G - Global Surgery Days/Package

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***Some portions of this document are up for discussion at the CPT Panel meeting and may be subject to change pending discussions with CMS.**

Rules Committee Recommendation

Global Surgery Days/package reporting rule

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Payers and providers are encouraged to reach an agreement regarding specific additional documentation that must be submitted with a claim when the rule states documentation may be required by the payer.

Modifiers involved

24, 25, 54, 55, 56, 57, 58, 78, 79 (see below for definitions)

This rule is applicable for the specific situations identified for these modifiers. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

Global Surgery rule definition

The number of days assigned to the Current Procedural Terminology (CPT®)[1]/HCPCS procedure codes in the column labeled GLOBAL DAYS of the Medicare Physician Fee Schedule (MPFS)[2] will be utilized to identify the post-operative period associated with the procedure.

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[2] References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html to access the MPFS Relative Value file.

- The global surgery rule applies to procedure codes listed in the column labeled GLOBAL DAYS of the MPFS with indicators of 000, 010, 090 and sometimes YYY.

- The global surgery rule is excluded from procedure codes outlined in the column labeled GLOBAL DAYS of the MPFS with an indicator of XXX.

- The global surgery rule is excluded from procedure codes outlined in the column labeled GLOBAL DAYS of the MPFS with an indicator of MMM, as they are maternity codes and are excluded from the usual global surgery days/package. For more information on maternity codes, view the Global Maternity Care reporting rule.

- The global surgery rule does not apply to procedure codes outlined in the column labeled GLOBAL DAYS of the MPFS with an indicator of ZZZ. These codes are related to another service and are always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post-service time.)

- Duration of the Global Surgical Period
    - Zero days (Typically endoscopies or minor surgeries) – There is no preoperative or postoperative period for endoscopies and minor surgeries. Visits on the same day of the procedure are generally included in the allowance for the procedure, unless a significant, separately identifiable service is also performed and reported with the appropriate modifier.
    - 10 days (Typically other minor surgeries) – There is no preoperative period for other minor surgeries and visits on the same day or 10 days after the procedure are generally not allowed as a separate service unless a significant and, separately identifiable service is also performed and reported with the appropriate modifier. The postoperative period is 10 days immediately following the day of surgery.
    - 90 days (Typically major surgeries) - The preoperative period for major surgeries is the day immediately prior to the day of the surgery, and the postoperative period is 90 days immediately following the day of surgery. Services provided on the day of surgery but prior to the surgery are considered preoperative, while services furnished on the same day but after the surgery are considered postoperative.
        - An evaluation and management service within the preoperative period that results in the decision for surgery is reportable with the appropriate modifier appended to the E/M code.
        - Significant and separately identifiable, unrelated evaluation and management work provided within the global period is reportable with the appropriate modifier appended to the E/M code.

- See Coding and adjudication guidelines below for modifiers that override the global surgery rule.

- **Surgical Package**
  The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services “included” in a given CPT surgical code, the following services are always included in addition to the operation per se:
    - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
    - Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical);

- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the postanesthesia recovery area;
- Postsurgical Pain Management by the surgeon;
- Complications directly related to the surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room, or are not related to other medical conditions of the patient;
- Typical postoperative follow-up care during the global period of the surgery that are related to recovery from the surgery;
- Supplies - Except for those identified as exclusions; and
- Miscellaneous Services - Items such as dressing changes; local incisional 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.

From a CPT coding perspective, this definition indicates that when a surgical procedure is reported with a CPT code, the items listed in that guideline are included (if performed) and are not reported separately. Since patients may have other disease(s) or injury(s) or may have undergone other diagnostic and/or therapeutic procedure(s), certain variables may impact reporting, and include: The type of procedure performed; The place where the surgery occurs; The time (during hospitalization) the surgery is performed; The insurance contract of each individual patient.

Therefore, because it is not possible to address all of these variables in each code descriptor, only the preoperative E/M service related to the procedure performed on the date immediately before the procedure (including the history and physical) is stated as inclusive of the CPT surgical package definition. It is important to note that this included E/M encounter must occur subsequent to the E/M encounter at which the decision for surgery was reached. For example, the E/M service is separately reported when a physician performs an office E/M service, and at that visit it is determined that surgery is necessary. The appropriate modifier must be appended.

Coding and adjudication guidelines

In certain circumstances it is appropriate to report additional medical or surgical services provided during the global surgical period. The following modifiers appended to the procedure code are used to identify these:

- Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period. The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during the 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

- Modifier 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. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated

with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines in the CPT codebook for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used in conjunction with a major surgical procedure (one that has 90 days postoperative follow up) to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

- Modifier 54: Surgical Care Only. When one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure code.

- Modifier 55: Postoperative Management Only. When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure code.

- Modifier 56: Preoperative Management Only. When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure code.

- Modifier 57, Decision for Surgery, is used to indicate that an evaluation and management service resulted in the initial decision to perform the surgery. Use of this modifier is limited to procedures with 90-day global periods.

- Modifier 58: Staged or Related Procedure or Service by the same Physician or Other Qualified Health Care Professional During the Postoperative Period. The use of the modifier 58 enables the payers to appropriately pay for the procedure per se and other associated postoperative services performed by the original surgeon or provider within or subsequent to its assigned global period (eg, 0 days, 10 days, 90 days). Modifier 58 is used to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure.

- Modifier 76, Repeat Procedure or Service by Same Physician, is used to indicate that a procedure or service was repeated subsequent to the original procedure or service in a separate operative session by the same physician.

- Modifier 78, Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period. When a procedure is related to the first (but not a repeat procedure) and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.

- Modifier 79, Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period. When a procedure or service performed during the postoperative period was unrelated to the original procedure, this circumstance is communicated by appending the modifier 79 to the unrelated procedure.

Refer to the CPT Surgical Package Definition for a listing of the elements that are included in the surgical package.

Care that can be separately reported and is not a part of the surgical package includes:

- Care of the condition for which a diagnostic procedure was performed or a concomitant condition
- Complications, exacerbations recurrence, or the presence of other diseases or injuries requiring additional services.

See Chapter 12, Sections 40.1-40.3 of the Medicare Claims Processing Manual[3] for further instruction including:

- Carrier edits
- Billing requirements

For services not subject to the global surgical package, see the following:

- CPT code set, Follow –Up Care for Diagnostic Procedures, page 58 and Follow-Up Care for Therapeutic Surgical Procedures, page 58 of the CPT codebook.

- Medicare Claims Processing Manual, Chapter 12, 40.1, B – Services Not Included in the Global Surgical Package.

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The Current Procedural Terminology (CPT®)[4] coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for global surgery and associated modifiers were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual[5] were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

MCCTF comment

The legislative intent was not to limit the edit to just the number of days, but also to address the global surgery package.

[3] Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04

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[5] Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

MCCTF definition
Physician may need to indicate a procedure or service was repeated subsequent to the original procedure or service

Description
It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

Additional definitions

Intraoperative Services
All intraoperative services that are normally included as a necessary part of a surgical procedure are included in the global package.

Preservice, intraservice and postservice work
The work involved in actually providing a service or performing a procedure is termed "intraservice work." For office visits, the intraservice period is defined as patient encounter time; for hospital visits, it is the time spent on the patient's floor; and for surgical procedures, it is the period from the initial incision to the closure of the incision. (ie, "skin-to-skin" time).

Work prior to and following provision of a service, such as surgical preparation time, writing or reviewing records, or discussion with other physicians, is referred to as "pre-service and post-service work." When preservice, intra-service, and postservice work are combined, the result is referred to as the "total work" involved in the service. For surgical procedures, the total work period is the same as the global surgical period, including recovery room time, normal postoperative hospital care, and office visits after discharge, as well as preoperative and intraoperative work.

Payment indicator definitions

The following are payment indicator definitions that are outlined in the column labeled GLOBAL of the MPFS for Global Surgery[6]. This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; initial evaluation and management services on the day of the procedure are payable with proper documentation showing that the evaluation and management service was necessary for the diagnosis/treatment.

010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

[6] Information taken from "[6] Information taken from "How to Use the Searchable Medicare Physician Fee Schedule (MPFS)", Centers for Medicare & Medicaid Services", Centers for Medicare & Medicaid Services.

MMM = Maternity codes; usual global period does not apply.

XXX = Global concept does not apply.

YYY = Carrier/MAC determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ = Code related to another service is always included in the global period of the other service.

Federation outreach

American Academy of Orthopaedic Surgeons (AAOS)
This recommendation was sent to Matt Twetten and Joanne Willer for review.

American College of Radiology (ACR)
This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

American College of Surgeons (ACS)
This recommendation was sent to Jennifer Jackson for review.

American Congress of Obstetricians and Gynecologists (ACOG)
This draft proposal was sent to James Scroggs and Anne Diamond of ACOG for review. ACOG responded that there are no procedures that are performed by ob-gyns that would have any deviation from the Rules Committee draft recommendation. The document reflects standard edits supported by CPT and CMS. The pre- and post-operative global periods are already defined for the procedures as listed in CPT. The document is consistent with what ACOG teaches in their Coding Workshops.

American Society of Anesthesiology (ASA)
This recommendation was sent to Sharon Merrick. Sharon indicated that anesthesia is not allowed under the CMS global surgery package and had nothing to bring forward.

Federation Payment Policy Workgroup
This recommendation has been sent to the Federation Payment Policy Workgroup for review.

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Appendix A - To be added to Data Sustaining Repository

Rationale

The following rationale was used to formulate the Rules Committee Recommendation:

- The Current Procedural Terminology (CPT®)[7] coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for global surgery and the modifiers listed were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy, as identified in the Medicare Physician Fee Schedule (MPFS) and the Medicare Claims Processing Manual[8], were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Exceptions

At the time of the initial review, the following exceptions were identified. This may not be a comprehensive listing of appropriate exceptions.

For services not subject to the global surgical package, see the following:

- CPT code set, Follow –Up Care for Diagnostic Procedures, page 58 and Follow-Up Care for Therapeutic Surgical Procedures, page 58 of CPT codebook.

- Medicare Claims Processing Manual, Chapter 12, 40.1, B – Services Not Included in the Global Surgical Package.

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[8] Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.