Part B Insider (Multispecialty) Coding Alert

MODIFIERS: Quick Tips Help You Differentiate Between Modifiers 58, 78, and 79

Hint: For complication with return to OR, look to modifier 78.

Can you easily distinguish between modifiers 58, 78, and 79? If not, you'll need to brush up on some modifier basics. Knowing when to apply each can mean the difference between complete reimbursement and costly claim denials.

Complications: You'll report modifier 78 (Unplanned return to the operating room for a related procedure during the postoperative period) when conditions arising from the initial surgery (complications) rather than the patient's condition -- call for a related procedure.

Staged procedures: You should append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) when a procedure or service is planned or anticipated at the time of the original procedure (staged), is more extensive than the original procedure, or represents therapy following a surgical procedure.

Tip: You need not return the patient to the operating room to report modifier 58. You must, however, return the patient to the OR to qualify for modifier 78.

Test Yourself With These Examples

Example 1: Suppose the physician places a gastrostomy tube (49440), but eight days later, the tube leaks and the doctor returns the patient to the OR to change the tube. Would this warrant appending modifier 78 or 58 to the tube change code (43760)?

Solution 1: You should append modifier 78 to the second procedure, advises **Linda Parks, MA, CPC, CMC, CMSCS,** an independent coding consultant in Atlanta. "The initial procedure (49440) has a 10-day global and the leak wasn't planned, so for the physician to get paid for this service, the modifier would be required."

Example 2: The surgeon excises an ischial pressure ulcer with ostectomy. Several days later, she closes the operative wound using a muscle flap.

Solution 2: For the initial procedure (the excision), you should report 15946 (Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure). You would claim the muscle flap closure at a separate session with 15734 (Muscle, myocutaneous, or fasciocutaneous flap; trunk). Append modifier 58 to 15734 to show the payer that the closure during the global period was anticipated at the time of the initial procedure.

How can you tell? When determining whether a procedure was "staged," check the physician's notes, because he'll often indicate that another procedure is planned. "In the final summary of the procedure, the physician would possibly state, 'the patient is to return to the office in x number of days for x procedure,'" says **Doug Williams, CPC,** business office manager at Consultants In Gastroenterology in Columbia, S.C. What if no OR trip takes place?

Medicare payers consider all postoperative complications "related" to the initial surgery unless the patient must be returned to the operating room.

For instance, suppose a patient 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 followup care.

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When modifier 79 counts: If, however, your physician must perform a procedure for an unrelated procedure during the global period of the first surgery, you should append modifier 79 (Unrelated procedure or service by the same physician during the postoperative period) to the subsequent procedure code.

In other words, if the same surgeon must perform a separate, unrelated surgery -- including all followup -- for an unexpected medical condition during the global period of a previous procedure, you should append modifier 79 to the subsequent procedural code(s).

For more tips on how to report post-surgical procedures, turn to page 188 and check out our clip-andsave chart, "Here's How to Simplify Your Postop Services Claims."

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