



Global Surgery



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Version 08/01/2025
Check for Updates



What's Changed?

- Added information about modifiers (page 9)
- Created a new G-code, HCPCS code G0559, for post-operative care services provided by a practitioner other than the one who performed the surgical procedure (or another practitioner in the same group practice) (page 9)

Substantive content changes are in dark red.

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This booklet explains parts of Medicare's global surgery package. It covers surgery, endoscopy, and split global surgical packages' billing and payment rules between 2 or more providers.

Global Surgical Package Definition

We set up a national global surgical package to make sure Medicare Administrative Contractors (MACs) consistently pay the same services across all jurisdictions.

This policy helps prevent Medicare payments for more or less comprehensive services than intended. We set up uniform payment policies and claims processing requirements for other surgical issues, including bilateral and multiple surgeries, co-surgeons, and team surgeons.

The global surgical package, also called global surgery, includes all necessary services normally provided by a provider (or members of the same group with the same specialty) before, during, and after a procedure. Providers in the same group practice, with the same specialty, must bill and accept payment as though they're a single physician.

Get more information in Sections 40–40.1 of the [Medicare Claims Processing Manual, Chapter 12](#).

FAQs

Is global surgery payment restricted to hospital inpatient settings?

Global surgery applies in any setting, including an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. When a surgeon visits a Medicare patient in an intensive care or critical care unit, we include these visits in the global surgical package.

Get more information in Sections 40–40.1 of the [Medicare Claims Processing Manual, Chapter 12](#).



How does Medicare classify global surgery?

We classify 3 types of global surgical packages based on the number of post-operative days:

0-Day Post-Operative Period (endoscopies and some minor procedures)

- No pre-operative period
- No post-operative days
- Generally, a visit on the procedure day isn't payable as a separate service

10-Day Post-Operative Period (other minor procedures)

- No pre-operative period
- Generally, a visit on the procedure day isn't payable as a separate service
- Total global period is 11 days; count the surgery day and the 10 days following the surgery day

90-Day Post-Operative Period (major procedures)

- 1-day pre-operative included
- Generally, the procedure day isn't separately payable
- Total global period is 92 days; count 1 day before surgery, the day of surgery, and the 90 days following the surgery day

NOTE: We let the surgeon or other practitioners separately bill and get paid for a post-discharge home visit according to the Comprehensive Care for Joint Replacement Model (CJR) conditions. During the 90-day post-operative period, we continue applying all other global surgery billing rules.

Where can I find the covered surgical procedures post-operative periods?

The [Medicare Physician Fee Schedule \(PFS\) Look-Up Tool](#) outlines each procedure code, including the global surgery indicator.

Under Modifier, select "Global" (Diagnostic Service) to display the global column in the tool. The global surgical payment rules apply to procedure codes with global surgery indicators 000, 010, 090, and sometimes, YYY:

- 000 codes identify endoscopies or some minor surgical procedures (0-day post-operative period).
- 010 codes identify other minor procedures (10-day post-operative period).
- 090 codes identify major surgeries (90-day post-operative period).
- YYY codes identify contractor-priced codes. MACs decide the global period. The global period for these codes is 0, 10, or 90 days.

NOTE: Not all contractor-priced codes have a YYY global surgical indicator. Sometimes we specify the global period as 000, 010, or 090.

Codes with ZZZ are surgical codes. They're add-on codes you must bill with another service. The Medicare PFS payment doesn't include post-operative work ZZZ codes. We pay the primary and add-on codes but apply the global period assigned to the primary code. Sometimes providers can use modifier -26 with global surgery indicator ZZZ. To see specific procedures that use modifier -26, review Addendum B for the fee schedule year. The [CY 2024 PFS Final Rule Addenda](#) is in the Downloads section.

We set the CPT Category III codes 0437T, 0439T, and 0443T to ZZZ global surgery days and identify other YYY codes:

- 44799: Global Surgery Days = YYY
- G9685 and G9686: Global Surgery Days = XXX
- G0498: Global Surgery Days = YYY

Codes with XXX show the global concept doesn't apply.

Get more information in Sections 40–40.1 of the [Medicare Claims Processing Manual, Chapter 12](#).

What services does Medicare include in the global surgery payment?

We include these services in the global surgery payment when added to surgery:

- Pre-operative visits after the decision to operate. For major procedures, this includes pre-operative visits the day before the surgery. For minor procedures, this includes pre-operative visits on the surgery day.
- Intra-operative services, normally a necessary part of a surgical procedure.
- All other medical or surgical services the surgeon provides during the post-operative period because the complications don't require more trips to the operating room.
- Follow-up post-operative recovery period visits.
- Post-surgical patient pain management.
- Supplies (except exclusions).
- Miscellaneous services, like dressing changes, local incision care, operative pack removal, cutaneous sutures and staples removal, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and urinary catheter removal, routine peripheral intravenous lines, nasogastric and rectal tubes; and tracheostomy tube changes and removals.

What services aren't included in the global surgery payment?

We exclude these global surgical payment services. You may bill them separately and get paid:

- Surgeon's first evaluation to find the need for major surgeries. Bill this separately using modifier –57 (Decision for Surgery). Only bill this separately for major surgical procedures.

NOTE: Always include the first minor surgical procedures and endoscopy evaluation in the global surgery package. We include minor surgery or endoscopy visits by the same provider on the same day in the global package unless they do a significant, separately identifiable service. Use modifier –25 to separately bill an identifiable Evaluation and Management (E/M) service by the same provider on the same procedure day.

- Other providers' related surgery services, except when the surgeon and the other providers agree on a transfer of care. Document this agreement through a letter or an annotation in the discharge summary, hospital record, or ASC record.
- Visits unrelated to the surgical diagnosis procedure unless the visits happen because of surgery complications.
- Underlying condition treatment or an added treatment course that's not part of normal surgery recovery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Distinct surgical procedures that happen during the post-operative period that aren't re-operations or complications treatment.

NOTE: A new post-operative period starts after the procedure. This includes procedures done in 2 or more parts when the decision to stage the procedure comes before the first procedure.

- Treatment for post-operative complications when the patient returns to the operating room (OR). An "OR" is a place of service specifically equipped and staffed solely for doing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It doesn't include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition is critical so there's not enough time for transporting to an OR).
- If a less extensive procedure fails, and the patient needs a more extensive procedure, we separately pay for the second procedure.
- Organ transplant immunosuppressive therapy.
- Critical care services (CPT codes 99291 and 99292) unrelated to surgery where a critically ill patient, seriously injured or burned, needs constant provider attendance. For critical care visits that are unrelated to the surgical procedure and done post-operatively, report modifier –FT.

How are minor procedures and endoscopies handled?

Minor procedures and endoscopies have 10-day or 0-day post-operative periods (shown by 010 and 000, respectively).

10-day post-operative period procedures: We don't allow separate post-operative visits or service payments within 10 days of surgery related to procedure recovery. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10 days, we separately pay for the major surgery. Minor procedure services by other providers generally aren't included in the global fee.

0-day post-operative period procedures: Post-operative visits beyond the procedure day aren't included in the surgery payment. Separately bill and get paid post-operative visits. Get more information in Section 40.1 of the [Medicare Claims Processing Manual, Chapter 12](#).

Global Surgery Coding & Billing Guidelines

Providers Who Provide the Entire Global Package

Providers providing the global package should only enter the surgical CPT procedure code. We don't allow billing separate visits or other services in the global package.

When different providers in a group practice take part in the patient's care, the group practice bills the entire global package if the providers reassign benefits to the group. Report the provider who does the surgery as the performing provider.

Get more information in Sections 40.2 and 40.4 of the [Medicare Claims Processing Manual, Chapter 12](#).

Providers Who Provide Part of a Global Surgical Package

More than 1 provider may provide services included in the global surgical package. Instances when the provider who does the surgical procedure can't provide the follow-up care may occur. If the providers agree on a transfer of care, they normally split post-operative and post-discharge payments among them and any other participating providers.

When more than 1 provider provides services in the global surgical package, the providers' approved sum may not exceed what we would pay if a single provider provided all services, except where stated policies allow higher payment. For example, when the surgeon provides only the surgery and another provider provides pre-operative and post-operative inpatient care, the joint payment may not exceed the global amount allowed.

The surgeon and the provider providing the post-operative care must keep a copy of the written transfer agreement in the patient's medical record. Where a transfer of care doesn't occur, we separately pay or deny the other provider's services for medical necessity reasons, depending on the case circumstances. Split global-care billing doesn't apply to procedure codes with a 0-day post-operative period.

Using Modifiers –54, –55, & –56

When providers agree on a transfer of care during the global period, distinguish the services using the right modifier:

- Surgical care only (modifier –54)
- Post-operative management only (modifier –55)
- Pre-operative care only (modifier –56)

Providers must use the same global surgery services CPT code and bill with modifiers –54, –55, or –56 **in the case of a formal transfer of care**. Report the same date of service and surgical procedure code on the surgical care and post-operative care bill. The date of service is the date the surgical procedure happened.

Modifier –54 shows the surgeon gave all or part of the post-operative care to another provider **and is used in any case when a practitioner plans to provide only a part of a global package (including but not limited to when there's a formal, documented transfer of care or an informal, non-documented but expected, transfer of care)**.

- Modifier –54 doesn't apply to assistant-at-surgery services
- Modifier –54 doesn't apply to an ASC's facility fees

The provider other than the surgeon who provides post-operative management services bills modifier –55.

- Use modifier –55 with the CPT procedure code for global periods of 10 or 90 days.
- The date of surgery is the service date and shows the date the surgeon transferred the patient to another provider. Providers must keep written transfer agreement copies in the patient's medical record.
- The provider accepting the patient's care must provide at least 1 service before billing any part of the post-operative care.
- This modifier isn't for assistant-at-surgery services or ASC facility fees.

Get more information in Sections 40.2 and 40.4 of the [Medicare Claims Processing Manual, Chapter 12](#).

Exceptions to Using Modifiers –54, –55, & –56

If a transfer of care doesn't happen, report occasional post-discharge provider services other than the surgeon using the E/M code. You don't need claim modifiers.

For CY 2025, we created a new add-on code, HCPCS code G0559, for post-operative care services provided by a practitioner other than the one who did the surgical procedure (or another practitioner in the same group practice). This add-on code shows the time and resources involved in post-operative follow-up visits provided by practitioners who weren't involved in providing the surgical procedure.

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Providers supplying minor emergency department follow-up services should bill the level E/M code without a modifier.

If a provider other than the surgeon must attend to an underlying condition or medical complication during a post-operative period, the other provider reports the E/M code. Claim modifiers aren't necessary; for example, a cardiologist managing underlying patient cardiovascular conditions. Get more information in Sections 40.2 and 40.4 of the [Medicare Claims Processing Manual, Chapter 12](#).

Pre-Operative Period Billing

First E/M Service Decision to Do Surgery

We don't include the E/M services that result in the first decision to do surgery on the day before, or the day of, major surgery in the global surgery payment. You may bill separately these services and get paid.

Use the CPT E/M code, modifier –57 (Decision for surgery) to identify a visit that results in the first decision to do surgery.

Don't use modifier –57 with minor surgeries. We don't include minor surgeries the day before the surgery global period. When the decision to do the minor procedure comes right before the service, we consider it a routine pre-operative service and you can't bill a visit or consultation with the procedure. MACs may not pay an E/M service billed with CPT modifier –57 if it's provided on the day of, or the day before, a procedure with a 000- or 010-day global surgical period.

Procedure Day Billing

Same Provider, Significant, Separately Identifiable E/M Service on the Same Procedure Day

Use modifier –25 (Significant, separately identifiable E/M service by the same provider on the day of procedure), which shows the patient's condition needed a significant, separately identifiable E/M service beyond the usual procedure or service pre-operative and post-operative care.

- Use modifier –25 with the appropriate level E/M service
- Use modifiers –24 (Unrelated E/M service by the same physician during a post-operative period) and –25 when a significant, separately identifiable E/M service on the procedure day falls within the post-operative period of another unrelated procedure

You don't need to report different diagnoses when reporting the E/M service on the same date as the procedure or other service. The physician or qualified non-physician practitioner (NPP) must sufficiently document the medically necessary E/M service and procedure in the patient's medical record to support the billed claim. We don't expect you to submit the documentation with the claim. Get more information in Section 30.6.6 of the [Medicare Claims Processing Manual, Chapter 12](#).

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Multiple Surgeries

We consider multiple surgeries as separate procedures when a single provider, or providers in the same group practice, perform on the same patient at the same operative session or on the same day. In these situations, we may allow separate payment. Co-surgeons, surgical teams, or assistants-at-surgery may take part in doing multiple surgeries on the same patient on the same day.

Surgeries subject to the multiple surgery rules have an indicator of '2' in the [Medicare PFS Look-Up Tool](#).

NOTE: Under Type of Information, select "All" for the multi-surg column to display. We apply the multiple procedure payment reduction based on the Medicare PFS-approved amount and not on the providers' submitted amounts. The larger submitted amount may or may not show the major surgery.

Distinguish multiple surgeries from parts of, or incidental to, a primary procedure. Don't separately bill these intra-operative services, incidental surgeries, or more major surgery components.

You may find instances when 2 or more providers each do distinctly different, unrelated surgeries on the same patient on the same day (for example, in some multiple trauma cases). When this happens, Medicare's multiple surgery payment adjustment rules may be inappropriate. You can find payment adjustments for co-surgeons in Table 3 of the [CY 2024 PFS](#).

Get more information in Section 40.6 of the [Medicare Claims Processing Manual, Chapter 12](#).

Co-Surgeons & Team Surgeons

Under some circumstances, it's necessary for 2 or more individual surgeons' skills to do surgery on the same patient during the same operative session. This may happen because of the complex nature of the procedures or the patient's condition (or both). In these cases, other providers aren't acting as assistants-at-surgery.

Use the following billing process when billing a surgical procedure or procedures where the patient's condition needs 2 surgeons or a team of surgeons:

- If 2 surgeons (each in a different specialty) do a specific procedure, each surgeon bills their procedure with modifier –62 (2 surgeons). Co-surgery also means 2 surgeons doing parts of the procedure simultaneously, like a heart transplant or bilateral knee replacements. We require the 2 surgeons to document certain services' medical necessity in the patient's medical record. Find more information in the [Medicare PFS Look-Up Tool](#).

NOTE: Some procedures need modifier –62. If both surgeons don't use the modifier, we return the claims unpaid.

- If a team of surgeons (more than 2 surgeons of different specialties) do a specific procedure, each surgeon bills the procedure using modifier –66 (Surgical team). The Medicare Fee Schedule Data Base (MFSDB) Field 25 identifies certain services submitted with modifier –66. You should sufficiently document the required services to show the team’s medical necessity. All team surgeons’ claims must contain enough information to allow pricing by report.
- If surgeons of different specialties each do a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the surgeons do the procedures through the same incision). If 1 surgeon does multiple procedures, the multiple procedure rules apply to that surgeon’s services.

When billing co-surgeons’ claims using modifier –62, the fee schedule amount for each co-surgeon is 62.5% of the global surgery fee schedule amount. We pay the team surgery (modifier –66) on a report basis.

Get more guidance in Section 40.8 of the [Medicare Claims Processing Manual, Chapter 12](#).

Assistant-at-Surgery Services

When providers do assistant-at-surgery services, the fee schedule payment equals 16% of the applicable surgical payment.

MACs may not pay assistants-at-surgery surgical procedures when a provider acts as an assistant-at-surgery in less than 5% of the cases for that procedure nationally. We find this through manual reviews.

You must get authorization before we pay assistant-at-surgery services claims. We only pay authorized procedures with these modifiers:

- –80 (Assistant surgeon)
- –81 (Minimum assistant surgeon)
- –82 (Assistant surgeon (when qualified resident surgeon not available))
- –AS (Physician assistants, nurse practitioners, and clinical nurse specialists)

Medicare’s assistant-at-surgery services policies on billing patients above the Medicare-allowed amount apply. Providers who bill a patient for an assistant-at-surgery service knowingly and willfully violate this prohibition and these procedures can become subject to penalties. Penalties vary based on the frequency and seriousness of the violation.

We pay Method II critical access hospitals (CAHs) assistant-at-surgery services provided by a physician or NPP who reassigned their billing rights to a Method II CAH when the CAH bills the procedure on type of bill 85X with revenue codes 96X, 97X, or 98X and an assistant-at-surgery modifier.

Get more information in Section 20.4.3 of the [Medicare Claims Processing Manual, Chapter 12](#).

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Post-Operative Period Billing

Unrelated Procedure or Service or E/M Service by Same Provider During Post-Operative Period

Two CPT modifiers simplify billing visits and other procedures during the surgical procedure post-operative period not included in the surgical procedure payment. These modifiers include:

- Modifier –79 (Unrelated procedure or service by the same provider during a post-operative period). The provider may show an unrelated procedure or service during a post-operative period to the original procedure. A new post-operative period starts when the provider bills the unrelated procedure.
- Modifier –24 (Unrelated E/M service by the same provider during a post-operative period). The provider may show an unrelated E/M service during the post-operative period to the original procedure. The provider must document the E/M service billed with modifier –24 and must send documentation supporting the unrelated service.

Post-Operative Claims-Based Reporting Requirements – CPT Code 99024

Practitioners **must** report post-operative E/M visits using CPT code 99024 if they:

- Practice in a group of 10 or more practitioners in 1 of these 9 states:
 - Florida
 - Kentucky
 - Louisiana
 - Nevada
 - New Jersey
 - North Dakota
 - Ohio
 - Oregon
 - Rhode Island

NOTE: You're exempt from required reporting if your practice has less than 10 practitioners, but we encourage you to report if possible.

- Provide global services under 1 of the required procedure codes. More than 100 practitioners nationally provide the required procedure codes more than 10,000 times annually or have more than \$10 million in annual allowed charges.

The term “practitioner” means physicians and NPPs who can provide and bill patient services under the PFS. Get more information in the [Claims-Based Reporting Requirements for Post-Operative Visits FAQs](#).

Medicare Requires Codes When Reporting Post-Operative Visits

Find more information on the [Global Surgery Data Collection](#) webpage. It shows the required reporting codes.

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Return to OR for Related Procedure During Post-Operative Period

When treatment for post-operative complications requires an OR return trip, bill the CPT code that describes the procedures during the return trip. If no such code exists, use the unspecified procedure code in the correct series, for example 47999 or 64999. Don't use the procedure code for the original surgery unless you repeat the same procedure.

Use the CPT code and report modifier –78 (Unplanned return to the operating or procedure room by the same provider following the first related procedure during the postoperative period).

The provider may also do another procedure during the first procedure post-operative period. When this next procedure relates to the first procedure and requires the operating room, bill it using modifier –78.

NOTE: The CPT modifier –78 definition doesn't limit its complications in treatment use.

Staged or Related Procedure or Service by Same Provider During Post-Operative Period

Modifier –58 (Staged or related procedure or service by the same provider during the post-operative period) helps bill staged or related surgical procedures during the first post-operative period procedure. Modifier –58 shows the procedure or service during the post-operative period is:

- Planned prospectively or at the original procedure's time
- More extensive than the original procedure
- For therapy following a diagnostic surgical procedure

Report modifier –58 with the staged procedure's CPT. A new post-operative period starts when you bill the next procedure in the series.



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Critical Care

We don't consider a seriously injured or burned patient's critical care services during a global surgical period as a surgical procedure. If specific circumstances apply, you can separately bill and get paid.

We may pay pre-operative and post-operative critical care added to a global fee if the services meet both these criteria:

- The patient is critically ill and requires constant provider attendance
- The critical care is typically unrelated to the specific anatomic injury or general surgical procedure done and goes beyond the normal procedure

These patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

For payment, these services must meet 2 reporting requirements:

1. Use CPT codes 99291/99292 and modifier –25 for pre-operative care or –24 for post-operative care.
2. Document the critical care unrelated to the specific anatomic injury or general surgical procedure; add an ICD-10-CM code for a disease or separate injury that clearly shows the unrelated critical care to surgery. This is acceptable documentation.

We don't bundle services like endotracheal intubation (CPT code 31500) and flow-directed catheter insertion. For example, we don't bundle Swan-Ganz (CPT code 93503), into critical care codes. We separately pay unrelated critical care with these services if the critical care is a significant, separately identifiable service, and reported with modifier –25. We exclude the time doing the pre-, intra-, and post-procedure work of these unbundled services (for example, endotracheal intubation) from the time providing critical care.

This policy applies to procedures with a 0-, 10-, or 90-day global period, including cardiopulmonary resuscitation (CPR) (CPT code 92950). CPR has a global period of 0 days and isn't bundled into critical care codes. Bill critical care with CPR if critical care is a significant, separately identifiable service and reported with modifier –25. We exclude CPR time from critical care time. In this instance, the provider who does the resuscitation must bill this service. Code team members may not each bill Medicare Part B CPR services.

Get more information on global surgery and critical care in Section 30.6.12, Part K, of the [Medicare Claims Processing Manual, Chapter 12](#).

Special Billing Situations

Care Provided in Different Jurisdictions

If you provide a part of the global surgery package care in different payment jurisdictions, bill the services to the MAC servicing each applicable jurisdiction. For example, if you do the surgery in 1 state and provide the post-operative care in another, bill the surgery with modifier –54 (Surgical care only) to the MAC where you did the surgery.

Bill post-operative care with modifier –55 (Postoperative management only) to the MAC servicing the jurisdiction where the post-operative care happened. This is true whether the same provider or group or different providers did the services.

Health Professional Shortage Area Service Payments Subject to Global Surgery Rules

We pay global surgery bonus payments when you provide the services in a Health Professional Shortage Area (HPSA). Use these guidelines for proper billing procedures:

- If the provider supplies the entire global package in an HPSA, they should bill the proper global surgical code with the applicable HPSA modifier
- If the provider supplies part of the global package in an HPSA, they should use an HPSA modifier to bill for the part provided in the HPSA

Billing Wrong Surgical or Other Invasive Patient Procedures; Doing Surgery or Other Invasive Procedures on the Wrong Body Part; and Doing Surgical or Other Invasive Procedures on the Wrong Patient

Providers must append 1 of these HCPCS modifiers to all lines related to any erroneous surgery:

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

Get more information on erroneous surgeries in Sections 140.6–140.8 of the [National Coverage Determinations Manual, Chapter 1, Part 2](#) and Section 230 of the [Medicare Claims Processing Manual, Chapter 32](#).

Billing Mohs Micrographic Surgical Procedures

We pay Mohs Micrographic Surgical services only when the Mohs surgeon acts as surgeon and pathologist. You can't bill us for these procedures if a provider other than the Mohs surgeon prepares or interprets pathology slides.

Billing Bilateral Procedures

The terminology for some procedure codes includes the terms “bilateral” (for example, code 27395: Lengthening of hamstring tendon; multiple tendons, bilateral) or “unilateral or bilateral” (for example, code 52290: Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment for bilateral surgery rules doesn't apply to CPT procedures identified as bilateral (or unilateral or bilateral) since the fee schedule shows more bilateral surgery work.

If a procedure isn't identified as a bilateral procedure (or unilateral or bilateral), providers must report the procedure using modifier -50. Report these procedures as a single line item.

NOTE: This differs from the CPT coding guidelines. They show you should bill bilateral procedures as 2-line items.

Don't use modifier -50 to report bilateral procedures when the code descriptors state “bilateral” or “unilateral or bilateral,” as in codes 27395 and 52290.

Get more information on bilateral surgeries in Section 40.7 of the [Medicare Claims Processing Manual, Chapter 12](#).

Resource

[Medicare Improperly Paid Physicians for Co-Surgery and Assistant-at-Surgery Services That Were Billed Without the Appropriate Payment Modifiers](#)

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