Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Modifier 78: Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period

Effective Date: **11/16/18**	Committee Approval Obtained: **11/16/18**	Section: **Coding**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup 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 CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

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

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

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, Amerigroup allows reimbursement for claims billed with Modifier 78 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 percent 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** and does not include 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.
	
	Nonreimbursable
	Amerigroup 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

Exemptions	• There are no exemptions to this policy.
History	• Biennial review approved and effective 11/16/18: Policy language updated; • Biennial review approved 11/07/16 • Biennial review approved 10/31/14 • Biennial review approved 5/24/11 and effective 7/24/11: History and Definitions sections updated; policy template updated • Review approved 10/20/08: Modifier definition/History section/policy template updated • Review approved 03/27/07 • Initial approval 05/22/06 with effective date of 10/01/06
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts • Optum Learning: Understanding Modifiers, 2014 edition • The Essential RBRVS, 2014 edition

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	• Assistant at Surgery (Modifiers 80/81/82/AS) • Modifier Usage • Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	• None