

<b>Policy</b>	<b>REIMB-015</b>
<b>Effective Date</b>	<b>09/01/2024</b>
Reviewed/Revised Date	07/17/2024
Next Review Date	07/17/2026
Origination Date	06/01/2024
Originated Department	Medical Management

### Modifier -78

<b>Audience</b>
Medical Management, Claims

<b>Purpose</b>
<p>Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

<b>Definition</b>
<p>Modifier -78 is used to report the unplanned return to the operating/procedure room by the same physician following an 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 the initial procedure). When this procedure is related to the first surgical procedure and requires the use of the operating/procedure room, it may be reported by adding the Modifier -78 to the related procedure.</p> <p>Consistent with CMS and CPT, modifier -78 should be reported with procedure codes to treat postoperative complications requiring a return trip to the operating room. Per CMS, an</p>

operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition were so critical there would be insufficient time for transportation to an operating room.)

## Policy/Procedure

**Mountain Health Co-Op may reimburse services surgical services appropriately appended with a modifier -78 at the reimbursement amount of 75% of the applicable Mountain Health Co-Op fee schedule when ALL the following criteria are met:**

- A. The return to the operating room is unplanned.
- B. The service is performed by the same physician who performed the initial procedure.
- C. The service is related to the initial procedure.
- D. The service is performed during the postoperative period of the initial procedure (10-90 days).

Modifier -78 is not covered if appended to procedures having a Global Days Value of 010 or 090, which also does not have an Intraoperative Percentage in the CMS National Physician Fee Schedule Relative Value File.

**Mountain Health Co-Op will not apply a new global period to a procedure meeting the above requirements and reported with a modifier -78.**

**Mountain Health Co-Op will NOT reimburse modifier -78 in conjunction with modifiers -76, -77, or -79, as these are inappropriate to bill together.**

*Note: If the unplanned return is for an unrelated procedure and both are performed by the same provider who performed the initial service, use Modifier -79 instead.*

*If the return to the operating room was planned or a staged procedure, use Modifier -58 instead.*

## Clinical Rationale

According to the CMS, Medicare Claims Processing Manual, Chapter 12, Section 40.4C: "When a CPT code billed with Modifier -78 describes the services involving a return trip to the operating room to deal with complications, pay the value of the intraoperative services of the code that describes the treatment of the complications."

## Applicable Coding

### Modifiers

**Modifier -78** Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

**References**

1. American Medical Association (AMA). Coding with Modifiers. 2024.
2. Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual; chapter 12; Sections 40.2.A.5 and 40.4.C; “Physician/Non-physician Practitioners.”  
<https://www.cms.gov/Regulations-and-Guidance/Manuals/downloads/clm104c12.pdf>
3. Centers for Medicare and Medicaid Services (CMS). “PFS Relative Value Files”  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>
4. Current Procedural Terminology (CPT®) Professional Edition (Chicago, IL: American Medical Association: ©2024).

**Vendors**

- Health Plan Services (HPS)

**Review/Revision/Approval History**

Date	Description
<b>06/01/2024</b>	<b>New Policy</b>

**Disclaimer**

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member’s benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

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