Use of CPT Modifiers 76, 78, and 79

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This article will provide an overview of CPT modifiers and focus specifically on the definition and use of modifiers 76, 78, and 79.

Use of Modifiers

CPT modifiers may be reported with a CPT code to indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition. Modifiers also enable health care professionals to efficiently respond to payment policy requirements established by other entities.

CPT modifiers may be used in many circumstances, including:

- altered services (eg, prolonged, service greater than usually required, unusual circumstances, part of a service);
- bilateral procedures;
- multiple procedures;
- professional component of the service/procedure only; and
- more than one physician/surgeon.

There is a distinct advantage to conveying as much information as possible to the third-party payer to ensure appropriate payment when billing for professional services, or services provided by an ambulatory surgery or other type of medical facility. Use of a modifier, in selected cases, enables the health care provider to explain special circumstances that surround the charge for reporting of the service and may affect claim payment. Use of an appropriate modifier can also prevent a claim from being denied.

Appendix A of the CPT codebook includes a complete list of currently accepted CPT modifiers and their descriptions as well as a limited list of HCPCS modifiers. CPT code users should examine modifier descriptions carefully for conditions that may limit use of a modifier to a specific section of the CPT codebook. For example, modifier 78, *Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period*, would only be appended to a CPT code

from the Surgery section.

Use of Modifier 76

Modifier 76 is used to report services or procedures that are repeated and provided by the same physician or qualified health care provider. The description reads:

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

Modifier 76 is used to denote to third-party payers that the procedure or service was repeated and that the bill is not a duplicate bill. A bill for a repeat of the same service using identical CPT codes is reported. At times, these repeated services are provided on the same day as the previous service, and without appending modifier 76, the third-party payer may assume a duplicate bill has been submitted. Documentation may be requested by the insurance carrier with modifier 76. Note: Both physicians and hospitals may report this modifier. This modifier may also be used for hospital outpatient reporting purposes. However, if the facility is reporting laboratory or pathology procedures or services to Medicare, modifier 76 should not be used.

Example (Modifier 76)

A patient presents to the Emergency Department (ED) with pleuritic chest pain and shortness of breath. A chest radiograph demonstrates a pneumothorax. A chest tube is inserted into the patient in the ED. A chest X-ray is performed after placement of the chest tube to verify the position of the chest tube. Both radiographs are interpreted by the radiologist.

CPT code and modifier reported for the first chest X-ray: 71020, 71020-26.

CPT code and modifiers reported for the second X-ray: 71020-26-76.

32551Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)

71020Radiologic examination, chest, 2 views, frontal and lateral;

CPT codes and modifier reported for the first procedure: 32551, 71020-26

CPT code and modifiers reported for the second procedure: 71020-26-76

Rationale

The physician performed a chest tube placement in the ED. A chest X-ray is typically performed before and after chest tube placement to define the disease state and verify the

position of the chest tube. Without modifier 76 appended to the second procedure (71020), the computer logic of the claims processing system would likely identify that a duplicate code was reported, resulting in denial, thus delaying payment. Modifier 26 ***Professional Component***, is also used because the physician provided the interpretation and report and not the technical portion of the procedure. Based on payer recognition (eg, Medicare), the HCPCS Level II modifier, TC, may be reported for the technical component of the radiology procedure (eg, cost of equipment, supplies, technician services). For the second X-ray examination, CPT code 71020 would be reported with both modifiers TC and 76 appended to indicate the technical component and the fact it is not a duplicate code.

Use of Modifier 78

Modifier 78 is used to explain circumstances when a patient is returned to the operating room for an unplanned subsequent surgical treatment by the same surgeon following an initial procedure. This may be for treatment of a complication related to the first procedure. This is distinct from staged or related procedure, which is reported with modifier 58. The description of the modifier is as follows:

It may be necessary to indicate that another procedure was performed by the same physician during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76).

Modifier 78 is placed after the subsequent procedure code to indicate to the third-party payer that an unplanned procedure, related to the initial procedure, was performed. The second procedure was necessary and unplanned, and is separate from the initial operation.

Example (Modifier 78)

A partial colectomy was performed in the hospital on March 1. The postoperative period for this procedure (code 44140) is 90 days. On March 15, the patient was returned to the operating room for treatment of partial dehiscence of the incision with secondary suturing of the abdominal wall. The secondary suturing was related to the original surgery.

CPT code reported for the first procedure: 44140

CPT code and modifier reported for the second procedure: 49900-78

Rationale

Because suturing of the abdominal wall was an unplanned procedure within the global period of the initial procedure to treat a complication, reporting modifier 78 indicates to the third-party payer that the procedure is related to the first procedure. The preoperative and postoperative care services, which are usually a part of the surgical package for a surgery, are not included when modifier 78 is used.

For those codes that include the terms *subsequent* or *reoperation*, modifier 78 is not applicable. For example, code 33011, *Pericardiocentesis; subsequent*, or the primary procedure (35301) associated with code 35393 *Reoperation, carotid, thromboendarterectomy, more than 1 month after original operation (List separately in addition to code for primary procedure in the descriptor nomenclature)*.

Use of Modifier 79

Modifier 79 is used to explain that a patient requires a procedure by the same surgeon for a condition completely unrelated to the condition for which the first operation was performed. The description of the modifier is as follows:

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76).

Modifier 79 is used to denote that the operating surgeon performed a procedure on a surgical patient during the postoperative period of an initial procedure for problems unrelated to the original surgical procedure. The procedure must be performed by the same physician and is reported by appending modifier 79 to the procedure code for the subsequent service. Modifier 79 is appended to report, for example, a colposcopy performed during the global period of a mastectomy by the same surgeon. (Note that modifier 79 should not be reported with procedures that are related to the original procedure and modifier 58 is used with staged procedures.) A new global period should start when this modifier is used.

Example (Modifier 79)

A 68-year-old woman had an unfortunate landing while bicycling and sustained a mildly non-displaced closed fracture of the right distal ulna. Because of the patient's condition and the nature of the injury, closed manipulation treatment was performed in the operating emergency room, with placement of a long-arm plaster splint. The patient was discharged. Later in the day, the patient returned to the emergency department after experiencing nasal bleeding with clots. After unsuccessful pressure packing insertion and the use of local vasoconstrictors, the patient was returned to the operating room, where bleeding was controlled by repair of a posterior arterial hemorrhage with cautery.

CPT codes(s) and modifier reported: 25535, 30905-79 (same date).

25535Closed treatment of ulnar shaft fracture; with manipulation

30905Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial

Rationale

In this case, the medical documentation reflected that the postprocedural bleeding was not attributable to the initial operation. Therefore, a different code describing the procedure would be reported with modifier 79 appended. As the same procedure was not repeated and the procedures were unrelated, modifier 76 would not be appropriate. The unrelated

procedure is reported with modifier 79 appended (30905-79). Modifier 79 would only be used when the second service is provided by the same physician who performed the initial service.

In summary, modifiers are appended to CPT codes for reporting additional information relevant to professional physician and nonphysician services provided in officebased and outpatient hospital or other facility settings, and they permit more concise reporting of the services rendered. For additional information on modifiers, see Appendix A of the CPT codebook for a complete list of currently accepted modifiers and their descriptions.

References

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