Reimbursement Policy

Effective Date.....10/30/2018
Reimbursement Policy Number R23

Global Surgical Package and Related Modifiers (24, 54, 55, 56, 57, 58, 76, 77, 78, and 79)

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Related Policies

Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

INSTRUCTIONS FOR USE
*Reimbursement policies are intended to supplement certain **standard** benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supersedes** the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy Proprietary information of Cigna. Copyright ©2019 Cigna*

Overview

The global surgical package includes all necessary services performed by the physician before, during and after a surgical procedure. Surgeries are categorized as either a minor or major procedure. Cigna follows the Centers for Medicare and Medicaid Services (CMS) definition of global surgery which includes the pre-operative, intra-operative and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.

Any services defined as being included in the global surgical package will not be separately reimbursed. In order for modifier to be reimbursed correctly, the modifier must be appended.

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Services Included in the Global Surgical Package

- 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 (e.g. diagnostic procedures performed at the same time as a more complex procedure, local infiltration, anesthesia blocks or topical anesthesia);
- 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; and
- 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.

Surgical supply codes billed by a physician or other health care professional on the same day as surgery will not be separately reimbursed. Payment for surgical supplies is included in the surgical reimbursement. HCPCS supply codes within the ranges of A4206-A4640, A4649-A5200, A6000-A8004, A9279, and A9900-A9999 will be denied when billed with a surgical procedure.

Items typically included in the global period when performed postoperatively and not separately reimbursable include:

- Dressing changes
- Local incisional care
- Removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts and splints
- Insertion, irrigation, and removal of urinary catheters
- Routine peripheral intravenous lines and nasogastric and rectal tubes
- Change and removal of tracheostomy tubes

Reimbursement per modifier (In order for modifier to be reimbursed correctly, the modifier must be appended).

Modifier	Modifier Description	Reimbursement
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period	Reimbursed at rate of 100% of the fee schedule or other allowed amount for the Evaluation & Management (E&M) service.
54	Surgical Care Only	Reimbursed at rate of 84% of the global surgical package* for the surgical procedure.
55	Postoperative Management Only	Reimbursed at rate of 9% of the global surgical package* for the surgical procedure. Note: If the transfer of care did not occur, services are reimbursed as an E&M or other appropriate code instead.
56	Preoperative Management Only	Reimbursed at rate of 7% of the global surgical package* for the surgical procedure.
57	Decision for Surgery	Reimbursed at rate of 100% of the fee schedule or other allowed amount when

		the E/M resulted in a decision for major surgery.
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	Reimbursed at 100% of the fee schedule or other allowed amount when modifier is appended correctly.
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	Reimbursed when medically necessary, at 100% of the fee schedule or other allowed amount.
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	Reimbursed when medically necessary, at 100% of the fee schedule or other allowed amount.
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	Reimbursed at rate of 70% of the global surgical package* for the surgical procedure.
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	Reimbursed when medically necessary, at 100% of the fee schedule or other allowed amount.

General Background

Definitions

Operating Room
CMS defines an operating room as "a place of service specifically equipped and staffed for the sole purpose of performing surgical procedures". It can include an Ambulatory Surgery Center, a cardiac catheterization suite, a laser suite or an endoscopy suite. It does not include a patient's room, minor treatment room, recovery room or an intensive care unit unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.

***Global Surgical Package** The global surgical package includes all necessary services performed by the physician before, during and after a surgical procedure. Surgeries are categorized as either a minor or major procedure. Cigna follows the CMS definition of global surgery which includes the pre-operative, intra-operative and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.

The three types of global surgical packages as defined by CMS are:

1) **CMS Global Service Indicator 000 – Zero Day Post-operative Period** (known as a **minor** procedure)
   a) No-pre-operative period
   b) No post-operative days
   c) Visit on day of procedure is generally not payable as a separate service.
   d) Includes endoscopies and some minor procedures
2) **CMS Global Service Indicator 010 – 10-Day Post-operative Period**.
   a) No pre-operative period (also known as a **minor** procedure)
   b) Visit on day of the procedure is generally not payable as a separate service
   c) Total global period is 11 days. Count the day of the surgery and 10 days following the day of the surgery
   d) Other minor procedures are included in this category
3) **CMS Global Service Indicator 090 – 90-Day Post-operative Period** (also known as a **major** procedure)
   a) One day pre-operative included
   b) Day of the procedure is generally not payable as a separate service
   c) Total global period is 92 days. Count 1 day before the day of the surgery, the day of the surgery, and 90 days immediately following the day of the surgery.

CMS assigns a global service indicator to each surgical CPT and HCPCS code. The global service indicator is found in the Medicare Physician Fee Schedule (MPFS) look-up tool.

In addition to 000, 010 and 090, CMS may also assign codes a "YYY" or "ZZZ" global service indicator. Codes with a "YYY" indicator are contractor-priced codes for which contractors determine the global period which could be 0, 10 or 90 days. Codes with a "ZZZ" global service indicator will be assigned a zero post- operative period.

Codes with a "ZZZ" designation are surgical codes; however, they are add-on codes that are always billed with another service. No post-operative work is included in the MPFS payment for these codes. Payment is made for both the primary and add-on codes and the global period is applied to the primary code.

Coding/Billing Information

Note: 1) The modifiers listed may not be all-inclusive.
2) Deleted modifiers which are not effective at the time the service is rendered may not be eligible for reimbursement.

Modifier 24

Modifier 24 is used to indicate an unrelated Evaluation and Management (E/M) service that is provided during the postoperative period.

According to the Current Procedural Terminology (CPT®) manual, "the physician may need to indicate that an E/M 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".

After surgery, there is a period of either zero (0), 10 or 90 days when normal postoperative care (evaluation of postoperative site) falls into what is called a "global period". During a 10 or 90 day global period, there is no separate reimbursement for services related to the surgery. Therefore, it is appropriate to use modifier 24 when, during the postoperative period, the physician provides an E/M service unrelated to the problem requiring the surgery.

Modifiers 54, 55 and 56

Prior to the CMS 1991 Final Rule, global surgical policies varied among carriers and administrators. The CMS 1991 Final Rule identified specific services included in the global surgical package when provided by the physician who performs the surgery; preoperative services the day before the surgery; intraoperative services that normally are a usual and necessary part of the surgical procedure; services provided by the surgeon within 90 days of the surgery that do not require a return trip to the operating room, and follow-up visits provided during this time by the surgeon that are related to the recovery from surgery; and post surgical pain management. The sum of the services approved for all physicians may not exceed what would have been approved if a single physician had provided all services.

Physicians in a group practice should bill for the entire global package, if the physicians reassign benefits to the group and all services are performed by two or more physicians within the group. The physician who performs the surgery is shown as the performing physician.

When the entire surgical package is performed by two or more physicians ***not*** in a group practice, the charges are submitted separately. Modifiers identifying the portion of the package performed are appended and reimbursement is distributed based on the following modifiers:

- Modifier 54 – Surgical Care Only
- Modifier 55 – Postoperative Management Only
- Modifier 56 – Preoperative Management Only

Reimbursement is reduced because only one portion of the global surgical package is performed. The total of all the service components for preoperative, postoperative and surgical care is 100% of the global fee*. The global surgical package pertains to major surgical procedures (those defined with a post operative period of between 10 days and 90 days) and consists of the preoperative management, surgical care and postoperative management.

When the operating surgeon does not provide the patient's postoperative care, an agreement for the patient's transfer of care from the surgeon to the physician handling the postoperative care must be maintained in the patient's medical records. This agreement can be in the form of a letter, discharge summary, chart notation or other written documentation, but both the operating surgeon and the physician who intends to provide responsibility of care is determined by the date of the transfer order.

If the transfer of care does not occur, the services of a physician, other than the surgeon, are reported by the appropriate evaluation and management (E/M) code or other code rather than through the use of Modifier 55.

Exceptions to the operative period may occur if the patient develops complications. Medically necessary services that require additional medical or surgical services necessitating a return trip to the operating room, may be paid separately from the global surgery amount. These services would be reported by appending modifier 78 to the surgical code.

Similarly, a patient may require services for problems or conditions unrelated to the original procedure. Under those circumstances, the services should be reported by using the modifier 79.

In summary, when the preoperative, postoperative and surgical care is split between two or more physicians, the sum of all approved physicians services will be the same global surgical fee as if one physician provided all of the care.

Modifier 57

Modifier 57 is appended to the E/M to represent the initial decision for major surgery (global period of 090 days) that will occur either the same day or the next day. It is not appended to E/M services when the surgery is scheduled for a date in the future (e.g. 2 weeks, 3 months).

Modifier 58

The Centers for Medicare and Medicaid Services developed the National Correct Coding Initiative (NCCI) to prevent inappropriate payment of services that should not be reported together. The NCCI Indicates: "If a procedure is planned or anticipated, because it was more extensive than the original procedure or service during the postoperative period or because it represents therapy after a diagnostic procedure, modifier 58 may be appended to the second procedure during the postoperative period. This may be because it was planned prospectively, because it was more extensive than the original procedure or because it represents therapy after a diagnostic procedural service. When an endoscopic procedure is performed for diagnostic purposes at the time of a more comprehensive therapeutic procedure, and the endoscopic procedure does not represent "scout" endoscopy, modifier 58 may be appropriately used to signify that the endoscopic procedure and the more comprehensive therapeutic procedure are staged or planned procedures".

Note: A new postoperative period will begin with the related, staged procedure appended with modifier 58.

Modifier 76

According to the American Medical Association, "it may be necessary to indicate that a procedure or service was repeated to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service". From a coding perspective, modifier 76 is intended to describe the same procedure or services repeated, rather than the same procedure being performed at multiple sites.

Cigna follows CMS who recognizes the use of modifier 76 as long as the procedure is performed in an operating room or place equipped specifically for procedures and the repeat procedure is supported by medical necessity documentation. The following are CMS examples of repeat procedures:

- Follow up x-rays (after chest tube placement, central venous line placement, new onset of distress, previous setting of fracture, etc.);
- Repeat electrocardiogram for evaluation and treatment of arrhythmia or ischemia;
- Repeat coronary angiogram or coronary artery bypass after abrupt closure of previously treated vessel.
- Rationale for medical necessity as outlined by CMS includes the following:
    - It was performed for comparative purposes;
    - The two services were performed at different times (may indicate actual time when submitting);
    - It was for follow-up after treatment of intervention;
    - It was to repeat a test at different intervals.

Note: Modifier 76 is not appropriate for use with repeat laboratory tests. Please refer to modifier 91 for Repeat Clinical Diagnostic Laboratory Tests.

Modifier 77

Modifier 77 is appended to a procedure or service code when the procedure or service is repeated by another physician (not by the original physician who performed the first procedure or service). This procedure or service is repeated on the same day or during the global days (if applicable). There are occasions when it may be necessary for another physician to repeat a procedure or service previously performed by a different physician. The physician would append modifier 77 to the procedure or service code if the procedure or service is repeated on the same day or during the global period (if applicable). Medical necessity must be documented to support the reason for the repeated procedure.

Modifier 78

Modifier 78 is used when it is necessary for the patient to return to the operating room for a related procedure by the same physician following an initial procedure during the postoperative period of the initial procedure.

Modifier 78 is appended to the subsequent procedure code when it is related to the first procedure and it requires the use of the operating/procedure room. The return to the operating/procedure room may occur on the same day as the original procedure or in the days following. However, they must be within the postoperative period for the initial procedure, be related to the initial procedure and be performed by the same physician.

- If a procedure is performed within the postoperative period but is unrelated to the initial procedure, modifier 79 (Unrelated procedure or service by the same physician during the postoperative period) may be reported.
- If the procedure is performed on the same day and is the same procedure as the initial procedure, modifier 76 (Repeat procedure or service by the same physician) is reported.
- The use of modifier 78 does not start a new global period.

Modifier 79

Modifier 79 is used to indicate that a procedure was performed during the postoperative period following another surgical procedure, but it was unrelated to the original surgery.

According to the American Medical Association, “the physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79.”

If a second procedure is performed by the same physician and it is unrelated to the previous procedure during the designated postoperative period, modifier 79 should be appended to communicate this.

Modifier 79 is often necessary with identical procedures that are not performed on the same day, such as cataract surgery, where both eyes are treated within a 90 day period. In this case, the diagnosis code for the cataract removal will be the same, but the HCPCS modifier code(s) RT and LT identify right and left and help differentiate the right and left side of the body. The RT and LT HCPCS modifiers should be used in addition to modifier 79 (when applicable), not in place of it. A new global/postoperative period for the second procedure begins with modifier 79.

References

1) Current Procedural Terminology (CPT®) Professional Edition (Chicago, IL: American Medical Association: ©2017).

2) The Centers for Medicare and Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 12 Physicians/Non Physician Practitioners, Section 40 Surgeons and Global Surgery

3) Optum 360, Understanding Modifiers, Chapter 1, Page 13 and Chapter 4, Page 54 - 85. Optum 360, West Valley City, UT.

Policy History/Update

Date	Change/Update
05/28/2019	Removed Cigna's definition of a physician group using same TIN.
10/30/2018	Updated to new template, added overview and updated reference section.
02/15/2018	Effective date for the change in reimbursement for Modifier 78 to 70% from 84%.
11/17/2017	Notification for the change in reimbursement for Modifier 78 to 70% from 84%. This change will become effective 02/19/2018.
10/27/2016	Policy template updated
02/28/2014	Effective date of combining Modifier 24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period, Modifier 54 Surgical Care Only, Modifier 55 Postoperative Management Only, Modifier 56 Preoperative Management Only, Modifier 57 Decision for Surgery, Modifier 58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period, Modifier 76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional, Modifier 77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional, Modifier 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, and Modifier 79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period Reimbursement Policies into one policy R23 Global Surgical Package and Related Modifiers. Policies M24, M54, M55, M56, M57, M58, M76, M77, M78 and M79 are now retired.