



Global Surgery Modifiers Fact Sheet

The Medicare allowed amount for surgical procedures includes payment for certain services related to the surgery when furnished by the physician who performs the surgery or by members of the same group with the same specialty. This method of pricing is known as the global surgery package. The following modifiers define services that can be allowed out side of the global surgery package. Please see the definition of each modifier to determine whether the code is appropriate for an Evaluation and Management (E/M) code or if the modifier should be used with a surgery procedure code.

GLOBAL SURGERY MODIFIERS		
22	Unusual Procedural Services	<ul style="list-style-type: none"> Surgeries for which services performed are significantly greater than usually required may be billed with modifier 22 Bill modifier 22 with the CPT code for the procedure performed. Sufficiently document services billed with modifier 22 to support the service furnished was significantly greater than usually required. Supporting documentation must include an operative report and statement on how the services furnished differ from the usual services furnished. Include in electronic submissions a statement that documentation is available in the extra narrative field. Modifier 22 may be use to document only services with 000, 010, 090 or YYY global periods on the Medicare Physician Fee Schedule Database (MPFSDB). The Website file is located at: http://www.cms.hhs.gov/PhysicianFeeSched/01_overview.asp



GLOBAL SURGERY MODIFIERS		
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	<ul style="list-style-type: none"> • Modifier 24 indicates the physician performed an unrelated E/M service during the post-operative period • Bill modifier 24 with the appropriate level of E/M service • Documentation supports E/M visits submitted with modifier 24 are unrelated to the post-operative care of the procedure. ICD-9 codes that clearly indicate the reason for the encounter was unrelated to surgical postoperative care may provide sufficient documentation. • If sufficiently documented, use Modifier 24 when furnishing an E/M service that is exclusively for treatment of the underlying condition and not for post-operative care. • Physicians who are managing immunosuppressant therapy during the post-operative period of a transplant may bill for the E/M service with modifier 24. ICD-9-CM V07.2 may be appropriate to document the need for this service. • Physicians who are managing chemotherapy during the post-operative period of a procedure may bill for the E/M service with modifier 24. ICD-9-CM V58.1 may be appropriate to document the need for this service. • Do not use modifier 24 Unrelated E/M service the same day as a procedure or to document treatment of a wound infection.
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service	<ul style="list-style-type: none"> • Modifier 25 indicates the patient's condition on the day of the procedure required a significant, separately identifiable E/M service beyond the usual preoperative and post-operative care associated with the procedure or service performed. • Bill modifier 25 with the appropriate level of E/M service • Bill modifiers 24 and 25 when a significant, separately identifiable E/M service on the day of a procedure falls within the post-operative period of another unrelated, procedure
50	Bilateral Procedure	<ul style="list-style-type: none"> • Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. • Check, the MPSFDB to be sure the surgical code is billable as bilateral. Checking the "Bilt Surg" column on the database • The following MPFSDB indicators show which procedures Medicare accepts with a modifier 50. <ul style="list-style-type: none"> • "0" indicates a unilateral code; Modifier 50 is not billable • "1" indicates modifier 50 can be appropriate. • "2" indicates a bilateral code; modifier 50 is not billable. • "3" indicates primary radiology codes; modifier 50 is billable. • "9" indicates that the concept does not apply. (office visit) • The CPT book specifies that a service could be a. unilateral, b. bilateral, or c. unilateral or bilateral. This modifier is not appropriate on codes where the CPT specifies b or c. • Inappropriately use receives an unprocessable denial message



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52	Reduced Service	<ul style="list-style-type: none"> Surgeries for which services performed are significantly less than usually required are billable with modifier 52. Bill modifier 52 with the CPT code furnished service. Sufficiently document services billed with modifier 52 to support services furnished was less than usually required.
53	Discontinued Procedure	<ul style="list-style-type: none"> Use Modifier 53 if a physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances, or those threatening the well-being of the patient. Bill modifier 53 in the first modifier field Procedure code 45378-53 is the only code CMS already assigned Relative Value Units (RVUS) and a fee schedule amount All other codes 53 are subject to carrier medical review and pricing, including additional documentation requests
54	Surgical Care Only	<ul style="list-style-type: none"> Modifier 54 indicates the surgeon is relinquishing all or part of the postoperative care to a physician outside the same group. Bill modifier 54 with the CPT code describing services furnished. Applies to MPFSDB codes that include 010 or 090 global periods CMS defines the modifier 54 differently than CPT 4 by including reimbursement of all preoperative care, the intra-operative surgical service, and all hospital postoperative care. The surgeon must keep a copy of the written transfer agreement in the beneficiary's medical record. Modifier 54 does not apply to assistant at surgery services. Modifier 54 does not apply to Ambulatory Surgical Center's facility fees.
55	Postoperative Management Only	<ul style="list-style-type: none"> The surgeon who furnished a portion of the outpatient postoperative care and the physician, other than the surgeon, who furnished postoperative management services bill with the 55 modifier. Bill modifier 55 with the CPT code describing the surgical procedure Bill modifier 55 for procedure codes with MPFSDB global periods of 010 or 090 Codes billed must show the date of surgery as the date of service, also indicate the date care was relinquished/ assumed. Keep copies of the written transfer agreement in the physician furnishing the postoperative cares beneficiary's medical record Provide at least one service before the receiving physician can bill for any part of the postoperative care. Not appropriate for assistant at surgery services Not appropriate for Ambulatory Surgical Center's facility fees.



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57	Decision for Surgery	<ul style="list-style-type: none"> • E/M service resulting in the decision to perform the surgery on the day before major surgery or on the day of major surgery (90 day post-op) is not included in the global surgery payment and is separately billable. • Bill Modifier 57 with the appropriate E/M code identifying a visit that resulted in the initial decision to perform surgery • Do not bill Modifier 57 in connection with minor surgeries because the decision to perform the minor procedure is done immediately before the service it is considered a routine preoperative service. • Bill modifiers 24 and 57 when furnishing an E/M service resulting in the initial decision to perform major surgery during the post-operative period of another, unrelated, procedure • Modifier 57 is not reportable for preplanned or prescheduled surgeries, or if the surgical procedure indicates performance in multiple sessions or stages.
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	<ul style="list-style-type: none"> • Modifier 58 indicates the physician, or member of the same group, planned the performance of a procedure or service during the postoperative period prospectively or at the time of the original procedure. • Bill modifier 58 with the subsequent performed procedure • Use during the post-operative period starting the day after the initial procedure. • Not appropriate for services performed on a single date of service. • Not appropriate when the MPFSDB indicates XXX global period. • Not appropriate with assistant at surgery • Not appropriate for Ambulatory Surgical Center's Facility fees
59	Distinct Procedural Service	<ul style="list-style-type: none"> • Modifier 59 indicates a procedure or service was distinct or separate from other services performed on the same day. • Represented by a different session or patient encounter, different procedure or surgery, different site, separate session, or separate injury (or area of injury) • Modifier 59 indicates the secondary, additional, or lesser procedure; • Modifier 59 is not valid on E/M Codes • Use modifier 59 <u>if no other valid modifier exists</u>. I.E. CMS established modifiers indicating services provided on the same date to different anatomic sites (i.e., for eyelids, E1 through E4; for fingers FA, and F1 through F9; for toes, TA, and T1 through T9; LT and RT).



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78	Return To The Operating Room For A Related Procedure During The Post-Operative Period	<ul style="list-style-type: none"> • Used to indicate the performance of a procedure during the post-operative period or on the same day as the original procedure to treat complications, which required return to the operating room • Bill modifier 78 with the CPT code describing the procedure(s) performed during the return trip. • Only use the procedure code for the original procedure if the identical procedure is repeated. • When the procedure code used to describe a service for treatment of complications is the same as the procedure code used in the original procedure, modifier 78 is still the correct modifier to use. • Modifier 78 reimbursement is intra-operative percentage only. • Use Modifier 78 to document treatment of complications only. • Use Modifier 78 to indicate services furnished in an operating room (OR). OR definition, for this purpose, is a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, laser suite, or endoscopy suite. It does not include a patient's room, minor treatment room, recovery room, or intensive care unit. • Does not apply to assistant at surgery services • Does not apply to Ambulatory Surgical Centers facility fees
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period	<ul style="list-style-type: none"> • Modifier 79 indicates the performance of a procedure or service during a post-operative period was unrelated to the post-operative care of the original procedure. • Bill Modifier 79 with the procedure performed. • Do not bill when the MPFSDB indicating XXX in the post-operative field. • Use modifier 79 on services during the post-operative period starting the day after the procedure. • Does not apply to assistant at surgery services • Does not apply to Ambulatory Surgical Center's facility fees