national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Spring 2025 Virtual Conference

Understanding Medicare Compliance for Part B Providers

Medicare Global Surgery

6/3/2025

NGSMU
NGS Medicare University

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2732_060325

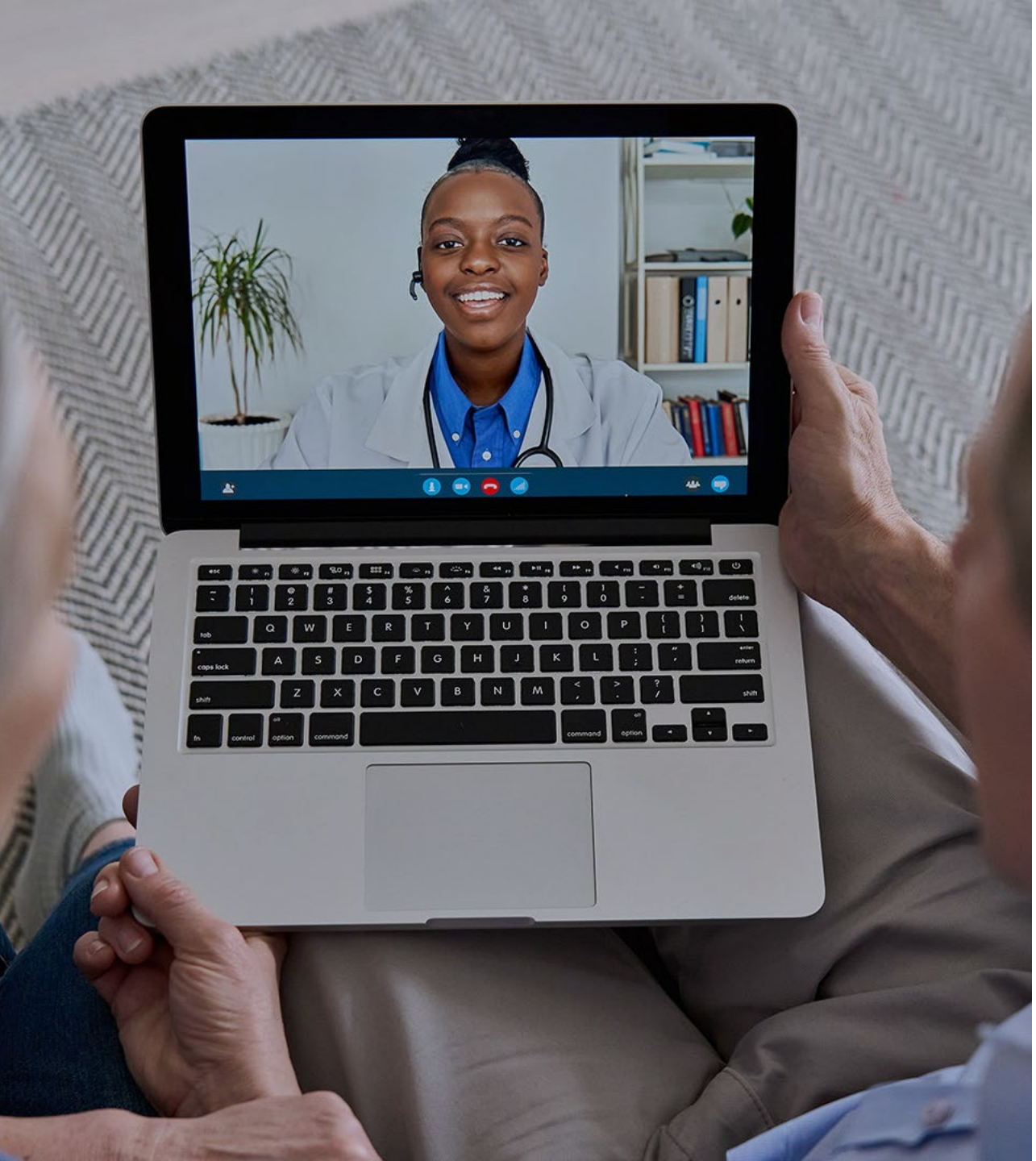
Today's Presenters

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

- Provider Outreach and Education Consultants
  - Nathan L. Kennedy, Jr., CHC, CPC, CPPM, CPB, CPMA, CPC-I
  - Christine Brauer, CPC, CPC-I, ICD-10-CM Approved Instructor

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.



Recording

Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events. **This includes the use of AI-assistant recording tools.**

Objective

At the conclusion of this session, you'll be able to

- Understand the global surgery concept
- Review self-service options for global surgery
- Identify proper modifier selection

Agenda

- Global Surgery Concept
- Global Surgery Indicators
- Introduction to Modifiers
- Evaluation and Management Modifiers
- Modifiers LT/RT and 50
- Modifiers Used for Split Care
- Additional Modifiers 58, 78 and 79
- 2025 Updates
- Wrap Up and Resources

Global Surgery Concept

Definition and Purpose

- Definition
  - Global surgery is defined as a single fee billed and paid to include all necessary services normally furnished by the surgeon before, during, and after the procedure
- Purpose
  - To allow payment for a surgical procedure which include the preoperative, intraoperative, and postoperative services
  - Surgical procedures 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 reimbursed as though they were a single physician

Global Surgery Settings

- Services may be furnished in any setting
  - Physicians' Office
  - Hospital (Inpatient or Outpatient)
  - Intensive or Critical Care Unit
  - Ambulatory Surgical Center

Services Included in Global Surgery Package

- Medicare payment includes
  - Preoperative visits after the decision is made to operate
  - Major procedures include preoperative visits the day before the day of surgery
  - Minor procedures include preoperative visits the day of surgery
- Intraoperative services
  - Normally a usual and necessary part of a surgical procedure

Additional Services Included in the Global Surgery Package

- Postoperative days
  - Begins the day after the surgical procedure
  - Follow up visits related to recovery from surgery
  - Post surgical pain management by surgeon
  - Treatment for complications
  - Miscellaneous services
    - Dressing change
    - Suture and staple removal
    - Bedside minor procedure

Services Not Included in Global Surgery Package

- Services excluded from global surgery
  - Initial evaluation resulting in decision for surgery (major)
  - Services of other physicians (in different group practice or different specialty within the same group)
- Visits unrelated to surgery diagnosis
- Diagnostic tests/procedures
- Clearly distinct surgical procedures during postoperative period
- Postoperative complications which require return trip to operating room

Additional Services Not Included in Global Surgery Package

- Unrelated critical care services for seriously injured or burned patient
- Treatment for underlying condition or added course of treatment
- Immunosuppressive therapy for organ transplant

Overview of Global Surgery Periods

Global Surgery Period	Definitions
0	Endoscopies and minor procedures
10	Other minor procedures
90	Major surgical procedures
XXX	Global surgery concept does not apply
YYY	Contractor priced
ZZZ	Add-on codes are always billed with another procedure There is no postoperative work included in the MPFSDB Payment is made for both primary and add-on codes

0 - Day Postoperative Period

- Applies to endoscopies and some minor procedures
  - No preoperative period
  - No postoperative period
  - Visit on the day of the procedure is generally not payable as a separate service
    - Modifier 25 would need to be reported for significant and separately identifiable E/M visit

10 - Day Postoperative Period

- Applies to other minor procedures
  - No preoperative period
  - Visit on the day of the procedure is generally not payable as a separate service
    - Modifier 25 would need to be reported for significant and separately identifiable E/M visit
  - Total global period is 11 days
    - Count the day of surgery, and
    - Count the ten days immediately following the day of surgery

90 - Day Postoperative Period

- Applies to major surgery procedures
  - One day preoperative visit (day before and the day of surgery)
  - All intraoperative services normally part of the recovery for the surgical procedure
  - Total global period is 92 days
    - Count one day before surgery
    - Count the day of surgery, and
    - Count the 90 days immediately following the day of surgery

Other Payment Rules

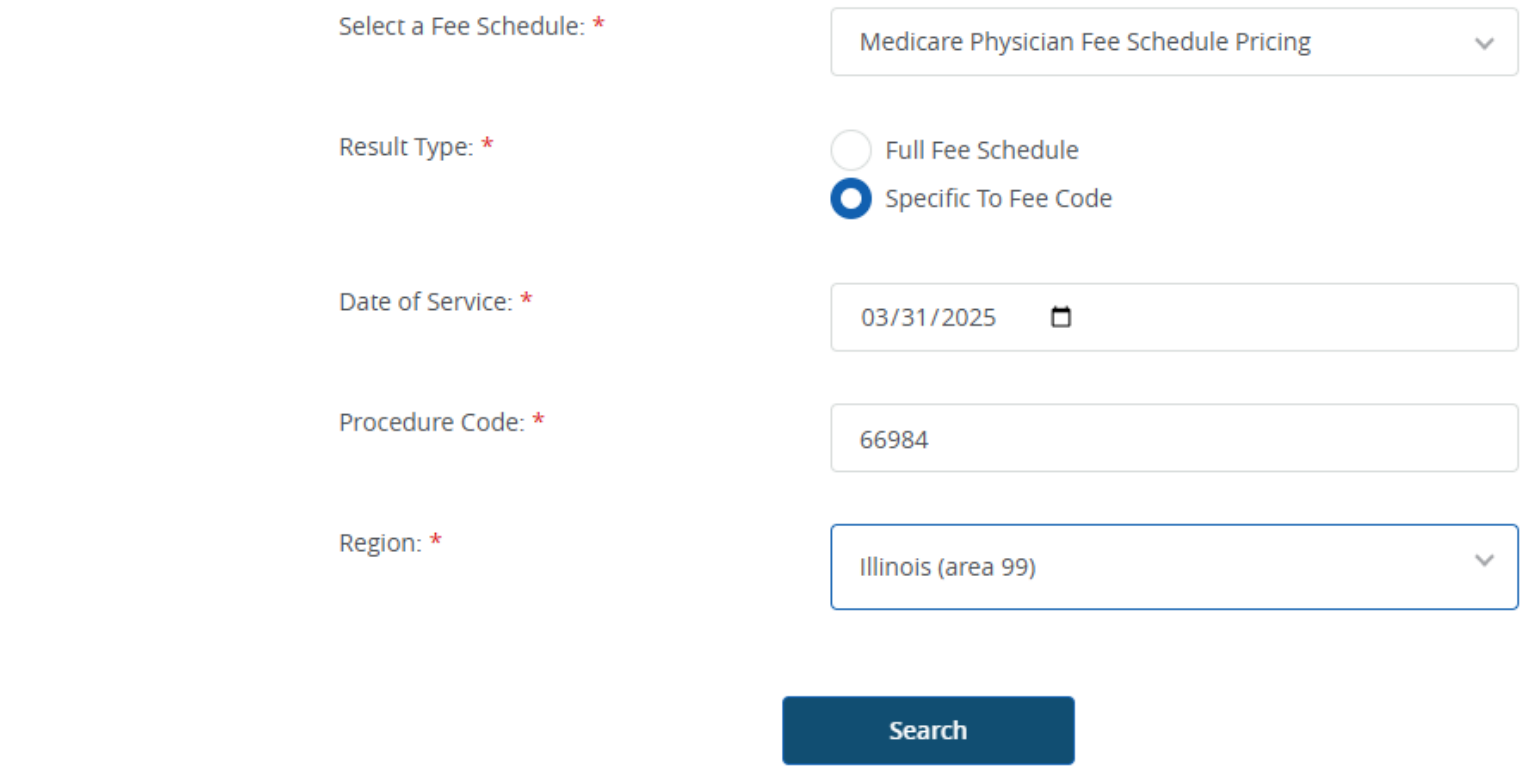
- XXX – global days
  - Global surgery concept does not apply
  - Modifiers should not be reported
- YYY – global days
  - Global period is contractor-priced
    - Contractors determine the global period of 0, 10 or 90 days
- ZZZ – global days
  - Add-on codes (AOCs) are always billed with another procedure
  - There is no postoperative work included in the MPFSDB
  - Payment is made for both primary and add-on codes

Global Surgery Indicators

Physician's Fee Schedule Code Search

- Some benefits of NGS physician fee schedule tool
  - Single code search
  - Fee schedule detail
  - General status indicators
  - Surgical indicators
    - Global surgery days
    - Bilateral surgery
    - Multiple procedures
    - Assistant at surgery

Fee Schedule Lookup



Fee Schedule Lookup

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
66984	01/01/2025	06102	99	Xcapsl ctrc rmvl w/o ecp

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	505.10	479.85	551.83	505.10	479.85	551.83

OPPS Capped Payment Rates (OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	0.00	0.00	0.00	0.00	0.00	0.00

The full Fee Schedule for this code can be downloaded in the following formats below:

Excel File **CSV File**

Database Indicators on Fee Schedule

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	505.10	479.85	551.83	505.10	479.85	551.83

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	32.3465	1.0000	7.35	8.23	8.23

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.55	1.000	0.912	1.381	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
090	1	0	10.00%	70.00%	20.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
2	1	1	0	0

Introduction to Modifiers

Modifiers

- Definition
  - A modifier provides the means to report or indicate that a service that has been performed has been altered by some specific circumstances from the procedure codes definition, however, the definition of the procedure code has not changed
- Purpose
  - Modifiers enable health care professionals to effectively respond to payment policy requirements

Claim Reporting

- Modifiers should be reported in Item 24D on the CMS-1500 claim form or the electronic equivalent
  - Loop 2400, Segment SV101 3-6
- Informational modifiers
  - Provides additional information but does not affect the reimbursement
  - Should be used in the second, third or fourth fields
    - When entering only informational modifiers the order does not matter

Code/Modifier Documentation

- Is there documentation to support the services reported?
  - Painting the picture of what is occurring during the patient encounter
- Are the codes that were reported correct to describe the services?
  - The modifier and CPT and/or HCPCS must match the documentation
- Should the codes be reported together on the claim based on the documentation?
  - Ensure the code pairs and terminology match what occurred during the encounter
- Is a modifier appropriate based on the documentation?
  - Proper selection of the correct modifier is essential

Evaluation and Management Modifiers

E/M Modifier Definitions

Modifier	Definition
24	Unrelated E/M services by the same physician or other qualified health care professional (QHP) during a postoperative period
25	Significant separately identified E/M services by the same physician or other QHP on the same day of the procedure or other service
57	Decision for surgery
FT	Unrelated E/M visit during a postoperative period, or on the same day as a procedure or another E/M visit

E/M Modifiers

- E/M services are part of the global period unless the service meets an exception
- When appropriate the following modifiers can be used during a global period
  - Modifier 24
  - Modifier 25
  - Modifier 57
  - Modifier FT – Critical care only
- Modifier should be reported on the E/M code only
- Same physician would include a physician(s) in the same group practice who are of the same specialty
- QHPs include nonphysician practitioners
- Documentation must support the use of any modifier

Modifier 24

- Definition
  - Unrelated E/M services by the same physician or QHPs during a postoperative period
- Purpose
  - Applied to two code sets
    - E/M services (99202-99499)
    - General ophthalmological services (92002-92014)
  - An unrelated E/M service is performed during the 10 or 90-day postoperative period
  - Documentation indicates the service was exclusively for treatment of the underlying condition and unrelated to the surgical procedure
  - The same diagnosis as the original procedure could be used for the new E/M if the problem occurs at a different anatomical site

Incorrect Use of Modifier 24

- Diagnosis is not the same, but is related
  - Treatment of infection from the surgery
  - Treatment of pain following the surgery
  - Related applies for inpatient care needed to treat infection or pain
- Surgeon asks a NPP in same group to provide the surgery follow up care
- Performing provider is not in the same group with the same specialty
- Exams performed for routine postoperative care
- Surgeon admits a patient to a skilled nursing facility for a condition related to the surgery
- Surgical procedures, labs, X-rays, or supply codes

Modifier 25

- Definition
  - A significant, separately identifiable E/M service by the same physician or qualified healthcare professional on the day of a procedure
- Purpose
  - The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date
- Modifier 25 should not be reported on procedure code 99211
  - Presenting problems are usually minimal

Incorrect Use of Modifier 25

- Adding
  - Decision for minor (zero or ten-day) surgery
  - Use based on diagnosis
  - Automatically by electronic health record or staff
  - Every time
- Critical care during global surgery period
- Should not be reported on procedure code 99211
- Do not append to the following E/M codes that are clearly for new patient only
  - 92002
  - 92004
  - 99202-99205
  - 99341-99345
  - Note: The codes listed above are listed as new patient codes and are automatically excluded from global surgery package edit. They are reimbursed separately from surgical procedures

Modifier 25 Documentation

- Significant
  - Great amount of additional work over and above what is normal with the procedure
- Separately identifiable
  - Medical records supports the significant service and can identify separately
- Suggestion
  - Perform a self-audit
  - Identify incorrect use
  - Make appropriate refunds

Modifier 57

- Definition
  - Use to indicate an E/M service resulted in **the initial decision to perform surgery** either the **day before a major surgery** (90 day global) or the **day of a major surgery**
- Global period includes the following
  - Day before surgery
  - Day of the surgery
  - Number of days following the surgery

Modifier FT

- Definition
  - Unrelated E/M visit during a postoperative period, or on the same day as a procedure or another E/M visit
- Purpose
  - Report
    - For critical care visits that are unrelated to the surgical procedure but performed on the same day; or
    - When critical care services provided during a global surgical period are unrelated to a surgical procedure
- References
  - MLN Matters® *MM12550 Revised: Internet-Only Manual Updates for Critical Care Evaluation and Management Services*
  - MLN Matters® *MM12543 Revised: Internet-Only Manual Updates (IOM) for Critical Care, Split/ Shared Evaluation and Management Visits, Teaching Physicians, and Physician Assistants*

FT Modifier Documentation

- When using the FT Modifier
  - Must support definition of critical care
    - Critically ill/injured patient
    - Acute impairment of one or more vital organ systems
    - Probability of imminent or life-threatening deterioration of the patient's condition
    - Involves high complexity decision-making
  - Unrelated to surgery procedure

Multiple Modifiers

- Decision for major surgery during postoperative period of another surgery
  - Modifier 24 and 57
- Significant, separately identifiable on same day as surgery within postoperative period of another surgery
  - Modifier 24 and 25
- Unrelated critical care during postoperative period of one surgery and decision for another major surgery
  - Modifier FT and 57

Modifiers LT, RT and 50

Modifier Definitions for LT, RT and 50

Modifier	Definition
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
50	Bilateral procedures that are performed at the same session or same day on both sides of the body

Modifiers LT and RT

- Modifier LT – Left side
  - Use modifier LT to identify procedures performed on the left side of the body
- Modifier RT – Right side
  - Use modifier RT to identify procedures performed on the right side of the body
- Modifiers are used with diagnostic and therapeutic services
  - Modifier LT and RT are used for unilateral services
  - Do not use LT and RT when performing bilateral services
    - Explore modifier 50
    - Bilateral Indicators

Modifier 50

- Definition
  - Bilateral Procedure - Use modifier for bilateral procedure performed at the same operative session
- Appropriate use
  - Code descriptor is key
    - Do not use modifier 50 when the terminology of the code include bilateral or unilateral
  - Report modifier 50 as a single line item with a unit of one
  - Medicare bases pricing for bilateral procedure on the indicator outlined on the fee schedule
    - 0 = does not apply
    - 1 = 150% payment adjustment for bilateral applies
    - 2 = 150% payment does not apply
    - 9 = bilateral payment does not apply

Bilateral Indicator of 1

- Modifier 50 identifies the bilateral procedure performed at the same operative session
- When reporting a procedure with a bilateral indicator of “1”
  - Report modifier 50
  - Report a unit of “1” on the same line of service
  - Do not report anatomical modifiers in addition to modifier 50
    - Report anatomical modifiers only when the service is performed unilaterally to show additional services are not a duplicate

Medically Unlikely Edits (MUEs)

- Definition
  - A MUE for a HCPCS/CPT code is the maximum unit of service (UOS) reported
    - For a single beneficiary on date of service or claim line
    - On a single date of service
- Purpose
  - CMS developed MUEs to reduce the paid claims error rates
- Be aware of the description of a HCPCS/CPT code when billing a service
  - Initial or subsequent
  - Single level or second level
- Many HCPCS/CPT codes have common or similar terms, but there are differences in the description
  - Some examples include
    - Bilateral or unilateral
    - Greater than or less than
    - With or Without
- Updated quarterly
- MUE tables do not address modifiers

MAI Assignments

- MAI indicators determine how the edits process in the system
- MLN Matters® *MM8853: Revised Modification to the Medically Unlikely Edit (MUE) Program*

MAI of 1	MAI 2	MAI 3
Claim line edit	Absolute date of service edit	Date of service edit
May require modifiers to distinguish	CMS gives no instances in which a higher value would be correct and payable	Appealed additional units are considered if there is adequate documentation of medical necessity to support reported units

MUE and Bilateral Surgical Procedures

- MUE edits may limit UOS
- Modifier 50 should be used to report bilateral surgical procedures as a single unit of service to avoid denials
  - Bill one line item with CPT code and append modifier 50
- References
  - MLN Matters® *SE1422 Revised: Medically Unlikely Edits (MUE) and Bilateral Surgical Procedures*
  - Medicare NCCI Policy Manual

HCPCS/CPT Code	MUE Values	MAI Indicator	MUE Rationale
64445	1	3 Date of Service Edit: Clinical	Clinical: Data
23515	1	2 Date of Service Edit: Clinical	CMS Policy

Problematic Use of Modifier 50

- Reporting Errors
  - Codes that indicate bilateral in the code descriptor
  - Midline organs
  - Different areas on the same side of the body
  - Not reported with add on codes
- Resolutions
  - Review the procedure code descriptor do not
    - Use the descriptor indicates bilateral, unilateral or same side of the body
    - Append to midline organs such as the bladder, uterus, esophagus or nasal septum
  - Review the bilateral surgery indicator:
    - Do not append when indicator is a 0, 2, 3 or 9

Modifiers Used for Split Care

Modifier 54 - Surgical Care Only

- Modifier 54 indicates that the surgeon is relinquishing all or part of the postoperative care to a physician
- Appropriate use
  - Surgeon performs surgery only
    - Bill surgical date of service
    - Append modifier 54 to surgical code
- Inappropriate use
  - If the patient is under surgeon's care for the full ten or 90 days of postoperative care, modifier is not required
  - Does not apply to ASC facility or assistant surgeon services

Modifier 55 - Postoperative Management Only

- Modifier 55 - Indicates the physician, other than the surgeon, who furnishes postoperative management services
- Appropriate use
  - Use with the surgical procedure code for global periods of ten or 90 days
  - Report the date of surgery as the date of service
  - Indicate the date care was relinquished or assumed in item 19 narrative of CMS-1500 claim form or electronic equivalent and the number of days
  - The receiving physician must provide at least one service before billing for any part of the postoperative care
  - Submit claim with number of units as one
- Inappropriate use
  - If patient is under surgeon's care for full ten or 90 days postoperative care
  - Doesn't apply to ASC facility or assistant surgeon services

Incorrect Use of Modifiers 54 and 55

- Modifiers 54 and 55
  - Incorrect date of service on claim
  - Modifier 55 with different surgical procedure
  - Item 19 on CMS 1500 claim form left blank
    - No assumed or relinquished dates indicated
    - No amount of days indicated
  - Maintain documented transfer agreement in medical record for physician furnishing postoperative care
  - Appropriate modifiers not used by surgeon or physician assuming postoperative care
    - Ex: Surgeon bills claim without appropriate modifier
      - Causes physician claim for postop care to deny
      - Claims billed in this manner appear as though surgeon did surgery and post-op care

Modifier 54 and 55 - Common Scenarios

- Example 1 Surgery only with no follow up care
  - Dr. Johnson performed cataract surgery (CPT 66984) on October 2
  - He transfers patient care to ophthalmologist, Dr. Pierce, on October 3
  - Dr. Pierce relinquished care on January 1
- Example 2 Surgery and partial follow up care
  - Dr. Johnson performed cataract surgery (CPT 66984) on October 2 and saw patient for follow up care through October 12
  - Dr. Johnson transfers care to patient's ophthalmologist, Dr. Pierce, who relinquished care on January 1

Modifier 54 and 55 – Example 1 Reporting Surgery Only with no Follow Up Care

- Surgeon's Care (Dr. Johnson)
  - Date: October 2
  - CPT: 66984 54
  - Date of service: 10/2
  - Item 19
    - Blank
- Comanaging Physician (Dr. Pierce)
  - Date: October 3- January 1
  - CPT: 66984 55
  - Date of service: 10/2
  - Item 19
    - Assumed postop care on 10/3 relinquished on 1/1
    - Include the number of days of care
      - 89 Days

Modifier 54 and 55 - Example 1 Reporting (Cont.)

- Surgeon's claim example

Date of Service	CPT Code/ Modifier	Quantity	Item 19
10/2/2022	66984 54	1	(Blank)

- Comanaging physician's claim example

Date of Service	CPT Code/ Modifier	Quantity	Item 19
10/2/2022	66984 55	1	Assumed postop care on 10/3 - relinquished on 1/1 for 89 days

Example 2 Split Care Breakdown Surgery and Partial Follow Up Care

- Surgeon's Care (Dr. Johnson)

Date	CPT
• October 2	66984 54
• October 2-12	66984 55

Date of service: 10/2

- Item 19
  - Assumed postop care on 10/2, relinquished on 10/12
  - Include the number of days of care
    - 11 days

- Comanaging Physician (Dr. Pierce)

Date	CPT
• October 13 – January 1	66984 55

Date of service: 10/2

- Item 19
  - Assumed postop care on 10/13 relinquished on 1/1
  - Include the number of days of care
    - 79 Days

Example 2 Split Care Breakdown (Cont.)

- Surgeon's claim example

Date of Service	CPT Code/ Modifier	Quantity	Item 19
10/2/2022	66984 54	1	(Blank)
10/2/2022	66984 55	1	Assumed postop care on 10/2, relinquished on 10/12

- Comanaging physician's claim example

Date of Service	CPT Code/ Modifier	Quantity	Item 19
10/2/2022	66984 55	1	Assumed postop care on 10/13, relinquished on 1/1 for 79 days

Additional Modifiers – 58, 78 and 79

Surgical Modifier Definitions

Modifier	Definition
58	Staged or related procedure by the same physician during the postoperative period
78	Unplanned return to the operating room by the same physician following initial procedure for a related procedure during the postoperative period
79	Unrelated procedure by the same physician during the postoperative period

Modifier 58 Staged or Related

- Definition
  - Staged or related procedure by the same physician or qualified healthcare professional during the postoperative period
- Purpose
  - Report on procedures
    - Planned or anticipated (staged) procedures
    - More extensive than original procedure
    - Therapy following a diagnostic, surgical procedure
- A new postoperative period begins when the next procedure in the series is billed

Incorrect Use of Modifier 58

- Staged procedure billing with modifier 58 does not apply to
  - Services billed by the ASC Facility
  - Procedures with 000 and XXX global periods
  - Unrelated procedures during the postoperative period
  - Reporting the treatment of a complication from original surgery that requires a return to operating room

Modifier 58 - Example

- A patient undergoes a left breast biopsy and the physician diagnoses breast cancer
  - One week later, the surgeon performs a modified radical left breast mastectomy
  - The biopsy was the primary procedure resulting in a more extensive procedure, append modifier 58 to the left breast mastectomy code
  - Modifier 58 is appropriate when the physician did not plan the subsequent procedure, when the procedure is more extensive than the first procedure

Modifier 58 Tips

- In surgical situations when a subsequent procedure takes place within the global period of the original procedure because the physician anticipated a planned (or staged) procedure, modifier 58 comes into play
  - Modifier 58 can apply when the subsequent procedure is
    - Unplanned
    - Related to the cause of the original procedure
    - More extensive than the original

Modifier 78

- Definition
  - Unplanned return to the operating room (OR) by the same physician or qualified professional following initial procedure for a related procedure during the postoperative period
- Purpose
  - To identify a related procedure during a postoperative period (ten or 90 days) requiring a return trip to the OR
    - To treat the patient for complications resulting from the original surgery
    - When the procedure code used to describe a service for a treatment of complications is the same as the procedure code used in the original procedure
- A new postoperative period does not begin

Place of Service - Operating Room

- Place of service specifically equipped and staffed for the sole purpose of performing procedures in
  - Operating Room
  - Cardiac Catheterization Suite
  - Laser Suite
  - Endoscopy Suite
- Does not include services performed in
  - Patient's room
  - A minor treatment room
  - Recovery room
  - Intensive care unit (ICU)
    - Exception: Patient was critical

Incorrect Use of Modifier 78

- Modifier reported errors on
  - Procedures outside of the global period
  - Unrelated procedures
  - ASC facility services
  - Procedures not provided in the OR setting
- Resolutions
  - Review the original surgical procedure for global period
    - Global days must be within a ten or 90 period
  - Review the medical record documentation and CPT terminology to verify that the service is related
  - ASC facilities should not append the modifier, only the physician who performed the service would append the modifier
  - Identify the related procedure during a postoperative period (ten or 90 days) requiring a return trip to the OR

Modifier 79

- Definition
  - Service is an unrelated procedure that was performed by the same physician during a postoperative period
- Purpose
  - To allow appropriate reporting of identical procedures performed on the same day, by the same physician, but are not the same service on the same anatomical site
- A new postoperative period begins when the unrelated procedure is billed
- Supporting documentation must substantiate the unrelated surgeries

Incorrect Use of Modifier 79

- Errors
  - Reporting modifier on procedures that are related
  - Reporting modifier on surgical procedures that have an XXX indicator or are outside the global period
  - Reporting on ASC facility claim
- Resolutions
  - Review the medical record documentation and CPT terminology to verify that the service reported is unrelated
  - Review the original surgical procedure for global period
    - Global days must be within a ten or 90 period
    - XXX indicator advises that the concept does not apply
  - ASC facilities should not append the modifier, only the physician who performed the service would append the modifier

When Not to Use Modifier 79

- When the two surgeries are related
- When a different physician or qualified healthcare professional performs the operation.
- When the operation happens outside the postop period

2025 Updates

Strategies for Improving Global Surgery Payment Accuracy

- Beginning with services furnished in CY 2025, modifier 54 will be required for **all** 90-day global surgical packages in any case when a practitioner plans to furnish only the surgical procedure portion of the global package (including both formal and other transfers of care)
  - Will improve payment accuracy
  - Inform CMS about how global package services are typically furnished
- For CY 2025, there will be no changes regarding the use of modifier 55 and modifier 56
  - Continue to bill exclusively in cases where there is a documented formal transfer of care

Strategies for Improving Global Surgery Payment Accuracy

- Add-on HCPCS code G0559 will be used for practitioners who did **not** furnish the surgical procedure and did not have the benefit of a formal transfer of care
  - List separately in addition to O/O E/M visit, new or established patient
  - Billed only once per practitioner during the 90-day global period (additional resource costs would be incurred upon the first visit)
  - Should **not** be billed by another practitioner in the same group practice as the surgeon or the same specialty
  - Will reflect the time and resources involved in postop follow up visits by practitioners not involved in furnishing the surgical procedure

Strategies for Improving Global Surgery Payment Accuracy

- Required elements for G0559, when possible and applicable
  - Reading available surgical note to understand the relative success of the procedure
  - Research the procedure to determine expected postoperative course and potential complications
  - Evaluate and physically examine the patient to determine whether the postoperative course is progressing appropriately
  - Communicate with the practitioner who performed the procedure
- Documentation should indicate the relevant surgical procedure, to the extent the billing practitioner can readily identify it

Wrap Up and Resources

Key Takeaways

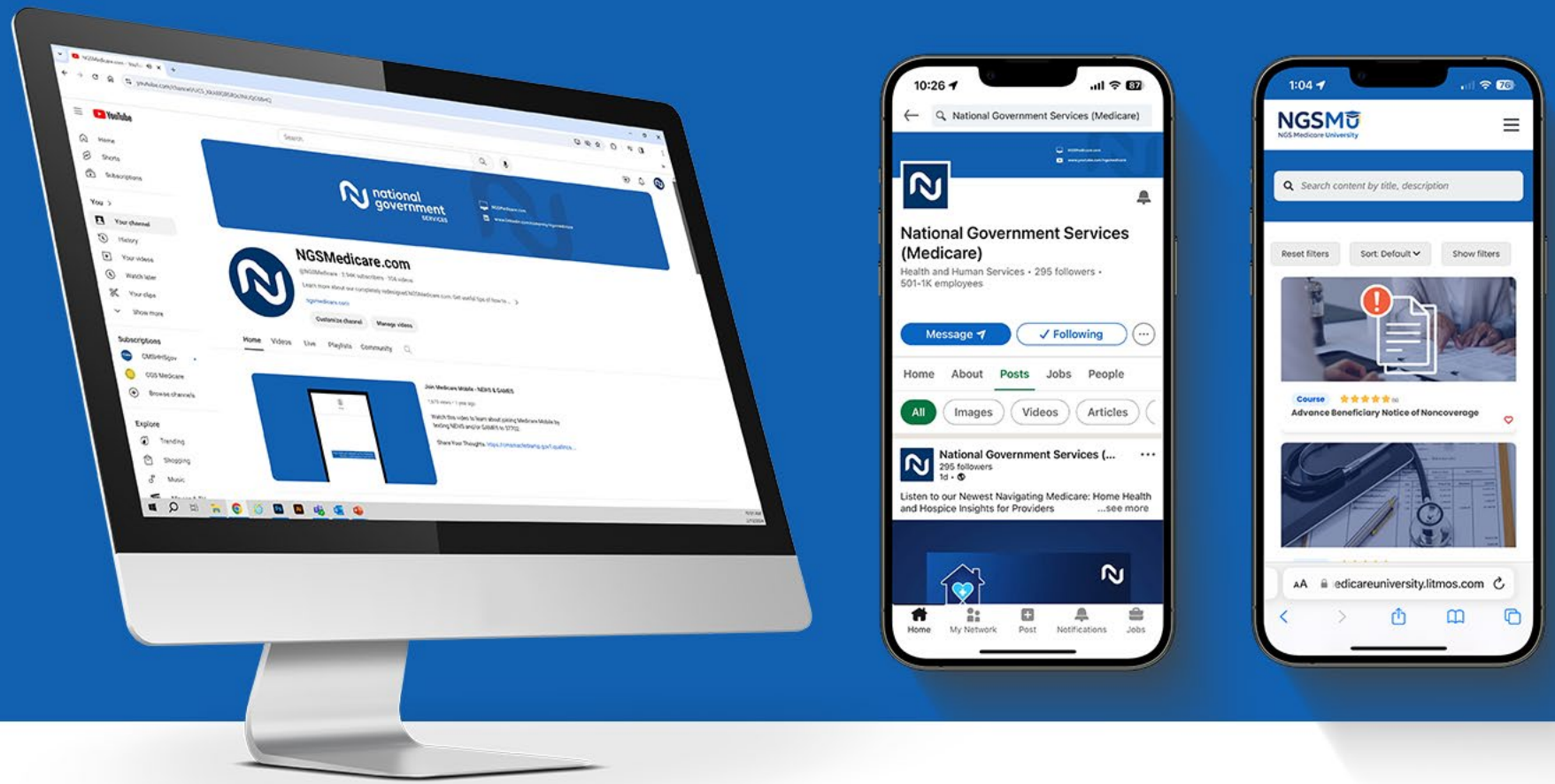
- The postoperative period begins the day after the surgical procedure
- Global surgery modifiers should only be reported during an active global period
- E/M services performed during a global period are often bundled into the payment for the surgical procedure

Key Takeaways

- Do not use modifier 50 when the terminology of the code include bilateral or unilateral
- Modifier LT and RT are used for unilateral services
- Split care services require narrative information when care is relinquished or assumed
- Modifier 58 is used for staged procedures
- Modifier 78 is used for related procedure during a postoperative period requiring a return trip to the OR
- Modifier 79 begins a new postoperative period when the unrelated procedure is billed

Resources and References

- MLN® Booklet *Global Surgery*
- Medicare Physician Fee Schedule (MPFS) Look-up Tool
- NGS Global Surgery Calculator
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 40
- NGS Global Surgery



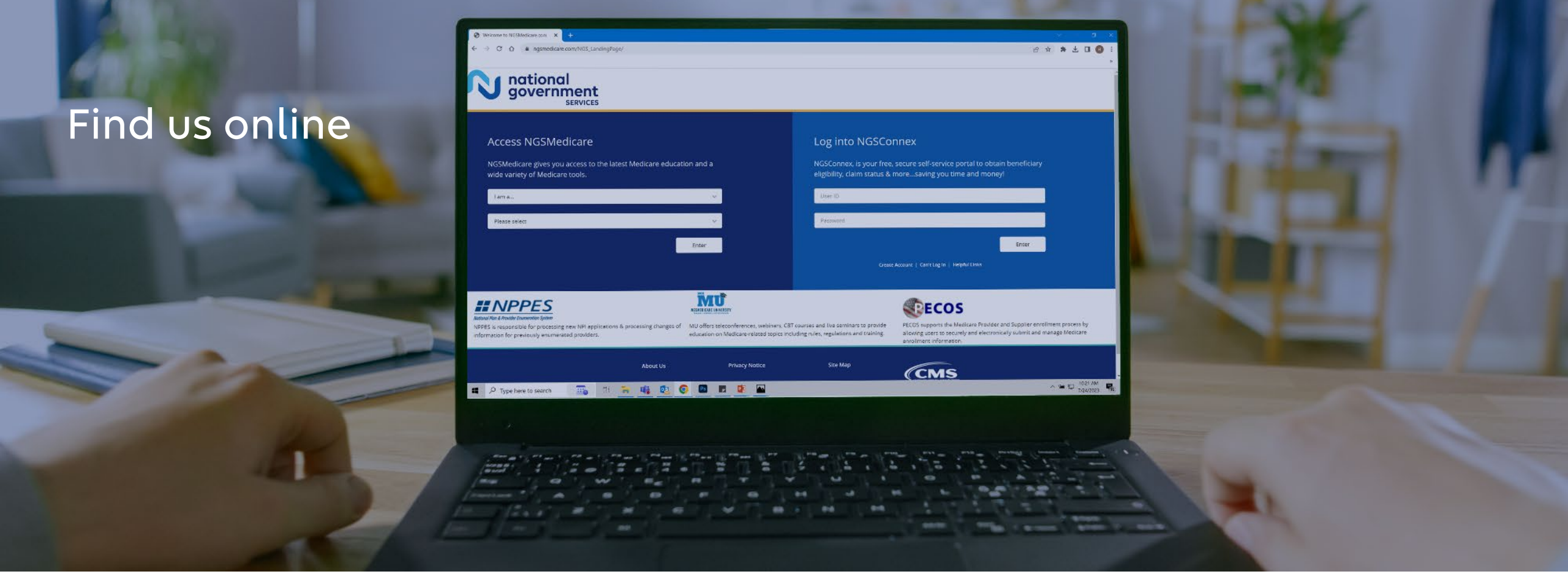
Connect with us on social media

[YouTube Channel](#)
Educational Videos

[Medicare University](#)
Self-paced online learning

[LinkedIn](#)
Educational Content

Find us online



www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

Sign up for Email Updates
Subscribe for Email updates at the top of any NGSMedicare.com webpage to stay informed of news

Questions?

Thank you!