Global surgery & related services

Multiple surgeries

Multiple surgeries are separate procedures performed by a physician on the same patient at the same operative session or on the same day. Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. Intraoperative services, incidental surgeries or components of surgeries will not be separately reimbursed.

Reimbursement is based on the following guidelines for multiple surgical procedures:

* 100% of the allowance for the highest valued procedure.
* 50% of the allowance for the second through the fifth highest valued procedures.

The regular multiple surgery rules, as referenced above, will be applied to the procedure codes below when billed for the same beneficiary on the same day, by the same physician.

Nuclear medicine 78802-78803, 78806-78807

These pricing rules apply to dermatology services:

* 100% of the allowance for the highest valued procedure.
* 50% of the allowance for the remaining procedures.

The limiting charge is 115% of the reduced payment amount for each procedure.

When more than five procedures are performed, reimbursement for the sixth and/or subsequent procedures will be reviewed on an individual consideration basis. Operative notes should be submitted with the claim when five or more surgical procedures are performed during the same operative session.

Reporting guidelines

Novitas does not recommend physician reporting modifier 51 on claims. The claims processing system has hard-coded logic to append the modifier to the correct procedure code/s.

However, if you do report modifier 51, follow the guidelines below:

* Report the highest valued procedure.
* Report any additional surgical procedures with modifier 51.

Example

* If you are billing for a repair of a rotator cuff (Code 23412), and a ligament release (code 23415), and a claviculectomy (code 23120), report the codes as follows:
* 23412
* 23415 - 51
* 23120 - 51
* If surgeons of different specialties are each performing a different procedure (with specific CPT codes) multiple surgery rules do not apply. If one of the surgeons performs multiple procedures, the multiple surgery rules apply to that physician's services.

Multiple endoscopy procedures

Endoscopic pricing is identified by an indicator of (3) under the "multiple procedures" field on the fee schedule.

When performing multiple procedures through the same endoscope, payment is made for the highest valued endoscopy (100% of the allowance). The code with the second highest value will be paid at the allowed amount minus the allowed amount for the base code. If there are multiple endoscopic codes and the allowed amount for a code is less than the base code allowed amount it will not be paid.

Example

* While performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon.
* The value of code 45380 and 45385 have the value of the diagnostic colonoscopy built in. Rather than paying 100 percent of the highest valued procedure 45385 and 50 percent for the next 45380, payment is made for the full value of the higher endoscopy (45378), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).
* Using the fee schedule amounts for the following participating provider base rate as for the state of Texas, the Dallas locality:

45378 $ 184.75

45380 $ 200.88

45385 $ 255.08

The physician would bill procedure codes 45380 and 45385. Payment would be made for the full value of 45385 ($255.08), plus the difference between the 45380 and 45378 ($54.20) for a total of $309.28.

Additional information on related and unrelated endoscopies refer to [CMS IOM Pub. 100-04 Medicare Professional Manual, Chapter 12 section 40.6 c.](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

Multiple interventional radiological procedures

If performing multiple interventional radiological procedures, payment for both the radiology code and the primary surgical code is 100% of the fee schedule. Subsequent surgical procedures will be reimbursed according to standard multiple surgery rules.

Global surgical package

* [Global Surgery Calculator for Jurisdiction L](https://www.novitas-solutions.com/webcenter/portal/MedicareJL/GlobalSurgeryCalc)
* [Global Surgery Calculator for Jurisdiction H](https://www.novitas-solutions.com/webcenter/portal/MedicareJH/GlobalSurgeryCalc)

The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The preoperative period included in the global fee for major surgery is 1 day. The postoperative period for major surgery is 90 days. The postoperative period for minor surgery is either 0 or 10 days depending on the procedure. For endoscopic procedures (except procedures requiring an incision), there is no postoperative period.

The Medicare approved amount for these procedures includes payment for the following services related to the surgery when furnished by the physician who performs the surgery. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, Ambulatory Surgical Centers (ASCs), physicians' offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (99291 and 99292) are payable separately in some situations.

The following services are included in the payment amount for a global surgery:

* Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.
* Intraoperative Services - Intraoperative services that are normally a usual and necessary part of a surgical procedure.
* Complications Following 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.
* Postoperative Visits - Follow-up visits within the postoperative period of the surgery that are related to recovery from the surgery.
* Postsurgical Pain Management - By the surgeon.
* Supplies.
* 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.

The following services are not included in the payment amount for a global surgery:

* The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery.
* Services of other physicians, except where the surgeon and the other physician(s) agree on the transfer of care. 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 complication of the surgery.
* Treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery.
* Diagnostic tests and procedures, including diagnostic radiological procedures.
* Clearly distinct surgical procedures during the postoperative period, which are not re-operations or treatment for complications (a new postoperative period begins with the subsequent procedure). This includes procedures done in 2 or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (codes 61533-61536, 61539, 61541 and 61543), which may be performed in succession within 90 days of each other.
* Treatment for postoperative complications requiring a return to the OR (operating room). An OR for this purpose is 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.
* For certain services performed in a physician's office.
* Immunotherapy management for organ transplants.
* Critical care services (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.

For minor surgeries and endoscopies, the Medicare program will not pay separately for an evaluation & management service on the same day as a minor surgery or endoscopy, unless a significant, separately identifiable service is also performed, for example, an initial consultation or initial new patient visit. As stated earlier, there is no postoperative period for endoscopic procedures (unless an incision is required) and minor surgical procedures have postoperative periods of 0 or 10 days, based on the procedure.

For a complete list of HCPCS/CPT modifiers, please visit the Modifiers page on the Claims Center of our website.

Add-On surgical procedures

CMS has assigned various surgical procedures with global surgery post-operative periods of "ZZZ".

These procedures, while surgical in nature, are add-on codes that are always billed with another procedure. There is no post-operative work included in the fee schedule amount for "ZZZ" codes.

When billed independent of another qualifying service, "ZZZ" procedures will be denied since they, by definition, are not stand-alone procedures. When billed in conjunction with a primary surgical procedure or qualifying service, both the primary and add-on code will be paid. The global surgery rules apply to the primary procedure.

Splitting post-operative care

Specific billing guidelines must be followed when the surgical procedure and the post-operative care is split between different physicians.

Modifiers 54 and 55 are used to indicate that two different physicians are rendering the surgical care and post-operative management services. The physician who is rendering the one-day preoperative care, the intraoperative services, and any in-hospital visits bills his/her services with the date of the surgery, the procedure code for the surgery, and a 54 modifier to indicate that the bill is reflective only of the surgical care.

The physician rendering the postoperative, out of hospital care associated with a given surgical procedure should bill for his/her services with the date of the surgery, the procedure code for the surgery, and a 55 modifier. If the surgeon also cares for the patient for some period following discharge, the surgeon should bill the surgery with a 55 modifier and indicate the portion of the post-op care provided in addition to the surgery with a 54 modifier (to indicate the intra-operative service).

In those cases where the postoperative care is "split" between physicians, the billing for the postoperative care should be reported as follows:

* Report the date of service using the date of the surgical procedure.
* Report the procedure code for the surgical procedure, followed by modifier 55.
* Report the date post-operative care began and ended along with the number of post-operative care days provided in the narrative field on electronic claims, or block 19 on the CMS-1500 claim form.

Both the surgeon and the physician(s) providing the post-operative care must keep a copy of the written transfer agreement in the beneficiary's medical records. Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service. Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he/she assumes care of the patient.

Where physicians agree on the transfer of care during the global period, the following modifiers are used:

* “-54” for surgical care only.
* “-55” for postoperative management only.

Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.

Providers must report the date post-operative care began and ended along with the number of post-operative care days provided on which care was relinquished or assumed. Both the surgeon and the physician(s) providing the post-operative care must keep a copy of the written transfer agreement in the beneficiary's medical records.

**Billing** example

Physician A performs a hysterectomy (58150) on 04/15/2021 in the hospital. The procedure has a 90-day global period. The patient was in the hospital for 8 days until 04/23/2021 during which time physician A administered post-operative care. On 04/24/2021, physician B took over the post-operative care, which was administered in the office.

Physician A reports split post-operative care

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of service | CPT code and modifier | Place of service | Quantity | How to report in item 19 or documentation field |
| 04/15/2021 | 58150-54 | 21 | 1 | blank |
| 04/15/2021 | 58150-55 | 21 | 8 | Post op care performed 04/16/21 to 04/23/21– 8 days |

Physician B reports split post-operative care

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of service | CPT code and modifier | Place of service | Quantity | How to report in item 19 or documentation field |
| 04/15/2021 | 58150-55 | 11 | 1 | Post op care assumed 04/24/21 to 07/14/2021 – 82 days |

Bilateral procedures

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. CMS has defined codes subject to the bilateral payment rule. Payment for claims reporting bilateral procedures is 150% of the fee schedule amount. The limiting charge is 115% of that amount.

Procedure codes containing the terms "bilateral" or "unilateral or bilateral" in their definitions are not subject to bilateral pricing. Payment for these services is 100% of the fee schedule for a surgical code. Procedure codes with terminology indicative of unilateral or bilateral services, as in code 27395 (lengthening of hamstring tendon; multiple, bilateral) or code 52290 (Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral) cannot be reported with the bilateral procedure code modifier 50 since the terminology for the code identifies the service as bilateral.

Certain procedures are not applicable to the 150% payment rule for bilateral procedures. Payment is 100% of the fee schedule for each side, e.g., codes 92225 and 92226. When performed bilaterally, report the codes with modifiers RT-LT or 50 to ensure proper payment.

Reporting guidelines

* Report the procedure code with modifier 50.
* Report a one in the number of services field.

For example, if you bill a bilateral mastectomy, report the service as a single line item: 19303 50.

Reference: Bilateral indicators

**Ass**istant at surgery

Some surgical procedures require a primary surgeon and an assistant surgeon. Payment will not be made for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service.

Payment for an assistant surgeon is limited to 16% of the fee schedule amount for the surgical procedure. The limiting charge is 115% of the assistant surgeon's fee schedule amount.

Additionally, the correct payment amount for assistant-at-surgery services furnished by PAs, NPs and CNSs is 80% of the lesser of the actual charge or, 85% of 16% of what a physician is paid under the MPFS for surgical services.

Reporting guidelines

Services for an assistant-at-surgery must be reported with one of the following modifiers as appropriate to the situation.

* Modifier 80 - Report this modifier when the services are performed in a non-teaching setting or in a teaching setting when a resident was available, but the surgeon opted not to use the resident. In the latter case, the service is generally not covered by Medicare unless the following circumstances exist and are reported on the claim form:
* Primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or post-operative cares of his/her patients.
* Exceptional medical circumstances existed, e.g., emergency, life-threatening situations such as multiple traumatic injuries requiring immediate treatment.
* Modifier 81 - Minimum assistant surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
* Modifier 82 - Report this modifier when there is no qualified resident surgeon available or when the services are performed in a teaching hospital that does not have an approved training program related to the medical specialty required for the surgical procedure.
* Modifier AS - Report this modifier when a physician assistant, nurse practitioner, or clinical nurse specialist serves as assistant at surgery.

Co-surgery

Under some circumstances, the individual skills of two surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physician is not acting as an assistant-at-surgery.

Co-surgery refers to surgical procedures involving two surgeons (each in a different specialty) performing parts of the procedure simultaneously, e.g., heart transplant or bilateral knee replacements. It is not always co-surgery when two doctors perform surgery on the same patient during the same operative session. Co-surgery is performed if the procedure(s) are part of and would be billed under the same surgical code. For example, when an otolaryngologist and a neurosurgeon perform an excision of a pituitary tumor (CPT code 61548), each physician reports code 61548 with modifier 62 (two surgeons). Payment for each surgeon is 62.5% of the Medicare Fee Schedule amount.

Co-surgery has not been performed when each physician performed a separate surgical procedure which is reported under a different surgical procedure code, e.g., a hammertoe operation (CPT code 28285) performed by a podiatrist and a palma fasciotomy (CPT code 26040) performed by a hand surgeon. When two unrelated procedures are performed, each physician should bill for and be paid the full global fee for the procedure he/she performed.

Eligible co-surgery procedure codes

There are 2 categories of surgical procedures for which co-surgery may be covered. Codes not listed in either category are not eligible for reimbursement for co-surgery.

These categories are referred to as "Indicators" on the fee schedule database.

* Indicator 1: procedure codes can be paid for co-surgery when an operative report supporting the need for co-surgeons (of different specialties) is submitted with the claim.
* Indicator 2: procedure codes do not require documentation of medical necessity for co-surgery unless performed by surgeons of the same specialty. If co-surgeons are of the same specialty, you must submit operative reports.

When performing co-surgery, it is important to communicate with the other surgeon's office to be certain that claims are submitted properly.

Team surgery

Team surgery also refers to a single procedure; however, it requires the skills of more than two surgeons of different specialties, working together to carry out various portions of a complicated surgical procedure. For example, a kidney transplant could involve the services of a general surgeon, urologist and/or vascular surgeon to remove the diseased kidney, to implant the donated kidney and to transplant the ureters.

CMS has identified those services for which team surgeons may be paid. Payment for codes defined as eligible for team surgery will be reimbursed on an individual consideration basis. The Limiting Charge is 115% of the fee schedule distributive share for each of the team physicians.

Reporting guidelines

Each surgeon should bill the procedure with modifier 66 (Team Surgery). Sufficient documentation establishing the medical necessity of a team of surgeons must accompany each claim, e.g., operative notes.

References

* [CMS Internet Only Manual Pub. 100-04, Claims Processing Manual, Chapter 12](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)
* Global Surgery Specialty page