



KEY CONCEPTS OUTLINE
Module 8: Surgical Services for Physicians:
Modifiers and More

I. The Global Surgical Package

A. Overview

1. The Concept

- a. Under Medicare's "global surgical package" concept, a single amount is paid for a defined "package" of preoperative, intraoperative, and postoperative services furnished by a single physician in connection with a surgical procedure. <Medicare Claims Processing Manual, Chapter 12 § 40>
 - (i) The services included in the global surgical package may be furnished in any setting (e.g., physician's office, hospital, ambulatory surgical center, ICU, CCU, etc.) <Medicare Claims Processing Manual, Chapter 12, § 40.1(A)>
 - (ii) In general, only services furnished by the physician who performed the surgical procedure are included in the surgical package.

2. Similar, But Not Identical To, the CPT Surgical Package Concept

- a. In general, Medicare's "global surgical package" is similar to the CPT "surgical package" concept.
 - (i) However, there are significant differences between what CPT includes in the package and what Medicare includes.
 - (a) In particular, unlike CPT, Medicare defines the postoperative care included in the package based on the days since the surgery (as discussed below). Also, there are significant differences in the treatment of complications (also discussed below).

3. "Major" versus "Minor" Procedures

- a. In general, the scope of services included in the surgical package depends on whether the particular surgery is considered by Medicare to be a “major procedure” or a “minor procedure.”

II. Using the Relative Value File to Determine if a Procedure is Major or Minor

A. Global Days

1. The scope of the global package is based on the “global days” field in the Relative Value File. In general, there are three possibilities.
2. Major Surgical Procedures
 - a. Major surgeries have a global days entry of “090.” <Medicare Claims Processing Manual, Chapter 12, § 40.1>
 - (i) Major surgeries with a global days entry of “090” have a 90 day postoperative period.
3. Minor Surgical Procedures (Including Endoscopies)
 - a. Minor surgeries have a global days entry of “000” or “010.” <Medicare Claims Processing Manual, Chapter 12, § 40.1>
 - (i) Minor surgeries with a global days entry of “010” have a 10 day postoperative period. Minor surgeries with a “global days” entry of “000” do not have a postoperative period beyond the day of surgery.
4. Determining the Duration of the Postoperative Period
 - a. To determine the duration of the postoperative period, begin counting on the day after the surgery. <Medicare Claims Processing Manual, Chapter 12 § 40.1(E)>
 - (i) Examples
 - (a) For a major procedure with a surgery date of January 5, the postoperative period ends April 5.
 - (b) For a minor procedure with a 10-day postoperative period and a surgery date of January 5, the postoperative period ends January 15.

5. MAC Determined Global Period

- a. For surgeries with a “global days” entry of “YYY,” CMS has not defined a national global period. <Medicare Claims Processing Manual, Chapter 12, § 40.1>
- (i) For YYY procedures, the global period is determined by the individual MACs. <Medicare Claims Processing Manual, Chapter 12, § 40.1>
- (a) However, the MAC must assign the YYY procedure a global period of either 0, 10, or 90 days. <Medicare Claims Processing Manual, Chapter 12, § 40.1>

III. Services Generally Included in the Surgical Package

A. Preoperative Services

1. Minor Surgeries

- a. In general, the surgical package for minor surgeries includes all preoperative visits beginning the **day of** the surgery. <Medicare Claims Processing Manual, Chapter 12, §§ 40.1(A), 40.1(C)>
- (i) Preoperative Visits on the Day of Minor Surgery Prior to Making the Decision to Perform the Surgery
 - (a) CMS guidance on this question is arguably inconsistent.
 - 1. The Claims Processing Manual, Chapter 12, § 40.1(A) states that the surgical package includes “preoperative visits after the decision is made to operate beginning . . . the day of surgery for minor procedures.” This seems to suggest that services furnished on the day of a minor procedure should be excluded from the surgical package if furnished prior to the decision for surgery.
 - a. However, the Claims Processing Manual, Chapter 12, § 30.6.6.C states “Carriers may no[t] pay for an evaluation and management service billed with the CPT modifier “57” if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.” In addition, the Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(4) states that “where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine

preoperative service and a visit or consultation is not billed in addition to the procedure.”

b. The “Significant and Separately Identifiable” Exception

- (i) If on the day of the procedure, the patient’s condition required an evaluation and management service that was significant and separately identifiable from the surgery, the evaluation and management service is separately billable. <Medicare Claims Processing Manual, Chapter 12 § 30.6.6(B)>
- (a) An E/M service is considered “significant and separately identifiable” if it goes “beyond the usual preoperative and postoperative care associated with the surgery.” <Medicare Claims Processing Manual, Chapter 12 §§ 30.6.6(B), 40.1 (C)>
- (b) Significant and separately identifiable E/M services are billed with modifier 25. <Medicare Claims Processing Manual, Chapter 12 §§ 30.6.6(B)>

2. Major Surgeries

- a. In general, the surgical package for major surgeries includes all pre-operative visits after the decision for surgery beginning the **day before** the surgery. <Medicare Claims Processing Manual, Chapter 12, § 40.1(A)>
- b. Services Furnished Prior to the Decision for Surgery
 - (i) Services furnished on the day before or the day of surgery that result in the decision to perform major surgery should be reported with the 57 “decision for surgery” modifier. <Medicare Claims Processing Manual, Chapter 12, §§ 30.6.7, 40.2(A)(4)>
- c. E/M Services Included In the Surgical Package
 - (i) Medicare Claims Processing Manual, Chapter 12, § 40.3(B) provides a list of E/M codes that are considered to be included in the surgical package.

B. Intraoperative Services

- 1. The surgical package includes the intraoperative services that are “normally a usual and necessary part of a surgical procedure.” <Medicare Claims Processing Manual, Chapter 12, § 40.1(A)>

C. Postoperative Services Related to Recovery from the Surgery

1. Postsurgical services that are “related to recovery from the surgery” are included in the surgical package if furnished during the applicable postoperative period. This includes:

- a. Dressing changes,
- b. Local incisional care,
- c. Removal of operative pack,
- d. Removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints,
- e. Insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes,
- f. Changes and removal of tracheostomy tubes, and
- g. Post surgical pain management. <Medicare Claims Processing Manual, Chapter 12, §§ 40.1(A), 40.1(C)>

D. Complications

1. The General Rule

- a. Services furnished during the postoperative period to address complications from the surgery are included in the surgical package. <Medicare Claims Processing Manual, Chapter 12, § 40.1(A)>
 - (i) This is the opposite of the CPT surgical package guidelines which exclude all services related to addressing complications from the CPT surgical package.

2. The “Return Trip to the OR” Exception

- a. Treatment for postoperative complications which requires a return trip to the OR is excluded from the surgical package and is therefore separately billable. <Medicare Claims Processing Manual, Chapter 12, § 40.1(B)>
 - (i) For purposes of the surgical package guidelines, an “OR” is defined as an area “specifically equipped and staffed for the sole purpose of performing procedures.”
 - (a) The following areas are all considered to be ORs:

1. Cardiac catheterization suite,
2. Laser suite, and
3. Endoscopy suite. <Medicare Claims Processing Manual, Chapter 12, § 40.1(B)>

(b) The following areas are not considered to be ORs:

1. Patient's room,
2. Minor treatment room,
3. Recovery room, and
4. Intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR). <Medicare Claims Processing Manual, Chapter 12, § 40.1(B)>

3. Billing for Complications

- a. When treatment of the complication is severe enough to require a return trip to the OR, the procedure should be billed with the 78 modifier to identify an unplanned trip to the OR for a related procedure during the post-operative period. <Medicare Claims Processing Manual, Chapter 12, § 40.4(C)>

4. Reimbursement of Complications

- a. The reimbursement for treatment of the complication that requires a return trip to the OR is reduced to the intraoperative portion of the surgical procedure. <Medicare Claims Processing Manual, Chapter 12, § 40.4(C)>

IV. Services Generally Excluded from the Global Surgical Package

A. Unrelated E/M Services Furnished During the Postoperative Period

1. General Rule

- a. In general, unrelated E/M services furnished during the postoperative period are separately billable. <Medicare Claims Processing Manual, Chapter 12, § 30.6.6(A)>
 - (i) Unrelated E/M services furnished during the postoperative period are billed with the 24 modifier.

B. Additional Treatments

1. General Rule

- a. The following treatment-related services are generally not included in the surgical package and are therefore separately billable:
 - (i) An added course of treatment, and
 - (ii) Treatment of an underlying condition not related to the normal recovery from surgery. <Medicare Claims Processing Manual, Chapter 12, § 40.1(B)>
- b. There is some overlap between this concept and the concept of staged or related procedures discussed below.

2. Example

- a. If surgical excision of a tumor (major procedure) is performed within 10 days of a biopsy (minor procedure), the tumor excision would be separately billable. <Medicare Claims Processing Manual, Chapter 12, § 40.1 (C)>

C. Diagnostic Tests and Procedures

1. Diagnostic tests and procedures, including diagnostic radiological procedures, are excluded from the surgical package and are therefore separately billable.
 - a. Although not entirely clear, presumably, both the professional and technical components of diagnostic tests are excluded from the surgical package. <Medicare Claims Processing Manual, Chapter 12, § 40.1(B)>

D. Staged or Related Procedures

1. The General Rule

- a. A “staged or related” procedure is excluded from the surgical package and is therefore separately billable. <Medicare Claims Processing Manual, Chapter 12, §§ 40.1(B), 40.2(A)(6)>
 - (i) Somewhat confusingly, the exclusion of “staged or related” procedures from the surgical package may seem inconsistent with the general rule (as discussed above) whereby procedures “related to recovery” are included in the surgical package.
 - (a) The key to understanding the distinction may be to focus on the term “recovery” rather than the term “related.”

2. Defining a “Staged or Related” Procedure

a. CPT Based Definition

- (i) CMS has, by and large, adopted the CPT definition of staged or related procedures. Under that definition the following are considered staged or related procedures:
 - (a) A second procedure planned prospectively or at the time of the original procedure,
 - (b) A second procedure that is more extensive than the original procedure, and
 - (c) A therapeutic procedure following a diagnostic surgical procedure. <Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(6)>

b. Alternate Definition

- (i) CMS also seems to use the phrase “clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications” to describe the concept of “staged or related” procedures. <Medicare Claims Processing Manual, Chapter 12, § 40.1(B)>

3. Effect on Postoperative Period

- a. The performance of a staged or related procedure starts a new postoperative period. <Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(6)>

4. Billing for Staged or Related Procedures

- a. Staged or related procedures during a postoperative period should be billed with the 58 modifier. <Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(6)>

E. Immunosuppressive Therapy for Organ Transplants

- 1. Immunosuppressive therapy for organ transplants is excluded from the surgical package and is therefore separately billable. <Medicare Claims Processing Manual, Chapter 12, § 40.1(B)>

V. Surgical Add-On Codes

A. Defining Surgical Add-on Codes

1. Surgical add-on codes are codes that are generally billed with another service. Payment is made for both the primary procedure and the add-on service. <Medicare Claims Processing Manual, Chapter 12, § 40.1>
 - a. No postoperative work is included in the payment amount for surgical add-on codes. <Medicare Claims Processing Manual, Chapter 12, § 40.1>

B. Identifying Surgical Add-on Codes

1. Surgical add-on codes have a “global days” entry of “ZZZ.”
 - a. In general, the CPT add-on codes (i.e., codes identified with a “+” in the CPT manual) are treated as a “surgical add-on” by Medicare.

VI. Split Global Care

A. Circumstances Under Which Global Care Is Divided

1. Occasionally, more than one physician may render a portion of the services included in the global surgery package. <Medicare Claims Processing Manual, Chapter 12 § 40.1(D)>
 - a. For example, a surgeon may perform the preoperative and intraoperative portions of the package and a primary care physician may perform the postoperative care, or portion thereof.
 - (i) This “transfer of care” must be an agreement between both or all of the physicians involved in the split global care.
 - (a) The transfer of care agreement may be in the form of a letter or an entry in the discharge summary or medical record. Both physicians must keep a copy in the beneficiary’s medical record. <Medicare Claims Processing Manual, Chapter 12 § 40.1(B); Medicare Claims Processing Manual, Chapter 12 § 40.2.(A)(3)>

B. Billing for Split Global Care

1. When more than one physician furnishes a component (i.e., preoperative, intraoperative or postoperative care) of the surgical package, the billing is handled as follows:
 - a. Surgical Care Only

- (i) When a physician furnished the surgical care only, he/she should report the appropriate surgical procedure code with modifier “54.” <Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(3)>

b. Postoperative Care Only

- (i) When a physician furnished the postoperative care only (in the case of a transfer of care), he/she should report the appropriate surgical procedure code with modifier “55.” <Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(3)>
 - (a) The date of service on the claim should be the same as that for the surgical procedure. <Medicare Claims Processing Manual, Chapter 12 § 40.2(A)(3)>
 - (b) The date on which care was relinquished or assumed, as applicable, must be shown on the claim in the “remarks field.” <Medicare Claims Processing Manual, Chapter 12 § 40.2(A)(3)>
 - 1. Where a transfer of care does not occur, occasional post-discharge services furnished by a physician other than the surgeon are separately billable using the appropriate E/M code without any of the split global care modifiers. <Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(3)>

c. Preoperative Care Only

- (i) The section of the Claims Processing Manual on split global care does not address how to handle a scenario involving a physician who furnished only the preoperative care. Although not clear, presumably, he/she should report the appropriate surgical procedure code with modifier “56.”
 - (a) On the other hand, the Claims Processing Manual instructs Contractors to assume that a physician who billed a surgery with the 54 modifier also provided the preoperative care.
 - 1. Interestingly, this seems inconsistent with the CPT definitions of the split global care modifiers.

C. Payment for Split Global Care

1. In General

- a. For a procedure with a postoperative period, the Relative Value File provides percentages of the total RVUs for the pre-, intra- and postoperative care.

(i) For split billing, the fee schedule amount for each component is determined by multiplying the total fee schedule amount (i.e., the amount that would apply if a single physician furnished the entire surgical package) by the appropriate percentage for the component furnished. <Medicare Claims Processing Manual, Chapter 12, § 40.4(B)>

(a) For procedures billed with the 54 modifier (surgical care only), the Contractors pay based on the total of the pre-operative and intra-operative percentages. <Medicare Claims Processing Manual, Chapter 12, § 40.4(B)>

2. Postoperative Care Provided by More than One Physician

a. Where more than one physician provides postoperative care, payment to each physician is pro-rated based on the number of days each physician “was responsible for the patient’s care.” <Medicare Claims Processing Manual, Chapter 12, § 40.4(B)>

VII. Special Circumstances Involving the Surgical Package

A. Nursing Facility Services Furnished During Postoperative Period

1. General Rule

a. Postsurgical nursing facility admissions and subsequent nursing facility visits are included in the surgical package. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.2(D)>

2. Exception

a. Nursing facility admissions (and, presumably, the subsequent nursing facility care) that are unrelated to the surgery are separately billable with the “24” modifier. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.2(D)>

B. Critical Care

1. General Rule

a. Critical care services furnished during the preoperative and postoperative period are separately billable if:

(i) The patient is critically ill and requires constant physician attendance, and

(ii) The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.
<Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(9)>

b. The Claims Processing Manual suggests that the critical care may be considered unrelated if it is furnished due to an injured or burned patient
<Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(9)>

2. Billing Issues

a. Critical care services, unrelated to the procedure, and provided in the global surgical period are to be reported with the -FT modifier. <Medicare Claims Processing Manual, Chapter 12, § 40.2(A)(9)>

VIII. The Multiple Procedure Payment Reduction

A. Defining “Multiple Procedures”

1. Multiple procedures are separate procedures (i.e., procedures for which there are separate HCPCS codes) performed by a physician or physicians in the same group practice for the same patient during the same operative session or on the same day. <Medicare Claims Processing Manual, Chapter 12, § 40.6(A)>

a. The “same day” language used in the Claims Processing Manual is arguably inconsistent with the CPT definition of multiple procedures. Under the CPT definition of the 51 “multiple procedure” modifier, only procedures performed during the “same session” are considered multiple procedures.

B. Billing for “Multiple Procedures”

1. The “more major” surgical procedure is billed normally (i.e., without the 51 modifier). <Medicare Claims Processing Manual, Chapter 12, § 40.6(B)>

a. Although not clear, presumably, the term “more major” means the procedure with the highest total RVUs.

2. The additional procedures are billed with the 51 modifier. <Medicare Claims Processing Manual, Chapter 12, § 40.6(B)>

C. Application of the Multiple Procedure Payment Reduction

1. In General

- a. The multiple procedure payment reduction only applies to those codes that have a “multiple procedure” indicator of “2” in the Relative Value file. <Medicare Claims Processing Manual, Chapter 12, § 40.6(C)>
 - (i) For procedures with a multiple procedure indicator of “2,” payment is made based on the relative value (i.e., “ranking”) of each procedure as follows:
 - (a) 100 percent of the fee schedule amount is allowed for the highest ranked procedure, and
 - (b) 50 percent of the fee schedule amount is allowed for the second through the fifth highest ranked procedures. <Medicare Claims Processing Manual, Chapter 12, § 40.6(C)(11)>
 - (ii) If there are more than five multiple procedures, the Contractor will pay for the first five procedures as set forth above and manually price the procedures ranked sixth and beyond. <Medicare Claims Processing Manual, Chapter 12, § 40.6(C)(12)>
 - (a) However, the payment for the procedures ranked sixth and beyond should not be less than 50% of the fee schedule amount.
- 2. Application of the Multiple Procedure Payment Reduction to Bilateral Procedures
 - a. For bilateral procedures, the ranking (and multiple procedure payment reduction, if applicable) is performed after application of the 150% bilateral procedure payment adjustment. <Medicare Claims Processing Manual, Chapter 12, § 40.6(C)(16)>
- 3. Special Rules for Multiple Endoscopic Procedures
 - a. Identifying Procedures Subject to the Special Rules
 - (i) The special rules for multiple endoscopic procedures apply to HCPCS codes that have a “multiple procedure” indicator of “3” in the Relative Value File. <Medicare Claims Processing Manual, Chapter 12, § 40.6(C)(13)>
 - (a) However, if a single endoscopic procedure (i.e., a procedure with a multiple procedure indicator of “3”) is billed with modifier 51 and the other procedures billed are not endoscopies, then the standard multiple procedure payment reduction rules apply. <Medicare Claims Processing Manual, Chapter 12, § 40.6(C)(13)>

b. Payment for Multiple Endoscopic Procedures

- (i) Payment for the highest ranked endoscopy is made at 100% of the fee schedule amount. <Medicare Claims Processing Manual, Chapter 12, § 40.6(C)(13)>
- (ii) Payment for the next highest ranked endoscopy is equal to the fee schedule amount for the code less the fee schedule amount for the “base endoscopy code” applicable to that code. <Medicare Claims Processing Manual, Chapter 12, § 40.6(C)(13)>
- (a) The base endoscopy code for endoscopic procedures is listed in the Relative Value file in the “endoscopic base” field. <Medicare Claims Processing Manual, Chapter 23, Addendum, MPFSDB Record Layout>
- (iii) The payment example set forth in the Claims Processing Manual, Chapter 12, § 40.6(C)(13) may be helpful in understanding payment for multiple endoscopic procedures.
- (iv) The special rules for multiple endoscopies do not apply to “unrelated endoscopies.” <Medicare Claims Processing Manual, Chapter 12, § 40.6(C)(14)>

IX. Bilateral Procedures

A. Defining Bilateral Procedures

- 1. Bilateral procedures are procedures performed on both sides of the body during the same operative session. <Medicare Claims Processing Manual, Chapter 12, § 40.7>

B. Unilateral versus Bilateral Procedures

- 1. The correct way to bill for bilateral procedures depends on whether CMS interprets the HCPCS code for the procedure to represent a unilateral procedure (one side only), a bilateral procedure, or if the procedure is characterized as being either unilateral or bilateral.
 - a. Whether CMS considers a code to be unilateral, bilateral, or either can be determined from the “bilateral surgery” indicator in the Relative Value File. <Medicare Claims Processing Manual, Chapter 23, Addendum, MPFSDB Record Layout>
 - (i) If the bilateral surgery indicator for a code is “1,” CMS considers the code to be unilateral.

(ii) If the bilateral surgery indicator for a code is “2,” CMS considers the code to be bilateral.

(iii) If the bilateral surgery indicator for a code is “0,” “3,” or “9,” the bilateral payment rules do not apply to the code.

C. Using Unilateral Codes to Bill for Bilateral Surgeries

1. If the code for a procedure is unilateral (i.e., the bilateral surgery indicator for the code is “1”) but the procedure was performed bilaterally, the procedure should be billed as follows:

- a. A single line item with modifier 50 appended to the procedure code, or
- b. Two separate line items, one with the procedure code and the LT modifier and one with the procedure code and the RT modifier. <Medicare Claims Processing Manual, Chapter 12, § 40.7(C)>

D. Payment of Bilateral Procedures

1. If a unilateral code is billed as a bilateral procedure, the allowable is based on the lower of 150 percent of the fee schedule amount or the amount charged. <Medicare Claims Processing Manual, Chapter 12, § 40.7(C)>

X. Co-Surgeons and Team Surgeons

A. Defining Co-Surgeons and Team Surgeons

1. Co-surgeons are two (co-surgeons) or more (team) surgeons working together to furnish a single procedure where the “individual skills” of two or more surgeons are required due to either the patient’s condition or the complexity of the surgical procedure. <Medicare Claims Processing Manual, Chapter 12, §§ 40.8(A), 40.8(B)>
 - a. Although not clear, there is language in the Claims Processing Manual that suggests that only physicians of different specialties may bill as co-surgeons or team surgeons. <Medicare Claims Processing Manual, Chapter 12, § 40.8>

B. Billing for Co-Surgeries and Team Surgeries

1. Only HCPCS codes with a “co-surgeons” or “team surgeons” indicator of “1” or “2” in the Relative Value file may be billed as a co-surgery or team surgery. <Medicare Claims Processing Manual, Chapter 12, § 40.8(C); Medicare Claims Processing Manual, Chapter 23, Addendum, MPFSDB Record Layout>

- a. If a procedure with a co-surgeon or team surgeon indicator of “1” or “2” was performed by co-surgeons or team surgeons, each surgeon should bill the HCPCS codes for the procedure with the 62 (co-surgeons) or 66 (team surgeons) modifier. <Medicare Claims Processing Manual, Chapter 12, § 40.8(C)>
- (i) If the co-surgeon or team surgeon indicator for the procedure is “1,” documentation supporting the need for the multiple surgeons must be submitted to the Contractor. <Medicare Claims Processing Manual, Chapter 12, § 40.8(C); Medicare Claims Processing Manual, Chapter 23, Addendum, MPFSDB Record Layout>

C. Payment for Co-Surgeries and Team Surgeries

1. Co-Surgeries

- a. The allowable for each co-surgeon is the based on 62.5% of the regular fee schedule amount for the procedure. <Medicare Claims Processing Manual, Chapter 12, § 40.8(B)>

2. Team Surgeries

- a. For team surgeries, each surgeon must submit sufficient documentation to the Contractor so they may know how to price the claim. <Medicare Claims Processing Manual, Chapter 12, § 40.8(B)>

XI. Assistant Surgeons

A. Defining an Assistant Surgeon (or “Assistant-at-Surgery”)

- 1. The Claims Processing Manual does not define the term “assistant surgeon.” Although not clear, presumably, CMS views an assistant surgeon as a physician/practitioner who furnished less services than a co-surgeon or team surgeon. <Medicare Claims Processing Manual, Chapter 12, § 40.8>

B. Assistant-at-Surgery Services Furnished By Non-Physician Practitioner Assistants

- 1. It appears that Medicare only recognizes physicians and NPPs as assistant surgeons. <Medicare Claims Processing Manual, Chapter 12, § 20.4.3>

C. Billing for Assistant-at-Surgery Services

1. Only HCPCS codes with an “assistant-at-surgery” indicator of “0” or “2” in the Relative Value File may be billed as assistant surgeon services. <Medicare Claims Processing Manual, Chapter 12, § 20.4.3; Medicare Claims Processing Manual, Chapter 23, Addendum, MPFSDB Record Layout>
 - a. If an assistant surgeon assisted with a procedure that has an assistant-at-surgery indicator of “0” or “2,” the assistant surgeon should bill the HCPCS code for the procedure with the 80, 81, 82, or AS (for NPPs) modifier. <Medicare Claims Processing Manual, Chapter 12, § 20.4.3>
 - (i) If the assistant-at-surgery indicator for the procedure is “0,” documentation supporting the need for the assistant surgeon must be submitted to the Contractor. <Medicare Claims Processing Manual, Chapter 12, § 20.4.3; Medicare Claims Processing Manual, Chapter 23, Addendum, MPFSDB Record Layout>

D. Payment for Assistant-at-Surgery Services

1. The allowable for assistant surgeons is 16% of the regular fee schedule amount for the procedure. <Medicare Claims Processing Manual, Chapter 12, § 20.4.3>

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Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

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Transmittals for Chapter 12

Version 08/01/2025
Check for Updates

A national definition of a global surgical package has been established to ensure that payment is made consistently for the same services across all A/B MAC (B) jurisdictions, thus preventing Medicare payments for services that are more or less comprehensive than intended. The national global surgery policy became effective for surgeries performed on and after January 1, 1992.

The instructions that follow describe the components of a global surgical package and payment rules for minor surgeries, endoscopies and global surgical packages that are split between two or more physicians. In addition, billing, mandatory edits, claims review, adjudication, and postpayment instructions are included.

In addition to the global policy, uniform payment policies and claims processing requirements have been established for other surgical issues, including bilateral and multiple surgeries, co-surgeons, and team surgeries.

40.1 - Definition of a Global Surgical Package (Rev. 11287; Issued:03-02-22; Effective:01-01-22; Implementation: 02-22-22)

B3-4821, B3-15900.2

Field 16 of the Medicare Fee Schedule Data Base (MFSDB) provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.

Codes with “090” in Field 16 are major surgeries. Codes with “000” or “010” are either minor surgical procedures or endoscopies.

Codes with “YYY” are A/B MAC (B)-priced codes, for which A/B MACs (B) determine the global period (the global period for these codes will be 0, 10, or 90 days). Note that not all A/B MAC (B)-priced codes have a “YYY” global surgical indicator; sometimes the global period is specified.

While codes with “ZZZ” are surgical codes, they are add-on codes that are always billed with another service. There is no postoperative work included in the fee schedule payment for the “ZZZ” codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code.

A. Components of a Global Surgical Package **B3-15011, B3-4820-4831**

A/B MACs (B) apply the national definition of a global surgical package to all procedures with the appropriate entry in Field 16 of the MFSDB.

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, 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 (CPT codes 99291 and 99292) are payable separately in some situations. (See section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.)

- 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;
- Intra-operative Services - Intra-operative 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 during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical Pain Management - By the surgeon;
- 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.

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B. Services Not Included in the Global Surgical Package

A/B MACs (B) do not include the services listed below in the payment amount for a procedure with the appropriate indicator in Field 16 of the MFSDB. These services may be paid for separately.

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure;
- 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 complications of the surgery;
- Treatment for the underlying condition or an added course of treatment which is not part of 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 two 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, 61534-61536, 61539, 61541, and 61543) which may be performed in succession within 90 days of each other;
- Treatment for postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as 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, separate payment can no longer be made for a surgical tray (code A4550). This code is now a Status B and is no longer a separately payable service on or after January 1, 2002. However, splints and casting supplies are payable separately under the reasonable charge payment methodology;
- Immunosuppressive therapy for organ transplants; and
- Critical care services (CPT codes 99291 and 99292) unrelated to the surgery, for example, where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. See section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.

Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.

A postoperative period of 10 days applies to some minor surgeries. The postoperative period for these procedures is indicated in Field 16 of the MFSDB. If the Field 16 entry is 010, A/B MACs (B) do not allow separate payment for postoperative visits or services within 10 days of the surgery that are related to recovery from the procedure. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately. Services by other physicians are not included in the global fee for a minor procedures except as otherwise excluded. If the Field 16 entry is 000, postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery. Separate payment is made in this instance.

See section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.

D. Physicians Furnishing Less Than the Full Global Package B3-4820-4831

There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative, post-discharge care is split between two or more physicians where the physicians agree on the transfer of care.

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global allowed amount).

Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case.

E. Determining the Duration of a Global Period

To determine the global period for major surgeries, A/B MACs (B) count 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

EXAMPLE:

Date of surgery - January 5

Preoperative period - January 4

Last day of postoperative period - April 5

To determine the global period for minor procedures, A/B MACs (B) count the day of surgery and the appropriate number of days immediately following the date of surgery.

EXAMPLE:

Procedure with 10 follow-up days:

Date of surgery - January 5

Last day of postoperative period - January 15

40.2 - Billing Requirements for Global Surgeries

To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.

A. Procedure Codes and Modifiers

Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers “-22” and “-25”).

1. Physicians Who Furnish the Entire Global Surgical Package

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical procedure only. Billing is not allowed for visits or other services that are included in the global package.

2. Physicians in Group Practice

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician. (For dates of service prior to January 1, 1994, however, where a new physician furnishes the entire postoperative care, the group billed for the surgical care and the postoperative care as separate line items with the appropriate modifiers.)

3. Physicians Who Furnish Part of a Global Surgical Package

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

- “-54” for surgical care only; or
- “-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 need not specify on the claim that care has been transferred. However, the date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field/free text segment on the claim form/format. Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary’s medical record.

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.

EXCEPTIONS:

- Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate evaluation and management code. No modifiers are necessary on the claim.
- If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using subsequent hospital

care codes for the inpatient hospital care and the surgical code with the “-55” modifier for the post-discharge care. The surgeon bills the surgery code with the “-54” modifier.

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- Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.
- If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate evaluation and management code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient.

4. Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery

Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.

In addition to the CPT evaluation and management code, modifier “-57” (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery. (Modifier “-QI” was used for dates of service prior to January 1, 1994.)

If evaluation and management services occur on the day of surgery, the physician bills using modifier “-57,” not “-25.” The “-57” modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.

5. Return Trips to the Operating Room During the Postoperative Period

When treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., 47999 or 64999. The procedure code for the original surgery is not used except when the **identical** procedure is repeated.

In addition to the CPT code, physicians use CPT modifier “-78” for these return trips (return to the operating room for a related procedure during a postoperative period.)

The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room, this circumstance may be reported by adding the modifier “-78” to the related procedure.

NOTE: The CPT definition for this modifier does not limit its use to treatment for complications.

6. Staged or Related Procedures

Modifier “-58” was established to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

The physician may need to indicate that the performance of a procedure or service during the postoperative period was:

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- a. Planned prospectively or at the time of the original procedure;
- b. More extensive than the original procedure; or
- c. For therapy following a diagnostic surgical procedure.

These circumstances may be reported by adding modifier “-58” to the staged procedure. A new postoperative period begins when the next procedure in the series is billed.

7. Unrelated Procedures or Visits During the Postoperative Period

Modifiers were established to simplify billing for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure.

Modifier “-79”: Reports an unrelated procedure by the same physician during a postoperative period. The physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure.

A new postoperative period begins when the unrelated procedure is billed.

Modifier “-24”: Reports an unrelated evaluation and management service by same physician during a postoperative period. The physician may need to indicate that an evaluation and management service was performed during the postoperative period of an unrelated procedure. This circumstance is reported by adding the modifier “-24” to the appropriate level of evaluation and management service.

Services submitted with the “-24” modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. A diagnosis code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

A physician who is responsible for postoperative care and has reported and been paid using modifier “-55” also uses modifier “-24” to report any unrelated visits.

For critical care visits that are unrelated to the surgical procedure and performed postoperatively, report modifier –FT as discussed in section 30.6.12.7 of this chapter.

8. Significant Evaluation and Management on the Day of a Procedure

Modifier “-25” is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made.

It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier “-25” to the appropriate level of evaluation and management service.

Claims containing evaluation and management codes with modifier “-25” are not subject to prepayment review except in the following situations:

- Effective January 1, 1995, all evaluation and management services provided on the same day as inpatient dialysis are denied without review with the exception of CPT Codes 99221-99223, 99251-99255, and 99238. These codes may be billed with modifier

“-25” and reviewed for possible allowance if the evaluation and management service is unrelated to the treatment of ESRD and was not, and could not, have been provided during the dialysis treatment;

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- When preoperative critical care codes are being billed within a global surgical period; and
 - When A/B MACs (B) have conducted a specific medical review process and determined, after reviewing the data, that an individual or group has high statistics in terms of the use of modifier “-25,” have done a case-by-case review of the records to verify that the use of modifier “-25” was inappropriate, and have educated the individual or group as to the proper use of this modifier.

For critical care visits that are unrelated to the surgical procedure but performed on the same day, report modifier -FT as discussed in section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.

9. Critical Care



Critical care services provided during a global surgical period must be unrelated to a surgical procedure and appended with the modifier -FT. For further information see section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.

10. Unusual Circumstances

Surgeries for which services performed are significantly greater than usually required may be billed with the “-22” modifier added to the CPT code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the “-52” modifier. The biller must provide:

- A concise statement about how the service differs from the usual; and
- An operative report with the claim.

Modifier “-22” should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier “-52.”

B. Date(s) of Service

Physicians, who bill for the entire global surgical package or for only a portion of the care, must enter the date on which the surgical procedure was performed in the “From/To” date of service field. This will enable A/B MACs (B) to relate all appropriate billings to the correct surgery. Physicians who share postoperative management with another physician must submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, he or she need only show the date of surgery when billing with modifier “-54.”

However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician providing the remaining postoperative care must show the date care was assumed. This information should be shown in Item 19 on the paper Form CMS-1500. See the related implementation guide for where to show this information on the ASC X12 837 professional claim transaction format.

C. Care Provided in Different Payment Localities

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If portions of the global period are provided in different payment localities, the services should be billed to the A/B MAC (B) servicing each applicable payment locality. For example, if the surgery is performed in one state and the postoperative care is provided in another state, the surgery is billed with modifier “-54” to the A/B MAC (B) servicing the payment locality where the surgery was performed and the postoperative care is billed with modifier “-55” to the A/B MAC (B) servicing the payment locality where the postoperative care was performed. This is true whether the services were performed by the same physician/group or different physicians/groups.

D. Health Professional Shortage Area (HPSA) Payments for Services Which Are Subject to the Global Surgery Rules

HPSA bonus payments may be made for global surgeries when the services are provided in HPSAs. The following are guidelines for the appropriate billing procedures:

- If the entire global package is provided in a HPSA, physicians should bill for the appropriate global surgical code with the applicable HPSA modifier.
- If only a portion of the global package is provided in a HPSA, the physician should bill using a HPSA modifier for the portion which is provided in the HPSA.

EXAMPLE

The surgical portion of the global service is provided in a non-HPSA and the postoperative portion is provided in a HPSA. The surgical portion should be billed with the “-54” modifier and no HPSA modifier. The postoperative portion should be billed with the “-55” modifier and the appropriate HPSA modifier. The 10 percent bonus will be paid on the appropriate postoperative portion only. If a claim is submitted with a global surgical code and a HPSA modifier, the A/B MAC (B) assumes that the entire global service was provided in a HPSA in the absence of evidence otherwise.

NOTE: The sum of the payments made for the surgical and postoperative services provided in different localities will not equal the global amount in either of the localities because of geographic adjustments made through the Geographic Practice Cost Indices.

40.3 - Claims Review for Global Surgeries

(Rev. 11287; Issued:03-02-22; Effective:01-01-22; Implementation: 02-22-22)

A. Relationship to Correct Coding Initiative (CCI)

The CCI policy and computer edits allow A/B MACs (B) to detect instances of fragmented billing for certain intra-operative services and other services furnished on the same day as the surgery that are considered to be components of the surgical procedure and, therefore, included in the global surgical fee. When both correct coding and global surgery edits apply to the same claim, A/B MACs (B) first apply the correct coding edits, then, apply the global surgery edits to the correctly coded services.

B. Prepayment Edits to Detect Separate Billing of Services Included in the Global Package

In addition to the correct coding edits, A/B MACs (B) must be capable of detecting certain other services included in the payment for a major or minor surgery or for an endoscopy. On a prepayment basis, A/B MACs (B) identify the services that meet the following conditions:

- Preoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure; or

- Same day or postoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure or endoscopy;

and -

- Services that were furnished within the prescribed global period of the surgical procedure;
- Services that are billed without modifier “-78,” “-79,” “-24,” “25,” or “-57” or are billed with modifier “-24” but without the required documentation; and
- Services that are billed with the same provider or group number as the surgical procedure or endoscopy. Also, edit for any visits billed separately during the postoperative period without modifier “-24” by a physician who billed for the postoperative care only with modifier “-55.”

A/B MACs (B) use the following evaluation and management codes in establishing edits for visits included in the global package. CPT codes 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99271, 99272, 99273, 99274, and 99275 have been transferred from the excluded category and are now included in the global surgery edits.

Evaluation and Management Codes for A/B MAC (B) Edits

92012	92014	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221
99222	99223	99231	99232	99233	99234
99235	99236	99238	99239	99241	99242
99243	99244	99245	99251	99252	99253
99254	99255	99261	99262	99263	99271
99272	99273	99274	99275	99291	99292
99301	99302	99303	99311	99312	99313
99315	99316	99331	99332	99333	99347
99348	99349	99350			
99374	99375	99377	99378		

NOTE: In order for the services of CPT codes 99291 or 99292 to be paid during the preoperative or postoperative period, the critical care service must be unrelated to the procedure. In these situations, the physician must append the modifier -FT ((unrelated evaluation and management (E/M) visit on the same day as another E/M visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated.))

See section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.

If a surgeon is admitting a patient to a nursing facility for a condition not related to the global surgical procedure, the physician should bill for the nursing facility admission and care with a “-24” modifier and appropriate documentation. If a surgeon is admitting a patient to a nursing facility and the patient’s admission to that facility relates to the global surgical procedure, the nursing facility admission and any services related to the global surgical procedure are included in the global surgery fee.

C. Exclusions from Prepayment Edits

A/B MACs (B) exclude the following services from the prepayment audit process and allow separate payment if all usual requirements are met:

Exceptions

See §§40.2.A.8, 40.2.A.9, and 40.4.A for instances where prepayment review is required for modifier “-25.” In addition, prepayment review is necessary for CPT codes 90935, 90937, 90945, and 90947 when a visit and modifier “-25” are billed with these services.

Exclude the following codes from the prepayment edits required in §40.3.B.

92002	92004	99201	99202	99203	99204
99205	99281	99282	99283	99284	99285
99321	99322	99323	99341	99342	99343
99344	99345				

40.4 - Adjudication of Claims for Global Surgeries (Rev. 11287; Issued:03-02-22; Effective:01-01-22; Implementation: 02-22-22)

A. Fragmented Billing of Services Included in the Global Package

Since the Medicare fee schedule amount for surgical procedures includes all services that are part of the global surgery package, A/B MACs (B) do not pay more than that amount when a bill is fragmented. When total charges for fragmented services exceed the global fee, process the claim as a fee schedule reduction (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global surgery allowed amount). A/B MACs (B) do not attribute such reductions to medical review savings except where the usual medical review process results in recoding of a service, and the recoded service is included in the global surgery package.

The maximum a nonparticipating physician may bill a beneficiary on an unassigned claim for services included in the global surgery package is the limiting charge for the surgical procedure.

In addition, the limitation of liability provision (§1879 of the Act) does not apply to these determinations since they are fee schedule reductions, not denials based upon medical necessity or custodial care.

Claims for surgeries billed with a “-22” or “-52” modifier, are priced by individual consideration if the statement and documentation required by §40.2.A.10 are included. If the statement and documentation are not submitted with the claim, pricing for “-22” is the fee schedule rate for the same surgery submitted without the “-22” modifier. Pricing for “-52” is not done without the required documentation.

Separate payment is allowed for visits and procedures billed with modifier “-78,” “-79,” “-24,” “-25,” “-57,” or “-58.” Modifier “-24” must be accompanied by sufficient documentation that the visit is unrelated to the surgery.


Critical care services furnished during the global period must be unrelated to the procedure. Separate payment is allowed for unrelated visits when the -FT modifier ((unrelated evaluation and management (E/M) visit on the same day as another E/M visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated.)) is appended.


A/B MACs (B) do not allow separate payment for evaluation and management services furnished on the same day or during the postoperative period of a surgery if the services are billed without modifier “-24,” “-25,” “-57” or “-FT”. These services should be denied. A/B MACs (B) do not allow separate payment for visits during the postoperative period that are billed with the modifier “-24” or “-FT” but without sufficient documentation. These services should also be denied. Modifier “-24” or “-FT” is intended for use with services that are absolutely unrelated to the surgery. It is not to be used for the medical management of a patient by the surgeon following surgery. Recognize modifier “-24” only for care following discharge unless:

- The care is for immunotherapy management furnished by the transplant surgeon;
- The documentation demonstrates that the visit occurred during a subsequent hospitalization and the diagnosis supports the fact that it is unrelated to the original surgery.


A/B MACs (B) do not allow separate payment for an additional procedure(s) with a global surgery fee period if furnished during the postoperative period of a prior procedure and if billed without modifier “-58,” “-78,” or “-79.” These services should be denied. Codes with the global surgery indicator of “XXX” in the MFSDB can be paid separately without a modifier.

B. Claims From Physicians Who Furnish Less Than the Global Package (Split Global Care)

 For surgeries performed January 1, 1992, and later, that are billed with either modifier “-54” or “-55,” A/B MACs (B) pay the appropriate percentage of the fee schedule payment. Fields 17-19 of the MFSDB list the appropriate percentages for pre-, intra-, and postoperative care of the total RVUs for major surgical procedures and for minor surgeries with a postoperative period of 10 days. The intra-operative percentage includes postoperative hospital visits.

 Procedures with a “000” entry in Field 16 have an entry of “0.0000” in Fields 17-19. Split global care does not apply to these procedures.

A/B MACs (B) multiply the fee schedule amount (Field 34 or Field 35 of the MFSDB) by this percentage and round to the nearest cent. Assume that a physician who bills with a “-54” modifier has provided both preoperative, intra-operative and postoperative **hospital** services. Pay this physician the combined preoperative and intra-operative portions of the fee schedule payment amount.

 Where more than one physician bills for the postoperative care, A/B MACs (B) apportion the postoperative percentage according to the number of days each physician was responsible for the patient’s care by dividing the postoperative allowed amount by the number of post-op days and that amount is multiplied by the number of days each physician saw the patient.

EXAMPLE

Dr. Jones bills for procedure “42145-54” performed on March 1 and states that he cared for the patient through April 29. Dr. Smith bills for procedure “42145-55” and states that she assumed care of the patient on April 30. The percentage of the total fee amount for the postoperative care for this procedure is determined to be 17 percent and the length of the global period is 90 days. Since Dr. Jones provided postoperative care for the first 60 days, he will receive $66 \frac{2}{3}$ percent of the total fee of 17 percent since $60/90 = .6666$. Dr. Smith’s 30 days of service entitle her to $30/90$ or .3333 of the fee.

Thus, Dr. Jones will be paid at a rate of 11.3 percent (66.7 percent of 17 percent). Dr. Smith will be paid at a rate of 5.7 percent (33.3 percent of 17 percent).

C. Payment for Return Trips to the Operating Room for Treatment of Complications

When a CPT code billed with modifier “-78” describes the services involving a return trip to the operating room to deal with complications, A/B MACs (B) pay the value of the intra-operative services of the code that describes the treatment of the complications. Refer to Field 18 of the MFSDB to determine the percentage of the global package for the intra-operative services. The fee schedule amount (Field 34 or 35 of the MFSDB) is multiplied by this percentage and rounded to the nearest cent.

When a procedure with a “000” global period is billed with a modifier “-78,” representing a return trip to the operating room to deal with complications, A/B MACs (B) pay the full value for the procedure, since these codes have no pre-, post-, or intra-operative values.

When an unlisted procedure is billed because no code exists to describe the treatment for complications, A/B MACs (B) base payment on a maximum of 50 percent of the value of the intra-operative services originally performed. If multiple surgeries were originally performed, A/B MACs (B) base payment on no more than 50 percent of the value of the intra-operative services of the surgery for which the complications occurred. They multiply the fee schedule amount for the original surgery (Field 34 or 35) by the intra-operative percentage for the procedure (Field 18), and then multiply that figure by 50 percent to obtain the maximum payment amount.

[.50 X (fee schedule amount x intra-operative percentage)]. Round to the nearest cent.

If additional procedures are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery, A/B MACs (B) pay the additional procedures as multiple surgeries. Only surgeries that require a return to the operating room are paid under the complications rules.

If the patient is returned to the operating room after the initial operative session, but on the same day as the original surgery for one or more additional procedures as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not also apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for bilateral procedures that are required as a result of complications from the original surgery, the complication rules would apply. The bilateral rules would not apply.

D. MSN and Remittance Messages

When A/B MACs (B) deny separate payment for a visit because it is included in the global package, include one of the following statements on the MSN to the beneficiary and the remittance notice sent to the physician.

1. Messages for Fragmented Billing by a Single Physician

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When a single physician bills separately for services included in the global surgical package which has already been billed:

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 4.

Group Code: CO
CARC: 97
RARC: N/A
MSN: 23.1

When a single physician bills separately for services included in the global surgical package which has not yet been billed/adjudicated:

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: B15
RARC: N/A
MSN: 23.1

2. Messages for Global Packages Split Between Two or More Physicians

When a physician furnishes only the pre- and intra-operative services, but bills for the entire package:

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: B20
RARC: N/A
MSN: 23.5

3. Message for Procedure Codes With “ZZZ” Global Period Billed as Stand-Alone Procedures

When a physician bills for a surgery with a “ZZZ” global period without billing for another service:

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 4.

Group Code: CO
CARC: 234
RARC: N390
MSN: 9.2, 9.3

4. Message for Payment Amount When Modifier “-22” Is Submitted Without Documentation

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 1.

Group Code: CO
CARC: 252
RARC: N706
MSN: 9.7

40.5 - Postpayment Issues

(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

It may not always be possible to identify instances where more than one physician furnishes postoperative care before the carrier has paid at least one of the physicians. In addition, situations where a physician renders less than the full global package but does not add the applicable modifier to the procedure code are not detectable until another physician submits a claim.

Several other categories of fragmented bills cannot be or are difficult to detect on a prepayment basis. When a new claim reveals fragmented billing by a single provider after payment for some services was already made to that physician, carriers must adjust the amount due on the new claim by the amount previously paid.

When a new claim indicates that an incorrect payment may have been made to another physician who submitted a previous bill, carriers must determine which bill is correct. (Review the claims and any submitted records to be sure that the providers correctly used modifiers and are billing for services that are included in the global fee. If necessary, a carrier representative must contact one or both physicians to determine which claim is correct.) If the carrier determines that the first claim is incorrect, they follow the overpayment procedures in the Medicare Financial Management Manual, Chapter 3, for recovery of the incorrect payment from the first physician. They pay the second physician according to the services performed. If the carrier determines that the second claim is incorrect, they deny payment.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: B20
RARC: N/A
MSN: 7.3

Carriers must include the appropriate language regarding beneficiary liability according to §40.4.D, above.

Nonparticipating physicians who furnish less than the full global package, but who bill for the entire global surgery, may be guilty of violating their charge limits. In addition, physicians who engage in such practices may be guilty of fraud. See the Medicare Financial Management Manual, Chapter 3, and the Medicare Program Integrity Manual, Chapter 3, for further information on recovery of overpayments, charge limit monitoring, and fraud.

40.6 - Claims for Multiple Surgeries

(Rev. 1, 10-01-03)

A. General



Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable. See Chapter 23 for a description of mandatory edits to prevent separate payment for those procedures. Major surgical procedures are determined based on the MFSDB approved amount and not on the submitted amount from the providers. The major surgery, as based on the MFSDB, may or may not be the one with the larger submitted amount.

Also, see subsection D below for a description of the standard payment policy on multiple surgeries. However, these standard payment rules are not appropriate for certain procedures. Field 21 of the MFSDB indicates whether the standard payment policy rules apply to a multiple surgery, or whether special payment rules apply. Site of service payment adjustments (codes with an indicator of “1” in Field 27 of the MFSDB) should be applied before multiple surgery payment adjustments.

B. Billing Instructions



The following procedures apply when billing for multiple surgeries by the same physician on the same day.

- Report the more major surgical procedure without the multiple procedures modifier “-51.”
- Report additional surgical procedures performed by the surgeon on the same day with modifier “-51.”


There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases). When this occurs, the payment adjustment rules for multiple surgeries may not be appropriate. In such cases, the physician does not use modifier “-51” unless one of the surgeons individually performs multiple surgeries.

C. A/B MAC (B) Claims Processing System Requirements




A/B MACs (B) must be able to:

1. Identify multiple surgeries by both of the following methods:
 - The presence on the claim form or electronic submission of the “-51” modifier; and
 - The billing of more than one separately payable surgical procedure by the same physician performed on the same patient on the same day, whether on different lines or with a number greater than 1 in the units column on the claim form or inappropriately billed with modifier “-78” (i.e., after the global period has expired);
2. Access Field 34 of the MFSDB to determine the Medicare fee schedule payment amount for each surgery;
3. Access Field 21 for each procedure of the MFSDB to determine if the payment rules for multiple surgeries apply to any of the multiple surgeries billed on the same day;

4. If Field 21 for any of the multiple procedures contains an indicator of “0,” the multiple surgery rules do not apply to that procedure. Base payment on the lower of the billed amount or the fee schedule amount (Field 34 or 35) for each code unless other payment adjustment rules apply;
5. For dates of service prior to January 1, 1995, if Field 21 contains an indicator of “1,” the standard rules for pricing multiple surgeries apply (see items 6-8 below);
6. Rank the surgeries subject to the standard multiple surgery rules (indicator “1”) in descending order by the Medicare fee schedule amount;
7. Base payment for each ranked procedure on the lower of the billed amount, or:
- 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure;
 - 50 percent of the fee schedule amount for the second highest valued procedure; and
 - 25 percent of the fee schedule amount for the third through the fifth highest valued procedures;
8. If more than five procedures are billed, pay for the first five according to the rules listed in 5, 6, and 7 above and suspend the sixth and subsequent procedures for manual review and payment, if appropriate, “by report.” Payment determined on a “by report” basis for these codes should never be lower than 25 percent of the full payment amount;
9. For dates of service on or after January 1, 1995, new standard rules for pricing multiple surgeries apply. If Field 21 contains an indicator of “2,” these new standard rules apply (see items 10-12 below);
10. Rank the surgeries subject to the multiple surgery rules (indicator “2”) in descending order by the Medicare fee schedule amount;
-  11. Base payment for each ranked procedure (indicator “2”) on the lower of the billed amount:
- 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure; and
 - 50 percent of the fee schedule amount for the second through the fifth highest valued procedures; or
12. If more than five procedures with an indicator of “2” are billed, pay for the first five according to the rules listed in 9, 10, and 11 above and suspend the sixth and subsequent procedures for manual review and payment, if appropriate, “by report.” Payment determined on a “by report” basis for these codes should never be lower than 50 percent of the full payment amount. Pay by the unit for services that are already reduced (e.g., 17003). Pay for 17340 only once per session, regardless of how many lesions were destroyed;

NOTE: For dates of service prior to January 1, 1995, the multiple surgery indicator of “2” indicated that special dermatology rules applied. The payment rules for these codes have not changed. The rules were expanded, however, to all codes that previously had a multiple surgery indicator of “1.” For dates of service prior to January 1, 1995, if a dermatological procedure with an indicator of “2” was billed with the “-51” modifier with other procedures that are **not** dermatological procedures (procedures with an indicator of “1” in Field 21), the standard multiple surgery rules applied. Pay no less than 50 percent for the dermatological procedures with an indicator of “2.” See §§40.6.C.6-8 above for required actions.

-  13. If Field 21 contains an indicator of “3,” and multiple endoscopies are billed, the special rules for multiple endoscopic procedures apply. Pay the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy. Access Field 31A of the MFSDB to determine the base endoscopy.

EXAMPLE

In the course of 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 physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).

A/B MACs (B) assume the following fee schedule amounts for these codes:

45378 - \$255.40

45380 - \$285.98

45385 - \$374.56

Pay the full value of 45385 (\$374.56), plus the difference between 45380 and 45378 (\$30.58), for a total of \$405.14.

NOTE: If an endoscopic procedure with an indicator of “3” is billed with the “-51” modifier with other procedures that are **not** endoscopies (procedures with an indicator of “1” in Field 21), the standard multiple surgery rules apply. See §§40.6.C.6-8 above for required actions.

14. Apply the following rules where endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures:

- Two unrelated endoscopies (e.g., 46606 and 43217): Apply the usual multiple surgery rules;
- Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608): Apply the special endoscopy rules to each series and then apply the multiple surgery rules. Consider the total payment for each set of endoscopies as one service;
- Two related endoscopies and a third, unrelated procedure: Apply the special endoscopic rules to the related endoscopies, and, then apply the multiple surgery rules. Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.

15. If two or more multiple surgeries are of equal value, rank them in descending dollar order billed and base payment on the percentages listed above (i.e., 100 percent for the first billed procedure, 50 percent for the second, etc.);

16. If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions. See §40.7 for bilateral surgery payment instructions.);

17. Round all adjusted payment amounts to the nearest cent;

18. If some of the surgeries are subject to special rules while others are subject to the standard rules, automate pricing to the extent possible. If necessary, price manually;

19. In cases of multiple interventional radiological procedures, both the radiology code and the primary surgical code are paid at 100 percent of the fee schedule amount. The subsequent surgical procedures are paid at the standard multiple surgical percentages (50 percent, 50 percent, 50 percent and 50 percent);

20. Apply the requirements in §40 on global surgeries to multiple surgeries;

21. Retain the “-51” modifier in history for any multiple surgeries paid at less than the full global amount; and

22. Follow the instructions on adjudicating surgery claims submitted with the “-22” modifier. Review documentation to determine if full payment should be made for those

D. Ranking of Same Day Multiple Surgeries When One Surgery Has a “-22” Modifier and Additional Payment is Allowed

B3-4826

If the patient returns to the operating room after the initial operative session on the same day as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not apply.

However, if the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.

Multiple surgeries are defined as separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable. See Chapter 23 for a description of mandatory edits to prevent separate payment for those procedures.

40.7 - Claims for Bilateral Surgeries

(Rev. 1, 10-01-03)

B3-4827, B3-15040

A. General



Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

The terminology for some procedure codes includes the terms “bilateral” (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or “unilateral or bilateral” (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as “bilateral” or “unilateral or bilateral” since the fee schedule reflects any additional work required for bilateral surgeries.

Field 22 of the MFSDB indicates whether the payment adjustment rules apply to a surgical procedure.



B. Billing Instructions for Bilateral Surgeries

If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier “-50.” They report such procedures as a single line item. (**NOTE:** This differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two line items.)

If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, physicians do not report the procedure with modifier “-50.”

C. Claims Processing System Requirements

A/B MACs (B) must be able to:

1. Identify bilateral surgeries by the presence on the claim form or electronic submission of the “-50” modifier **or** of the same code on separate lines reported once with modifier “-LT” and once with modifier “-RT”;

2. Access Field 34 or 35 of the MFSDB to determine the Medicare payment amount;

3. Access Field 22 of the MFSDB:

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- If Field 22 contains an indicator of “0,” “2,” or “3,” the payment adjustment rules for bilateral surgeries do not apply. Base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply.

NOTE: Some codes which have a bilateral indicator of “0” in the MFSDB may be performed more than once on a given day. These are services that would never be considered bilateral and thus should not be billed with modifier “-50.” Where such a code is billed on multiple line items or with more than 1 in the units field and A/B MACs (B) have determined that the code may be reported more than once, bypass the “0” bilateral indicator and refer to the multiple surgery field for pricing;

- If Field 22 contains an indicator of “1,” the standard adjustment rules apply. Base payment on the lower of the billed amount or 150 percent of the fee schedule amount (Field 34 or 35). (Multiply the payment amount in Field 34 or 35 for the surgery by 150 percent and round to the nearest cent.)

4. Apply the requirements §§40 - 40.4 on global surgeries to bilateral surgeries; and
5. Retain the “-50” modifier in history for any bilateral surgeries paid at the adjusted amount.

(NOTE: The “-50” modifier is not retained for surgeries which are bilateral by definition such as code 27395.)

40.8. - Claims for Co-Surgeons and Team Surgeons

(Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

A. General



Under some circumstances, the individual skills of two or more 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 physicians are not acting as assistants-at-surgery.

B. Billing Instructions



The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-62.” Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the MFSDB. (See §40.8.C.5.);
- If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-66.” Field 25 of the MFSDB identifies certain services submitted with a “-66” modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing “by report.”

- If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services. (See §40.6 for multiple surgery payment rules.)

For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for **each** co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.

C. Claims Processing System Requirements

Carriers must be able to:

1. Identify a surgical procedure performed by two surgeons or a team of surgeons by the presence on the claim form or electronic submission of the "-62" or "-66" modifier;
2. Access Field 34 or 35 of the MFSDB to determine the fee schedule payment amount for the surgery;
3. Access Field 24 or 25, as appropriate, of the MFSDB. These fields provide guidance on whether two or team surgeons are generally required for the surgical procedure;
4. If the surgery is billed with a "-62" or "-66" modifier and Field 24 or 25 contains an indicator of "0," payment adjustment rules for two or team surgeons do not apply:
 - Carriers pay the first bill submitted, and base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply;
 - Carriers deny bills received subsequently from other physicians and use the appropriate MSN message in §40.8.D. As these are medical necessity denials, the instructions in the Program Integrity Manual regarding denial of unassigned claims for medical necessity are applied;
5. If the surgery is billed with a "-62" modifier and Field 24 contains an indicator of "1," suspend the claim for manual review of any documentation submitted with the claim. If the documentation supports the need for co-surgeons, base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount (Field 34 or 35);
6. If the surgery is billed with a "-62" modifier and Field 24 contains an indicator of "2," payment rules for two surgeons apply. Carriers base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount (Field 34 or 35);
7. If the surgery is billed with a "-66" modifier and Field 25 contains an indicator of "1," carriers suspend the claim for manual review. If carriers determine that team surgeons were medically necessary, each physician is paid on a "by report" basis;
8. If the surgery is billed with a "-66" modifier and Field 25 contains an indicator of "2," carriers pay "by report";

NOTE: A Medicare fee may have been established for some surgical procedures that are billed with the "-66" modifier. In these cases, all physicians on the team must agree on the percentage of the Medicare payment amount each is to receive. If carriers receive a bill with a "-66" modifier after carriers have paid one surgeon the full Medicare payment amount (on a bill **without** the modifier), deny the subsequent claim.

9. Apply the rules global surgical packages to each of the physicians participating in a co- or team surgery; and

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10. Retain the “-62” and “-66” modifiers in history for any co- or team surgeries.

D. Beneficiary Liability on Denied Claims for Assistant, Co- surgeon and Team Surgeons

When the procedure is subject to the statutory restriction against payment for assistants-at-surgery, such payment shall be denied.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 54
RARC: N/A
MSN: 15.11

Carriers include the following statement in the MSN:

"You cannot be charged for this service." (Unnumbered add-on message.)

If Field 23 of the MFSDB contains an indicator of “0” or “1” (assistant-at-surgery may not be paid) for procedures CMS has determined that an assistant surgeon is not generally medically necessary.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 54
RARC: N/A
MSN: 15.12

For those procedures with an indicator of “0,” the limitation on liability provisions described in Chapter 30 apply to assigned claims. Therefore, carriers include the appropriate limitation of liability language from Chapter 21. For unassigned claims, apply the rules in the Program Integrity Manual concerning denial for medical necessity.

Where payment may not be made for a co- or team surgeon, deny the claim

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 54
RARC: N/A
MSN: 15.13

Where payment may not be made for a two surgeons, deny the claim.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO

Also see limitation of liability remittance notice Remittance Advice Remark Code Alert M27 and use when appropriate.

40.9 - Procedures Billed With Two or More Surgical Modifiers

(Rev. 1, 10-01-03)

B3-4829

A/B MACs (B) may receive claims for surgical procedures with more than one surgical modifier. For example, since the global fee concept applies to all major surgeries, A/B MACs (B) may receive a claim for surgical care only (modifier “-54”) for a bilateral surgery (modifier “-50”). They may also receive a claim for multiple surgeries requiring the use of an assistant surgeon.

Following is a list of possible combinations of surgical modifiers.

(NOTE: A/B MACs (B) must price all claims for surgical teams “by report.”)

- Bilateral surgery (“-50”) and multiple surgery (“-51”).
- Bilateral surgery (“-50”) and surgical care only (“-54”).
- Bilateral surgery (“-50”) and postoperative care only (“55”).
- Bilateral surgery (“-50”) and two surgeons (“-62”).
- Bilateral surgery (“-50”) and surgical team (“-66”).
- Bilateral surgery (“-50”) and assistant surgeon (“-80”).
- Bilateral surgery (“-50”), two surgeons (“-62”), and surgical care only (“-54”).
- Bilateral surgery (“-50”), team surgery (“-66”), and surgical care only (“-54”).
- Multiple surgery (“-51”) and surgical care only (“-54”).
- Multiple surgery (“-51”) and postoperative care only (“55”).
- Multiple surgery (“-51”) and two surgeons (“-62”).
- Multiple surgery (“-51”) and surgical team (“-66”).
- Multiple surgery (“-51”) and assistant surgeon (“-80”).
- Multiple surgery (“-51”), two surgeons (“-62”), and surgical care only (“-54”).
- Multiple surgery (“-51”), team surgery (“-66”), and surgical care only (“-54”).
- Two surgeons (“-62”) and surgical care only (“-54”).
- Two surgeons (“-62”) and postoperative care only (“55”).
- Surgical team (“-66”) and surgical care only (“-54”).
- Surgical team (“-66”) and postoperative care only (“55”).

Payment is not generally allowed for an assistant surgeon when payment for either two surgeons (modifier “-62”) or team surgeons (modifier “-66”) is appropriate. If A/B MACs (B) receive a bill for an assistant surgeon following payment for co-surgeons or team surgeons, they pay for the assistant only if a review of the claim verifies medical necessity.

50 - Payment for Anesthesiology Services

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

A. General Payment Rule

Version 08/01/2025
Check for Updates