New York | Medicare Advantage

Reimbursement Policy

Subject: **Modifier 78**	
Policy Number: **G-06016**	Policy Section: **Coding**
Last Approval Date: **09/27/2023**	Effective Date: **09/27/2023**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **providers.anthem.com/ny******

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem Medicare Advantage covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem Medicare Advantage strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem Medicare Advantage allows reimbursement for claims billed with modifier 78 unless provider, federal, or CMS contracts and/or requirements indicate otherwise, when the following criteria are met:

- The return to the operating or procedure room is unplanned.
- The procedure appended with modifier 78 is:
  - The appropriate surgical code for the procedure performed.
  - Performed by the same physician who provided the initial procedure.
  - Related to the initial procedure.
  - Performed during the postoperative period of the initial procedure.

Reimbursement is based on 70% of the fee schedule or contracted/negotiated rate of the surgical procedure code when the modifier is valid for the service performed. Reimbursement is based on the surgical procedure **only**, not including preoperative or postoperative care. Procedures rendered during the postoperative period and not billed with modifier 78 are normally denied as included in the global surgical package.

When an assistant surgeon is used during the global period in the same operative session, assistant surgeon rules apply.

Non-reimbursable

Anthem Medicare Advantage does **not** allow reimbursement for modifier 78 billed in the following circumstances including, but not limited to:

- With nonsurgical codes.
- With codes denoting *subsequent, related,* or *redo* in the description.

Related Coding
Standard correct coding applies

Policy History	
09/27/2023	Review approved: removed *Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period* from the policy title; updated reimbursement “based on a percentage calculated by the Medicare Physician Fee Schedule Data Base (MPFSDB)” to “based on 70% of the fee schedule or contracted/negotiated rate”
11/16/2018	Review approved and effective: policy language updated
11/07/2016	Review approved: policy template updated
01/01/2015	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023
- State contract

Definitions	
Modifier 78	Used to indicate that a subsequent procedure was performed during the postoperative period of the original surgical procedure. The subsequent procedure must be related to the original procedure and must require a return trip to the operating or procedure room.
General Reimbursement Policy Definitions	

Related Policies and Materials
Modifier Usage
Modifiers 50 and 51: Multiple and Bilateral Surgery
Modifiers 80, 81, 82 and AS: Assistant at Surgery