Codify
BY AAPC

# Part B Insider (Multispecialty) Coding Alert

## Reader Questions: Planning Determines Difference Between Modifiers 58, 78

**Question:** In December, a patient had extracorporeal shock wave lithotripsy, which carries a 90-day global. This was for a ureteral stone. The patient returned in February with pain and an x-ray showed the stone unchanged in the ureter. Therefore, the urologist performed a ureteroscopy and stone extraction. I billed this to the insurance with a 58 modifier, but it is being denied. How should I be coding instead?

**Answer:** You are still in the 90-day global of the extracorporeal shock wave lithotripsy (ESWL), but you are now providing a more invasive surgical procedure. Your coding for the treatment of the same stone that remains in the same location in the ureter and appears to have not been fragmented by the ESWL is correct coding.

Use modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) to indicate the more invasive nature of the present treatment, the ureteroscopy. However, although your coding is correct, the carrier may view this scenario as a complication of the initial ESWL and require modifier 78 (Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period) on the ureteroscopy code 52352 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus [ureteral catheterization is included]) instead of modifier 58.

**Additionally:** It is possible that this payer does not recognize modifier 58. If it doesn't, even with documentation and an appeal, the claim will not be paid. However, since the second procedure was more invasive, and if your urologist's documentation stated this, and the insurance company does recognize 58, then you should appeal.