CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11287	**Date: March 2, 2022**
	Change Request 12550

Transmittal 11195, dated January 20, 2022, is being rescinded and replaced by Transmittal 11287, dated, March 2, 2022 to revise the IOM updates for Pub 100-04 Chapter 12 Sections 40.1 through 40.4. All other information remains the same.

SUBJECT: Internet-Only Manual Updates for Critical Care Evaluation and Management Services

I. SUMMARY OF CHANGES: This Change Request updates the Internet-Only Manual (IOM) to conform with updated policies published in the "CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies" final rule (CMS-1751-F) for critical care evaluation and management services. The IOM sections updated here include Pub. 100-04, chapter 12.

EFFECTIVE DATE: January 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 22, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/40.1 - Definition of a Global Surgical Package
R	12/40.2 - Billing Requirements for Global Surgeries
R	12/40.3 - Claims Review for Global Surgeries
R	12/40.4 - Adjudication of Claims for Global Surgeries

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11287	Date: March 2, 2022	Change Request: 12550

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SUBJECT: Internet-Only Manual Updates for Critical Care Evaluation and Management Services

EFFECTIVE DATE: January 1, 2022
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IMPLEMENTATION DATE: February 22, 2022

I. GENERAL INFORMATION

A. Background: This Change Request updates the Internet-Only Manual (IOM) to conform with updated policies published in the "CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies" final rule (CMS-1751-F) for critical care evaluation and management services. The IOM sections updated here include Publication (Pub.) 100-04, Chapter 12.

B. Policy: The Medicare Benefit Policy Manual, Pub. 100-04, Chapter 12, has been revised as follows:

- 40.1 Definition of a Global Surgical Package: Added language to direct reader to critical care updates in section 30.6 of the same chapter
- 40.2 Billing Requirements for Global Surgeries: Added language regarding use of the modifier -FT when billing unrelated procedures or evaluation and management visits during the postoperative period
- 40.3 Claims Review for Global Surgeries: Added language regarding the modifier – FT (unrelated evaluation and management visit)
- 40.4 Adjudication of Claims for Global Surgeries: Added language indicating that critical care services during the global period must be unrelated to the procedure

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12550.1	Contractors shall be aware of the updates listed in this CR to IOM Pub. 100-04, Chapter 12.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12550.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Liane Grayson, liane.grayson@cms.hhs.gov , Scott Lawrence, scott.lawrence1@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

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.

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.*

C. Minor Surgeries and Endoscopies

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

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.

- 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:

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

*M*odifiers 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 99221-9223, 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;

- 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

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:

Services listed in §40.1.B; and
Services billed with the modifier "-25," "-57," "-58," "-78," or "-79."

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 it 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.

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.

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 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.

6666 x .17 = .11333 or 11.3%; and

3338 x .17 = .057 or 5.7%.

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

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

When a physician submits a claim with modifier "-22" but does not provide additional 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