



OptumInsight Learning:

Understanding Modifiers

2015

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- If a CPT code exists for the related procedure, append modifier 78 to it. If no CPT code exists for the related procedure, append the modifier to an unlisted procedure code. For Medicare patients, payment is limited to the amount allotted for intraoperative services only. [Note: For each surgical CPT code, most third-party payers have established a certain reimbursement percentage for each of the three components (i.e., preoperative, intraoperative and postoperative).]
- Do not use modifier 78 if treatment for postoperative complications did not require a return trip to the operating room.
- A new postoperative period does not begin with the use of the 78 modifier.
- An operating room is defined by CMS as a place of service specifically equipped and staffed for the sole purpose of performing procedures. This includes cardiac catheterization suites, laser suites and endoscopy suites. It does not include a patient's room, a minor treatment room, a recovery room or an intensive care unit.
- CMS reimbursement is made only for the intraoperative portion as identified in the MPFSDB.
- CPT codes for use with modifier 78 are 10021–69990 and 90281–99199, 99500–99607, when appropriate.

Clinical Examples

Example #1:

A single vessel coronary graft 33510 is performed. In the patient's room that evening it is noted his vital signs are unstable, and it is observed that hemorrhagic complications following the surgery have occurred. The patient is returned to the operating room on the same date to locate and control the source of hemorrhage.

Submit CPT codes 33510 and 35820-78.

Example #2:

A femoral-popliteal nonautogenous bypass graft (35656) is placed. Infection is noted in the lower extremity within the follow-up period (during the 90 days after the surgery) of the bypass graft. The patient is returned to the operating room for exploration and debridement.

CPT code 35860-78 is submitted for the subsequent exploration procedure.

Example #3:

A patient presents for hernia repair with ligation of spermatic veins for varicocele. An incision is made in the affected area and the spermatic cords are exposed. The cord is brought up into the incision and the structures of the cord are dissected, the veins identified and ligated. The hernia is repaired and the dilated veins are ligated through a separate incision in the scrotum. The patient is sent to the recovery room in satisfactory condition. Later in the day, the patient's operative site bleeds and requires a return to the operating room to stop the bleeding.

Submit CPT code 35840-78, for the exploration for postoperative hemorrhage, thrombosis or infection, abdomen.

Example #4:

Operative Report:

Preoperative Diagnosis: Abdominal aortic aneurysm

Postoperative Diagnosis: Same

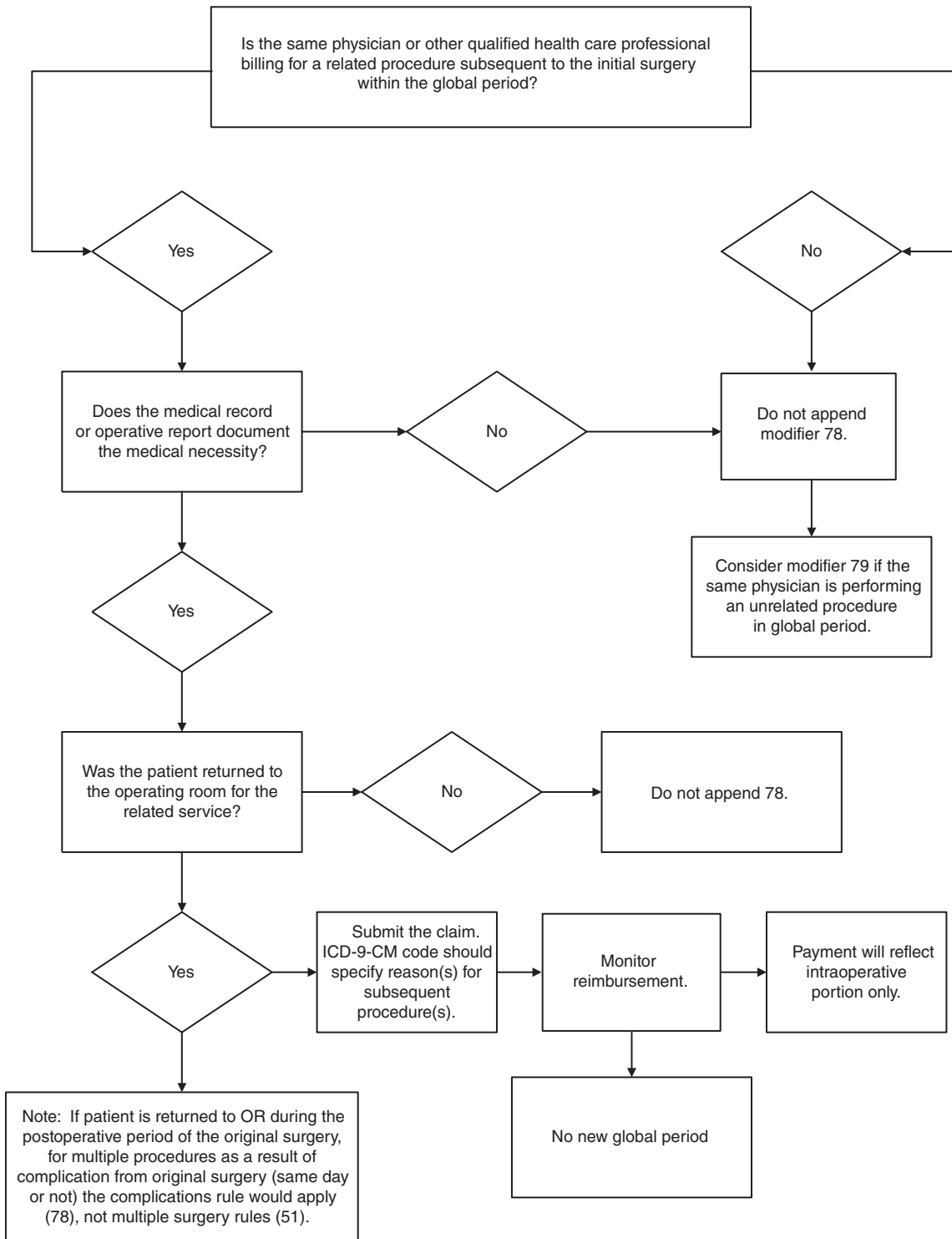


QUICK TIP

Hospital ASC and Outpatient Coders

Medicare's instructions for modifiers 78 and 79 in hospital ASC or hospital outpatient facilities include in the definition procedures requiring a "return to the operating room on the same day." Use modifier 78 for a procedure related to the initial procedure on the same day and modifier 79 for a procedure on the same day that is unrelated to the initial procedure.

Modifier 78



Note: Postoperative period for hospital outpatient prospective payment claims is defined as same calendar day.

Appendix A: Summary of the 2011 OIG Work Plan

A MESSAGE FROM THE OFFICE OF INSPECTOR

GENERAL

We are pleased to present the *Office of Inspector General Work Plan for Fiscal Year 2011*. This publication provides brief descriptions of activities that the Office of Inspector General (OIG) plans to initiate or continue with respect to the programs and operations of the Department of Health & Human Services (HHS) in fiscal year (FY) 2011. To place the Work Plan in context, we describe below our mission and activities, organization, program integrity resources, work-planning process, and related matters.

Mission and Activities

OIG's operational mission is to protect program integrity and the well-being of program beneficiaries by detecting and preventing waste, fraud, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws. We carry out our mission by conducting audits, evaluations, and investigations; providing guidance to industry; and, when appropriate, imposing civil monetary penalties, assessments, and administrative sanctions. We work closely with HHS and its Operating and Staff Divisions; the Department of Justice (DOJ) and other agencies in the executive branch; Congress; and States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds.

Core Values

Integrity: Acting with independence and objectivity.

Credibility: Building on a tradition of excellence and accountability.

Impact: Yielding results that are tangible and relevant.

Organization

Following are descriptions of the OIG components that carry out our audit, evaluation, investigation, enforcement, and compliance activities.

- The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS's programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.
- The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in HHS programs. OEI reports also present practical recommendations for improving program operations.
- The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in almost every State and the District of Columbia, OI actively coordinates with DOJ and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, or civil monetary penalties.
- The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.