Part B Insider (Multispecialty) Coding Alert

Answer 'Yes' 3 Times, Apply Modifier 78

Return to the OR is a must

If you want to be sure when you should apply modifier 78 -- instead of similar modifiers such as modifier 58 and modifier 79 -- you need only ask yourself three questions. If all the answers come up "yes," you are safe to assume that 78 is your modifier of choice.

1. Does the Procedure Fall Within a Global?

You would only apply modifier 78 (Unplanned return to the operating/procedure room by the same physician following an initial procedure for a related procedure during the postoperative period) if a subsequent procedure by the same surgeon falls within the global period of an earlier surgery.

For instance, you might apply modifier 78 for a procedure that occurs on day 30 following a major surgery with a 90-day global period.

Note that modifier 78 is not the only modifier that may apply for procedures during the global period. You must satisfy two more conditions before you can select modifier 78 confidently.

2. Is the Procedure 'Related' to the Initial Surgery?

When appending modifier 78, you should be sure the available documentation substantiates that the surgeon performed the subsequent procedure due to conditions arising from the initial surgery.

AMA instructions from CPT Assistant (Feb. 2008, page 3) stress, "When using modifier 78, the procedure is directly associated with the performance of the initial procedure."

In other words: You should append modifier 78 when coding for the surgeon's treatment of a complication(s). A complication may be related to the initial procedure, but it is not necessarily related to the patient's initial condition, affirms **Jo Ann F. Kergides, CPC-H,** physician services coder at **UMDNJ-SOM Vascular Surgery** in Stratford, N.J.

Tip: If the medical record does not indicate clearly the reason for the subsequent surgery, you should check with the operating physician prior to selecting a modifier.

Example: The surgeon removes spinal instrumentation (for example, 22852, Removal of posterior segmental instrumentation) during the global period of the initial placement (such as 22842, Posterior segmental instrumentation [e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires]; 3 to 6 vertebral segments) because the patient's body rejects the device.

In this case, because the complication is related to the initial surgery (although, again, the complication is not related to the condition that prompted the surgeon to place the instrumentation initially), you would report 22852 with modifier 78.

3. Is There a Return to the OR?

Finally, the subsequent procedure must require that the surgeon return the patient to the operating room (OR), explains

Maggie M. Mac, CMM, CPC, CMSCS, CCP, ICCE, consulting manager for **Pershing, Yoakley & Associates** in Clearwater, Fla. You cannot append 78 if the physician treats the complication(s) in the office.

Example: Two weeks following diskectomy (for example, 63075, Diskectomy, anterior, with decompression of spinal cord and/or nerve root[s], including osteophytectomy; cervical, single interspace) the patient develops an infection at the site of the surgical incision.

To treat the infection, the surgeon returns the patient to the OR for debridement (for example, 11000, Debridement of extensive eczematous or infected skin; up to 10 percent of body surface).

In this case, you should report 11000-78 with a diagnosis that describes the wound infection.

Note that this service meets all three requirements for modifier 78:

1. The subsequent procedure by the same surgeon occurs within the global period of the initial procedure.

2. The subsequent procedure is a complication of the initial procedure.

3. The subsequent procedure requires that the surgeon return the patient to the OR.

For CMS, no OR means no separate code: For Medicare carriers, you cannot charge separately for complications that the surgeon handles in an outpatient setting. These could include infection, bleeding, or perforation. The surgery's global period covers such services, according to the Medicare guidelines.

For instance, the patient in the example above develops a minor infection at the surgical wound site. The surgeon simply cleans and dresses the wound in his office. In this case, the original procedure's global surgical package includes the uncomplicated follow-up care.

Watch for private payer exception: Private payers, however, may allow you to report a separate service if the surgeon treats a complication in the office.

For instance, if the surgeon inspects and cleans a post-operative infection, changes the patient's dressings, and administers antibiotics, a non-Medicare payer may allow you to report an E/M service (such as 99213) with modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period) appended.

Here's why: Payers following CPT guidelines do not consider postoperative infections as necessarily "related" to the initial surgery. Modifier 24 indicates to the payer that the E/M service during the global period of the initial service is for a "new" problem (that is, the post-operative wound infection) and is therefore not bundled as part of the global surgical package.

Don't Expect Total Reimbursement With 78

When you're filing claims with modifier 78, you shouldn't expect to receive the full fee schedule reimbursement amount. Procedures billed with modifier 78 include only the service's "intraoperative" portion, and carriers generally reimburse them at 65-80 percent of the full fee schedule value, says **Patrice Young, CPC, CMSCS,** with **Commonwealth Orthopaedic Associates** in Pennsylvania. In other words, if you report a procedure with modifier 78, you will not receive the portion of payment assigned to the pre- and post-operative care usually associated with that procedure.