JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.024
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	Subject **Staged, Related and Unrelated Procedures**	*Supersedes Date*	08/01/2020
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This document applies to the following Participating Organizations:

Advantage MD EHP Priority Partners US Family Health Plan

Keywords: Modifier 58 , Modifier 78, Modifier 79

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes billed should denote the services and/or procedures performed.

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to

prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

JHHP recognizes that it may be necessary to indicate that the performance of a procedure or service during the postoperative period has occurred. Consistent with CMS guidance, JHHP will reimburse eligible procedures and services with a global days indicator of 010 or 090, when they are appropriately reported with modifiers 58, 78, or 79. When one of these modifiers is reported on a subsequent procedure, and the patient's record supports it, the subsequent procedure will not be considered included in the Global Surgical Package of the earlier procedure and will be considered for separate reimbursement, if appropriate.

III. POLICY STATEMENT

Consistent with CMS guidance, JHHP allows reimbursement for the use of modifiers 58, 78 or 79, when billed with global surgery codes appropriately and correctly. Inappropriate, or incorrect use of the modifiers will result in denial of the surgery. To determine the global period of a surgery, refer to the Medicare Physician Fee Schedule Data Base (MPFSDB). Each line of business possesses its own unique guidelines for benefit and payment purposes, as such JHHP will align with regulatory, state and federal guidance for supplies/services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY FOR MODIFIER 58

1. A. Modifier "-58" was established to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.
   B. Report modifier 58 when a procedure or service during the postoperative period was:
      1. Planned prospectively or at the time of the original procedure;
      2. More extensive than original procedure; or
      3. For therapy following a diagnostic surgical procedure.
      4. When performing a second or related procedure during the postoperative period.
   C. Do not append the -58 modifier to ambulatory surgical center (ASC) facility fee claims.
   D. Modifier 58 does not apply to procedures with XXX global period or to unrelated procedures during the postoperative period.
   E. Do not submit modifier 58 on assistant surgery services because global surgery rules do not apply to assistants.
      1. Refer to JHHP's Assistant-at-Surgery policy for more information.
   F. The incorrect use of a modifier when not appropriate may result in denial of the subsequent surgery.

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V. BILLING GUIDELINES AND PAYMENT METHODOLOGY FOR MODIFIER 78

1. A. Modifier "-78" may only be submitted with surgery codes.
   B. Use modifier 78 to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure) when the subsequent procedure is related to the first and requires the use of an operating or procedure.
      i. The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room, this circumstance may be reported by adding the modifier “-78” to the related procedure.
   C. Supporting documentation must be maintained in the patient's medical record. The documentation must substantiate that the surgeries are related and that the subsequent surgery required a return to the operating room.
   D. Modifiers 50 and 78 cannot be submitted for the same service. Bilateral rules are not applicable when modifier 78 applies.
   E. Do not submit modifier 78 on assistant surgery services because global surgery rules do not apply to assistants.
      i. Refer to JHHP’s Assistant-at-Surgery policy for more information.
   F. The incorrect use of a modifier when not appropriate may result in denial of the subsequent surgery.

VI. BILLING GUIDELINES AND PAYMENT METHODOLOGY FOR MODIFIER 79

1. A. Modifier 79 is a pricing modifier and must be reported in the first position.
   B. Modifier 79 must only be submitted with surgery codes.
   C. Submit modifier 79 when an unrelated subsequent surgery is performed by the same surgeon within the global period of a major or minor surgery, regardless of whether the subsequent surgery required a return to the operating room.
      i. If related to the original procedure, it is considered part of the global period.
   D. If the subsequent surgery is related to the initial surgery but does not require a return to the operating room and both are performed by the same surgeon, the subsequent surgery cannot be submitted separately. The global fee for the initial surgery includes additional related surgical procedures that do not require a return to the operating room.
   E. Do not submit modifier 79 on assistant surgery services because global surgery rules do not apply to assistants.
   F. In rare cases where the second surgery performed and is inadvertently submitted to JHHP and paid before the first surgery is submitted to JHHP, providers must submit modifier 79 with the first surgery performed.
   G. Supporting documentation must be maintained in the patient's medical record. The documentation must substantiate that the surgeries are unrelated.

VII. EXCEPTIONS and EXCLUSIONS

Maryland Waiver Providers are required to bill services in accordance to the Health Services Cost Review Commission (HSCRC) rules and regulations, and will be reimbursed under the HSCRC payment methodology.

1. **PPMCO:** Please consult the authoritative guidance found in the Maryland Medicaid Manuals to obtain specific information on policy, benefits, and coverage not addressed in this policy, as JHHP will reimburse services in accordance with MDH guidance.
   i. In alignment with the Maryland Department of Health (MDH), JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
   ii. Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.

iii. Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

2. **USFHP**: JHHP will process and reimburse claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional, specific information on policy, benefits, and coverage, not addressed in this policy.

VIII. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
Global Period/Days Value	Global Period is the time frame that applies to certain procedures subject to a Global Surgical Package concept whereby all necessary services normally furnished by a physician (before, during and after the procedure) are included in the reimbursement for the procedure performed. Modifiers should be used as appropriate to indicate services that are not part of the Global Surgical Package.
Major Surgical Procedure	A procedure having a Global Days Value of 090. To determine the global period for major surgeries, JHHP counts 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.
Medicare Fee Schedule Data Base (MFSDB)	The MFSDB provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.
Minor Surgical Procedure	If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure.To determine the global period for minor surgeries, JHHP counts the day of surgery, and the 10 days immediately following the day of surgery.
Operating Room	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 was so critical there would be insufficient time for transportation to an operating room.

Global Day Period

Global Day Period	Description

0 or 000	Corresponds to endoscopic or minor procedures with related preoperative and postoperative relative value units on the day of the procedure only, included in the fee schedule payment amount. • No pre-operative period • No post-operative days • Visit on day of procedure is generally not payable as a separate service
10 or 010	Corresponds to other minor procedures with preoperative relative values on the day of the procedure and postoperative values during a 10-day postoperative period included in the fee schedule amount. • No pre-operative period • Visit on day of the procedure is generally not payable as a separate service • Total Global Period is 11 days. Count the day of the surgery and 10 days following the day of the surgery.
90 or 090	Corresponds to major surgery with a one-day preoperative period and 90-day postoperative period included in the fee schedule payment amount. • One day pre-operative included • Day of the procedure is generally not payable as a separate service • Total Global Period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery.
XXX	Global concept does not apply. Modifiers 58, 78, and 79 are not considered valid for procedures with this Global Days indicator.
YYY	YYY codes identify contractor-priced codes. CMS MACs determine the global period. The global period for these codes is 0, 10, or 90 days. Example: • CPT 44799: Global Surgery Days = YYY • G0498: Global Surgery Days = YYY

ZZZ	Codes with “ZZZ” are surgical codes, they are add-on codes that are always billed with another service. There is no postoperative work included in the fee schedule payment for the “ZZZ” codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code. Modifiers 58, 78, and 79 are not considered valid for procedures with this Global Days indicator.

Modifier Definitions & Associated Payment Reductions: Modifiers 58, 78, and 79 must be reported in the primary position. When a subsequent modifier is reported that also reduces the fee schedule amount, the respective payment adjustment(s) will be applied after the modifier in the primary position.

Modifier	Definition	Payment Reduction
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period: It may be necessary 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 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 required a return to the operating or procedure room (e.g., unanticipated clinical condition), see modifier 78.*	Covered services paid at 100% of the contracted rate

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. 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 an operating room, it may be reported by adding modifier 78 to the related procedure.	Covered services paid at 85% of the contracted rate.
79	Unrelated Procedure by the Same Physician or Other Qualified Health Care Professional 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.	Covered services paid at 100% of the contracted rate.

IX. REFERENCES

This policy has been developed through consideration of the following:

- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Maryland Medicaid Provider Program Resources and Fee Schedules
- Medicare Claims Processing Manual Chapter 12
- Medicare Physician Fee Schedule Data Base (MPFSDB)
- Medicaid NCCI Policy Manual | CMS
- Medicare NCCI Policy Manual | CMS
- MLN907166 – Global Surgery (cms.gov)
- TRICARE Manual

X. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By

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3/27/2024	*Revision*	Updated: • Policy formatting • About Section • Exceptions & Exclusion Section • Enhanced policy language • Reference table • Codes, Terms, Definition table included	Reimbursement Policy Committee (RPC)