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# Dermatology Coding Alert

## READER QUESTIONS: Planning, Extent Distinguish 58 and 78

**Question:** When should we use modifier 78 instead of modifier 58?

Tennessee Subscriber

**Answer:** When a physician has to perform a procedure during the global period of another procedure, deciding between modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) and modifier 78 (Return to the operating room for a related procedure during the postoperative period) depends on whether the second procedure was planned, was more extensive, or was for therapy.

**Modifier 58:** You should use modifier 58 when a subsequent procedure is already planned at the time of the original procedure, is more extensive than the first procedure, or for therapy following a diagnostic surgical procedure.

For example, if a urologist performs a TURP, notes in the medical chart that a second surgery may be needed, and then two months later removes more of the patient's prostate, you would report 52601 (Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete [vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included]) for the first procedure.

Then, because the repeat TURP falls within the 90-day global period of the first surgery, you should use 52614 (Transurethral resection of prostate; second stage of two-stage resection [resection completed]) and append modifier 58 to indicate that the second surgery is related to the original TURP and that the urologist expected the second-stage procedure.

**Modifier 78:** You should append modifier 78 when an unplanned procedure is related to the first. The most common use of modifier 78 is for procedures a physician performs in the operating room that address unanticipated complications resulting from the initial procedure.

For example, following an appendectomy (44950) the patient develops an abdominal abscess that the physician must drain. In this case, you should report 49021-78 (Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous).

**Payment variations:** When you use modifier 78, expect a big reduction in the procedure's reimbursement. Insurance companies will pay you a surgical fee that excludes the preoperative and postoperative care allowance. The global period does not reset, however.

When you append 58, on the other hand, you will get paid the whole surgical fee, but the global period is reset with each procedure.

The answers to the Reader Questions were provided and/or reviewed by **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CHCC,** president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J.

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