



Global Surgery Booklet



Target Audience: Physicians

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DEFINITION OF A GLOBAL SURGICAL PACKAGE

This booklet is designed to provide education on the components of a global surgery package. It includes information about billing and payment rules for surgeries, endoscopies, and global surgical packages that are split between two or more physicians.

Medicare established a national definition of a global surgical package to ensure that Medicare Administrative Contractors (MACs) make payments for the same services consistently across all jurisdictions.

This policy helps prevent Medicare payments for services that are more or less comprehensive than intended. 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 surgeons. The information that follows describes the components of a global surgical package and billing and payment rules for surgeries, endoscopies, and global surgical packages that are split between two or more physicians.

The global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for a surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Sections 40 and 40.1.

FREQUENTLY ASKED QUESTIONS:

Is the global surgery payment restricted to hospital inpatient settings?

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

For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Sections 40 and 40.1.

How is Global Surgery classified?

There are three types of global surgical packages based on the number of post-operative days.

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

- No pre-operative period
- No post-operative days
- Visit on day of procedure is generally not payable as a separate service

10-Day Post-operative Period (other minor procedures).

- No pre-operative period
- Visit on day of the procedure is generally not payable as a separate service.
- Total global period is 11 days. Count the day of the surgery and the 10 days immediately following the day of the surgery.

90-day Post-operative Period (major procedures).

- One day pre-operative included
- Day of the procedure is generally not payable as a separate service.
- Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery.

Note: Per MLN Matters® Article [MM9533](#), CMS allows for the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions when related to comprehensive care for Joint Replacement Model (CJR). All other Medicare rules for global surgery billing during the 90-day post-operative period continue to apply.

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

The [Medicare Physician Fee Schedule \(MPFS\) look-up tool](#) provides information on each procedure code, including the global surgery indicator. This tool is available at <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>. Note: you must select “Show All Columns” to display the “global” column. The payment rules for global surgical packages apply to procedure codes with global surgery indicators of 000, 010, 090, and, sometimes, YYY.

- Codes with “000” are endoscopies or some minor surgical procedures (zero day post-operative period).
- Codes with “010” are other minor procedures (10-day post-operative period).
- Codes with “090” are major surgeries (90-day post-operative period).
- Codes with “YYY” are contractor-priced codes, for which MACs determine the global period. The global period for these codes will be 0, 10, or 90 days. Note: not all contractor-priced codes have a “YYY” global surgical indicator. Sometimes the global period is specified as 000, 010, or 090.

While codes with “ZZZ” are surgical codes, they are add-on codes that you must bill with another service. There is no post-operative work included in the MPFS payment for the “ZZZ” codes. Payment is made for both the primary and the add-on code(s), and the global period assigned is applied to the primary code. There are times when the modifier 26 may be appropriate for use with the global surgery indicator of “ZZZ”. To see specific procedures where the 26 modifier may be appropriate, review the Addendum B for the fee schedule year. For example, for 2016, see the CY 2016 PFS Final Rule Addenda for 2016 at the top of the “Downloads” section at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1631-F2.html>.

For example, as noted in MLN Matters® Article [MM9633](#), effective July 1, 2016, the global surgery days for CPT Category III codes 0437T, 0439T, and 0443T were set to ZZZ. Other such codes are identified as YYY.

Effective January 1, 2016, CMS issued the following code changes affecting global surgery:

- 44799: Global Surgery Days = YYY
- G9685 and G9686: Global Surgery Days = XXX
- G0498: Global Surgery Days = YYY
- For more information, refer to MLN Matters Article [MM9749](#).

In addition, codes may also have an “XXX” indicating the global concept does not apply.

For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Sections 40 and 40.1.

What services are included in the global surgery payment?

Medicare includes the following services in the global surgery payment when provided in addition to the surgery:

- Pre-operative visits after the decision is made to operate. For major procedures, this includes pre-operative visits the day before the day of surgery. For minor procedures, this includes pre-operative visits the day of surgery.
- Intra-operative services that are normally a usual and necessary part of a surgical procedure
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery
- Post-surgical pain management by the surgeon
- Supplies, except for those identified as exclusions
- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes

What services are not included in the global surgery payment?

The following services are not included in the global surgical payment. These services may be billed and paid for separately:

- Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries. This is billed separately using the modifier “-57” (Decision for Surgery). This visit may be billed separately only for major surgical procedures.

Note: The initial evaluation for minor surgical procedures and endoscopies is always included in the global surgery package. Visits by the same physician on the same day as a minor surgery or endoscopy are included in the global package, unless a significant, separately identifiable service is also performed. Modifier “-25” is used to bill a separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure.

- Services of other physicians related to the surgery, 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 that occur during the post-operative period which are not re-operations or treatment for complications

Note: A new post-operative 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.

- Treatment for post-operative complications requiring 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.
- Immunosuppressive therapy for organ transplants
- Critical care services (CPT codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

How are minor procedures and endoscopies handled?

Minor procedures and endoscopies have post-operative periods of 10 days or zero days (indicated by 010 and 000, respectively).

For 10-day post-operative period procedures, Medicare does not allow separate payment for post-operative 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 generally not included in the global fee for minor procedures.

For zero day post-operative period procedures, post-operative visits beyond the day of the procedure are not included in the payment amount for the surgery. Post-operative visits are separately billable and payable. For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), 40.1.

GLOBAL SURGERY CODING AND BILLING GUIDELINES

Physicians Who Furnish the Entire Global Package

Physicians who furnish the surgery and furnish all of the usual pre-and post-operative care may bill for the global package by entering the appropriate CPT code for the surgical procedure only. Separate billing is not allowed for visits or other services that are included in the global package.

When different physicians in a group practice participate in the care of the patient, the group practice bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is reported as the performing physician.

For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Sections 40.2 and 40.4.

Physicians Who Furnish Part of a Global Surgical Package

More than one physician may furnish services included in the global surgical package. It is possible that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the post-operative, post-discharge care is split among 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 provided all services, except where stated policies allow for higher payment. For instance, when the surgeon furnishes only the surgery and a physician other than the surgeon furnishes pre-operative and post-operative inpatient care, the resulting combined payment may not exceed the global allowed amount.

The surgeon and the physician furnishing the post-operative care must keep a copy of the written transfer agreement in the beneficiary's medical record. 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. Split global-care billing does not apply to procedure codes with a 0-day post-operative period.

Using Modifiers “-54” and “-55”

Where physicians agree on the transfer of care during the global period, services will be distinguished by the use of the appropriate modifier:

- Surgical care only (modifier “-54”)
- Post-operative management only (modifier “-55”)

The physician must use the same CPT code for global surgery services billed with modifiers “-54” or “-55.” The same date of service and surgical procedure code should be reported on the bill for the surgical care only and post-operative care only. The date of service is the date the surgical procedure was furnished.

Modifier “-54” indicates that the surgeon is relinquishing all or part of the post-operative care to a physician.

- Modifier “-54” does not apply to assistant-at-surgery services.
- Modifier “-54” does not apply to an Ambulatory Surgical Center (ASC’s) facility fees.

The physician, other than the surgeon, who furnishes post-operative management services, bills with modifier “-55.”

- Use modifier “-55” with the CPT procedure code for global periods of 10- or 90-days.
- Report the date of surgery as the date of service and indicate the date that care was relinquished or assumed. Physicians must keep copies of the written transfer agreement in the beneficiary’s medical record.
- The receiving physician must provide at least one service before billing for any part of the post-operative care.
- This modifier is not appropriate for assistant-at-surgery services or for ASC facility fees.

For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Sections 40.2 and 40.4.

Exceptions to the Use of Modifiers “-54” and “-55”

Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate E/M code. No modifiers are necessary on the claim.

Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of E/M code, without a modifier.

If the services of a physician, other than the surgeon, are required during a post-operative period for an underlying condition or medical complication, the other physician reports the appropriate E/M code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular

conditions of a patient. For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Sections 40.2 and 40.4.

PRE-OPERATIVE PERIOD BILLING

E/M Service Resulting in the Initial Decision to Perform Surgery

E/M 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. Therefore, these services may be billed and paid separately.

In addition to the CPT E/M code, modifier “-57” (Decision for surgery) is used to identify a visit that results in the initial decision to perform surgery.

The modifier “-57” is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. When the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine pre-operative service and a visit or consultation is not billed in addition to the procedure. MACs may not pay for an E/M service billed with the CPT modifier “-57” if it was provided on the day of, or the day before, a procedure with a 000- or 010-day global surgical period.

DAY OF PROCEDURE BILLING

Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure

Modifier “-25” (Significant, separately identifiable E/M service by the same physician on the same day of the procedure), indicates that the patient’s condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care associated with the procedure or service.

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

Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified non-physician practitioner in the patient’s medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim. For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Sections 30.6.6.

Claims for Multiple Surgeries

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.

Surgeries subject to the multiple surgery rules have an indicator of “2” in the [MPFS look-up tool](#).

NOTE: you must select “Show All Columns” for the “mult surg” column to display. The multiple procedure payment reduction will be applied based on the MPFS approved amount and not on the submitted amount from the providers. The major surgery may or may not be the one with the larger submitted amount.

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.

There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (for example, in some multiple trauma cases). When this occurs, the payment adjustment rules for multiple surgeries may not be appropriate.

For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Section 40.6.

Claims for Co-Surgeons and Team Surgeons

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 procedures and/or the patient’s condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

The following billing procedures apply when billing for a surgical procedure or procedures that require 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” (Two surgeons). Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, such as, heart transplant or bilateral knee replacements. Certain services that require documentation of medical necessity for two surgeons are identified in the MPFS look-up tool.

NOTE: Some procedures require modifier “-62” and will be returned without payment if it is not used by both surgeons.

- 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” (Surgical team). 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.

With regard to payment, for co-surgeons (modifier 62), the fee schedule amount related 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. See MLN Matters® Article [SE1322](#).

For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Section 40.8.

Claims for Assistant-at-Surgery Services

For assistant-at-surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the surgical payment.

MACs may not pay assistants-at-surgery for surgical procedures in which a physician is used as an assistant-at-surgery in fewer than five percent of the cases for that procedure nationally. This is determined through manual reviews.

Procedures billed with the assistant-at-surgery physician modifiers "-80" (Assistant Surgeon), "-81" (Minimum assistant surgeon), "-82" (Assistant surgeon (when qualified resident surgeon not available)), or the AS modifier (physician assistants, nurse practitioners and clinical nurse specialists), are subject to the assistant-at-surgery policy. Accordingly, Medicare pays claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized.

Medicare's policies on billing patients in excess of the Medicare allowed amount apply to assistant-at-surgery services. Physicians who knowingly and willfully violate this prohibition and bill a beneficiary for an assistant-at-surgery service for these procedures may be subject to the penalties contained under §1842(j)(2) of the Social Security Act (the Act). Penalties vary based on the frequency and seriousness of the violation.

Method II Critical Access Hospitals (CAHs) assistant-at-surgery services rendered by a physician or non-physician practitioner that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is billed on type of bill 85X with revenue code (RC) 96X, 97X, or 98X and an appropriate assistant-at-surgery modifier.

For more details, refer to MLN Matters® Article [MM6123](#), "Payment of Assistant-at-Surgery Services in a Method II Critical Access Hospital (CAH)."

For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Section 20.4.3.

POST-OPERATIVE PERIOD BILLING

Unrelated Procedure or Service or E/M Service by the Same Physician During a Post-operative Period

Two CPT modifiers are used to simplify billing for visits and other procedures that are furnished during the post-operative period of a surgical procedure, but not included in the payment for surgical procedure. These modifiers are:

- Modifier “-79” (Unrelated procedure or service by the same physician during a post-operative period). The physician may need to indicate that a procedure or service furnished during a post-operative period was unrelated to the original procedure. A new post-operative period begins when the unrelated procedure is billed.
- Modifier “-24” (Unrelated E/M service by the same physician during a post-operative period). The physician may need to indicate that an E/M service was furnished during the post-operative period of an unrelated procedure. An E/M service billed with modifier “-24” must be accompanied by documentation that supports that the service is not related to the post-operative care of the procedure.

Special Reporting for Certain Practitioners for CPT code 99024

Practitioners are required to report post-operative E/M visits using CPT code 99024 if they:

- Practice in one of the following nine states: Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, or Rhode Island; **and**
- Practice in a group of ten or more practitioners;
- Practitioners who only practice in practices with fewer than 10 practitioners are exempted from required reporting, but are encouraged to report if feasible and,
- Provide global services under one of the required procedure codes. The required procedure codes are those that are furnished by more than 100 practitioners and either are nationally furnished more than 10,000 times annually or have more than \$10 million in annual allowed charges.

The term “practitioner” is used to refer to both physicians and nonphysician practitioners (NPPs) who are permitted to bill Medicare under the PFS for services furnished to Medicare beneficiaries (see 81 FR 80172). This reporting is required for post-operative visits during the global period for procedures with dates of service on or after July 1, 2017. For more information, see [Claims-Based Reporting Requirements for Post-Operative Visits](#).

Codes for Which Reporting on Post-Operative Visits is Required

As of January 1, 2018, there are some changes made to the list of codes for which reporting is required. These changes are made necessary by changes in the coding system.

The following CPT codes no longer need to be reported: CPT codes 15732, 34802, and 34825 are deleted. Reporting is not required after December 31, 2017.

CPT codes 30140, 36470, and 36471 have a 0-day global period so reporting is not needed.

The [Codes for Required Global Surgery Reporting \(CY 2018\) \[ZIP, 20KB\]](#) shows the codes for which reporting is required on or after January 1, 2018.

Return to the OR for a Related Procedure during the Post-Operative Period

When treatment for complications requires a return trip to the operating room, physicians bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, the physician should use the unspecified procedure code in the correct series, which is, 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 report modifier “-78” (Unplanned return to the operating or procedure room by the same physician following initial procedure for a related procedure during the post-operative period).

The physician may also need to indicate that another procedure was performed during the post-operative 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 modifier “-78” does not limit its use to treatment for complications.

Staged or Related Procedure or Service by the Same Physician During the Post-operative Period

Modifier “-58” (Staged or related procedure or service by the same physician during the post-operative period) was established to facilitate billing of staged or related surgical procedures done during the post-operative period of the first procedure. Modifier “-58” indicates that the performance of a procedure or service during the post-operative period was:

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

Modifier “-58” may be reported with the staged procedure’s CPT. A new post-operative period begins when the next procedure in the series is billed.

Critical Care

Critical care services furnished during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances.

Pre-operative and post-operative critical care may be paid in addition to a global fee if:

- The patient is critically ill and requires the constant attendance of the physician; and
- The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.

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

In order for these services to be paid, two reporting requirements must be met:

- CPT codes 99291/99292 and modifier “-25” for pre-operative care or “-24” for post-operative care must be used; and
- Documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-10 code for a disease or separate injury which clearly indicates that the critical care was unrelated to the surgery is acceptable documentation.

Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter, for example, Swan-Ganz (CPT code 93503) are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing the pre, intra, and post procedure work of these unbundled services, for example, endotracheal intubation, shall be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0, 10 or 90 day global period including cardiopulmonary resuscitation or CPR (CPT code 92950). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care may be billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing CPR shall be excluded from the determination of the time spent providing critical care. In this instance, it must be the physician who performs the resuscitation who bills for this service. Members of a code team must not each bill Medicare Part B for this service.

For more information, on Global Surgery and Critical care refer to the Medicare Claims Processing Manual, [Chapter 12](#), Section 30.6.12, Part K.

SPECIAL BILLING SITUATIONS

Care Provided in Different Payment Localities

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

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.

Billing Wrong Surgical or Other Invasive Procedures Performed on a Patient; Surgery or Other Invasive Procedure Performed on the Wrong Body Part; and Surgical or Other Invasive Procedures Performed on the Wrong Patient

Providers are required to append one of the following applicable HCPCS modifiers to all lines related to the erroneous surgery or surgeries:

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

For more details, refer to the National Coverage Determination Manual, [Chapter 1](#), Part 2, Section 140.6, 140.7, and 140.8

Additional information is available in the Medicare Claims Processing Manual, [Chapter 32](#), Section 230.

Billing for Mohs Procedure

Medicare will only reimburse for Mohs Micrographic Surgical (MMS) services when the Mohs surgeon acts as both surgeon and pathologist. You may not bill Medicare for these procedures if preparation or interpretation of pathology slides is performed by a physician other than the Mohs surgeon. For more information, refer to MLN Matters® Special Edition Article [SE1318](#).

Billing for Bilateral Procedures

The terminology for some procedure codes includes the terms “bilateral” (such as code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or “unilateral or bilateral” (for example, 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.

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.”

For more information, refer to the Medicare Claims Processing Manual, [Chapter 12](#), Section 40.7.

RESOURCES

The following table shows the resources available for billing Medicare for Global Surgeries:

FOR MORE INFORMATION ABOUT...	RESOURCE
Surgeons and global billing	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
Medicare Physician Fee Schedule (MPFS) Look-up Tool	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSLookup/index.html
MMPFS Fact Sheet (ICN 006814), which includes information on physician services, Medicare PFS payment rates, and Medicare PFS payment rates formula	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareRemit_0408.pdf
Billing wrong surgical or other invasive procedures	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
MLN Matters Article SE1322 on billing and payment rules for global surgical packages that are split between two or more physicians	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1322.pdf
MLN Matters Article SE1318 on Mohs Surgery	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1318.pdf

Hyperlink Table

EMBEDDED HYPERLINK	COMPLETE URL
Medicare Claims Processing Manual, Chapter 12	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
MLN Matters Article MM9533	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9533.pdf
MLN Matters Article MM9633	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9633.pdf
MLN Matters Article MM9749	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9749.pdf
MLN Matters Article MM6123	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6123.pdf
National Coverage Determination Manual, Chapter 1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf
Medicare Claims Processing Manual, Chapter 32	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf
Codes for Required Global Surgery Reporting (CY 2018) [ZIP, 20KB]	https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Downloads/CY-2018-Codes-for-Required-Global-Surgery-Reporting.zip
Claims-Based Reporting Requirements for Post-Operative Visits	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Global-Surgery-FAQs.pdf

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