Which Modifier Should I Use?

Here's some advice on using -58, -76, -77, -78, and -79.

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This month, we will discuss the procedure and service modifiers -58, -76, -77, -78, -79. Within this article, the term "same physician" refers to you or anyone within your billing group and the phrase "different physician" refers to anyone not in your billing group.

Modifiers are used to provide additional information to third-party claim payers or reviewers explaining what was done and why they should be covered. Typically, they are used when circumstances are out of the ordinary for the care rendered to a particular patient. These circumstances could be because of a variety of reasons which might include: the patient developed a complication which required a return to the operating room, a series of similar or identical services needed to be performed, an additional unrelated procedure was performed on a patient in a post-operative global period.

-58 Same or related procedure or service by the same physician during the post-operative period

When you find yourself in a situation where multiple procedures or services are required that typically are performed in a single setting but in this particular situation need to be spaced out or repeated due to the specific medically necessary surgical plan, then the modifier -58 is the correct modifier to utilize. It is defined as "staged or related procedure or service by the same physician during the post-operative period". This circumstance may be reported by adding modifier -58 to the staged or related procedure if:

- the service was planned or anticipated (staged);
- the service was more extensive than the original procedure; or
- the service is for therapy following a surgical procedure.

Examples of the correct use of the -58 modifier could include situations such as: subsequent wound debridement of the same wound, return to the operating room for more proximal resection of an osteomyelitic bone after initial resection, implantation of antibiotic impregnated beads after initial bone resection, and closure of an open transmetatarsal amputation wound after wound VAC therapy. The subsequent service or procedure does not have to be performed in the operating room. The -58 modifier differs from the -78 and -79 modifiers in that it describes a planned additional procedure and a service for a related problem. The -76 and -77 modifiers are included in the -58 modifier and do not need to be additionally reported. The -58 should be appended to each procedure for which it applies and as frequently as it applies.

The -76 and -77 modifiers are included in the -58 modifier and do not need to be additionally reported.

-76 Repeat procedure or service by the same physician

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 or service. There is no timeframe for this modifier. It is utilized when the same procedure or service code is used subsequently to previously being used. Examples of the correct use of the -76 modifier could include situations such as: a matricectomy was performed on multiple digits at the same setting, pre- and post-reduction radiographs, the identical bunionectomy procedure was performed on the right foot two months after a bunionectomy was performed on the left foot.

-77 Repeat procedure by another physician

When you need to report a procedure or service that was previously performed by another physician, then the -77 would be the appropriate modifier. The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This would be an unusual situation. This modifier is procedure code-specific and anatomical location is irrelevant. Examples of the correct usage of the -77 modi-

Continued on page 56

Which Modifier? *(from page 55)*

fier could be when another physician performed a matricectomy and you subsequently did the same procedure on the same or a different toe (or even on the same toe) or when another physician did an incision and drainage and you needed to repeat the procedure. This situation may be reported by adding modifier -77 to the repeated procedure or service.

-78 Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the post-operative period

It may be necessary to indicate that another procedure was performed during the post-operative period of the initial procedure. This differs from -58 in that this is an unplanned procedure in the operating room, whereas -58 is a planned procedure. When a subsequent procedure is related to a previous procedure and requires the use of an operating or procedure room, it may be reported by adding modifier -78 to the related procedure. This is not necessarily a repeat procedure; therefore, if the patient needs to be taken back to the operating room for an unplanned procedure that was the same procedure initially reported, then you would append both the -76 and -78. If the patient had an unplanned procedure that did not require a return to the operation room, such as a suture dehiscence or minor post-operative infection that could be managed in the office, then that is not a reportable or billable service as it is included in the original surgical post-operative global period.

An example of the correct usage of the -78 modifier is treating a patient that previously had a bunionectomy with metatarsal osteotomy who fell and disrupted the osteotomy site. This is an unplanned return to the operating room for fixation of the osteotomy and reportable with the appropriate CPT code appended with the -78.

An example of the correct usage of the -78 modifier is treating a patient that previously had a bunionectomy with metatarsal osteotomy who fell and disrupted the osteotomy site.

-79 Unrelated Procedure or Service by the Same Physician during the post-operative period

It may be necessary to indicate that another procedure was performed during the post-operative period of the initial procedure (unplanned procedure following initial procedure). This differs from -78 in that this procedure was unrelated to the original procedure. An example of correct usage could be performing a hammertoe repair on the left foot two months after a bunionectomy was performed on the right foot. The procedures are unrelated to each other, and the second procedure should be reported with the -79. If the same unrelated procedure is reported such as a bunionectomy on the left foot followed two months later by an identical bunionectomy on the right foot, then you would report the appropriate CPT code with both modifiers -76 and -79.

An example of correct usage of the -79 modifier could be performing a hammertoe repair on the left foot two months after a bunionectomy was performed on the right foot.

Scenario #1

You do radiographs (3 views right foot) for a suspected new right 2nd metatarsal phalangeal joint dislocation, then reduce the dislocation. You take radiographs post-reduction and realize from these radiographs that the reduction is incomplete and therefore you need to do further reduction. You take additional radiographs after the second reduction attempt and find the treatment was successful that time.

This episode of care is correctly coded as

- Appropriate evaluation and management service with -57
- Pre-reduction radiographs CPT 73630 -RT
- Appropriate MTPJ closed dislocation reduction with -RT
- Post-reduction radiographs CPT 73630- RT- 58
- The second MTPJ reduction is included in the first attempt and not separately billable as it is during the same episode of care.
- Additional post-reduction radiographs are coded as CPT 73630-RT-58
- DME is separately billable.

Scenario #2

A wound is debrided to the level of bone in the operating room. Subsequent debridement of the same wound to the level of muscle is performed in the office one week later. Additional debridement of subcutaneous tissue in the same wound is performed one week later. Two weeks later the wound is healed without need for any further debridement.

This episode of care is correctly coded as:

- Appropriate evaluation and management code with -57 (refer to previous articles for usage of the -57 and -25)
- CPT 11044 unmodified for the first debridement
- CPT 11042-58 for the second debridement
- CPT 11042-58 for the third debridement
- The appropriate evaluation and

Continued on page 58

Which Modifier? *(from page 56)*

management codes are reported unmodified for any medically necessary visits after the last debridement because the global period for CPT 11042-11044 is zero days.

Scenario #3

A patient has a bunion with metatarsal osteotomy on the right foot performed and is healing normally for three weeks when they fall and displace the right first metatarsal osteotomy and internal fixation. During that fall, they also break and displace the contralateral 5th toe proximal phalanx, which requires a closed phalangeal fracture reduction to repair the deformity. The decision was made to repair both injuries at the same surgical episode in the operating room at which time the right foot metatarsal displacement is repaired and the left 5th toe phalangeal fracture is reduced and splinted in place.

This episode of care is correctly coded as:

- 28296-RT for the initial bunionectomy on the right foot
- Appropriate evaluation and management code with -24 -57 for the work-up of the left 5th toe fracture (see additional articles for definition of -24 modifier)
- In office radiographs of both right and left foot CPT 73620-RT, CPT 73630 -LT-76
- Appropriate CPT code with -RT-78 for the work involved in reducing and fixating the right first metatarsal displacement
- Appropriate CPT code with -LT-79-59 for the work involved in reducing the left 5th toe fracture (see additional articles for the definition of -59)
- Appropriate CPT imaging code with -RT-26 for interpretation of intraoperative imaging of the right foot
- Appropriate CPT imaging code with -LT-76-26 for interpretation of intraoperative imaging of the left foot

Conclusion

Modifiers allow the physician to provide additional information to third-party claim reviewers and payers in hopes that the claim will be adjudicated appropriately in a timely manner. A thorough understanding of modifiers is necessary to properly code medically necessary services that may be unique and potentially confusing due to their individual circumstances. **PM**

References

2019 AMA CPT Book
2019 APMA Coding Resource Center

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