Kansas City

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Global Surgical Package

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Description

Surgical procedures include the operation itself, local infiltration, metacarpal/digital block or topical anesthesia, when used, and normal, uncomplicated follow-up care. This concept is referred to as a "package" for surgical procedures, and typically begins the day before surgery. The global package includes pre-operative, surgical and post- operative services by the same individual practitioner or practitioners in the same practice (same NPI). When the package is split between practitioners in different practices the surgical procedure is billed with the -54, -55, and/or -56 modifiers.

Policy

Surgeries should be billed globally if the surgery itself, pre and post- op services are performed by either the same practitioner or by different practitioners from the same practice/under the same tax ID. If different practitioners under different tax IDs perform different portions of the surgical package, the pre-, intra-, and post-op services should be split and billed appropriately.

Surgeries are assigned a global period of 0 (zero), 10 or 90-day post-operative period. To determine the surgical global period, refer to the CMS physician fee schedule

(See http://www.cms.gov/apps/physician- fee-schedule/overview.aspx).

Surgical Care Only Modifier -54

The post-operative period includes all visits by the primary surgeon unless the visit is for a problem unrelated to the diagnosis for which the surgery was performed or is for an added course of treatment other than the follow-up care that is usually associated with the surgical procedure.

When billing for the surgery only, submit the surgical procedure code with a modifier -54 and an appropriately reduced charge to reflect that post-operative care was not provided.

Pre- or Post-Op Management Modifiers -55 and -56

When billing for pre- and/or post-operative services only, submit the surgical procedure code with the modifier -55 or -56 as appropriate. Pre- and/or post-operative services are billed only one time and include all visits within the designated period. Thus, only one payment will be made for the pre- and/or post-op care.

If care during the post-operative period is relinquished to another practitioner from a different practice, both practitioners should bill for their portion of post-operative care also with the surgical procedure code and the -55 modifier. However, both practitioners must report the date the care was relinquished. The reimbursement for the post-op care will be divided between the practitioners based on each practitioner's portion of their post-op care.

Please see table below for modifier payment reduction.

MODIFIER	MODIFIER DESCRIPTION	PRICING/FUNCTIONALITY
54	Surgical care only	▪ Reimbursement is 80% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ When one physician performs a surgical procedure and another provides preoperative and/or postoperative management. The surgeon who performs the surgical procedure reports this modifier.
55	Postoperative Management Only	▪ Reimbursement is 20% of the 5-digit allowable. ▪ When one physician performed the postoperative management and another physician performed the surgical procedure.
56	Preoperative Management Only	▪ Reimbursement is 1% of the 5-digit allowable.

		▪ When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure. Blue KC requests the physician or practitioner use the appropriate level E/M code instead of the modified surgery or medicine code.

Unrelated E/M Modifier -24

If an unrelated Evaluation and Management (E/M) Service is performed by the same physician* during a postoperative period, the modifier -24 should be submitted.

By appending the -24 modifier to an unrelated E/M service you are indicating that the patient's condition requires a significant, separately identifiable E/M service above and beyond the other service provided, or beyond the usual pre-operative and postoperative care associated with the procedure that was performed. Services appended with a –24 modifier must be sufficiently documented in the patient's medical record that the visit was unrelated to the post-operative care of the procedure. An ICD-10-CM that clearly indicates that the reason for the encounter was different and unrelated to the post-operative care may provide sufficient documentation.

Significant Unrelated Procedure or Service – Modifier 25

If a significant, separately identifiable evaluation and management (E/M) Service is performed by the same physician* during a postoperative period, the modifier -25 should be submitted.

By appending the -25 modifier to an unrelated E/M service you are indicating that the patient's condition requires a significant, separately identifiable E/M service above and beyond the other service provided, or beyond the usual pre-operative and postoperative care associated with the procedure that was performed. Services appended with a –25 modifier must be sufficiently documented in the patient's medical record that the visit was unrelated to the post-operative care of the procedure. An ICD-10-CM that clearly indicates that the reason for the encounter was different and unrelated to the post-operative care may provide sufficient documentation.

Decision for Surgery Modifier -57

Modifier -57 is appended to indicate that the E/M service resulted in the initial decision to perform surgery either the day before or the day of a major surgical procedure (90- day global period).

Do not append this modifier when a minor surgical procedure (0 or 10 day

global period) is performed.
Modifier -57 should not be used to report an E/M service that was pre-planned or prescheduled the day before or the day of surgery, as the E/M would be included as part of the global surgical package.
Modifier –57 may not affect edits or payment. However, if applicable, the modifier should be appended to the E/M. Services denied may be considered on subsequent appeal.

Two Surgeons Modifier -62

Modifier -62 is appended to indicate that two surgeons were needed. Under certain circumstances, two surgeons may function simultaneously as primary surgeons performing distinct parts of a total surgical service. Services should be submitted with both surgeons using the modifier -62 on each appropriate line item code. When two surgeons act as co-surgeons, Modifier -62 rules apply. If one or both surgeons perform additional separate services, each report only those additional services provided. If one co-surgeon acts as an assistant for additional procedures, those services are reported with either Modifier -80 or -81.

Surgical Team Modifier -66

Modifier -66 is appended when highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Each participating surgeon would report the same CPT code and modifier -66.
All claims for team surgery must contain sufficient information to support the medical necessity for a surgical team. Copies of this documentation should be sent with claims.

Repeat Procedure by Same Physician Modifier -76

Modifier 77 is appended to indicate that a basic procedure or had to be repeated by the same physician. Use of this modifier indicates the procedure is a repeat and not a duplicate.

Repeat Procedure by Another Physician Modifier -77

Modifier -77 is appended to indicate that a basic procedure or service performed by one physician has been repeated by a second physician. This modifier usually is used during the postoperative period of the basic procedure. The second physician adds the modifier to the procedure code used by the first physician.

Return to the Operating Room Modifier -78

If a procedure needs to be repeated on the same day or in postoperative, due to complications, modifier -78 is to be used. Reimbursement for this modifier will be intra-operative percentage only. This modifier will not apply to AS, Assistant Surgeons. Modifier 78 will need to be filed with documentation to completely support the need to return to the operation room.

Unrelated Procedure or Service Modifier -79

If an unrelated procedure or service is performed by the same physician* during a postoperative period of another procedure, the modifier -79 should be submitted.

Services appended with a –79 modifier must be sufficiently documented in the patient's medical record that the visit was unrelated to the post-operative care of the procedure.

Assistant Surgeon Modifier 80
Minimum Assistant Surgeon Modifier -81

Append modifier -80 or -81 when services of a second surgeon is needed as a minimum assistant or assistant for surgery, these are reviewed on an individual consideration basis. Documentation is required and needs to note what services were provided by each provider.

*Same Physician

Blue KC defines the "same physician" as the same physician(s) or qualified health care practitioner(s) of the same or similar specialty within the same clinical practice.

99024-Postoperative follow-up visit

This is used when the service that is being provided is normally included in the surgical package, to indicate that an E&M service was performed during a postoperative period for a reason(s) related to the original procedure. This service would be provided by the "same physician."

The following services are included in the surgical service payment and are not separately reimbursed:

- Pre-operative visits–one day prior for major surgeries and on the same day a major or minor surgery is performed.
- Intra-operative services.
- Post-operative visits.
- Post-surgical pain management by the surgeon.
- Supplies, except for those identified as exclusions.
- 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.
- Complications following surgery, all additional medical or surgical services required of the surgeon during the post-operative period which do not require an additional trip to the operating room.

Documentation Submission

Documentation/operative report must identify and describe the procedures performed and the names and dates of care if the package is split. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

The following applies to all claim submissions;
All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue KC Medical Policy criteria, policies found under Provider Payment Policy, Provider Office Guide and all other provisions of the Provider Service Agreement (Agreement). In the event that any new codes are developed during the course of the Provider's Agreement, such new codes will be paid according to the standard or applicable Blue KC fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement. Eligible services will be subject to the subscriber benefits, Blue KC fee schedule amount, and any coding edits.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Policy History

DATE	DESCRIPTION
	Approval Date
7/1/2019	Effective Date
