

Modifiers for Services and Procedures During the Postoperative Period

Reimbursement Policy ID: RPC.0069.2400

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 and 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 or unrelated 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).

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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 030 days as determined by the health plans Department of Health and Human Services. See reimbursement policy RPC.0012.2400 for Global Surgical Package & Split Surgical Care & RPC.0004.2400 Assistant Surgeon.

- 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.
- When two separate surgical procedures are performed on the same DOS at different operative sessions, both procedures will be allowed 100% of the established rate. To report, submit the second procedure with modifier 78 or 79. This will ensure that both procedures will be reimbursed at 100% of the established rate. If not reported in this manner, the lower priced of the two procedures will be reimbursed at 50%. All surgical procedures performed on the same DOS must be filed on the same claim form whenever possible.
- 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 the 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. Healthcare Common Procedure Coding System (HCPCS).
- III. International Statistical Classification of Diseases and Related Health Problems (ICD).
- IV. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>
- V. Applicable Medicaid Fee Schedule(s).
- VI. <https://provider.scdhhs.gov/internet/pdf/manuals/Physicians/Manual.pdf>
- VII. <https://provider.scdhhs.gov/internet/pdf/manuals/Medical%20Clinics/Manual.pdf>

Attachments

N/A

Associated Policies

RPC.0012.2400 Global Surgical Package & Split Surgical Care
RPC.0004.2400 Assistant Surgeon

Policy History

09/2026	<ul style="list-style-type: none">Removed the next review dateReplaced the plan name with “the health plan”
07/2026	Reimbursement Policy Committee Approval
04/2026	Added additional information for Modifier 78 and 79 <ul style="list-style-type: none">Added modifier 58Updated Edit sourcesUpdated 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 <ul style="list-style-type: none">No major changes
04/2025	Revised Preamble
05/2024	Reimbursement Policy Committee Approval