healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Modifier Usage for Distinct Procedure and Global Surgery Services		
Policy Number:	PO-RE-071v2		
Effective Date:	9/1/2023	**Last Approval Date:**	6/30/2026

I. Policy Description

Modifiers have been defined by the American Medical Association (AMA) and adopted by the Centers for Medicare and Medicaid Services (CMS) to provide additional information regarding the services rendered. The National Correct Coding Initiative (NCCI) Policy Manual also provides directions on modifier use:

Modifiers may be appended to HCPSC/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use (Medicare NCCI Policy Manual, January 2023, pg. I-12The program considers the information on the claim, and in the patient's claim history, to determine if the modifier has been used correctly. Modifiers 24,58, 59, 78, 79 XE, XS, XP and XU comprise many of the overriding modifiers appended to services. The program evaluates the correct use of overriding modifiers.

The information below applies to the following lines of business:

• Child Health Plus (CHP)	• Essential Plan (EP)
• Integrated Benefit Dual Plan (IB-Dual)	• Medicaid Advantage Plus/MAP (CompleteCare)
• Medicaid Managed Care (MMC)	• IB Dual
• Medicare Advantage HMO	• Personal Wellness Plan (HARP)
• Medicare PPO	• Qualified Health Plan (QHP)

Initial Claims Reimbursement

a. *Distinct Procedural Services: Modifiers 59, XE, XP, XS, or XU*: CMS established the National Correct Coding Initiative (NCCI) program to ensure the correct coding of services. NCCI Procedure-to Procedure (PTP) edits prevent inappropriate payment of services that should not be reported together. Each edit has column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI PTP-associated modifier, both column one and column two codes are eligible for payment. (Linker & Grider, 2020).

b. *Global Surgery Services: Modifier 24 & 57*: An Evaluation & Management service performed within the global period of a procedure is included in the payment of the original surgical procedure unless the appropriate modifier is appended, and modifier requirements are met. For major and minor surgical procedures, postoperative Evaluation & Management services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are Evaluation & Management services related to complications of the surgery. Routine follow-up care for the procedure is included in the global services package unless the treating patient is returned to the OR, or is treated for an unrelated condition. (Medicare NCCI Policy Manual, January 2023, Page I-11)

c. *Global Surgery Services: Modifier 58,78 & 79*: The global surgical package as defined by CMS and AMA includes all services routinely performed by the provider or group during the preoperative, intraoperative, and postoperative period of the surgery. A procedure performed in the global period of a previous procedure is included in the payment of the original surgical procedure unless the appropriate modifier is appended, and modifier requirements are met. ***Modifier 58*** indicates a staged or related procedure or service by the same provider during the postoperative period. ***Modifier 78*** indicates an unplanned return to the operating or procedure room by the same provider following the initial procedure for a related procedure during the postoperative period. ***Modifier 79*** indicates an unrelated procedure or service by the same provider during the postoperative period.

Adjudication and Appeal Process

1. Reimbursement for Modifier Usage services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. If Healthfirst determines that the applicable electronic or paper claims billed without the correct modifier in the correct format may be rejected or denied. The modifier must be in capital letters if alpha or alphanumeric. Rejected or denied claims must be resubmitted with the correct modifier in conjunction with the code-set and diagnosis codes to be considered for reimbursement. Corrected and resubmitted claims are subjected to timely filing guidelines. The use of correct modifiers does not guarantee reimbursement.

3. If you have claims that you believe are incorrectly processed due to the incorrect use of modifiers, please refer to the Healthfirst provider manual for appeal instructions. Additional information can be found in the CPT book and NCCI manuals on CMS's website regarding the appropriate use of modifiers.

4. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17, "Billing & Claims Processing".*

II. Applicable Codes

Code	Description	Comment
Modifier 24	Used to identify unrelated Evaluation and Management services by the same provider during the postoperative period of a procedure.	
Modifier 57	Used to identify a decision for surgery. This modifier is only used with an E/M service	
Modifiers 58	Staged or Related Procedure by the same physician or other qualified health care professional during the postoperative period	
Modifier 59	Distinct Procedural Services	Allows separate reimbursement for procedures that would otherwise deny per code editing. If the code being billed is subject to multiple surgery procedure reimbursement reduction, the applicable reduction will also apply.
Modifier XE	Separate encounter, a service that is distinct because it occurred during a separate encounter	
Modifier XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner.	
Modifier XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure	
Modifier XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service	
Modifiers 78	An unplanned return to the operating or procedure room by the same provider following the initial procedure for a related procedure during the postoperative period.	
Modifiers 79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	

III. Definitions

Term	Meaning
NCCI	National Correct Coding Initiative
PTP	Procedure-to Procedure
E/M	Evaluation & Management

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Medicare NCCI Policy Manual
HCPCS Release & Code Sets | CMS

VI. Revision History

Revision Date	Summary of Changes
5/11/2026	**Annual Review:** Policy reviewed as part of the annual review process; no substantive changes to policy intent. **Adjudication Section:** Updated the adjudication section to include standard organizational boilerplate language and messaging. **Line of Business Section:** Updated the Line of Business (LOB) section to

	align with the organization's standard LOB language and format.

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.