Coding for multiple surgical procedures

By Emily H. Hill, PA

Many times, more than one surgical procedure is performed during the same encounter. When that occurs, a modifier(s) is required to explain the circumstance to the payer. Understanding which modifier to use is important for ensuring appropriate reimbursement. Let's look at a couple of surgical scenarios to help clarify the proper selection of these modifiers.

Beatrice's surgery

Beatrice, a 52-year-old with painful fibroids, menorrhagia, a urethrocele, and a rectocele, agreed to surgery. Her gynecologist, Dr. Arragon, performed a vaginal hysterectomy and a combined anteroposterior colporrhaphy.

Adriana's surgery

Adriana, a 42-year-old with documented fibroids and anemia, scheduled surgery with her gynecologist, Dr. Luciana. An ultrasound also identified a left ovarian cyst. Adriana underwent a supracervical hysterectomy, as had been discussed with her, but her tubes and ovaries were left in place. At the same time, Dr. Luciana opened and drained the ovarian cyst and sent a biopsy of the cyst wall to pathology. She then removed the cyst capsule from Adriana's ovary.

How would you have coded these cases? Read on for the report of services and an explanation of the code and modifiers.

Understanding the codes and modifiers

Beatrice's surgery. CPT provides several codes for reporting a vaginal hysterectomy (Table 1), depending on the weight of the uterus and the performance of additional associated procedures. Because Beatrice's uterus was less than 250 g and a bilateral salpingo-oophorectomy also was performed, Dr. Arragon reported CPT code 58262 (Figure 1). Unlike the total abdominal hysterectomy codes, there are distinct vaginal hysterectomy codes to describe the removal of just the uterus and a hysterectomy with removal of tube(s) and/or ovary(s). Since no CPT code includes both vaginal hysterectomy and anteroposterior (A/P) repair, code 57260 also is reported.

Table 1: CPT codes for vaginal hysterectomy

58260	Vaginal hysterectomy, for uterus 250 grams or less
58262	with removal of tube(s), and/or ovary(s)
58263	with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	with repair of enterocele
58290	Vaginal hysterectomy, for uterus greater than 250 grams
58291	with removal of tube(s), and/or ovary(s)
58292	with removal of tube(s), and/or ovary(s), with repair of enterocele
58293	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294	with repair of enterocele
58550	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less
58552	with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams
58554	with removal of tube(s) and/or ovary(s)

Figure 1. Dr. Arragon's report on Beatrice's surgery

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)			22. MEDICAID RESUBMISSION CODE	
1. 218.0	Submucous leiomyoma			
2. 618.0	Urethrocele		23. PRIOR AUTHORIZATION NUMBER	
3. 618.8	Other specified genital prolapse			
4. 626.2	Menorrhagia			

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT-4/HCPCS	MODIFIER	E DIAGNOSIS CODE	F RVUs	G DAYS OR UNITS
		21		58262		1, 4		1
		21		57260	- 51	2, 3		1

57260- Combined anteroposterior colporrhaphy

Modifier –51 (multiple procedures) is appended to the A/P repair since more than one procedure was performed in the same setting by the same surgeon. This modifier is used regardless of whether the procedures are performed on the same or different anatomical site(s) or whether one or more incisions are required. Since payers generally reduce payment for multiple procedures beyond the first, the modifier is appended to the code for the lesser-valued service. In this scenario, that's the A/P repair. It's best to list the full fee for each service and let the payer make the multiple procedure reduction. Some payers' computer systems are pre-programmed to reduce fees for procedures done beyond the first one. If you make the reduction yourself, and then the payer discounts it again, you won't get the proper reimbursement.

Adriana's surgery. Currently there is only one CPT code to describe a supracervical hysterectomy. The code and payment are unchanged regardless of whether tubes and ovaries are removed or left in place. In cases in which the uterus, tubes, and ovaries are removed, lesser procedures, such as an ovarian cystectomy, generally are not reported separately. In Adriana's case, however, only the uterus was removed. The ovarian cystectomy is reported as an additional service since it was not integral to the hysterectomy (Figure 2). In situations such as this, the –59 modifier (distinct procedural service) is used instead of the –51 modifier that was applied in Beatrice's case.

Figure 2. Dr. Luciana's report on Adriana's surgery

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)			22. MEDICAID RESUBMISSION CODE	
1. 218.9	Leiomyoma			
2. 626.2	Menorrhagia		23. PRIOR AUTHORIZATION NUMBER	
3. 620.2	Ovarian cyst			
4.				

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT-4/HCPCS	MODIFIER	E DIAGNOSIS CODE	F RVUs	G DAYS OR UNITS
		21		58180		1, 2		1
		21		58925	- 59	3		1

58180- Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)

58925- Ovarian cystectomy, unilateral or bilateral

Modifier –59 is used to indicate situations in which codes not normally reported together are being submitted because of special circumstances. Since an ovarian cystectomy would not ordinarily be reported with a hysterectomy, modifier –59 is used to indicate the atypical circumstances of Adriana's surgery. The modifier helps to clearly specify situations in which a service is distinct and separate from others performed on the same day. Notice that the ovarian biopsy and cyst aspiration were not reported since they are considered incidental to the ovarian cystectomy.

The multiple procedure payment reduction usually is the same with the –59 modifier as with the –51 modifier.

Should you use a –51 or a –59 modifier?

Determining whether to use the –51 or the –59 modifier can be challenging. Simply put, the purpose of the –59 modifier is to prevent the service from being bundled or included in the payment for another service. As a rule of thumb, if a lesser procedure is always or almost always performed in conjunction with another procedure, then it is considered "bundled" into the payment for the primary procedure. Payers may base bundling decisions on CPT guidelines and definitions or internal policies. Some use Medicare's bundling rules, known as the Correct Coding Initiative (CCI).

A few general strategies may be helpful in determining when to use the –59 instead of the –51 modifier. First, determine if one of the services has a "separate procedure" designation in CPT. (This is the term in parentheses after the code descriptor.) Essentially, these procedures are considered an integral component of another procedure or service and are not separately reported. Separate procedure codes *can be reported* if they are performed independently or as a distinct or unrelated service from other procedures also being reported. In these situations, the –59 modifier is appended to the code with the separate procedure designation.

Another technique is to review published bundling guidelines, such as the CCI. If a procedure is considered a component of another procedure being performed, then consider attaching the –59 modifier to the "component" code. For example in Adriana's case, aspiration and biopsy of an ovarian cyst are always bundled into a cystectomy. There is no provision for use of a modifier to bypass the bundle rule. In contrast, the cystectomy is bundled into the hysterectomy, but a modifier is permitted to denote that distinct services were performed. The –59 modifier should not be used simply to express disagreement with the CCI, but rather as a way to indicate special circumstances such as was the case with Adriana's surgery.

The CCI is updated quarterly and can be found on Medicare's Web site at http://www.cms.hhs.gov/physicians/cciedits/ or on The American College of Obstetricians and Gynecologists' (ACOG) Web site at http://www.acog.com/ under the member access section.

Finally, use other resources offered by ACOG. Its Committee on Coding and Nomenclature produces the *Components of Correct Procedural Coding OB/GYN Coding Manual* to assist ACOG Fellows in addressing the bundling rules of third-party payers. The majority of procedures performed by obstetricians and gynecologists are reviewed by the Committee to determine what procedures are included or excluded from the primary procedure. Additional comments are also included that may further specify when the –59 modifier is needed. These guidelines and comments reflect the opinion of the members of the Committee based on practice

standards and knowledge of the CPT process and the assignment of values under the Resource Based Relative Value Scale (RBRVS). A new publication, *The Essential Guide to Coding in Obstetrics and Gynecology*, devotes chapters to the global surgical package and the appropriate use of modifiers.

In summary, the –59 modifier indicates that a distinct procedure has been performed on the same day as another service. It is used when services *not typically reported together* have been performed due to special circumstances.

The –51 modifier indicates that multiple services were provided at the same session and there is no reasonable expectation that the services will be bundled into a single payment. It is used when services *not typically performed in conjunction with each other* are carried out at the same session.

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