LifeWise Assurance Company

Payment Policy

cmi_051765

Title	**Modifier 58 - Staged or Related Procedure or Service by Same Physician or Other Qualified Healthcare Professional during Postoperative Period**		
Number	**CP.PP.238.v2.4**		
Last Approval Date	09/04/24	**Original Effective Date**	10/01/04
Replaces			
Cross Reference	• *Modifier 76 – Repeat Procedure by the Same Provider* • *Modifier 78 – Unplanned return to the Operating Room for a Related Procedure* • *Modifier 79 – Unrelated Procedure/Service by the Same Provider During Postoperative Period* • *Multiple Surgical Reductions* • *Global Surgery*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services appended with Modifier 58 that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Policy	The Plan recognizes modifier 58 appended to a service to indicate a staged or a related subsequent **pre-planned** procedure was performed during the global period of the initial surgical procedure **by the same physician or same other qualified healthcare professional who performed the initial procedure**. Appending modifier 58 to another surgical service breaks the global period of the first procedure and resets the global period based on the subsequent staged procedure. Documentation in the member's medical chart or records must indicate **prospective plans** for returning the patient to the operating room for additional procedures during the global period of the initial surgery. Modifier 58 should not be used on procedure codes which indicate in their description "one or more sessions" (e.g., codes 41530, 66762, 67208, 67210, 67218, 67220 and 67229). These codes are defined by their CPT code description as consisting of one or more subsequent sessions and the Relative Value Units (RVUs) attached to such codes already reflect the multiple sessions. When it is necessary to indicate that a basic procedure or service was **repeated** by the same physician or same other qualified healthcare professional after the original procedure or service, modifier 76- *Repeat Procedure by the Same Provider* should be added to the service. For treatment of a problem or complication that requires an **unplanned** return trip to the operating room for a **related** surgical procedure by the same physician or same other qualified healthcare professional during the postoperative period, modifier 78- *Unplanned return to the Operating Room for a Related Procedure* should be added to the service.

	For treatment of a problem or complication that requires a **return trip to the operating room for an unrelated surgical procedure by the same physician or other qualified healthcare professional** during the postoperative period, modifier 79- *Unrelated Procedure/Service by the Same Provider During Postoperative Period* should be added to the service. Modifier 58 should **never** be billed with modifier 78 or 79 on the same service. Multiple surgical reductions may be applied when more than one surgery is rendered during the subsequent return trip to the operating room.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None
References	• American Medical Association's Current Procedural Terminology (AMA/CPT); Professional Edition codebook • The Centers for Medicare and Medicaid Services (CMS) • National Correct Coding Initiative (NCCI) guidelines

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	09/04/24; 12/13/23; 01/17/23; 02/10/22; 02/25/21; 03/05/20; 04/08/19; 04/19/18; 07/18/17; 08/08/16; 08/10/15; 08/10/14; 08/15/13; 08/19/12; 08/29/11; 11/22/09; 01/29/09; 06/09/07; 05/05/06; 11/06/05; 08/29/05; 10/21/04	
Version History	04/19/18	Annual review; no changes
	04/08/19	Annual review; no changes
	03/05/20	Annual review; no changes
	02/25/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms. Added code examples for procedure codes with "one or more sessions" in their code descriptions. Further clarified when the use of modifiers 78 and 79 are more appropriate.
	02/10/22	Annual review; no changes
	01/17/23	Annual review; no changes
	12/13/23	Annual review; no changes
	09/04/24	Annual review; no changes

This policy was published on September 09, 2024