Modifiers for Services and Procedures During the Postoperative Period

Reimbursement Policy ID: RPC.0069.0900

Recent review date: 07/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

When an unplanned return to the operating or procedure room occurs during the postoperative period of another procedure, modifier 58, 78 or 79 must be appended to the appropriate surgical codes for proper reimbursement.

Exceptions

Modifier 58, 78 and 79 is not appropriate for Place of Service (POS) 11 (office).

Reimbursement Guidelines

The health plan recognizes claims submitted with Modifier 78 when an unplanned related return to the operating room occurs during the global period of the original procedure by the same provider or same Tax Identification Number (TIN). Modifier 78 is appended to claims with a global surgical period of 010 or 090 days as determined by the Medicare Physician Fee Schedule (MPFS). (See reimbursement policy RPC.0012.0900 for Global Surgical Package & Split Surgical Care & RPC.0004.0900 Assistant Surgeon).

- The health plan will reduce the reimbursement amount for claims submitted with Modifier 78 to reimburse for the “intraoperative” portion of the procedure only, not including preoperative and postoperative care.

- The health plan recognizes claims submitted with Modifier 79 when an unrelated procedure or service performed by the same provider or same Tax Identification Number (TIN) during the postoperative period.

- Use modifier 58 to report a staged or related procedure or service performed by the same physician during the postoperative period of the initial procedure. Use modifier 58 to report a staged procedure that is planned prospectively at the time of the initial procedure, a staged or related procedure that is more extensive than the original procedure.

Definitions

Modifier 78-Unplanned Return to the Operating/Procedure Room
The 78 modifier is used to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure).

Modifier 79- Unrelated procedure or Service Performed by the Same Physician in the Postoperative Period
Modifier 79 is used to indicate a return to the operating room for an unrelated condition or injury during the postoperative period by the same physician or other Qualified Health Professional.

Modifier 58 - Staged or related surgical procedures
Modifier 58 is used to indicate a staged or related surgical procedure performed by the same physician during the postoperative period of an initial surgery.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare & Medicaid Services (CMS), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.
V. Applicable Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0012.0900 Global Surgical Package & Split Surgical Care
RPC.0004.0900 Assistant Surgeon

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
07/2026	Reimbursement Policy Committee Approval
06/2026	Added additional information for Modifier 78 and 79 • Added modifier 58 • Updated policy name from “Modifier 78” to “Modifiers for Services and Procedures During the Postoperative Period”
09/2025	Reimbursement Policy Committee Approval
08/2025	Biennial Review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
04/2024	Revised preamble
11/2023	Reimbursement Policy Committee Approval