Codify
BY AAPC

Modifier Coding Alert

Modifier Mix-Ups:Add Modifier 58 to Claim for Proper Postop Procedure Reimbursement

Rely on the medical record for to solidify staging.

Choosing the right modifier to represent the clinical situation when you are coding subsequent procedures during the postoperative period can be a challenge. Make your job easier by becoming comfortable with modifier 58 (Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period).

Continue reading to learn when you should attach modifier 58 and see how it differs from other postoperative procedure modifiers.

Start by Learning How to Use Modifier 58

When your physician performs a procedure or service during the postoperative global period of a prior procedure, you'll need a modifier to prevent the payer from bundling the reimbursement into the original procedure's pay. Turn to modifier 58 when the second service was:

- Planned or anticipated at the time of the original procedure
- More extensive than the original procedure
- For therapy following a diagnostic surgical procedure.

Pointer: When you read, in the medical record, that the physician anticipated a subsequent surgery or procedure, a red flag should go up that you need modifier 58. Look for when your physician made the decision. The surgeon may make the decision for a subsequent surgery at the time of the original surgery or once the surgeon knows the outcome of the surgery and the status of the patient.

Example: A patient has a malignant melanoma (172.6, Malignant melanoma of skin of upper limb including shoulder) removed from his shoulder. The physician takes a lymph node biopsy (38510, Biopsy or excision of lymph node[s]; open, deep cervical node[s]). If pathology determines that the lymph node has metastatic malignancy, the physician plans to schedule the patient to come back for a lymph node dissection.

Code it: For this scenario, submit lymph node biopsy procedure code 38510 with malignant melanoma diagnosis code 172.6. When the patient comes back in for the lymph node dissection (38500-38555, Biopsy or excision of lymph node(s); ...), you will attach modifier 58 to that procedure code.

Explanation: "The 58 is used on the lymph node dissection because when the physician takes the biopsy, they know there is a chance that the patient may have to return for additional surgery," says **Robin E. Richards, CPC,** a senior coder in Pittsburgh, Pa.

Another example where you might attach modifier 58 to planned subsequent procedures performed in the postop period is in plastic surgeries where further procedures follow the initial procedure, but take place in a separate operative session. "In many plastic procedures, such as a breast reconstruction, there are a number of steps that must be performed in a specific order," says **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CPCO,** owner of PB Healthcare Consulting and Education Inc. in Austin, Texas.

Avoid Attaching the Wrong Modifier

CPT® 2023 American Medical Association. All rights reserved.

Codify BY AAPC

Be careful when it comes to choosing the most accurate modifier for surgical procedures during the global period. Make sure you don't confuse modifier 58 with 78 (Unplanned return to the operating/procedure room by th same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period) or 79 (Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period).

"I think the 58 modifier is underused because people are quick to go directly to the 78 and 79 postoperative modifiers," Richards adds.

Bottom line; Use modifier 58 when the provider knows or suspects that another related procedure is necessary during the postop period. In contrast, use modifiers 78 or 79 when there is an unanticipated postop condition, related or not, requiring the patient return to the operating room during the postop period.

Additionally: Look at the global period of the initial procedure code. If the initial procedure has a 0-day global period, which does not have a postop period, you do not need modifier 58 on the second procedure.

For example: If your provider performs an excision by a needle and not a scalpel (38510) as in the previous example above, you need to report 38505 (Biopsy or excision of lymph node[s]; by needle, superficial [eg, cervical, inguinal, axillary]). If the physician then performs the follow-up, staged lymph node dissection due to the pathology findings, you won't need to attach 58 to that procedure code. Code 38505 has a 0-day global period, so you won't be in a global period when the second procedure takes place, thus you don't need a modifier

CPT® 2023 American Medical Association. All rights reserved.