Advancing Female Pelvic Medicine
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AUGS Coding and Reimbursement Committee
Article Regarding -59 Modifier Distinct Procedural Services

The utilization of the -59 modifier has recently experienced increased scrutiny and denial by insurance companies which has prompted this brief review.

The -59 modifier is defined 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 services performed on the same day." (Centers for Medicare and Medicaid Services/National Correct Coding Initiative (CMS/NCCI)).

This modifier is utilized when two procedures are performed during the same surgical encounter that are usually considered bundled or integral to each other. The modifier is appropriate to use when the procedures are separate and distinct indicating that two or more procedures are performed at different anatomic sites or different patient encounters. The documentation for modifier reporting is critical and should always include medical necessity for the procedures as well as specific diagnosis to justify the additional procedure and define the different anatomical sites. Typically, it is beneficial if this is discussed in the admission documentation and preoperative clinical records. The operative report should clearly describe the reason for performing the additional procedure, and include a separate paragraph describing the additional procedure in detail.

A typical example for FPMRS of appropriate -59 modifier utilization is to describe the separate apical support procedure performed at the time of hysterectomy for prolapse. However, payors are monitoring for misuse of the apical suspension codes because the apical support procedure is frequently reported at the time of a "routine" hysterectomy when only the routine work of distal ligament to cuff incorporation is coded/billed as the apical support procedure and separate billing for apical suspension is not indicated.

Routine distal incorporation of suspensory ligaments into the vaginal cuff is considered a component of typical hysterectomy work by ACOG/AUGS/CPT and payors; It is already reimbursed with hysterectomy reporting. Apical support work is reported only when the additional work of separate apical support is completed (please see the typical intraoperative work described in either USL or SSL procedure completion).

Historically, there has been confusion because of code pair edits (bundling) by NCCI; However, this issue was addressed in April 2015 thanks to the advocacy of AUGS and ACOG with the remedy proposed by NCCI for the incorrect code pair edit was the use of the -59 modifier when clinically appropriate.

Correct coding and documentation with granular presentation of medical necessity and surgical technique will often alleviate confusion between payors and providers in use of the -59 modifier. Please ensure appropriate diagnosis assignation to procedure reporting to further avoid delays in payment.

If encountering continued difficulty and appeals are nonproductive, please notify AUGS at info@augs.org.