Payment Policy: Visits On Same Day as Surgery

Reference Number: CC.PP.040
Product Types: ALL
Effective Date: 03/06/2024

Revision Log
Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

The global surgical reimbursement package includes E/M services, anesthesia, immediate post-operative care, written orders, evaluating the patient in the post anesthesia recovery area and typical postoperative follow-up care provided by a physician before, during and after a procedure.

Evaluation and Management (E/M) services performed on the same day as a surgical procedure are included in the global surgical reimbursement package for the surgery and therefore are not separately reimbursable. Specific Current Procedural Terminology (CPT®) modifiers are taken into consideration prior to a denial determination.

For purposes of this policy, "Same Day visits" refers to the E/M services that occur on the same day as the surgical procedure.

The global surgical reimbursement package includes:

1. Pre-operative visits after the decision for surgery. Major procedures include visits that occur the day prior to and the day of surgery.
2. Minor procedures include visits that occur on the day of surgery.
3. Post-operative visits related to the patient's recovery from the procedure.
4. Intra-operative services that are a routine part of the surgical procedure
5. Additional medical or surgical services that require the surgeon's attention during the post-operative period. This includes complications of surgery but does not include return trips to the operating room.
6. Post-surgical pain management by the surgeon.
7. Supplies
8. Dressing changes, local incision care, removal of operative pack, cutaneous staples, sutures, etc.

The global surgical period does not include:

1. Initial consultation or evaluation by the surgeon to determine the need for surgery. This is billed separately using *Modifier 57, Decision for Surgery.* This modifier may only be used for major surgical procedures.
2. Services required by other physicians related to the surgery, except when the primary surgeon and other physician agree to transfer the patient's care. Modifiers 54 and 55 should be used to identify each physician's participation in the patient's surgical care. Modifier 54 denotes surgical care only, while modifier 55 denotes post-operative management only.

3. Treatment for the underlying condition that was the cause for surgery or for an added course of treatment which is not considered part of the normal recovery from the surgery process.
4. Diagnostic tests and procedures including diagnostic radiologic procedures. However, if the surgical procedure results in an inpatient admission, outpatient diagnostic testing and therapeutic services are bundled into the payment for the inpatient admission.
5. Distinct surgical procedures that occur during the post-operative period but are not related to treatments for complications from the original surgery or the need for a second operation related to the original surgery.
6. Treatment for post-operative complications requiring a return trip to the operating room.
7. Failure of a less extensive procedure that requires a more extensive procedure.
8. Immunosuppressive therapies for organ transplants.
9. Critical care services (CPT code 99291 & 99292) that are unrelated to the surgery.

See the Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual Chapter 12, Section 40.1 for further information.

The purpose of this policy is to define payment criteria for E/M services when billed with surgical procedures having a 000, 010 or 090, MMM, and ZZZ global period to be used in making payment decisions and administering benefits.

Application
E/M services billed within the global surgical period applies to Inpatient hospitals, Outpatient hospitals, Ambulatory Surgical centers, and Physician E/M services.

Policy Description
According to CMS, certain E/M services are not separately reportable when billed on the same day as a minor, major or maternity procedure. Instead, these E/M services are subsumed into the reimbursement for the surgical procedure. Necessary services performed before, during or after a surgical procedure are considered components of the surgical procedure.

The global surgical period is determined by the number of post-operative days allowed for the surgical procedure. This policy refers to the following types of global surgical periods:

Minor Surgeries and Endoscopies: 000-Zero Day Post-Operative Period. For minor surgeries and endoscopies with a 000-day global period, the global period applies only to visits and other services that occur on the same day as the surgery. Visits that occur on the same day as the surgery are not reimbursed as a separate service unless the visit is significant and separately identifiable from the reason for the surgery. The appropriate modifier (25) must be appended to the E/M service when this occurs. The 000-day post-operative period is defined as:

a. **No Pre-operative period**: The global concept does not apply to visits and other services rendered the day prior to a surgical procedure.
b. **Same Day Visits Included**: E/M Services that occur on the same day as a minor surgery or endoscopy are included in the global surgery reimbursement package and therefore are not payable as a separate service.

c. **No Post-operative period**: These procedures have no post-operative days assigned. This means that post-operative visits beyond the day of the minor surgery or endoscopy are not included in the payment for the surgery. Thus, they are separately reimbursable.
d. **Separate and Distinct Same Day Visits:** Since an inherent E/M component is considered included in the reimbursement of a minor surgical procedure with a 000-day global period, it is not separately reimbursable. However, if the reason for the visit that occurred on the same day as a minor procedure or endoscopy is separate and distinct from the procedure, the provider may append the appropriate modifier (25) to the E/M procedure code to document this circumstance.

Minor Surgeries: 10-Day Post-operative Period. Includes other minor surgeries and some endoscopies. For minor surgeries and endoscopies with a 10-day global period, the global period applies to visits and other services that occur on the same day as surgery and the 10 days following the surgical procedure. Visits that occur on the same day as surgery are not reimbursed as a separate service unless the visit is significant and separately identifiable from the reason for the original surgery. The appropriate modifier (25) must be appended to the E/M service. The 10-day post-operative period is defined as:

a. **No pre-operative period**: The global concept does not apply to visits and other services rendered the day prior to a surgical procedure.
b. **Same Day Visits Included**: E/M services that occur on the same day as a minor surgery or endoscopy are included in the global surgery reimbursement package and therefore are not separately payable.
c. **10-Day post-operative period**: E/M services that occur within 10 days of surgery are not separately payable.
d. **Total global period:** 11 days; the day of the surgery counts as day one and the 10 days following surgery.
e. **Diagnostic Biopsy Prior to Major Surgery:** If a diagnostic biopsy with a 10-day global surgical period occurs before a major surgery, on the same day, or in the 10-day period; the major surgery is reported as a separate service.

Major Surgeries: 90-Day Post-operative Period. Includes major surgical procedures. Visits on the day prior to the major surgery or on the same day as the major surgery are not reimbursed as a separate service. The 90-day post-operative period is defined as:

a. **One Day Pre-Operative Period**: The day immediately before the day of surgery is not separately payable.
b. **Same Day Visits Included**: E/M Services that occur on the same day as a major surgery are included in the global surgery reimbursement package and therefore are not separately payable.
c. **Decision for Surgery (Modifier 57):** E/M services on the day before or on the day of the major surgery are reimbursable when those visits result in the decision to perform surgery. The appropriate "decision for surgery" modifier must be appended to the E/M service to document the decision for surgery.

d. **90-Day Post-operative Period**: E/M services that occur within 90 days immediately following surgery are not payable as a separate service.
e. **Total Global Period:** 92 days; the one day prior to surgery, the day of the surgery and the 90 days following surgery.

Maternity Procedures: MMM. Includes maternity visits that occur during the period before childbirth (antepartum) and on the same day of the delivery procedure. Visits that occur during the antepartum period, on the same date of service, or during the post-operative period of 45 days are not recommended for separate reimbursement if the procedure includes antepartum or postpartum care.

a. **270-Day antepartum:** Preoperative period.
b. **Same Day Visits Included**: Visits that occur on the same date of delivery are included in the global maternity package and are not reimbursed as a separate service.
c. **45-Day Post-partum period**: E/M services that occur within the 45 days immediately following the delivery are not payable as a separate service.

ZZZ Procedures: Includes surgical add-on procedure codes that must be billed with the primary surgical procedure and are defined as:

a. Add-on surgical procedure codes.
b. Must be billed with another primary service and cannot stand alone.
c. When separate payment is made for an E/M service billed with a ZZZ surgical code, the provider is reimbursed for both the primary code and the add-on.
d. The global surgical period is based off the primary procedure code. If the primary procedure includes an inherent E/M code, separate reimbursement is not allowed.
e. Professional component modifier 26 may be appropriate for use with some procedures with a ZZZ global surgery indicator.

Global surgical periods for surgical procedures can be found in the CMS Medicare Physician Fee Schedule; this information can be located via the link listed in the References below.

Reimbursement

The Health Plan's code editing software analyzes claims on a prepay basis as follows:

1. Evaluates claim lines, procedure codes, diagnosis codes and modifiers to determine if an E/M service was billed on the same day as a surgery with a global surgical period of 000, 010, 090, MMM, or ZZZ days.
2. Claim lines containing E/M codes billed on the same day as a minor, major or maternity procedure are denied. These services are considered included in the payment for the surgical procedure.
3. Modifiers 25 and 57 are considered prior to a denial determination.
4. Reviews claim lines billed on the same claim and across claims in patient's history.
5. Reviews claims billed across multiple dates of service.

Documentation Requirements

Modifier 25

Claim lines with modifier 25 appended to the E/M are subject to prepayment clinical claims validation. Use of this modifier indicates that a significant, separately identifiable E/M service occurred on the same day as the surgery when the patient's condition required a visit beyond the normal pre-operative and post-operative care. Use of the modifier is substantiated by documentation that satisfies the relevant criteria for the E/M service reported. If documentation supports that a significant and separately identifiable E/M service was performed, the E/M service is reimbursed; otherwise, the E/M is denied. To avoid incorrect denials, all applicable diagnosis codes should be assigned that indicate the need for additional E/M service.

Modifier 57

Claim lines with modifier 57 appended to the E/M are subject to prepayment clinical claims validation. This involves analysis of E/M and surgical dates of service, diagnosis codes, procedure codes billed and other claim information to determine if the initial decision to perform surgery occurred on the day before or the day of a major surgery. If documentation supports the initial decision to perform surgery, the E/M service is reimbursed; otherwise, the E/M is denied.

Appeals/Reconsiderations

In the event the provider disagrees with the prepayment claims edit determination, the provider has an opportunity to submit an appeal or reconsideration request (dependent upon health plan rules) for reconsideration of payment. All medical records/supporting documentation must accompany the request.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Related Policies

Policy Name	Policy Number
Clinical Validation of Modifier 25	CC.PP.013
Pre-operative Visits	CC.PP.041
Post-operative Visits	CC.PP.042

References

1. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched
2. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
3. Current Procedural Terminology (CPT), 2024
4. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
5. https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf

Revision History	
11/07/2016	Initial Policy Draft Created
03/01/208	Policy reviewed and updated, added 99224-99226
04/01/2019	Conducted review and updated policy
11/1/2019	Annual Review completed
11/1/2020	Annual Review completed
11/30/2021	Annual review completed; links updated
12/01/2022	Annual review completed; removed code tables since this information can be found in CPT resources; added link to Global Surgery Fact Sheet
12/01/2023	Annual review completed, removed link to Global Surgery Fact Sheet since it is not working.
03/06/2024	Annual review completed; updated policy details to explain the global surgery package prior to edit for clarification; added Global Surgery Booklet link for reference.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.