

## Part B Insider (Multispecialty) Coding Alert

### Modifiers: Learn the Tricks to Untangling Differences in Modifiers 58, 78, and 79

#### **Don't miss out on extra pay when global period resets.**

Just because you routinely append modifiers to your claims doesn't mean you're filing correctly and getting the most appropriate pay. Brush up on your modifier know-how with these tips for three of the trickiest choices: modifiers 58, 78, and 79.

Selecting between these modifiers can be carrier-specific in some situations, says **Jacqui Jones**, office manager for Benjamin F. Balme, MD, PC in Klamath Falls, Ore. Remember All Possible Uses for 58

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 might 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 physician 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 (Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period). 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 undergoes a transurethral resection of an enlarged prostate gland (TURP). Four days following the surgery, the patient experiences heavy bleeding and hematuria, and returns to the operating room for surgery to control the bleeding. This represents a complication that required a return to the OR for treatment within the global period of the initial procedure.

In this scenario, you would report 52214 (Cystourethroscopy, with fulguration [including cryosurgery or laser surgery] of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands). Append modifier 78 to 52214 to indicate that your physician performed surgery in the operating room due to complications after a prior procedure.

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.

## **Check All Diagnoses to Justify 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.

**Example:** The patient is in the global period for a partial mastectomy (19301, Mastectomy, partial [e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy]). During that time, the patient has an appendectomy (such as 44970, Laparoscopy, surgical, appendectomy) because of acute appendicitis. You should append modifier 79 to the appendectomy code.

You should receive full reimbursement for the second procedure because a new global period starts with the unrelated procedure. And because you'll be dealing with multiple global periods, monitor follow-ups carefully to ensure you correctly track the patient's care.

**Remember OR restriction:** Medicare will only pay for treating a complication during the surgical global period if treatment requires a return to the operating room. Modifiers 58 and 78 do not apply if the Medicare beneficiary does not return to the OR.