Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

This policy applies to professional providers only. The global surgery package payment concept does not apply to facilities.

Reimbursement Guidelines

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.

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

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.

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.

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.

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.

Multiple Procedures During the Same Surgical Session

Modifiers 78 and 79 should not 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 should 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).

Fee Adjustments for Services within a Global Period

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:

<table>
<thead>
<tr>
<th>For claims processed prior to July 1, 2018: (regardless of the date of service)</th>
<th>For claims processed on or after July 1, 2018: (regardless of the date of service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>70% of the global allowance for that procedure.</td>
<td>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/EOCCO claims: 70% of the global allowance for that procedure.</td>
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</tbody>
</table>

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.
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.

Determining Whether Services Are Related, Staged, or Unrelated

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.

- Services treating complications from the original surgery are always related.
- Procedures to treat or assist with expected developments in the healing process are always related.
- 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).
- When the subsequent procedure would not have been needed if the original surgery had never been performed:
  - Services on the operative site or contiguous structures are related to the original surgery.
  - 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.)
- Procedures to treat the same or similar problems in the contra-lateral, non-operative organ, extremity, or joint are unrelated.

Examples (not an all-inclusive list):

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

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

- 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).
  - 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.
  - 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.
➢ 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.

➢ 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.

➢ 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.

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

**Documentation for Review**

Staged or anticipated procedures are a very specific type of related procedures. 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. Regardless of where the surgeon chooses to include this information, the office should either attach this documentation to the claim billed with modifier 58 or 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.

In order to verify that services are indeed unrelated to the original surgery creating the global period, Moda Health may request the preoperative history and physical and the operative report for both the original and the subsequent surgeries or procedures. When reporting services with modifier 79, billing offices should either attach this documentation to the claim or be prepared to submit this supporting documentation for review upon request.

**Codes, Terms, and Definitions**

**Acronyms Defined**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>E/M</td>
<td>Evaluation and Management</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>EOCCO</td>
<td>= Eastern Oregon Coordinated Care Organization</td>
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<tr>
<td>FESS</td>
<td>= Functional Endoscopic Sinus Surgery</td>
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<tr>
<td>HCPCS</td>
<td>= Healthcare Common Procedure Coding System</td>
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<tr>
<td>MPFSDB</td>
<td>= (National) Medicare Physician Fee Schedule Database (aka RVU file)</td>
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<tr>
<td>RVU</td>
<td>= Relative Value Unit</td>
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**Modifier Definitions:**

<table>
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<tbody>
<tr>
<td>Modifier 58</td>
<td><strong>Staged or Related Procedure or Service by the Same Physician During the Postoperative Period:</strong> 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. <strong>Note:</strong> For treatment of a problem that requires a return to the operating/procedure room (eg. unanticipated clinical condition), see modifier 78.</td>
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<tr>
<td>Modifier 78</td>
<td><strong>Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period:</strong> 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).</td>
</tr>
<tr>
<td>Modifier 79</td>
<td><strong>Unrelated Procedure or Service by the Same Physician During the Postoperative Period:</strong> 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).</td>
</tr>
</tbody>
</table>

**Coding Guidelines**

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\textsuperscript{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\textsuperscript{10}, CPT Assistant\textsuperscript{1,8}, CMS\textsuperscript{12})

Cross References


References & Resources


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


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 Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should 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 applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.