Part B Insider (Multispecialty) Coding Alert

What Qualifies As 'More Extensive?' Find Out Now

If same condition prompts initial and follow-up procedures, 58 applies

The AMA revised CPT language for modifier 58 earlier this year and followed up by offering additional instructions on how to apply the modifier correctly. As in the past, however, to use this modifier appropriately you should be sure that the surgeon performs and documents a supplementary service during the global period of a related procedure.

Choose 58 for 'Go-Beyond' Procedures

You may consider modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) for a procedure or service the surgeon performs during the postoperative period if the procedure or service is:

a) planned or anticipated (staged);

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 (or both):

• related to the underlying problem/diagnosis that prompted the initial surgery, or

• anticipated at the time the surgeon performs the initial surgery.

In other words: The patient's condition, rather than the results of a previous surgery, dictates the need for additional procedures. For procedures unrelated to the underlying condition prompting the initial surgery or for an un-anticipated return to the operating room, you would select a modifier other than 58.

Look to documentation for a clue: Often, the physician knows up front that a procedure will have subsequent stages. In a best-case scenario, the physician should acknowledge -- in his documentation -- the possibility that he or she will have to return to the operating room, which can give you a hint that you'll need to apply modifier 58 in the subsequent procedure.

Place of Service Isn't an Issue

The physician does not need to return the patient to the operating room (OR) to use modifier 58. The physician may provide a postoperative procedure or service, for instance, in his office or other outpatient setting -- as long as the documentation clearly supports the need for the staged procedure.

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, often, it can be). Rather, the surgeon's subsequent procedure need only "go beyond" the work he 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.

Example: A patient undergoes surgery to remove a lesion from the base of the skull. The surgeon must also perform

secondary repair of the dura to arrest the loss of cerebro-spinal fluid.

The surgeon undertakes the surgical approach, lesion removal and primary closure (61580-61598 and 61600-61616, as appropriate) during a single, extended operative session. The secondary repair, planned prospectively during the first session, generally occurs days later.

You should report 61618 (Secondary repair of dura for CSF leak, anterior, middle or posterior cranial fossa following surgery of the skull base ...) for the subsequent, planned session. You would append modifier 58 to indicate a staged procedure.

Example 2: The doctor performs a left frontotemporal craniotomy for evacuation of a subdural hematoma, replaces the bone flap and closes the incision. The surgeon reports 61312 (Craniectomy or craniotomy, for evacuation of hematoma, supratentorial; extradural or subdural).

While recovering, the patient worsens. A CT scan reveals left hemispheric swelling with impending herniation. The surgeon performs a large left fronto-parietotemporal craniotomy with dural opening and placement of the bone flap in the abdominal wall for treatment of intracranial hypertension.

Here, you would report 61322 (Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy) for the subsequent craniotomy and +61316 (Incision and subcutaneous placement of cranial bone flap).

You'd append modifier 58 to both 61322 and +61316 to show that these procedures were related to the original condition, but more extensive than the initial procedure. Be sure that the documentation includes separate operative reports for both craniotomies.

Good news: Modifier 58 resets the postoperative clock -- thus beginning a new postoperative period -- and does not result in reduced payment for the service.

Avoid the 'Complications' Trap

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, according to the AMA's CPT Assistant (Vol. 18, Issue 2, Feb. 2008, page 3).

The follow-up procedure should arise because of the same condition that prompted the initial procedure. This means that you should not use modifier 58 to describe treatment for a complication -- that is, for a different condition -- that arises as a result of or following an initial procedure. A complication, therefore, may be related to the initial procedure, but it is not related to the patient's initial condition.

For complications that require a return to the operating room (such as bleeding or infection), you should instead append modifier 78 (Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period) to the follow-up procedure.