical modifiers so that the two procedure codes may be reported together and allow separate payment for each of the procedures. Please see Chapter 1 of the General Correct Coding Policies (https://www.augsg.org/assets/1/6/CHAP1-gencorrectcodingpolicies_final103117.pdf).

Most of us are familiar with the -51 Multiple Procedures modifier, which allows surgeons to submit and be reimbursed for two or more surgical procedures performed together in the same patient, on the same date of service. The combination of a vaginal hysterectomy (CPT code 58260) with an AP repair (CPT code 57260) and a pubovaginal sling (CPT code 57288) is a common example. A billing person would add a -51 modifier to the latter two codes in order to be reimbursed for all three procedures.

Modifier -59, the Distinct Procedural Services modifier, is an NCCI associated modifier. For the NCCI, its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. However, this important modifier is often misunderstood or used incorrectly.

The -59 modifier can be used to identify those special circumstances where the NCCI edit should not apply. NCCI has created, and updates on a quarterly basis their set of edit tables, which define which pair edits are always mutually exclusive, and those pair edits in which they have determined that NCCI modifiers can be used to override the edit pair in these special circumstances. Many coding books will help to summarize the NCCI Edit Tables to help clinicians understand when it may be appropriate to use this modifier. Another great reference for providers is the Coding Today software available by subscription through the AUGS website. For more information about the AUGS Coding Today Software, please visit <http://augsg.codingtoday.com/>.

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The -59 modifier is officially referred to as the Distinct Procedural Service modifier, to reflect the fact that NCCI acknowledges that under certain circumstances it may be necessary for a physician to perform two “related” services on the same day, and that the second service is distinct or independent from the other service. It is very important for the physician to understand that NCCI requires that the documentation supports that these services are distinct, either because they are performed during a different session on the same date, or more commonly, are performed on a different anatomic site or organ system. NCCI further states that the -59 modifier should only be used when another more descriptive modifier is not available.

NCCI has specifically stated that this modifier should not be used as an attempt to bypass Procedure to Procedure edits unless the proper criteria are met and separate documentation is provided within the body of the operative report to satisfy the criteria required by NCCI for separate reimbursement:

Modifier -59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not 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.

The use of the -59 modifier can be especially challenging with Urogynecologic and gynecologic surgical procedures, because from an NCCI perspective, the appropriate use of this modifier requires that the services be performed at separate anatomic sites or organs. There has been some confusion over the years because the FPMRS specialist considers the pelvis and pelvic floor as consisting of multiple anatomic compartments, and the NCCI in general considers the pelvis as a single anatomically related region, especially when the two procedures are approached through a same incision or orifice. (e.g. vaginal incision). Furthermore, NCCI typically does not consider the treatment of contiguous structures in the same anatomic region to represent different anatomic sites. It is therefore important that the FPMRS specialist use language throughout their documentation that reflects that these are separate anatomic sites within the pelvic floor.

The most common example of an appropriate use of the -59 modifier is the reporting of the combination of a vaginal or laparoscopically assisted vaginal hysterectomy with an apical vaginal suspension, such as a high uterosacral suspension (CPT code 57283), SSLS (CPT code 57282) or sacral colpopexy.

As many AUGS members are aware, NCCI bundled vaginal hysterectomy procedures with apical vaginal suspensions on 10/1/14, in a manner such that the pair edit could not be overridden with a -59 modifier. They subsequently agreed to change these pair edits to allow the use of a -59 modifier when an apical vaginal suspension is performed along with a vaginal hysterectomy, as of 4/1/15 (and retroactive to 10/1/14). A similar change was made to the Procedure to Procedure pair edits between laparoscopic hysterectomy and these codes, effective 4/1/16.

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At the present time, the proper use of NCCI edits to code for a vaginal hysterectomy, with AP repair and an intraperitoneal colpopexy is as follows:

CPT code 58260 (vaginal hysterectomy)

CPT code 57260-51 (AP repair)

CPT code 57283-59 (Intraperitoneal colpopexy – e.g. high uterosacral suspension)

Finally, it is not sufficient to simply list the -59 modifier for reimbursement. It is important that the surgeon document in the operative report that a separate procedure was necessary to correct the apical prolapse and should detail the additional steps taken to resuspend the vagina.

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