![moda HEALTH]	Reimbursement Policy Manual	Policy #:	RPM010

Policy Title:	Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures		
Section:	Modifiers	Subsection:	Surgery

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:	
Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB for professional revenue codes only (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Type:	Professional providers only. The global surgery package payment concept does not apply to facilities.
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	9/22/2004	Initially Published:	7/25/2011
Last Updated:	3/13/2024	Last Reviewed:	3/13/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		3/13/2024	

Reimbursement Guidelines

A. Surgical Procedures Performed Within the Global Period of a Previous Surgery

1. The longest global period for any procedure code from the original date of surgery applies to the entire surgical session and all subsequent services until the global period is complete.

2. When using modifiers, choose the appropriate modifier for the situation, and use that modifier correctly.

3. The failure to use a needed modifier when appropriate may result in denial of the subsequent surgery. The incorrect use of a modifier when not appropriate may also result in denial of the subsequent surgery.

4. Modifiers 58, 78, and 79 are not valid to use with or attach to evaluation and management (E/M) procedure codes. Modifiers 58, 78, and 79 are considered valid for procedures with a Global Days

indicator setting of 010 or 090. Modifiers 58, 78, and 79 are not considered valid for procedures with a Global Days indicator setting of 000, XXX, or ZZZ.

5. Modifiers 58, 78, and 79 are mutually exclusive to one another; only one of these modifiers may apply to a service or procedure performed within a postoperative global period.

6. Services may not be "unrelated" to the procedure code creating the postoperative global period and also "related" to another procedure code performed by the same physician during that same original surgical session.

> For example:
> A septoplasty (30520, 90-day global) and a functional endoscopic sinus surgery (FESS, 0-day or 10-day global) are performed during the same surgical session. An endoscopic sinus debridement (31237, S2342) is performed in the office 14 days later. Because the debridement is related to the FESS, then it is also related to the septoplasty, and the 90-day global period applies to the post-operative sinus debridement.

B. Multiple Procedures During the Same Surgical Session

Modifiers 78 and 79 are not to be used to distinguish multiple procedure codes performed during the same operative session. The postoperative period does not begin until the surgical session ends. This is not a valid use of modifier 78 or 79 and represents a billing error.

> For example:
> During the initial surgery performed by this provider, a variety of procedures are performed on multiple skin lesions in multiple locations during the same surgical session. Neither modifier 78 nor modifier 79 are appropriate to be attached to the procedure codes for the second and third lesions treated. Treatment of a second, separate lesion is correctly identified with the Distinct Procedural Service modifier (-59) or Separate Structure (-XS).

C. Fee Adjustments for Services within a Global Period

1. An unplanned return to the operating/procedure room for a related procedure during a postoperative global period (modifier 78) will be eligible for reimbursement as follows:

For claims processed prior to July 1, 2018: (regardless of the date of service)	For claims processed on or after July 1, 2018: (regardless of the date of service)
70% of the global allowance for that procedure.	Medicare Advantage claims, Participating Providers: 70% of the global allowance for that procedure. Medicare Advantage claims, Out-of-Network Providers: Intra-operative portion of the global allowance. Commercial and Medicaid claims: 70% of the global allowance for that procedure.

2. Modifiers 58 (staged, related) and 79 (unrelated) are not subject to any global period allowance reductions. Documentation may be required for review to verify the services were staged or unrelated to the original surgical session.

3. Modifiers 58, 78, and 79 do not bypass the usual multiple procedure fee reductions, bilateral fee adjustments, assistant surgeon fee adjustments, or any other applicable adjustments which may apply to a particular line item or situation.

D. Determining Whether Services Are Related, Staged, or Unrelated

1. When determining whether a subsequent procedure is related, staged, or unrelated to the original surgery, both the reason for the original surgery and the reason for the subsequent procedure must be considered.

   a. Services treating complications from the original surgery are always related.

   b. Procedures to treat or assist with expected developments in the healing process are always related.

   c. Services associated with returning the patient to the appropriate post-procedure state are always related, and unless they require a return to the operating/procedure room, reimbursement is included in the global surgery fee for the original surgical procedure(s).

   d. When the subsequent procedure would not have been needed if the original surgery had never been performed:
      i. Services on the operative site or contiguous structures are related to the original surgery.
      ii. Services on a different body organ or unrelated operative site may be unrelated to the original surgery. (In addition to modifier 79, use XS or another anatomical modifier as appropriate.)

   e. Procedures to treat the same or similar problems in the contra-lateral, non-operative organ, extremity, or joint are unrelated.

2. **Examples** (not an all-inclusive list):

   a. Left eye cataract removal within the global period of right eye cataract removal is **unrelated;** submit with modifiers 79 and LT.

   b. Right total knee replacement within the global period of left total knee replacement is **unrelated;** submit with modifiers 79 and RT.

   c. 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa) performed on the operative joint during the global period is **related.** Do not report with modifier 79, 58, or any other modifier (*see general anesthesia exception below).
      i. If performed in the office or at the bedside, 20610 is not eligible to be separately reported or reimbursed during the postoperative global period. This service is included in the global surgery package for the original surgery.
      ii. If general anesthesia is required with a return to the operating room, then 20610 is eligible for separate reimbursement for the intraoperative work; *submit with modifier 78.

   d. 20610 (Arthrocentesis, aspiration and/or injection) performed in the office during the global period of a joint surgery but on a different, non-operative joint is **unrelated** and may be separately reported with modifiers 79 and XS.

e. A Kenalog injection to the skin graft/flap site following Moh's surgery and flap repair is **related**. This service is included in the global surgery package for the original surgery. Do not report with modifier 79, 58, or any other modifier.

f. A skin lesion is removed with Mohs surgery and repaired with a skin graft (90-day global period). Three weeks later during the global period of the first surgery, a second lesion in the same body area (e.g., nose, forehead) but not touching the first lesion is also removed with Mohs surgery and repaired with an adjacent tissue transfer technique. Treatment of these two lesions (which are separate and distinct, not touching) on different days is considered **unrelated**; submit the second surgery with modifier 79.

g. Insertion of a cannula for hemodialysis to treat acute renal failure following a femoral-popliteal bypass graft is **unrelated**.

E. Documentation for Review of Staged or Unrelated Procedures.

1. Staged or anticipated procedures (modifier 58) are a very specific type of related procedures.

   a. Documentation that the subsequent procedure was a staged or anticipated procedure of the original surgery may be included in the operative report for the original surgery or the preoperative documentation.

   b. Regardless of where the surgeon chooses to include this information, the office should either:

      i. Attach this documentation to the claim billed with modifier 58.

      ii. Be prepared to submit this supporting documentation for review upon request in order to support the billing of the subsequent procedure as a staged procedure and qualify for the reimbursement rate for staged procedures.

2. Unrelated procedures (Modifier 79).

   a. In order to verify that services are indeed unrelated to the original surgery creating the global period, the following is requested:

      i. The preoperative history and physical for the original date of surgery or procedure(s).

      ii. The operative report for the original date of surgery or procedure(s).

      iii. The preoperative history and physical for the subsequent date of surgery or procedure(s).

      iv. The operative report for the subsequent date of surgery or procedure(s).

   b. When reporting services with modifier 79, billing offices need to either:

      i. Attach this documentation to the claim.

      ii. Be prepared to submit this supporting documentation for review upon request.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
FESS	=	Functional Endoscopic Sinus Surgery
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
UB	=	Uniform Bill

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 58	**Staged or Related Procedure or Service by the Same Physician During the Postoperative Period:** The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg. unanticipated clinical condition), see modifier 78.
Modifier 78	**Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period:** It may be necessary to indicate that another procedure was performed 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 the operating/procedure room, it may be reported by adding the modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76).
Modifier 79	**Unrelated Procedure or Service by the Same Physician During the Postoperative Period:** 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 the modifier 79. (For repeat procedures on the same day, see modifier 76).

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

When modifier 58 is used, the staged relationship to the original surgery must be documented in the medical record. This does not necessarily mean that the final decision to perform the subsequent surgery or the date it will be performed is known at the time of the original surgery. "Decisions to perform subsequent procedure(s) may depend on the outcome of the surgery and the patient's postoperative status. The term *anticipated* was added [to the description for modifier 58] because physicians can anticipate the potential for subsequent procedure(s) but cannot always predict it." (CPT Assistant[1])

Modifier 78 may not be used with place of service 11 (office). Modifier 78 requires a return to the operating room or procedure room (e.g. Cath Lab, Interventional Radiology Procedure Room, Endoscopy Room). (Modifier definition[10], CPT Assistant[1,8], CMS[12])

Cross References

A. "Global Surgery Package for Professional Claims", Moda Health Reimbursement Policy Manual, RPM011.

B. "Postoperative Sinus Debridement Procedures", Moda Health Reimbursement Policy Manual, RPM009.

C. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.

D. "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service." Moda Health Reimbursement Policy Manual, RPM027.

E. "Procedure Codes Assigned to Surgical Benefit Categories." Moda Health Reimbursement Policy Manual, RPM023.

References & Resources

1. "Coding Clarification: Modifiers 58 and 78", CPT Assistant, February 2008, page 3.

2. CMS Manual System, Medicare Claims Processing Manual (Pub. 100-4), Chapter 12, § 40.2 – 40.4.

3. CMS National Correct Coding Initiative Policy Manual, Chapter 1 General Correct Coding Policies, § C.

4. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. American Medical Association, 2004.

5. "Modifiers Used with Surgical Procedures", *CPT Assistant*, Fall 1992, page 15.

6. "Coding Commentary: Modifiers -21, -25, -57, -58", *CPT Assistant*, Winter 1993, page 26.

7. "Modifiers, Modifiers, Modifiers: A Comprehensive Review", *CPT Assistant,* May 1997, page 1, 4.

8. "Coding Communication: More on Modifiers", *CPT Assistant*, September 1997, page 4.

9. "Coding Commentary: Global Surgical Package", *CPT Assistant*, Fall 1992, page 10.

10. "Coding Communication: Global Surgical Package", *CPT Assistant*, August 1998, page 5.

11. American Medical Association. "Appendix A – Modifiers." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.

12. CMS Manual System, Medicare Claims Processing Manual (Pub. 100-4), Chapter 12, § 40.1, B, "Services Not Included in the Global Surgical Package".

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery

- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
3/13/2024	Clarification/Update: Section C.1: Removal of EOCCO since Medicaid also includes another group. Rephrased "should" to reduce ambiguity.
10/12/2022	Formatting/Update: Change to new header. Includes Idaho. Acronym table: 7 entries added. Cross References: 1 entry added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
7/25/2011	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
9/22/2004	Original Effective Date (with or without formal documentation). Policy based on CMS policy.