Part B Insider (Multispecialty) Coding Alert

Reader Question: Note Return to OR for Global Procedures

Question: Our physician performed a percutaneous hardware removal during the global period from the surgery, and he wants to code it as 10120 (Removal of foreign body) but that doesn't seem appropriate. Can you advise me on the right code?

Virginia Subscriber

Answer: The answer depends on whether the physician took the patient to the operating room (OR) to remove the hardware or if he did it in the office. If the physician did the procedure in the office, then it's included in the global payment for the original surgery.

If he returned the patient to the OR, you can report 20670 (Removal of implant; superficial [eg, buried wire, pin or rod] [separate procedure]). You'll typically need to append either modifier 58 (Staged or related procedure by the same physician during the postoperative period) or 78 (Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period) to 20670, depending on which scenario applies to the case.

Here's the difference: The descriptor for modifier 58 seems self-explanatory: Staged or related procedure by the same physician during the postoperative period. Coders sometimes trip, however, when they forget that modifier 58 actually applies to subsequent procedures that fall into one of three categories:

Planned or anticipated (staged): A good example would be an infected hand that has to be debrided several times over the course of a couple of weeks. You won't use a modifier on the first procedure, but will add modifier 58 on the subsequent procedures.

More extensive than the original procedure: The surgeon manipulates a patient's ulnar fracture. An x-ray at the follow-up appointment shows that the reduction failed, so the physician completes pinning or an open reduction with internal fixation (ORIF). Code the procedure as needed (with 25545, Open treatment of ulnar shaft fracture, includes internal fixation, when performed, for example) and append modifier 58.

Therapy or treatment following a surgical or diagnostic procedure: This could apply to a soft tissue biopsy followed at a later date by malignant tumor excision.

Global tip: You'll only append modifier 58 to the second procedure if it occurs during the first procedure's global period. The date of the second procedure resets the global period. You should expect 100 percent reimbursement for procedures you file with modifier 58.

Verify 'Surprise' Before Reporting 78: If your doctor completes a second -- but unplanned -- procedure related to the first, you might need modifier 78. Before appending modifier 78, confirm that the follow-up procedure was related to the original procedure but unplanned and that it occurred during the global period.

Example: A patient presents with a closed supracondylar humerus fracture. The doctor performs manipulation, which you report with 24535 (Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; with manipulation, with or without skin or skeletal traction). The fracture displaces and the patient returns for internal fixation with open treatment without intercondylar extension. You'll report 24545 (Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension) and append modifier 78.

Pay change: Because the second procedure was related to the global procedure and was unplanned, the original procedure's global period stays intact. The second procedure's global period begins on the date of that surgery. Expect a reduction in pay for the second procedure, however.

Unrelated? Consider 79: Sometimes a patient returns to the operating room for a procedure that's not related to the first surgery, but still within the first procedure's global period. In that case, you'll consider appending modifier 79 (Unrelated procedure or service by same physician in the postoperative period).

Caveat: Before reporting modifier 79, verify that your physician does not perform the second procedure because of complications related to the first. You must have a different diagnosis supporting the return to surgery and your use of modifier 79.

For example, your surgeon performs total knee replacement for Mrs. Brown. A few weeks later she comes to the office with aseptic bursitis of the elbow (726.33, Olecranon bursitis). The physician completes bursectomy (24105, Excision, olecranon bursa). You'll append modifier 79 because the bursectomy is unrelated to the original knee replacement procedure and has a different diagnosis. You should receive full reimbursement for the second procedure because a new global period starts with the unrelated procedure.