PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_051729

Title	**Modifier 79 – Unrelated Procedure/Service by Same Provider during Postoperative Period**		
Number	**CP.PP.147.v2.9**		
Last Approval Date	08/12/24	**Original Effective Date**	12/01/12
Cross Reference	• *Multiple Surgical Reductions* • *Multiple Endoscopy Procedure Reductions* • *Global Surgery* • *Modifier 58 – Staged or Related Procedure or Service by Same Physician or Other Qualified Healthcare Professional During Postoperative Period* • *Modifier 78 – Unplanned return to the Operating Room for a Related Procedure by the same Physician or Other Qualified Healthcare Professional During the Postoperative Period*		

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 Modifier 79 that is 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 79 when appended to a surgical service to indicate that a completely **unrelated** procedure or service was performed during the postoperative period by the same physician or other qualified healthcare professional that rendered the **original procedure.** Documentation in the patient's medical record must clearly indicate that the subsequent surgical procedure is **unrelated to the prior original surgery**. The new unrelated procedure is usually linked to a different diagnosis. A new post-operative period will then begin for the unrelated procedure. Modifier 79 is not appropriate when billing procedures that are performed on dates of service **following an initial procedure with 0-days global period.** Modifier 79 is appropriate when billing procedures performed on dates of service **following an initial procedure with 10-days or 90-days global period** as defined in the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule. Modifier 79 should not be appended to Evaluation and Management (E&M) codes or ambulatory surgery center (ASC) facility services billed on a CMS-1500 claim form. If the subsequent surgery is **related** to the initial surgery requiring a return to the operating room, and both the subsequent and original surgeries are performed **by the same provider,** the subsequent procedure must be billed with modifier 78-*Unplanned return to the Operating Room for a Related Procedure by the same Physician or Other Qualified Healthcare Professional During the Postoperative Period*.

	Staged or pre-planned procedures should be billed with modifier 58-*Staged or Related Procedure or Service by Same Physician or Other Qualified Healthcare Professional During Postoperative Period*. Multiple surgical reductions may be applied to applicable services billed when multiple surgical procedures are billed for the same patient by the same provider on the same day. Modifiers 58, 78 and 79 do not bypass the usual multiple procedure fee reductions, bilateral fee adjustments, assistant surgeon fee adjustments, or any other applicable adjustments which may apply. Modifier 58, 78 and 79 cannot be billed together on the same procedure code. These modifiers are mutually exclusive and only one of these modifiers may be appended.
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 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(CPT), Professional Edition

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	08/12/24; 11/09/23; 12/07/22; 01/07/22; 01/27/21; 02/10/20; 02/18/19; 02/27/18; 04/10/17; 05/23/16; 05/30/15; 06/08/14; 06/09/13; 06/10/12; 07/05/11; 07/04/10; 08/10/09; 10/10/08; 09/24/07; 08/28/06; 08/29/05; 05/31/05; 10/08/04; 03/29/04; 03/29/03; 07/18/00	
Version History	02/27/18	Added paragraph to indicate modifiers 58, 78 and 79 do not bypass fee adjustments
	02/18/19	Added to first paragraph that documentation in medical record is needed to indicate the procedure is unrelated to original surgery
	02/10/20	Added second and seventh paragraphs indicating scenarios when modifier 79 should not be billed
	01/27/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms
	01/07/22	Annual review; no changes
	12/07/22	Annual review; no changes
	11/09/23	In the Policy section, added further clarification on correct coding for modifier 79 in the first, second and last paragraphs.
	08/12/24	In the Policy section, added the third paragraph to indicate that modifier 79 is not valid following an initial procedure with 0-day global period

		and is valid following an initial procedure with 10-days or 90-days global periods as noted in the CMS National Physician Fee Schedule.

This policy was published on August 15, 2024