



POLICY INFORMATION			
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NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/> PROFESSIONAL	<input checked="" type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input type="checkbox"/> AMBULATORY SURGERY	<input type="checkbox"/> LAB	<input type="checkbox"/> OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA²	<input checked="" type="checkbox"/> FEP³	<input type="checkbox"/> DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.



Description/Application

Blue KC enforces pre-and post-operative global days based on CMS standards.

Reimbursement for surgical procedures includes payment for all related services and supplies that are routine and necessary for performing the procedure and recovery.

Most medical and surgical procedures include preprocedure, intra-procedure, and post-procedure work and have either a 0, 10 or 90 day global package. Claims for services considered to be directly related to pre-procedure, intra-procedure, and post procedure work are included in this global reimbursement and will not be paid separately

This global “package” typically begins the day before surgery. When the package is split between practitioners in different practices or providers with different taxonomy codes, the surgical procedure is billed with the 54, 55, and/or 56 modifiers.

Surgeries should be billed globally if the surgery itself, and pre- and post-op services are performed by either the same practitioner or by different practitioners from the same practice/under the same tax ID.

If different practitioners under different tax IDs perform different portions of the surgical package, the pre-, intra-, and post-op services should be split and billed appropriately.

Policy

Minor Surgery- 0-day global period includes:

- Related E&M services performed the same day to a 0-day procedure
- Preventive and preventive-like visits performed the day prior to the same day of a 0-day procedure
- All anesthesia and anesthetic services performed by the surgeon
- Post operative pain management, including epidural management or subarachnoid drug administration
- All related supplies

Minor Surgery- 10-day global period includes:

- Related E&M services performed the same day to a 10-day procedure
- Related E&M services performed within 10 postoperative days of a 10-day procedure
- Preventive and preventive-like visits performed the day prior to the same day of a 10-day procedure
- Care management and transitional care services performed within 10 postoperative days of a 10-day procedure
- Any additional medical or surgical services provided within 10 postoperative days due to complications of the original minor surgery
- All anesthesia and anesthetic services performed by the surgeon
- Post operative pain management, including epidural management or subarachnoid drug administration



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- All related supplies

Major Surgery- 90-day global period includes:

- Related E&M services performed the day prior or the same day to a 90-day procedure
- Related E&M services performed within 90 postoperative days of a 90-day procedure
- Preventive and preventive-like visits performed the day prior or the same day to a 90-day procedure.
- Care management and transitional care services performed within 90 postoperative days of a 90-day procedure
- Any additional medical or surgical services provided within 90 postoperative due to complications of the original major surgery
- All anesthesia and anesthetic services performed by the surgeon
- Post operative pain management, including epidural management or subarachnoid drug administration
- All related supplies

Global surgery guidelines apply to the primary surgeon, assistant surgeon, and co-surgeon.

To determine the surgical global period for a procedure or surgery, refer to the CMS physician fee schedule or CMS list of Global Codes.

[Physician Fee Schedule](#)

[CMS List of Global Codes](#)

Surgical Care Only Modifier 54

When billing for the surgery only, submit the surgical procedure code with a modifier -54 and an appropriately reduced charge to reflect that post-operative care was not provided.

Pre- or Post-Op Management Modifiers 55 and 56

When billing for pre- and/or post-operative services only, submit the surgical procedure code with the modifier 55 or 56 as appropriate. Pre and/or post-operative services are billed only one time and include all visits within the designated period. Thus, only one payment will be made for the pre- and/or post-op care.

If care during the post-operative period is relinquished to another practitioner from a different practice, both practitioners should bill for their portion of post-operative care also with the surgical procedure code and the -55 modifier. However, both practitioners must report the date the care was relinquished. The reimbursement for the post-op care will be divided between the practitioners based on each practitioner's portion of their post-op care.

Unrelated E/M Modifier 24

If the same physician performs an unrelated Evaluation and Management (E/M) service during a postoperative period, modifier 24 should be append to that E/M code.

By appending the modifier 24 to an unrelated E/M service you are indicating that the patient's condition requires a significant, separately identifiable E/M service beyond the other service provided, or beyond the usual pre-operative and postoperative care associated with the procedure that was performed.



Services appended with modifier 24 must be sufficiently documented in the patient's medical record that the visit was unrelated to the post-operative care of the procedure. An ICD-10-CM that clearly indicates that the reason for the encounter was different and unrelated to the post-operative care may provide sufficient documentation.

Significant Unrelated Procedure or Service Modifier 25

If the same physician performs a significant, separately identifiable evaluation and management (E/M) service during a postoperative period, modifier 25 should be appended to that E/M code.

By appending modifier 25 to an unrelated E/M service you are indicating that the patient's condition requires a significant, separately identifiable E/M service beyond the other service provided, or beyond the usual pre-operative and postoperative care associated with the procedure that was performed.

Services appended with modifier 25 must be sufficiently documented in the patient's medical record that the visit was unrelated to the post-operative care of the procedure. An ICD-10-CM diagnosis code that clearly indicates the reason for the encounter was different and unrelated to the post-operative care may provide sufficient documentation.

Decision for Surgery Modifier 57

Modifier 57 is appended to indicate that the E/M service resulted in the initial decision to perform surgery either the day before or the day of a major surgical procedure (90- day global period). Do not append this modifier when a minor surgical procedure (0- or 10-day global period) is performed.

Modifier 57 should not be used to report an E/M service that was pre-planned or prescheduled the day before or the day of surgery, as the E/M would be included as part of the global surgical package.

Modifier 57 may not affect edits or payment. However, if applicable, the modifier should be appended to the E/M. Services denied may be considered on subsequent appeal.

Repeat Procedure by Same Physician Modifier 76

Modifier 76 is appended to indicate that a basic procedure had to be repeated by the same physician. Use of this modifier indicates the procedure is a repeat and not a duplicate.

Repeat Procedure by Another Physician Modifier 77

Modifier 77 is appended to indicate that a basic procedure or service performed by one physician has been repeated by a second physician. This modifier usually is used during the postoperative period of the basic procedure. The second physician adds the modifier to the procedure code used by the first physician.

Return to the Operating Room Modifier 78

If a procedure needs to be repeated on the same day or in postoperative, due to complications, modifier 78 is to be used. Reimbursement for this modifier will be intra-operative percentage only. This modifier will not apply to AS, Assistant Surgeons. Modifier 78 will need to be supported with documentation to verify the need to return to the operation room.

Unrelated Procedure or Service Modifier 79

If the same physician performs an unrelated procedure or service during a postoperative period of another procedure, the modifier 79 should be submitted. Services appended with a 79 modifier must be sufficiently documented in the patient's medical record that the visit was unrelated to the post-operative care of the procedure.

Same Physician

Blue KC defines the "same physician" as the same physician(s) or qualified health care practitioner(s) of the same or similar specialty within the same clinical practice.



CPT 99024 Postoperative follow-up visit

This is used when the service that is being provided is normally included in the surgical package, to indicate that an E&M service was performed during a postoperative period for a reason(s) related to the original procedure. This service would be provided by the “same physician

Coding

MLN 907166 Global Surgery
CMS List of Global Codes

Related Documents

N/A

References and Resources

Centers for Medicare and Medicaid Services
American Medical Association CPT Manual

Revision History

Version	Date	Summary of Revisions
001	07/01/2019	Initial version
002	07/01/2020	Annual review, no changes were made
003	07/01/2021	Annual review, no changes were made
004	07/01/2022	Removed table with pricing percentages
005	07/01/2023	Annual review with no changes
006	11/03/2023	Added statement saying, Blue KC enforces pre-and post-operative global days based on, but not limited to, CMS standards. Added additional language identifying minor and major surgeries and added link to CMS list of Global Codes.
007	07/01/2024	Annual review with no changes
008	07/01/2025	Annual review with no changes