Global Period Surgical Modifiers— "58", "78", & "79"

Here is some guidance on the proper use of these modifiers.

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Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

The global period, as defined by CMS, is a "global surgical package, also called global surgery,[that] includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. Global surgery applies in any setting, including an inpatient hospital, outpatient hospital, Ambulatory Surgical Center (ASC), and physician's office. When a surgeon visits a patient in an intensive care or critical care unit, Medicare includes these visits in the global surgical package."

CPT primarily focuses on the comprehensive nature of some procedure codes, noting they include some procedure or service components. This is an excerpt from CPT:

"In defining the specific services "included" in a given CPT surgical code, the following services related to the surgery when furnished by the physician or other qualified health care professional who performs the surgery are included in addition to the operation per se:
• Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)
• Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
• Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals
• Writing orders
• Evaluating the patient in the post-anesthesia recovery area
• Typical post-operative follow-up care."

AMA's *CPT Assistant* (August 1998) notes that it is typical that the surgeon will see a patient "several times as part of the normal, uncomplicated follow-up care (e.g., to remove sutures, to evaluate the results of the surgery, and to check for complications)." In other words, all typically normal follow-up is included in the allowance for the surgery. Well, that was 1998.

Over the years, CMS has led the way in re-inventing what's in and what's out of the global package. The result is a broader, more inclusive global surgical package definition. With the changes the idea that only

> **Over the years, CMS has led the way in re-inventing what's in and what's out of the global package (period).**

"normal, uncomplicated follow-up care" would be included gave way to any and all related follow-up care, including the treatment of complications would be included in the global package…unless there was a medical necessity to "return to the operating room" for the care.

Modifier "-78"
Return to the Operating Room for Related Procedure During the Post-Operative Period

The "-78" modifier is typically associated with a complication that resulted from a previous procedure. By definition, there must be evidence of a return to the operating room. That re-

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turn to the operating room can occur anytime in a 10- or 90-day global period (although if the same procedure is repeated on the same day, because of a complication, use a "-76" [repeat procedure modifier]). Medicare describes an "operating room" to include a typical operating room and endoscopy suite. It would not include an office treatment room, minor treatment room, patient's room, ICU, or recovery room. Non-Medicare payers may be more lenient in their operating room requirements (check with individual payers regarding their definition of "operating room" as it relates to the "-78" modifier). In all cases, there needs to be clear evidence of medical necessity for the return to the operating room.

The "-78" modifier can be appended to an unlisted procedure code if no existing CPT surgical code exists. The global period does not "begin anew" with the "-78" modifier use. In most cases, payers only allow reimbursement for the surgeon's intra-operative work (approximately 50% of the total fee schedule allowance). Also, if, for example, a patient had a bunionectomy with osteotomy performed, and several days later tripped and displaced the capital portion of the metatarsal, the return to the operating room to remove the fixation, realign the metatarsal head, and fixate it with a larger surgical screw (achieving a "solid" osteotomy site fixation), would not be CPT 28296-78; it would be either an open treatment of metatarsal fracture or an unlisted procedure. In other words, you do not repeat the original procedure code unless you actually performed another bunionectomy with osteotomy.

Examples of a "-78" Modifier Use

A return to the operating room to:
• Evacuate a large hematoma post-multiple midtarsal joint arthrodesis;
• Repair an extensive wound dehiscence of a surgical site (especially if the original surgery took significantly longer than expected to perform or the tissue was roughly handled);
• Perform an incision and drainage of a deep wound abscess that fol-

lowed repair of laceration of tendons and other soft tissue (mower injury);
• Removal and replacement of internal fixation due to failure of the hardware to stabilize bone.

Modifier "-58"
Staged or Related Procedure or Service by the Same Physician During the Post-Operative Period

The "-58" modifier differs considerably from the "-78" (return to the operating room for a related surgery complication in a post-operative period). While they have "related procedure" and "post-operative period"

in common, procedures performed and appended with a "-58" modifier do not require an actual return to the operating room (although that is an option) and are not the result of complication of the original surgery.

The "-58" modifier has three separate indications for its use: 1) if the surgeon determines (and documents) prior to or in the course of performing the "initial" procedure, that subsequent related (staged) procedures will be required within the global period to achieve an ultimate surgical result; 2) if the surgeon is required to perform a more extensive procedure than the original procedure to achieve the best possible surgical result; or 3) if therapy is required following a diagnostic surgical procedure. Typically, foot and ankle surgeons apply the "-58" modifier for circumstances related to 1) and 2) above.

While the concept of staged procedures is relatively straightforward, there is some confusion regarding the "more extensive than the original procedure" category. When is the more extensive procedure a "complication" versus a failure of a lesser procedure to achieve the original goal? This is even more puzzling if the more extensive procedure is performed in an operating room. Well,

let's see if this clears things up:

If a complication and return to the operating room for treatment can be attributed to something directly or indirectly associated in the performance of the original surgery, a "-78" modifier would be applied. Post-operative infection is a complication. Pain from a poorly placed protruding surgical screw is a complication.

If a more extensive procedure is needed to be performed, not because of any performance issues, but failure of the original procedure to achieve its desired result, a "-58" modifier would be applied.

Unlike the "-78" modifier, the original procedure global period gets reset ("begins anew") with the "-58" modifier use.

Examples of a "-58" Modifier Use

• Transmetatarsal amputation following failure of digital amputation sites to heal;
• Performance of a wide excision of a lesion four days following a biopsy;
• Secondary closure of an open wound site in which osteomyelitic bone was excised and soft tissue debrided;
• Adjustment of an external fixation device under general anesthesia during the course of treatment/healing;
• The removal of the initial cast and re-application of a below-the-knee cast within the post-operative period;
• Attempting a closed manipulation of a fracture site which remained unstable; scheduling the patient for an open reduction fixation of the fracture in two days following reduction in swelling.

Some Final Points and Reminders

• Unlike the "-78" modifier, the original procedure global period gets reset ("begins anew") with the "-58" modifier use. In most cases, payers allow 100% of the total fee schedule allowance.
• It is critical, if you are going

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to use the "-58" modifier under its "staged" option, to document prior to performance of the procedure, the need for staging additional procedures or the possibility that additional procedures will need to be performed to achieve the ultimate surgical goal.

• The "-58" modifier is not used when there is a complication of the original surgery requiring a return to the operating room.

• Modifier "-58" procedures are not required, but may be performed in an operating room.

Modifier "-79"
Unrelated Procedure or Service by the Same Physician During the Post-Operative Period

There is no mystery surrounding when and where to use the "-79" modifier. If you are performing a procedure in a post-operative period that is unrelated to the original procedure, you use the "-79" modifier. Period. The billing for the unrelated procedure most likely will have a different diagnosis code (unless the diagnosis code has no laterality choices).

Even though the surgeon is in the global period of a previous surgery, with a "-79" modifier appended, the unrelated "new" surgery is reimbursed at 100% the fee schedule for the procedure code (additional procedures would also be appended with a "-79" modifier as well as a "-59" [or "-51" or "X"] modifier, and be reimbursed according to the payer's multiple procedure rule).

Keep in mind that the "new" procedure must be unrelated to the "old-but-still-in-a-global-period" procedure(s), both of which you performed. You do not apply a "-79" modifier if the patient is in "someone else's" (not you or a foot/ankle specialist from your group) global period.

Examples of a "-79" Modifier Use
• Performing a left bunionectomy six weeks after performing a right bunionectomy;
• Doing any surgery in a post-operative period that has nothing whatsoever to do with the original surgery.

So, if you do a matrixectomy on a Medicare patient, and one week later when you see the patient, you discover an abscess in the matrixectomy site which you incise and drain, do you modify CPT 10060 with a:
• "-58" modifier—because you pre-planned to have an abscess to I&D…?(NO)
• "-78" modifier—because this is an unplanned complication…which you returned to the operative room…oops…you I&D'ed it in a treatment room…?(NO)
• "-79" modifier—because the abscess is unrelated to matrixectomy although surprisingly it appeared in the proximal nail groove of the same side of the same toe on which you performed the matrixectomy…?(NO)
• No modifier is needed, included in the CPT 11750 allowance. This is—according to Medicare—a normal, even expected global period complication…no extra dough…Medicare thanks you…(AGGHH)

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The Day Before the Clinical Conference—Marriott Marquis, New York, New York. Topics will include discussions of the new bunionectomy CPT codes; discussions on E/M and documentation; DME Updates; presentations and panel discussions on out with the old (PQRS) in with the new (MIPS), registries, as well as "tomorrow's practices"; "Legally Yours"; and "ICD-10: The 'Final' Questions". Speakers: Harry Goldsmith, DPM; Jeffrey Lehrman, DPM; David Freedman, DPM; Jim Christina, DPM; John Guiliana, DPM; Michael Brody, DPM; Barry Block, DPM, JD; Paul Kesselman, DPM; Larry Santi, DPM. For more information and registration, go to www.codingline.com and click on the "Events—New York" tab for more information; or go to https://www.expotracshows.com/podiatric/2017/codingline/. **PM**

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.