PREMERA BLUE CROSS
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# Payment Policy

cmi_162302

| Title | Global Surgery | | |
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| Number | CP.PP.389.v2.1 | | |
| Last Approval Date | 10/03/24 | Original Effective Date | 08/10/14 |
| Cross Reference | • *Modifier 24 – Unrelated E&M Service by the Same Physician in the Postoperative Period*<br>• *Modifier 25 – Significant, Separately Identifiable Evaluation and Management (E&M) Service on the Same Day of a Procedure or Other service*<br>• *Modifier 54/55/56 – Surgical Care Only / Postoperative Care Only / Preoperative Care Only*<br>• *Modifier 57 – Decision for Surgery*<br>• *Modifier 58 – Staged or Related Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During Postoperative Period*<br>• *Modifier 76 – Repeat Procedure or Service by Same Physician or Other Qualified Healthcare Professional*<br>• *Modifier 77 – Repeat Procedure by Another Physician or Other Qualified Healthcare Professional*<br>• *Modifier 78 – Unplanned Return to the Operating Room for a Related Procedure*<br>• *Modifier 79 – Unrelated Procedure or Service by the Same Provider During Postoperative Period*<br>• *Multiple Surgical Reductions* | | |

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.

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| **Purpose** | To identify how the Plan defines "global surgical periods" for procedures 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** | Global surgery or global surgical package is a period that starts either with the day of or the day before the procedure and ends sometime after the procedure based on whether the procedure is classified as a minor or major procedure.<br><br>The global surgical package/global surgery includes all necessary services that are normally furnished by a provider before (preoperative), during (intraoperative) and after (postoperative) the procedure.<br><br>Global surgery applies to any applicable procedure performed in an inpatient or outpatient hospital, ambulatory surgery center or a provider's office setting. A single reimbursement is made for all care associated with a global surgical package.<br><br>The Plan primarily utilizes as its main source, the "Global Days indicator flag" as established in the current version of the National Physician Fee Schedule (NPFS), maintained by the Centers for Medicare and Medicaid Services (CMS), to determine whether a procedure code does/does not have a specified global surgery period. (LINK) |

The Plan recognizes the following "global days indicator flags" which indicate specific global day periods:

- **<u>000 days Postoperative Period (simple/minor procedures, endoscopies)</u>**
  - No preoperative period and no postoperative period
  - A visit on the day of the procedure is not payable as a separate service
  - Global period is the day of the procedure

- **<u>010 days Postoperative Period (minor procedures)</u>**
  - No preoperative period
  - A visit on the day of the procedure is considered part of the procedure and not payable as a separate service
  - The total global period is 11 days: the day of procedure as 1 day and 10 days immediately following the day of the procedure
  - Services rendered during this 11-day period which are related to the original minor procedure are considered part of the global payment made for the minor procedure and are not billable/payable as a separate service.

- **<u>090 days Postoperative Period (major surgical procedures)</u>**
  - One day preoperative period included in the procedure
  - Visit on the day of the procedure is considered part of the procedure and not payable as a separate service
  - The total global period is 92 days: count 1 day before the procedure, 1 day as the day of the procedure and 90 days immediately following the procedure
  - Services rendered during this 92-day period which are related to the original major procedure are considered part of the global payment made for the initial major surgical procedure and are not billable nor payable as a separate service

- **<u>Other "global surgical" indicator flags:</u>**

  - **<u>MMM – Maternity codes</u>**
    - Usual global periods do not apply. Global periods are carrier/Plan determined
    - The Plan applies the following global periods to these "MMM" designated codes:

| Global Period | Codes |
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| 49 days | 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 |
| 0 (zero) days | 59409, 59412, 59414, 59514, 59612, 59620 |
| Concept not applicable | 59425, 59426, 59430 |

  - **<u>XXX – Global periods do not apply</u>**

- **YYY – Carrier/Plan determined**: Carrier/Plan determines whether the global periods apply and establishes postoperative period (on a case-by-case basis)

- **ZZZ – Related to another service (Add-on codes)**:
  - No postoperative work is included in these codes.
  - These are codes which are related to another primary service, and which are always included in the global period of the primary service
  - Global period is assigned to the Primary Code only

**Services Included in the Global Surgery Payment**

The Plan considers the following services to be "included" in the global surgery payment and are not eligible for separate reimbursement:

- For **major surgical procedures**, related preoperative visits after the decision is made to operate (e.g., pre-operative visits the day before surgery)
- For **minor procedures**, the decision to perform a minor procedure is included in the minor procedure, unless a significant and separately identifiable E&M service unrelated to the decision for the minor surgery is rendered
- Intraoperative services that are a part of the surgical procedure
- All medical and surgical services the surgeon provides during the postoperative period, which are the result of complications which do not require a return trip to the Operating Room
- Services of other physicians from the same clinic as the original surgeon (all under the same Tax Identification Number (TIN)) and specialty
- Follow up visits, such as E&M, care management and transitional care management, in a postoperative period that are **related** to the recovery from the initial surgery
- Supplies for postoperative surgical complications or treatments
- Postoperative pain management **by the surgeon** unless the complexity is outside the scope of the surgeon
- Miscellaneous surgical supplies and services such as dressing changes, incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes; changes and removal of tracheostomy tubes
- Local infiltration, digital blocks, or topical anesthesia
- Immediate post-operative care
- Writing orders
- Evaluating patients in post-anesthesia recovery
- Medical/Surgical services required by surgeon during the post-operative period

**Services Not Included in the Global Surgery Payment**

The Plan excludes the following services from the global surgery payment and eligible for separate reimbursement when billed:

- Initial consultation or evaluation of the problem by the provider to determine the need or decision for a major surgical procedure identified with an appropriate modifier
- Services of other physicians **not in the same clinic/same specialty and same TIN** as the primary surgeon that are related to the procedure and identified with an appropriate modifier
- **Visits unrelated to the diagnosis of the procedure** to be performed as identified with an appropriate required modifier
- Treatment of underlying conditions or added course of treatment which are not related to the procedure as identified with an appropriate modifier
- Diagnostic tests and procedures (e.g., diagnostic radiologic procedures)
- **Clearly distinct surgical procedures** that occur in postoperative period are not re-operation or treatment for complications as identified with an appropriate modifier
- Treatment for postoperative complications that **necessitate a return to the Operating Room**
- Immunosuppressive therapy for organ transplants
- Critical care services (CPT 99291, 99292) **unrelated** to the surgery
- Failed less extensive initial procedure(s) which subsequently requires a more extensive procedure as identified with an appropriate modifier.

**Unrelated E&M service by the Same Physician in the Post-Operative Period: Modifier 24**

When an E&M or eye examination service is rendered for an **unrelated service** that is provided by the same physician or other qualified healthcare professional during the postoperative global surgical period, *modifier 24 – Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional during a Postoperative Period* must be appended to the E&M service.

This **unrelated service** must be clearly documented in the patient's medical record to establish how the visit is **unrelated** to the condition that initially required the surgery.

Do not append modifier 24 on an E&M visit or eye exam service related to:

- A surgical complication or infection which does not require a return trip to the Operating Room;
- The removal of sutures or other wound treatment which are all considered part of the global surgical package;
- A service rendered on the same date as the surgical procedure; or
- A routine postoperative exam

**Significant, Separately Identifiable E&M Service on the Same Day of a Procedure or Other Service: Modifier 25**

When a separately identifiable E&M service is performed by the same physician or other qualified healthcare professional on the same date of service of a procedure or other service, and that E&M represents a significant and separately identifiable service **above and beyond the usual preoperative and postoperative care associated with the procedure performed,** *modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional on the Same Day of the Procedure or other Service* must be appended to the E&M service.

Modifier 25 is not appended to an E&M service that resulted in the decision to perform a major surgery (90-day global period) or to an E&M service performed on the same day as a minor surgical procedure (00 or 10-day global period) when the **sole reason** for the patient encounter was for the performance of a minor procedure.

The use of modifier 25 indicates that the patient's medical record documents that the service being billed is a significant and separately billable service, above and beyond the usual preoperative and postoperative care associated with the procedure performed.

Appending modifier 25 to an E&M service will not automatically allow payment of the E&M service that is submitted with another procedure or service performed on the same date of service unless the documentation supports the significant, separate and distinct nature of the E&M service.

**Performing "partial global package" services: Modifiers 54, 55 and 56**

An appropriate modifier must be used when a physician or other qualified healthcare professional furnishes **only a portion of a global surgical package** and relinquishes other portion(s) of the surgical package to another physician or other qualified healthcare professional **belonging to a different practice**.

Each of the physicians or other qualified healthcare professionals involved in the care to the member must bill the same surgical procedure code, the same date of service of the surgery and identify their portion of the surgical package using the following modifiers:

- **Modifier 54 –** ***Surgical Care Only***
  - This modifier is used to indicate that a physician or other qualified healthcare professional performed **only the surgical care,** and another physician or other qualified healthcare professional performed the preoperative or postoperative care, each provider belonging to a different practice
  - Services rendered by Emergency Room providers who perform a minor or major global surgical procedure (10 and 90 days respectively) in the ER should append this modifier to their services since the member is not expected to receive postoperative care in the ER setting
  - Modifier 54 does not apply to assistant-at-surgery services or any Ambulatory Surgery Center **facility fees**
- **Modifier 55 –** ***Postoperative Management Only***
  - This modifier is used to indicate that a physician or other qualified healthcare professional other than the initial surgeon performed **only the postoperative care** and another physician or other

qualified healthcare professional performed the surgical care, each provider belonging to a different practice
    - The date of the surgery is the service date and indicates when postoperative care was transferred to another physician
    - Modifier 55 does not apply to assistant-at-surgery services or any ASC facility fees
    - Modifier 55 is appended to procedure codes with global periods of 10 or 90 days
- **Modifier 56 – *Preoperative Management Only***
    - This modifier is used to indicate that a physician or other qualified healthcare professional performed **only the preoperative care** and other physicians, or other qualified healthcare professional performed the surgical care, each provider belonging to a different practice
    - Modifier 56 is appended to procedure codes with global periods of 10 or 90 days

**Initial Decision to Perform Surgery: Modifier 57**

When an E&M visit is performed that results in the **initial decision** to perform **major surgery with a 90-day global period**, *modifier 57 – Decision for Surgery* must be appended to the E&M visit which may occur the day before or the day of a major surgery. The decision for surgery, made during the preoperative period, must be documented in the medical records for the E&M visit.

Modifier 57 should not be appended to an E&M code on the same day as a **minor procedure** (0- or 10-day global period). The E&M is considered **part of preoperative care** and is included/bundled into the global fee for the minor procedure. In contrast, the preoperative period for a **major procedure** is defined as the day before and the day of the procedure.

Modifier 57 should not be added to an E&M service which **sole purpose** is to render a preoperative evaluation.

**Staged Procedures During Global Period: Modifier 58**

When an additional anticipated pre-planned or more extensive subsequent surgical procedure is rendered during a postoperative period and that additional procedure is a **related planned or staged procedure to the initial surgery,** performed by the same physician as the initial procedure, the subsequent or staged procedure must be appended with *modifier 58 – Staged or Related Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period*.

This modifier indicates that the physician who performed the initial procedure prospectively planned to return the patient to the operating room for an additional procedure(s) during the initial global period of the first surgery. Modifier 58 is not used on procedures whose code descriptions already indicate multiple sessions or procedures.

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.

Appending modifier 58 to a staged or related procedure breaks or terminates the global period of the first procedure and resets the global period calculation based on the subsequent or staged procedure.

Modifier 58 should never be billed with modifier 78 or 79 on the same service.

**Repeat Procedure by the Same Provider: Modifier 76**

When it is necessary to repeat the same identical service or procedure by the **same physician or other qualified healthcare professional for the same patient**, often but not always, on the same day but as a separate and distinct subsequent session, during the global period of the initial procedure, these services must be appended with *modifier 76 – Repeat Procedure or Service by the Same Physician or other Qualified Healthcare Professional.*

Modifier 76 is not appropriate for surgical codes that already indicate multiple procedures on the same date of service according to their code descriptions. Modifier 76 should NOT be appended to the same procedure code already appended with modifier 77, 78 or 79. Documentation must support the need for repeating the same service/procedure by the same provider.

**Repeat Procedure by Another Provider: Modifier 77**

When it is necessary to repeat the same identical service or procedure by a **different physician or qualified healthcare professional for the same patient**, often but not always, on the same day, but at a separate and distinct subsequent session, during the global period of the initial procedure, these services mut be appended with *modifier 77 – Repeat Procedure by Another Physician or Other Qualified Healthcare Professional.*

Modifier 77 should NOT be appended to the same procedure code already appended with modifier 76, 78 or 79. Documentation in the medical record should indicate the need to repeat the same procedure or service by another provider.

**Unplanned Return to the Operating Room for Related Procedure During the Global Period: Modifier 78**

When an **unplanned return** to the operating room for either treatment for postoperative complications related to the original surgery or a surgery **related to the original surgery** which started the postoperative period, occurs within a 10-day or 90-day global period, these services must be appended with *modifier 78 – Unplanned Return to the Operating Room by the Same Physician or Other Qualified Healthcare Professional Following Initial Procedure for a Related Procedure During the Postoperative Period*.

The decision for an **unplanned return** to the operating room is made by the same physician or other qualified healthcare professional that performed the initial surgery.

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| | Unplanned unrelated surgeries submitted with modifier 78 do not restart or begin a new global period.<br><br>Documentation in the medical record must support the need for an unplanned return to the Operating Room for a related procedure.<br><br>**Unrelated Surgical Procedure During the Global Period: Modifiers 79**<br><br>When a provider who performs an initial procedure or service that has a 10 or 90 day postoperative global period, performs an additional procedure or service during the postoperative global period of the initial procedure that is **unrelated to the original procedure** (typically at a different anatomic location) that started the global period, the physician or other healthcare professional must submit the services with *modifier 79 – Unrelated Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period*.<br><br>Modifier 79 is not appropriate when billing procedures that are performed on dates of service **following an initial procedure with a 0-days global period**. Modifier 79 is appropriate when billing procedures performed on dates of service **following an initial procedure with a 10-day or 90-day global period** as defined in the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS).<br><br>Documentation in the patient's medical record should clearly indicate that the subsequent surgical procedure is unrelated to the prior original surgery.<br><br>Modifier 79 is only appended during the global period of an initial unrelated procedure. Overlapping global periods are created as a result.<br><br>Modifier 79 should not be appended to the same service/procedure code already appended with modifier 58 or 78.<br><br>**Multiple Procedure Reductions**<br><br>When multiple surgical procedures are billed for the same patient by the same provider on the same date of service, multiple procedure reductions may be applied to applicable services billed, based primarily on the current CMS NPFS "Multiple Procedure Flag" 2 – Standard payment adjustment rules for multiple procedure apply. (LINK) |
| **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.<br><br>Violations of this policy may be grounds for corrective action, up to and including termination of employment. |
| **Exceptions** | |
| **Laws, Regulations & Standards** | None |

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| **References** | • American Medical Association's Current Procedural Terminology, (AMA/CPT) Professional edition, codebook<br>• Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File (NPFS)<br>• American Academy of Orthopedic Surgeons (AAOS)<br>• American College of Obstetrics and Gynecology (ACOG)<br>• CMS Publication 100-04-Claims Processing Manual, Chapter 12, Section 40<br>• CMS MLN Booklet MLN907166-Global Surgery, December 2023 |

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| **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** | 10/03/24; 01/16/24; 03/13/23; 11/07/22; 12/02/21; 12/30/20; 01/10/20; 01/10/19; 02/06/18; 06/13/17; 06/26/16; 08/10/15; 08/10/14 | |
| **Version History** | 02/06/18 | • Clarification of the 000/010/090 global days sections; Clarification of the ZZZ-add-on codes section;<br>• Added statement regarding services from providers under the same Tax ID# as the primary surgeon and added clarification on how to bill services unrelated to the original surgery |
| | 01/10/19 | Annual Review; no changes |
| | 01/10/20 | Corrected the description of global surgery flag "ZZZ" |
| | 12/30/20 | • Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms<br>• Added link to National Physician Fee Schedule in the Policy statement<br>• Added clarification to the Modifiers 24 and 25 segment regarding "minor" surgical procedures |
| | 12/02/21 | Add Cross References to Modifier 76 and 77 Payment Policies<br>Inserted a new paragraph in the Policy section on Modifier 76 and 77 to address repeated procedures by the same or another provider |
| | 11/07/22 | • Services Included in the Global Surgery Payment section: revised the first bullet and added the second bullet<br>• Modifier 54 section: added second bullet on the use of Modifier 54 by Emergency Room providers who perform minor or major surgery in the ER<br>• Modifier 57 section: added clarification on the need for documentation in medical records to support decision for surgery<br>• Modifier 24 section: created a new section for modifier 24. Added bullet points of examples when modifier should not be appended<br>• Modifier 25 section: created a new section for modifier 25. Added clarification on when modifier 25 is valid. Added a paragraph from the Modifier 25 Policy indicating appending modifier 25 does not automatically allow for payment unless documentation supports a separate and distinct service<br>• Modifier 58 section: added a paragraph indicating that documentation in the medical record indicates plans to return patient to the Operating Room<br>• Modifier 76 section: created a new section for modifier 76. Added reference that documentation supports the need to repeat the procedure |

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| | | • Modifier 77 section: created new section for modifier 77<br>• Modifier 79 section: added a statement on the need for the documentation to support that the procedure is unrelated to the original surgery<br>• Multiple Procedure Reduction section: added a link to the CMS National Physician Fee Schedule |
| | 03/13/23 | In the Policy section, added the following clarifications:<br>• Clarified in the fourth and fifth paragraphs the name of the "Global Days" indicator flag used from the CMS National Physician Fee Schedule<br>• Under the "010-minor surgery" section, added the fourth bullet similar to the fourth bullet under the "090-major surgical procedures" section.<br>• IN the section for Modifier 24, removed duplicate sub-bullets |
| | 01/16/24 | In the Policy section, added the following:<br>• In the section "Other Global Surgical Indicator Flag", added the third bullet to the subsection "ZZZ-Related to another service"<br>• In the section "Services Included in Global Surgical Payment", minor clarifications added to the first, fourth and ninth paragraphs<br>• In the section "Services Not Included in the Global Surgery Payment", added the last bullet<br>• In the section on Modifiers 54, 55, and 56 section, added additional clarification to the second paragraph middle of the sentence<br>• In the Modifier 54 sub-section, added the third bullet<br>• In the Modifier 55 sub-section, added the second, third and fourth bullets<br>• In the Modifier 56 sub-section, added the second bullet<br>• IN the Modifier 57 section, minor clarification to the second sentence<br>• In the Modifier 76 section, in the last paragraph, added the last sentence referencing supporting documentation in the records for the modifier<br>• In the Modifier 77 section, in the second paragraph, added the first sentence<br>• In the Modifier 78 section, added the third paragraph referencing supporting documentation in the records for the modifier<br>• In the Modifier 79 section, added the fourth paragraph |
| | 10/03/24 | In the Policy section, the following updates were made:<br>• In the Services Included in the Global Surgery Payment section, the last five bullets are added.<br>• In the modifier 25 section, in the second paragraph, the global day periods added for both the major and minor procedures<br>• In the modifier 57 section, the 90-day global period statement added to major surgery and added the second paragraph<br>• In the modifier 76 section, deleted the reference to documentation in the first paragraph since it was also stated in the second paragraph<br>• In the modifier 78 section, deleted a paragraph that referenced adjustment to reimbursement to reflect an unplanned return to the operating room<br>• In the modifier 79 section, added the second paragraph |

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| | | • In the Multiple Procedure Reductions section, added that Multiple Procedure Flag indicator code “2” is used to identify those procedures that are subject to multiple procedure reductions |