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Reimbursement Policy
Modifier 78

Policy Number: **G-13001**
Policy Section: **Coding**
Last Approval Date: **9/11/2025**
Effective Date: **9/11/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to https://provider.wellpoint.com.

Policy

The health plan allows reimbursement for claims billed with modifier 78 unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise, 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% of the fee schedule or the 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, not including preoperative or postoperative care. Procedures rendered during the postoperative period and not billed with modifier 78 are normally not eligible for reimbursement as included in the global surgical package.

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When an assistant surgeon is used during the global period in the same operative session, assistant surgeon rules apply.

Nonreimbursable
We do not allow reimbursement for modifier 78 billed in the following circumstances, including, but not limited to:

- With non-surgical codes.
- With codes denoting *subsequent*, *related*, or *redo* in the description.

Related Coding

Standard correct coding applies.

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.

Related Policies and Materials

- Global Surgical Package
- Modifier Usage
- Modifiers 50 and 51: Multiple and Bilateral Surgery
- Modifiers 80, 81, 82, and AS: Assistant at Surgery

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Medicare Physician Fee Schedule Data Base (MPFSDB)
- Optum EncoderPro 2025
- State contract

Policy History

- **09/11/2025 -** Review approved and effective: updated Related Policies and Materials section to include “Global Surgical Package””
- **09/27/2023 -** Review approved and effective: removed “Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period” from the policy title; changed reimbursement “based on a percentage calculated by the MPFSDB” to “based on 70% of the fee schedule or contracted/negotiated rate”
- **11/16/2018 -** Review approved: policy language
- **11/07/2016 -** Review approved: policy template updated
- **01/01/2015 -** Initial approval

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.