SURGERY MODIFIERS & GLOBAL PERIOD

Coding Surgical Procedures-General Guidance on Surgical Modifiers

Global Surgery Coding and Billing Guidelines

- Physicians who furnish the surgery and furnish all the usual pre-and post-operative care may bill for the global package by entering the appropriate surgical procedure CPT code. Separate billing is not allowed for visits or other services that are included in the global package.
- When different physicians in a group practice (same specialty) participate in the care of the patient, the group practice bills for the entire global package. The physician who performs the surgery is reported as the performing physician.

Multiple Surgeries

- Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.
- The multiple procedure payment reduction will be applied based on the Medicare Physician Fee Schedule (MPFS) approved amount and not on the charge amount from the providers. *The major surgery may or may not be the one with the larger amount charged*.
- Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.
- There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (for example, in some multiple trauma cases). When this occurs, the payment adjustment rules for multiple surgeries may not be appropriate.

Billing for Bilateral Procedures

- The terminology for some procedure codes includes the terms “bilateral” (such as code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or “unilateral or bilateral” (for example, code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as “bilateral” or “unilateral or bilateral” since the fee schedule reflects any additional work required for bilateral surgeries.
- If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier “-50.” They report such procedures as a single line item.
- If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, physicians do not report the procedure with modifier “-50.”
- *Payers may differ in the way they require the bilateral procedures to be reported*

Bundled Services Overview

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. The coding policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

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Example:
CMS has a spreadsheet indicating bundled codes:

Column1/Column 2 Edits											
Column 1	Column 2	*=in existence	Effective	Deletion	Modifier	PTP Edit Rationale					
		prior to 1996	Date	Date	0=not allowed						
				*=no data	1=allowed						
					9=not applicable						
21346	64550		20090401	20090401	9	Standards of medical / surgical practice					
21346	69990		20000605	*	0	Misuse of column two code with column one code					
21346	90760		20060101	20081231	1	Standards of medical / surgical practice					

In some cases, use of a modifier to indicate a separate: site, session, practitioner, or unusual non-overlapping circumstances (modifiers XS, XE, XP, XU or 59) is allowed only when supported by documentation.

When another modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

In other cases, a modifier is not allowed, and the codes may not be billed together (circumstances may vary, but it is usually for same day procedures).

Unrelated E/M Service

When a patient is seen for a problem that is unrelated to a recently performed procedure, for which the global period is still active, a modifier may be used to indicated that the encounter is unrelated.

24 - The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

> **Example:** A patient has an incision and drainage of pilonidal cyst CPT10080 on 1/15 in the office by his Primary Care Provider. On 1/19 returns to his Primary Care Provider to ask about a mole on his arm that he just noticed changed in appearance. The physician would be able to bill for the 1/19 encounter using modifier 24 despite the having just billed 4 days earlier for an I&D of a pilonidal cyst, which has a 10-day global period.

Modifiers-Decision for Surgery

When a procedure is performed the same day or one day after the decision for *major surgery* (90 day global) is made, use modifier 57 with the E/M code for the encounter during which the decision was made.

57 - An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

Modifiers-Reduced Procedures

52 - Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. When a service or procedure is partially reduced or eliminated

> **Example:** The only code describing the procedure has a bilateral definition, but it is performed unilaterally
> **Example:** An endometrial biopsy that could not be completed due to a stenotic cervix), a modifier is provided to indicate that the service performed does not meet the whole definition of the code

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Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled due to extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

Modifiers–Discontinued Procedure

When a procedure is discontinued prior to completion there are different modifiers depending on who is us reporting the procedure (physician or facility) and when it is discontinued. When reporting these modifiers, it is necessary to document the reason for discontinuing the procedure.

53 - Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to *extenuating circumstances or those that threaten the well-being of the patient*, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure.

Example: Patient requests insertion of an IUD. After consent, Dr Y attempts to insert a copper IUD. Dr. Y tries to insert IUD several times, but the patient has a stenotic cervical Os and is having pain. Dr. Y desists.

Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled due to *extenuating circumstances or those that threaten the well-being of the patient* prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

73 - Due to *extenuating circumstances or those that threaten the well-being of the patient*, the physician may cancel a surgical or diagnostic procedure after the patient's surgical preparation (including sedation when provided and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73.

Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

74 - Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74.

Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

Category	Modifier	Place of Service
Reduced	52	Any
Discontinued	53	Office
Discontinued	73	Facility (in/outpatient) and ASC (Prior To Anesthesia)
Discontinued	74	Facility (in/outpatient) and ASC (Post Anesthesia)

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Global Period

- 0-Day Post-Operative Period (endoscopies and some minor procedures).
  - No pre-operative period
  - No post-operative days
  - Visit on day of procedure is generally not payable as a separate service

- 10-Day Post-Operative Period (other minor procedures).
  - No pre-operative period
  - Visit on day of the procedure is generally not payable as a separate service.
  - Total global period is 11 days. Count the day of the surgery and the 10 days immediately following the day of the surgery.

- 90-day Post-Operative Period (major procedures).
  - One day pre-operative included
  - Day of the procedure is generally not payable as a separate service.
  - Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery.

- What services are included in the global surgery payment?

  Medicare includes the following services in the global surgery payment when provided in addition to the surgery:

  - Pre-operative visits after the decision is made to operate. For major procedures, this includes pre-operative visits the day before the day of surgery. For minor procedures, this includes pre-operative visits the day of surgery.
  - Intra-operative services that are normally a usual and necessary part of a surgical procedure
  - All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room
  - Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery
  - Post-surgical pain management by the surgeon
  - Supplies, except for those identified as exclusions
  - Miscellaneous services, such as dressing changes, local 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 intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes

- What services are NOT included in the global surgery payment?

  The following services are not included in the global surgical payment. These services may be billed and paid for separately:

  - Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries. This is billed separately using the modifier “-57” (Decision for Surgery). This visit may be billed separately only for major surgical procedures.

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Note: The initial evaluation for minor surgical procedures and endoscopies is always included in the global surgery package. Visits by the same physician on the same day as a minor surgery or endoscopy are included in the global package, unless a significant, separately identifiable service is also performed. Modifier "-25" is used to bill a separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure.

- Services of other physicians related to the surgery, except where the surgeon and the other physician(s) agree on the transfer of care (i.e. sending patient to PCP/different specialist). This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery
- Diagnostic tests and procedures, including diagnostic radiological procedures
- Clearly distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications

Note: A new post-operative period begins with the subsequent procedure. This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure.

- Treatment for post-operative complications requiring a return trip to the Operating Room (OR). An OR, for this purpose, is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR).
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Immunosuppressive therapy for organ transplants
- Critical care services (CPT codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

Resources:

1. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf
2. www.encoderpro.com
3. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

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Surgery Related Modifiers

22	Increased Procedural Services **(When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work). (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).**
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period **(Applies to E/M code ONLY)**
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service **(Applies to E/M code ONLY)**
50	Bilateral Procedure
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery **(Applies to E/M code ONLY)**
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service XE- Separate encounter, a service that Is distinct because it occurred during a separate encounter XP- Separate practitioner, a service that is distinct because it was performed by a different practitioner XS- Separate structure, a service that is distinct because it was performed on a separate organ/structure XU- Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service
62	Two Surgeons
63	Procedure Performed on Infants less than 4 kg
66	Surgical Team
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
RT	Right side
LT	Left side
PA	Surgery Wrong Body Part
PB	Surgery Wrong Patient
PC	Wrong Surgery on Patient