Part B Insider (Multispecialty) Coding Alert

MODIFIERS: Focus on Modifier 79 Compliance -- Before Your Carrier Does

Our tips help you report modifier 79 the right way.

CMS wants to make it crystal clear: If you are reporting modifier 79 (Unrelated procedure or service by the same physician during the postoperative period), your claims better be airtight, or you'll be hearing from your MAC.

On Feb. 13, CMS issued transmittal 442, which advised contractors to "strengthen program safeguards to prevent improper payment for modifier 79." This came on the heels of an OIG report indicating that modifier 79 had a vast potential for fraud.

To make sure you're reporting modifier 79 properly, check out these quick tips:

How can you tell? One of the most common areas for error with modifier 79 is in determining whether the procedure was unrelated to the surgery that prompted the global period.

Tip: If the second surgery takes place on a different body part or different side of the body, modifier 79 is usually the right one, says **Kerry Sheskier,** billing manager with Winthrop University Hospital in Bethpage, N.Y. "If there is a totally different diagnosis and if the doctor notes in his first paragraph that the patient had a previous surgery (with no mention of it being a complication from the first or mentioning it is staged and related to the first)," you've got another clue.

Example: "If the patient is in a global period for a creation of an AV fistula because of end stage renal disease and during that time the patient has an appendectomy because of appendicitis, there is really no need to query the physician," says **Betsy Donnelly,** coder with Martin Memorial Health Systems in Florida. "However, there are times when I am not certain if an operation is related to the original or not and I will query the physician, but that is rare."

"Another thing that you must keep in mind is the type of insurance the patient has," Donnelly says. "Medicare carriers and those that follow Medicare guidelines consider all complications related to the original surgery and they would require a modifier 78 if the patient was brought back to the operating room; these visits are not billable if there is no return to the OR. But, per CPT guidelines, complications are not a part of the global package and are billable with modifier 79."

Final thought: Don't leave your modifier decision to chance. "After reviewing the operative report, if the coder is unsure, then they should definitely confer with the surgeon before using this modifier,"says **Connie Treonze,** practice administrator with Associated Orthopaedics in Union, N.J. "It should not be a guess."

To read the CMS transmittal on modifier 79, go online to www.cms.hhs.gov/transmittals/downloads/R442OTN.pdf.