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Part B Insider (Multispecialty) Coding Alert

PART B REVENUE BOOSTER: Nail Down Your Modifier Choice When Deciding Between 58 and 78

Once you realize the differences, selection can be a breeze

If CPT can't guide you to the right postsurgical modifier choice, we-ve got just the advice for you.

Despite the fact that CPT 2008 revised the text explaining modifier 58 (Staged or related procedure or service by the same physician during the postoperative period), many practices are still confused about how to interpret modifier 58 and when to use it rather than modifier 78.

This year, CPT advised that you may append modifier 58 to staged or related procedures that were -planned or anticipated- at the time of the original surgery -quot; not just ones that your surgeon planned in advance.

Nonetheless, many readers have submitted questions about modifiers 58 and 78 to the Insider, so we-ve got a quick primer on how to distinguish between the two.

You should apply modifier 58 when a procedure or service during the postoperative period is:

a) planned prospectively at the time of the original procedure (staged), or

b) more extensive than the original procedure, or

c) for therapy following a diagnostic surgical procedure.

In each case, the subsequent procedure or service is either related to the underlying problem/diagnosis that prompted the initial surgery or anticipated at the time the surgeon performs the initial surgery (or both), says **Jay Neal**, a consultant in Atlanta.

In other words, the patient-s condition, rather than the results of a previous surgery, dictates the need for additional procedures. You should not use modifier 58 if the patient needs a follow-up procedure because of surgical complications or unexpected postoperative findings that arise from the initial surgery.

The surgeon does not need to return the patient to the operating room (OR) for you to use modifier 58. The surgeon may provide a postoperative procedure or service, for instance, in his or her office or other outpatient setting. In all cases, however, the same physician must provide both the initial service/procedure and the follow-up procedure that requires modifier 58.

Don't be confused by -more extensive-: A -more extensive- procedure to which you append modifier 58 doesn't need to be more complex or time-intensive than the original procedure (although it can be). Rather, the surgeon's subsequent procedure need only be more extensive than the work he or she performed during the initial procedure. Here again, however, the patient's condition--not complications from the initial surgery--must drive the decision to perform an additional procedure.

If it's a complication, turn to 78: Unlike modifier 58, you should apply modifier 78 (Return to the operating room for a related procedure during the postoperative period) when conditions arising from the initial surgery--rather than the patient's condition--call for a related procedure.

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-Modifier 78 is the -complication- modifier,- says **Sandra Jongebreur, CPC-GENSG, CPC, CPC-H, PCS, FCS,** a coder for **Raafat Abdel-Misih, MD, PA**, in Wilmington, Del. -This modifier is used when a patient is returned to the OR or procedure room for a -related- problem within the global period. This usually is used when the patient has an infection, etc., and needs to be returned to the OR to correct the issue.-

You may notice lower reimbursement with modifier 78. -When claims are processed with modifier 78, you are only paid for the intraoperative piece of the procedure,- Jongebreur notes. -Sur-gical procedures are paid for the pre-, post- and intraoperative work involved. When billing with modifier 78, you are only reimbursed for the intraoperative work. Also, the global period does not start again with the procedure billed with modifier 78,- she advises.

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

Remember: Modifier 78 re-quires that the surgeon return the patient to the OR. For Medicare payers, any initial surgery complications that the surgeon handles in an outpatient setting, such as infection, bleeding or perforation, are covered under the surgery's global period, according to Medicare guidelines.

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