Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Steer Clear Of Post-Op Modifier Mix-Ups With These 3 Clues

Discover denial-proof uses for 78, 79 and 80

Post-operative procedure claims often require modifiers, but choosing the right one depends on the patient's status and whether the physician received a helping hand from an assistant surgeon. Check out the clues below to understand which modifiers you should append under which exact circumstances.

1. Don't Use Modifier 78 Without An Operating Room

Basics: If your physician performs a procedure and then the patient returns to the operating room with complications, you need to look at modifier 78 (Return to the operating room for a related procedure during the postoperative period). You'll typically use this modifier when there is a complication after a procedure, such as bleeding from the surgical site, says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS,** a leading national authority on medical coding and reimbursement.

Take note: The follow-up procedure must be serious enough that your physician performed it in the operating room--or you can't use modifier 78. "There must be an operating room involved in order to even consider this code, and it has to be for a related procedure," Jandroep says.

Example: A patient undergoes a transurethral resection of an enlarged prostate gland (TURP). Four days following the surgery, the patient experiences heavy bleeding and hematuria, and returns to the operating room for surgery to control the bleeding. This represents a complication that required a return to the OR for treatment within the global period of the initial procedure.

In this scenario, you would report 52214 (Cystourethroscopy, with fulguration [including cryosurgery or laser surgery] of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands). Append modifier 78 to 52214 to indicate that your physician performed surgery in the operating room due to complications after a prior procedure.

Tip: Modifier 78 does not reset the global surgical period, says **Catherine Brink, CMM, CPC**, president of **HealthCare Resource Management Inc.** in Spring Lake, NJ. In the example above, the global period of the initial surgery, the TURP, would still be in effect.

What to expect: When you append modifier 78, Medicare will only pay the physician the work RVU for the second procedure. This isn't the case with most other payors.

2. Apply 79 To New Circumstances

Basics: You should apply modifier 79 (Unrelated procedure or service by the same physician during the postoperative period) when:

• your physician must undertake the subsequent surgery for conditions unrelated to an initial surgery, and

• the subsequent surgery occurs during the global period of the initial surgery.

In other words, Jandroep says, if the same physician performs a separate evaluation and a distinct, unrelated surgery--including all follow-up--for an unanticipated surgical condition during the global period of a previous procedure, you

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should append modifier 79 to the subsequent surgical procedural code(s).

Example: A patient undergoes a transurethral resection of an enlarged prostate gland. Four days following surgery, he has an episode of left renal colic secondary to a left ureteral calculus. Because of persistent pain and obstruction of the left kidney, the physician places a double-J stent within the left ureter and kidney to bypass the obstruction and relieve the pain.

For the placement of the double-J stent, you would report code 52332 (Cystourethroscopy, with insertion of indwelling ureteral stent [e.g., Gibbons or double-J type]) and append modifier 79 to indicate an unrelated surgical procedure performed within the 90-day global of the TURP.

The diagnosis for this second procedure should be different and separate from the diagnosis of the TURP, which would be 600.01 (Hypertrophy [benign] of prostate with urinary obstruction). The diagnosis codes you would report for the stent placement are 592.1 (Calculus of ureter) and 591 (Hydronephrosis).

Note: When you append modifier 79 to a surgical code, you will receive full payment for the second procedure, but a new global period may begin. Without appending modifier 79, payors are not likely to reimburse your practice for the second procedure, Brink says.

3. Use Modifier 80 For Surgical Assistance

Basics: If your physician only acts as a "second pair of hands" in the operating room, assisting the primary surgeon, you should append modifier 80 (Assistant surgeon) to the procedure code. An assistant surgeon does not have to provide his own operative notes, but the primary surgeon should note the second physician's name as the assistant surgeon in his operative report.

Be aware: Payment is much less for an assistant surgeon than for a co-surgeon. For an assistant surgeon, Medicare allows 16 percent of the total allowed amount. Coding experts advise against billing the full global fee for the assistant's fee because this may confuse the carrier as to who was the surgeon and who was the assistant, and often one surgeon remains unpaid.

When the physician acts as an assistant to another surgeon, the primary surgeon does not need to use any modifiers, but the assisting surgeon does. Both physicians should report the same surgical procedure codes, and the assistant surgeon should append modifier 80 to each surgical code for which he acted as an assistant.

Example: Your urologist assists another urologist in performing a radical nephrectomy, 50230 (Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy). Your urologist would report 50230-80 as the assistant surgeon.

Caution: For Medicare patients, check the fee schedule database to determine if you may use modifier 80.

A "0" in the Asst Surg column means that you can append 80 but you'll need to provide supporting documentation, while a "1" means the assistant surgeon cannot be paid. A "2" means the assistant surgeon can be paid without supporting documentation, and a "9" indicates that the concept of assistant surgeon does not apply.

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