Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

Bulletin Number:	RP-042		
Subject:	Global Surgery and Subsequent Services		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	January 1, 2026	**Revised Date:**	January 2026
Date Reviewed:	December 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan.

PURPOSE:

This policy is to provide direction on The Plan's reimbursement of global surgery services and subsequent hospital visits and hospital discharge day management services. Surgery is classified as either definitive/major or diagnostic/minor. Definitive/major surgical procedures have designated post-operative days (90 days) while diagnostic/minor surgical procedures have ten (10) or zero (0) post-operative days. The post-operative global periods are assigned by The Centers for Medicare and Medicaid Services (CMS) identified by the Global Days indicator on the Medicare Physicians' Fee Schedule (MPFS). Procedures that carry a global period indicator of YYY on the MPFS are at carriers' discretion to determine and apply post-operative periods.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Pre and Post-operative Care

In-hospital, the allowance for a surgical procedure includes payment for routine in-hospital pre-operative care and routine post-operative care, in or out of the hospital, when provided by the surgeon, his assistant, or associate as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days).

***Other than in-hospital**, the allowance for a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days), includes routine post-operative care when provided by the surgeon, his assistant, or associate.

***Note**: As permitted under state license/accreditation and Highmark policies.

Note: Reimbursement may be made for an unrelated Evaluation and Management (E/M) service by the same physician during the post-operative period when modifier 24 is reported with the E/M service.

Surgery and Medical Care on the Same Day

Regardless of place of service, medical care provided on the same day as a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) by the same physician, for the same condition is not eligible for reimbursement.

An E/M visit is included in the global allowance for the surgery and not separately reimbursable and when the medical care is contractually excluded, the visit is not covered.

Note: Reimbursement may be made for a significant, separately identifiable E/M service by the same physician on the same day as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) when modifier 25 is reported with the E/M code. When the 25 modifier is reported, the patients' records must clearly document separately identifiable medical care was rendered. Modifier 25 should only be used on claims for E/M services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. The plan will reimburse for an E/M service provided on the day of a procedure with a global fee period only when the physician indicates the service was for a significant, separately identifiable E/M service above and beyond the usual pre- and post-operative work of the procedure. Both the medically necessary E/M service and the procedure must be sufficiently documented in the patient's medical record by the physician or other qualified non-physician practitioner to support the claim for these services.

Reimbursement may also be made for an E/M service that results in the initial decision to perform the surgery when modifier 57 is reported with the E/M code.

Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  The Plan will reimburse claim lines at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29999	39499	45999	58579	G0186	0526T	0620T	0727T	0810T
15999	30999	39599	46999	58679	0164T	0527T	0644T	0730T	0823T
17999	31299	40799	47379	58999	0165T	0530T	0646T	0737T	0824T
19499	31599	40899	47399	59898	0253T	0531T	0655T	0739T	0825T
20999	31899	41599	47579	59899	0274T	0532T	0656T	0744T	0861T
21089	32999	41899	47999	60659	0308T	0569T	0657T	0745T	0862T
21299	33999	42299	48999	60699	0335T	0571T	0671T	0775T	0863T
21499	34841	42699	49329	64999	0345T	0572T	0672T	0790T	0867T
21899	34842	42999	49659	66999	0449T	0573T	0674T	0793T	0888T
22899	34843	43289	49999	67299	0450T	0574T	0675T	0795T	0908T
22999	34844	43499	50549	67399	0505T	0580T	0677T	0796T	0909T
23929	34845	43647	50949	67599	0510T	0582T	0679T	0797T	0910T
24999	34846	43648	51999	67999	0511T	0584T	0680T	0798T	0950T
25999	34847	43659	53899	68399	0515T	0585T	0681T	0799T	0956T
26989	34848	43999	54699	68899	0516T	0586T	0682T	0800T	0967T
27299	37501	44238	55559	69300	0517T	0594T	0686T	0801T	0968T
27599	37799	44799	55899	69399	0518T	0614T	0714T	0802T	0969T
27899	38129	44899	55970	69799	0519T	0543T	0719T	0803T	0994T
28899	38589	44979	55980	69949	0520T	0544T	0725T	0805T	0995T
29799	38999	45499	58578	69979	0525T	0545T	0726T	0809T	1003T
									1012T

The following codes have a Global value of 10 days:

0440T	0445T	0588T	0643T	0673T	0785T	0817T	0959T	0966T	1013T
0441T	0581T	0600T	0647T	0699T	0786T	0818T	0960T	0970T	1015T
0442T	0583T	0601T	0660T	0793T	0787T	0819T	0964T	0971T	
0444T	0587T	0632T	0661T	0784T	0816T	0901T	0965T	0988T	

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Global Surgery

Certain services are paid for under what are known as “global fees”. These fees incorporate the reimbursement for services performed at different times by the same provider (or group), but all in conjunction with one medical procedure or episode of care.

Standard packages of preoperative, intra-operative and post-operative services are included in the payment for a surgical procedure.

All surgical procedures are classified as one of the following:

1. Major surgery: Procedures have a 90-day post-operative period
2. Minor or Endoscopic surgery: Procedures have either a 10-day post-operative period or a 0-day post-operative period.

Components of a Global Surgical Package

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package.

The approved amount for surgical procedures includes reimbursement for the following services related to the surgery when furnished by the physician who performs the surgery:

Pre-operative Visits: Pre-operative visits beginning with the day before the date of surgery for major procedures (those having a Global Days value of 90) and the day of surgery for minor procedures (those having a Global Days value other than 90).

Intraoperative Services: Intra-operative services normally a usual and necessary part of the surgical procedure, including post-operative work in the hospital.

Complications Following Surgery: All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.

Post-operative Visits: Follow-up visits during the post-operative period of the surgery related to recovery from the surgery.

Post-surgical Pain Management: By the surgeon.

Supplies: See exception to this under "Services not included in the Global Surgical Package."

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.

A surgical tray (A4550) is not separately reimbursable because it is considered a bundled service, therefore, it is non-covered and non-billable to the member.

Services Not Included in the Global Surgical Packages

The following services are not included in the global surgical package and can be paid for separately in addition to the surgical procedure:

- The initial evaluation of the problem by the surgeon to determine the need for surgery. Modifier 57 must be reported with the E/M service if this evaluation is the day before major surgery or the day of major surgery (those procedures having a Global Days value of 90). The initial evaluation is always included in the allowance for a procedure having a Global Days value other than 90.
- A visit on the same day as a minor or endoscopic procedure for a significant separately identifiable service, above and beyond care normally associated with the procedure. Modifier 25 must be reported with the E/M service to identify it as a significant separately identifiable service. Modifier 25 should only be used on claims for E/M services and only when these services are

provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 must be added to the E/M code on the claim. Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the practitioner in the patient's medical record to support the claim for these services.

- Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.
- 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 following the patient's discharge unrelated to the diagnosis for which the surgical procedure is performed (unless due to complications of the surgery). Modifier 24 must be reported with the E/M service to identify it as unrelated. Additionally, sufficient documentation must show that the visit was unrelated to the surgery. A diagnosis code that clearly indicates the reason for the encounter was unrelated to the surgery is sufficient documentation.
- 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.
- Physical therapy.
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatments for complications. Modifier 58 should be used to identify procedures done in two (2) or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Modifier 79 must be reported to identify unrelated procedures performed during the post-operative period.
- Treatment for postoperative complications which require a return trip to the operating room. An operating room for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures, including 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). Modifier 78 must be reported with the subsequent surgical procedure.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately. Modifier 58 must be reported with the second procedure.
- Major surgery performed on the same day or in the postoperative period of a diagnostic biopsy with a 10-day global period is separately payable.
- Splints and casting supplies for fractures or dislocations may be reimbursed when performed in a physician's office (codes A4649 and L0210).
- Recasting's during the global period of the treatment of a fracture. Modifier 58 (staged procedure) or Modifier 79 (unrelated procedure) should be reported with the recasting code.
- Immunosuppressive therapy for organ transplants. Modifier 24 should be reported to identify the care (even if it is during the same hospital stay as the surgical procedure). It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.
- Critical care services (code 99291) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. Modifier 25 must be

reported with code 99291 if rendered in the pre-operative period and modifier 24 for post-operative care. Documentation the critical care was unrelated to the specific anatomic injury or surgical procedure must be submitted. A diagnosis code which clearly indicates the critical care was unrelated to the surgery is acceptable documentation.

Subsequent Hospital Visits During the Global Surgery Period

Reimbursement for surgical procedures includes all the services and visits (e.g., E/M visits) part of the global surgery reimbursement including when such surgical procedures may be fragmented. Subsequent Hospital Care visits (codes 99231, 99232 and 99233) are not separately reimbursed when included in the global surgery payment.

Hospital Discharge Day Management Service

A Hospital Discharge Day Management Service, (codes 99238 or 99239) is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is reimbursed per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (codes 99231, 99232 and 99233) for a final visit.

Reimbursement for general paperwork is included through the pre-and post-service work of evaluation and management (E/M) services.

Applicable codes: 99231 99232 99233 99238 99239

Subsequent Hospital Visit and Discharge Management on Same Day

Payment will only be made for the hospital discharge management code on the day of discharge unless it is also the day of admission.

Physicians shall use the Observation or Inpatient Care Services (Including Admission and Discharge Services) for a hospital admission and discharge occurring on the same calendar date and when the following criteria are met:

1. When the patient was admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care can be reported by the physician. The Hospital Discharge Day Management service shall not be reported for this scenario.
2. When a patient was admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician can report an Initial Hospital Care and a Hospital Discharge Day Management service.
3. When a patient was admitted to inpatient hospital care for a minimum of eight (8) hours but less than twenty (24) hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), can be reported.

A subsequent hospital visit in addition to a hospital discharge day management service reported for the same date of service by the same physician is not eligible for reimbursement.

Applicable codes: 99234 99235 99236 99238 99239

Hospital Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed, even if the paperwork is delayed to a subsequent date.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  PA, WV, DE - will reimburse lines reporting modifier 78 at the code specific intra-op percent (of the approved allowance) as defined on the Medicare Physician Fee Schedule (MPFS). The intra-op rates will be evaluated on an annual basis with the release of the January Medicare Physician Fee Schedule, for changes to existing codes and application to any new codes issued throughout the previous year.

  NY - will reimburse lines reporting modifier 78 at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29999	39499	45999	58579	G0186	0526T	0620T	0727T	0810T
15999	30999	39599	46999	58679	0164T	0527T	0644T	0730T	0823T
17999	31299	40799	47379	58999	0165T	0530T	0646T	0737T	0824T
19499	31599	40899	47399	59898	0253T	0531T	0655T	0739T	0825T
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21089	32999	41899	47999	60659	0308T	0569T	0657T	0745T	0862T
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22899	34843	43289	49999	67299	0450T	0574T	0675T	0795T	0908T
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The following codes have a Global value of 10 days:

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0441T	0581T	0600T	0647T	0699T	0786T	0818T	0960T	0970T	1015T
0442T	0583T	0601T	0660T	0793T	0787T	0819T	0964T	0971T	
0444T	0587T	0632T	0661T	0784T	0816T	0901T	0965T	0988T	

DEFINITIONS:

Modifier	Definition
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional
57	Decision for surgery
58	Staged or related procedure/service by the same physician or other qualified health care professional during the postop period
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional, following initial procedure
79	Unrelated procedure/service, by the same physician or other qualified healthcare professional during postoperative period
FT	Unrelated evaluation and management (E&M) visit during a postoperative period, or on the same day as a procedure or another E&M visit

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-005: Modifiers 54 and 55
- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT

- RP-035: Correct Coding Guidelines

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- CMS Online Manual Pub. 100-4, Chapter 12, Sections 30.6.9.1 and 30.6.9.2. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 1460, CR 5794. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1460CP.pdf
- CMS Online Manual Pub. 100-04, Chapter 12, 40.0-40.44. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 954, CR 5025. https://chfs.ky.gov/agencies/dph/dafm/Documents/IVMM5025.pdf

POLICY UPDATE HISTORY INFORMATION:

7 / 2022	Added 0714T, 0719T, 0725T, 0726T, 0727T, 0730T, 0737T, to the global YYY codes sections for MA and Commercial. Removed MP S-52 reference.
8 / 2022	Added 0643T to the global YYY codes sections for MA and Commercial.
1 / 2023	Removed codes 0163T, G2170, G2171 and added 0739T, 0744T, 0745T and 0775T to the global YYY code sections for MA and Commercial.
6 / 2023	Administrative policy review with no changes in policy direction
7 / 2023	Added 0793T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0805T, 0809T, 0810T, to the global YYY codes sections for MA and Commercial
1 / 2024	Added 0784T, 0785T, 0786T, 0787T, 0790T, 0816T - 0819T, 0823T - 0825T, 0861T - 0863T, to the global YYY codes sections for MA and Commercial.
7 / 2024	Added 0867T, 0888T, to the global YYY codes sections for MA and Commercial.
1 / 2025	Added 0901T, 0908T-0910T to the global YYY codes sections for MA and Commercial. Removed 0553T, 0567T, 0568T, and 0616T-0618T.
7 / 2025	Added 0950T, 0956T, 0959T, 0960T, 0964T-0971T, to the global YYY codes sections for MA and Commercial
1 / 2026	Added 0994T, 0995T, 0988T, 1003T, 1012T, 1013T, 1015T, to the global YYY codes sections for MA and Commercial

IMPORTANT INFORMATION

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the member's contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-042		
Subject:	Global Surgery and Subsequent Services		
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***Other than in-hospital**, the allowance for a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days), includes routine post-operative care when provided by the surgeon, his assistant, or associate.

***Note**: As permitted under state license/accreditation and Highmark policies.

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Reimbursement may also be made for an E/M service that results in the initial decision to perform the surgery when modifier 57 is reported with the E/M code.

Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  The Plan will reimburse claim lines at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29999	39499	45999	58579	G0186	0525T	0545T	0726T	0809T
15999	30999	39599	46999	58679	0164T	0526T	0620T	0727T	0810T
17999	31299	40799	47379	58999	0165T	0527T	0644T	0730T	0823T
19499	31599	40899	47399	59898	0253T	0530T	0646T	0737T	0824T
20999	31899	41599	47579	59899	0274T	0531T	0655T	0739T	0825T
21089	32999	41899	47999	60659	0275T	0532T	0656T	0744T	0861T
21299	33999	42299	48999	60699	0308T	0569T	0657T	0745T	0862T
21499	34841	42699	49329	64999	0335T	0571T	0671T	0775T	0863T
21899	34842	42999	49659	66999	0345T	0572T	0672T	0790T	0867T
22899	34843	43289	49999	67299	0449T	0573T	0674T	0793T	0888T
22999	34844	43499	50549	67399	0450T	0574T	0675T	0795T	0908T
23929	34845	43647	50949	67599	0505T	0580T	0677T	0796T	0909T
24999	34846	43648	51999	67999	0510T	0582T	0679T	0797T	0910T
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28899	38589	44979	55980	69949	0519T	0543T	0719T	0803T	
29799	38999	45499	58578	69979	0520T	0544T	0725T	0805T	

The following codes have a Global value of 10 days:

0266T	0441T	0581T	0600T	0647T	0699T	0786T	0818T	0960T	0970T
0267T	0442T	0583T	0601T	0660T	0793T	0787T	0819T	0964T	0971T
0268T	0444T	0587T	0632T	0661T	0784T	0816T	0901T	0965T	
0440T	0445T	0588T	0643T	0673T	0785T	0817T	0959T	0966T	

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Global Surgery

Certain services are paid for under what are known as “global fees”. These fees incorporate the reimbursement for services performed at different times by the same provider (or group), but all in conjunction with one medical procedure or episode of care.

Standard packages of preoperative, intra-operative and post-operative services are included in the payment for a surgical procedure.

All surgical procedures are classified as one of the following:

1. Major surgery: Procedures have a 90-day post-operative period
2. Minor or Endoscopic surgery: Procedures have either a 10-day post-operative period or a 0-day post-operative period.

Components of a Global Surgical Package

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package.

The approved amount for surgical procedures includes reimbursement for the following services related to the surgery when furnished by the physician who performs the surgery:

Pre-operative Visits: Pre-operative visits beginning with the day before the date of surgery for major procedures (those having a Global Days value of 90) and the day of surgery for minor procedures (those having a Global Days value other than 90).

Intraoperative Services: Intra-operative services normally a usual and necessary part of the surgical procedure, including post-operative work in the hospital.

Complications Following Surgery: All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.

Post-operative Visits: Follow-up visits during the post-operative period of the surgery related to recovery from the surgery.

Post-surgical Pain Management: By the surgeon.

Supplies: See exception to this under "Services not included in the Global Surgical Package."

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.

A surgical tray (A4550) is not separately reimbursable because it is considered a bundled service, therefore, it is non-covered and non-billable to the member.

Services Not Included in the Global Surgical Packages

The following services are not included in the global surgical package and can be paid for separately in addition to the surgical procedure:

- The initial evaluation of the problem by the surgeon to determine the need for surgery. Modifier 57 must be reported with the E/M service if this evaluation is the day before major surgery or the day of major surgery (those procedures having a Global Days value of 90). The initial evaluation is always included in the allowance for a procedure having a Global Days value other than 90.
- A visit on the same day as a minor or endoscopic procedure for a significant separately identifiable service, above and beyond care normally associated with the procedure. Modifier 25 must be reported with the E/M service to identify it as a significant separately identifiable service. Modifier 25 should only be used on claims for E/M services and only when these services are

provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 must be added to the E/M code on the claim. Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the practitioner in the patient's medical record to support the claim for these services.

- Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.
- 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 following the patient's discharge unrelated to the diagnosis for which the surgical procedure is performed (unless due to complications of the surgery). Modifier 24 must be reported with the E/M service to identify it as unrelated. Additionally, sufficient documentation must show that the visit was unrelated to the surgery. A diagnosis code that clearly indicates the reason for the encounter was unrelated to the surgery is sufficient documentation.
- 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.
- Physical therapy.
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatments for complications. Modifier 58 should be used to identify procedures done in two (2) or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Modifier 79 must be reported to identify unrelated procedures performed during the post-operative period.
- Treatment for postoperative complications which require a return trip to the operating room. An operating room for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures, including 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). Modifier 78 must be reported with the subsequent surgical procedure.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately. Modifier 58 must be reported with the second procedure.
- Major surgery performed on the same day or in the postoperative period of a diagnostic biopsy with a 10-day global period is separately payable.
- Splints and casting supplies for fractures or dislocations may be reimbursed when performed in a physician's office (codes A4649 and L0210).
- Recasting's during the global period of the treatment of a fracture. Modifier 58 (staged procedure) or Modifier 79 (unrelated procedure) should be reported with the recasting code.
- Immunosuppressive therapy for organ transplants. Modifier 24 should be reported to identify the care (even if it is during the same hospital stay as the surgical procedure). It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.
- Critical care services (code 99291) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. Modifier 25 must be

reported with code 99291 if rendered in the pre-operative period and modifier 24 for post-operative care. Documentation the critical care was unrelated to the specific anatomic injury or surgical procedure must be submitted. A diagnosis code which clearly indicates the critical care was unrelated to the surgery is acceptable documentation.

Subsequent Hospital Visits During the Global Surgery Period

Reimbursement for surgical procedures includes all the services and visits (e.g., E/M visits) part of the global surgery reimbursement including when such surgical procedures may be fragmented. Subsequent Hospital Care visits (codes 99231, 99232 and 99233) are not separately reimbursed when included in the global surgery payment.

Hospital Discharge Day Management Service

A Hospital Discharge Day Management Service, (codes 99238 or 99239) is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is reimbursed per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (codes 99231, 99232 and 99233) for a final visit.

Reimbursement for general paperwork is included through the pre-and post-service work of evaluation and management (E/M) services.

Applicable codes: 99231 99232 99233 99238 99239

Subsequent Hospital Visit and Discharge Management on Same Day

Payment will only be made for the hospital discharge management code on the day of discharge unless it is also the day of admission.

Physicians shall use the Observation or Inpatient Care Services (Including Admission and Discharge Services) for a hospital admission and discharge occurring on the same calendar date and when the following criteria are met:

1. When the patient was admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care can be reported by the physician. The Hospital Discharge Day Management service shall not be reported for this scenario.
2. When a patient was admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician can report an Initial Hospital Care and a Hospital Discharge Day Management service.
3. When a patient was admitted to inpatient hospital care for a minimum of eight (8) hours but less than twenty (24) hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), can be reported.

A subsequent hospital visit in addition to a hospital discharge day management service reported for the same date of service by the same physician is not eligible for reimbursement.

Applicable codes: 99234 99235 99236 99238 99239

Hospital Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed, even if the paperwork is delayed to a subsequent date.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  PA, WV, DE - will reimburse lines reporting modifier 78 at the code specific intra-op percent (of the approved allowance) as defined on the Medicare Physician Fee Schedule (MPFS). The intra-op rates will be evaluated on an annual basis with the release of the January Medicare Physician Fee Schedule, for changes to existing codes and application to any new codes issued throughout the previous year.

  NY - will reimburse lines reporting modifier 78 at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29999	39499	45999	58579	G0186	0525T	0545T	0726T	0809T
15999	30999	39599	46999	58679	0164T	0526T	0620T	0727T	0810T
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19499	31599	40899	47399	59898	0253T	0530T	0646T	0737T	0824T
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21089	32999	41899	47999	60659	0275T	0532T	0656T	0744T	0861T
21299	33999	42299	48999	60699	0308T	0569T	0657T	0745T	0862T

21499	34841	42699	49329	64999	0335T	0571T	0671T	0775T	0863T
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22899	34843	43289	49999	67299	0449T	0573T	0674T	0793T	0888T
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28899	38589	44979	55980	69949	0519T	0543T	0719T	0803T	
29799	38999	45499	58578	69979	0520T	0544T	0725T	0805T	

The following codes have a Global value of 10 days:

0266T	0441T	0581T	0600T	0647T	0699T	0786T	0818T	0960T	0970T
0267T	0442T	0583T	0601T	0660T	0793T	0787T	0819T	0964T	0971T
0268T	0444T	0587T	0632T	0661T	0784T	0816T	0901T	0965T	
0440T	0445T	0588T	0643T	0673T	0785T	0817T	0959T	0966T	

DEFINITIONS:

Modifier	Definition
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional
57	Decision for surgery
58	Staged or related procedure/service by the same physician or other qualified health care professional during the postop period
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional, following initial procedure
79	Unrelated procedure/service, by the same physician or other qualified healthcare professional during postoperative period
FT	Unrelated evaluation and management (E&M) visit during a postoperative period, or on the same day as a procedure or another E&M visit

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-005: Modifiers 54 and 55
- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- CMS Online Manual Pub. 100-4, Chapter 12, Sections 30.6.9.1 and 30.6.9.2. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 1460, CR 5794. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1460CP.pdf
- CMS Online Manual Pub. 100-04, Chapter 12, 40.0-40.44. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 954, CR 5025. https://chfs.ky.gov/agencies/dph/dafm/Documents/IVMM5025.pdf

POLICY UPDATE HISTORY INFORMATION:

11 / 2018	Implementation
6 / 2021	Added Commercial and Medicare Advantage direction pertaining to services carrying the YYY global day indicator.
7 / 2021	Added additional codes to the YYY section for both Medicare Advantage and Commercial
11 / 2021	Added NY region applicable to the policy
12 / 2021	Added Medicare Advantage note for modifier 78 reduction. Delaware MA added as applicable to the policy. Codes 43499, 0356T, 0444T, 0445T, 0660T, 0661T, G2170, G2171 added to the global YYY codes sections for both MA and Commercial.
1 / 2022	Removed codes 0356T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0466T, 0467T, 0548T, 0549T, 0550T, 0551T, D7220, D7230, D7240, D7241, D7250, and added codes 0671T-0675T, 0677T, 0679T, 0680T-0682T, 0686T, 0699T, to the global YYY codes sections for MA and Commercial. Added modifier FT.
7 / 2022	Added 0714T, 0719T, 0725T, 0726T, 0727T, 0730T, 0737T, to the global YYY codes sections for MA and Commercial. Removed MP S-52 reference.
8 / 2022	Added 0643T to the global YYY codes sections for MA and Commercial.
1 / 2023	Removed codes 0163T, G2170, G2171 and added 0739T, 0744T, 0745T and 0775T to the global YYY code sections for MA and Commercial.
6 / 2023	Administrative policy review with no changes in policy direction
7 / 2023	Added 0793T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0805T, 0809T, 0810T, to the global YYY codes sections for MA and Commercial

1 / 2024	Added 0784T, 0785T, 0786T, 0787T, 0790T, 0816T - 0819T, 0823T - 0825T, 0861T - 0863T, to the global YYY codes sections for MA and Commercial.
7 / 2024	Added 0867T, 0888T, to the global YYY codes sections for MA and Commercial.
1 / 2025	Added 0901T, 0908T-0910T to the global YYY codes sections for MA and Commercial. Removed 0553T, 0567T, 0568T, and 0616T-0618T.
7 / 2025	Added 0950T, 0956T, 0959T, 0960T, 0964T-0971T, to the global YYY codes sections for MA and Commercial

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-042		
Subject:	Global Surgery and Subsequent Services		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	January 1, 2025	**Revised Date:**	January 2025
Date Reviewed:	December 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy is to provide direction on The Plan's reimbursement of global surgery services and subsequent hospital visits and hospital discharge day management services. Surgery is classified as either definitive/major or diagnostic/minor. Definitive/major surgical procedures have designated post-operative days (90 days) while diagnostic/minor surgical procedures have ten (10) or zero (0) post-operative days. The post-operative global periods are assigned by The Centers for Medicare and Medicaid Services (CMS) identified by the Global Days indicator on the Medicare Physicians' Fee Schedule (MPFS). Procedures that carry a global period indicator of YYY on the MPFS are at carriers' discretion to determine and apply post-operative periods.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Pre and Post-operative Care

In-hospital, the allowance for a surgical procedure includes payment for routine in-hospital pre-operative care and routine post-operative care, in or out of the hospital, when provided by the surgeon, his assistant, or associate as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days).

***Other than in-hospital**, the allowance for a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days), includes routine post-operative care when provided by the surgeon, his assistant, or associate.

***Note**: As permitted under state license/accreditation and Highmark policies.

Note: Reimbursement may be made for an unrelated Evaluation and Management (E/M) service by the same physician during the post-operative period when modifier 24 is reported with the E/M service.

Surgery and Medical Care on the Same Day

Regardless of place of service, medical care provided on the same day as a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) by the same physician, for the same condition is not eligible for reimbursement.

An E/M visit is included in the global allowance for the surgery and not separately reimbursable and when the medical care is contractually excluded, the visit is not covered.

Note: Reimbursement may be made for a significant, separately identifiable E/M service by the same physician on the same day as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) when modifier 25 is reported with the E/M code. When the 25 modifier is reported, the patients' records must clearly document separately identifiable medical care was rendered. Modifier 25 should only be used on claims for E/M services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. The plan will reimburse for an E/M service provided on the day of a procedure with a global fee period only when the physician indicates the service was for a significant, separately identifiable E/M service above and beyond the usual pre- and post-operative work of the procedure. Both the medically necessary E/M service and the procedure must be sufficiently documented in the patient's medical record by the physician or other qualified non-physician practitioner to support the claim for these services.

Reimbursement may also be made for an E/M service that results in the initial decision to perform the surgery when modifier 57 is reported with the E/M code.

Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  The Plan will reimburse claim lines at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

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The following codes have a Global value of 90 days:

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27599	37799	44799	55899	69399	0517T	0594T	0686T	0801T	
27899	38129	44899	55970	69799	0518T	0614T	0714T	0802T	
28899	38589	44979	55980	69949	0519T	0543T	0719T	0803T	
29799	38999	45499	58578	69979	0520T	0544T	0725T	0805T	

The following codes have a Global value of 10 days:

0266T	0441T	0581T	0600T	0643T	0661T	0793T	0786T	0817T	0901T
0267T	0442T	0583T	0601T	0647T	0673T	0784T	0787T	0818T	
0268T	0444T	0587T	0632T	0660T	0699T	0785T	0816T	0819T	
0440T	0445T	0588T							

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Global Surgery

Certain services are paid for under what are known as “global fees”. These fees incorporate the reimbursement for services performed at different times by the same provider (or group), but all in conjunction with one medical procedure or episode of care.

Standard packages of preoperative, intra-operative and post-operative services are included in the payment for a surgical procedure.

All surgical procedures are classified as one of the following:

1. Major surgery: Procedures have a 90-day post-operative period
2. Minor or Endoscopic surgery: Procedures have either a 10-day post-operative period or a 0-day post-operative period.

Components of a Global Surgical Package

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package.

The approved amount for surgical procedures includes reimbursement for the following services related to the surgery when furnished by the physician who performs the surgery:

Pre-operative Visits: Pre-operative visits beginning with the day before the date of surgery for major procedures (those having a Global Days value of 90) and the day of surgery for minor procedures (those having a Global Days value other than 90).

Intraoperative Services: Intra-operative services normally a usual and necessary part of the surgical procedure, including post-operative work in the hospital.

Complications Following Surgery: All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.

Post-operative Visits: Follow-up visits during the post-operative period of the surgery related to recovery from the surgery.

Post-surgical Pain Management: By the surgeon.

Supplies: See exception to this under "Services not included in the Global Surgical Package."

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.

A surgical tray (A4550) is not separately reimbursable because it is considered a bundled service, therefore, it is non-covered and non-billable to the member.

Services Not Included in the Global Surgical Packages

The following services are not included in the global surgical package and can be paid for separately in addition to the surgical procedure:

- The initial evaluation of the problem by the surgeon to determine the need for surgery. Modifier 57 must be reported with the E/M service if this evaluation is the day before major surgery or the day of major surgery (those procedures having a Global Days value of 90). The initial evaluation is always included in the allowance for a procedure having a Global Days value other than 90.
- A visit on the same day as a minor or endoscopic procedure for a significant separately identifiable service, above and beyond care normally associated with the procedure. Modifier 25 must be reported with the E/M service to identify it as a significant separately identifiable service. Modifier 25 should only be used on claims for E/M services and only when these services are

provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 must be added to the E/M code on the claim. Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the practitioner in the patient's medical record to support the claim for these services.

- Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.
- 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 following the patient's discharge unrelated to the diagnosis for which the surgical procedure is performed (unless due to complications of the surgery). Modifier 24 must be reported with the E/M service to identify it as unrelated. Additionally, sufficient documentation must show that the visit was unrelated to the surgery. A diagnosis code that clearly indicates the reason for the encounter was unrelated to the surgery is sufficient documentation.
- 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.
- Physical therapy.
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatments for complications. Modifier 58 should be used to identify procedures done in two (2) or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Modifier 79 must be reported to identify unrelated procedures performed during the post-operative period.
- Treatment for postoperative complications which require a return trip to the operating room. An operating room for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures, including 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). Modifier 78 must be reported with the subsequent surgical procedure.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately. Modifier 58 must be reported with the second procedure.
- Major surgery performed on the same day or in the postoperative period of a diagnostic biopsy with a 10-day global period is separately payable.
- Splints and casting supplies for fractures or dislocations may be reimbursed when performed in a physician's office (codes A4649 and L0210).
- Recasting's during the global period of the treatment of a fracture. Modifier 58 (staged procedure) or Modifier 79 (unrelated procedure) should be reported with the recasting code.
- Immunosuppressive therapy for organ transplants. Modifier 24 should be reported to identify the care (even if it is during the same hospital stay as the surgical procedure). It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.
- Critical care services (code 99291) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. Modifier 25 must be

reported with code 99291 if rendered in the pre-operative period and modifier 24 for post-operative care. Documentation the critical care was unrelated to the specific anatomic injury or surgical procedure must be submitted. A diagnosis code which clearly indicates the critical care was unrelated to the surgery is acceptable documentation.

Subsequent Hospital Visits During the Global Surgery Period

Reimbursement for surgical procedures includes all the services and visits (e.g., E/M visits) part of the global surgery reimbursement including when such surgical procedures may be fragmented. Subsequent Hospital Care visits (codes 99231, 99232 and 99233) are not separately reimbursed when included in the global surgery payment.

Hospital Discharge Day Management Service

A Hospital Discharge Day Management Service, (codes 99238 or 99239) is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is reimbursed per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (codes 99231, 99232 and 99233) for a final visit.

Reimbursement for general paperwork is included through the pre-and post-service work of evaluation and management (E/M) services.

Applicable codes: 99231 99232 99233 99238 99239

Subsequent Hospital Visit and Discharge Management on Same Day

Payment will only be made for the hospital discharge management code on the day of discharge unless it is also the day of admission.

Physicians shall use the Observation or Inpatient Care Services (Including Admission and Discharge Services) for a hospital admission and discharge occurring on the same calendar date and when the following criteria are met:

1. When the patient was admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care can be reported by the physician. The Hospital Discharge Day Management service shall not be reported for this scenario.
2. When a patient was admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician can report an Initial Hospital Care and a Hospital Discharge Day Management service.
3. When a patient was admitted to inpatient hospital care for a minimum of eight (8) hours but less than twenty (24) hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), can be reported.

A subsequent hospital visit in addition to a hospital discharge day management service reported for the same date of service by the same physician is not eligible for reimbursement.

Applicable codes: 99234 99235 99236 99238 99239

Hospital Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed, even if the paperwork is delayed to a subsequent date.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  PA, WV, DE - will reimburse lines reporting modifier 78 at the code specific intra-op percent (of the approved allowance) as defined on the Medicare Physician Fee Schedule (MPFS). The intra-op rates will be evaluated on an annual basis with the release of the January Medicare Physician Fee Schedule, for changes to existing codes and application to any new codes issued throughout the previous year.

  NY - will reimburse lines reporting modifier 78 at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29999	39499	45999	58579	G0186	0525T	0545T	0726T	0809T
15999	30999	39599	46999	58679	0164T	0526T	0620T	0727T	0810T
17999	31299	40799	47379	58999	0165T	0527T	0644T	0730T	0823T
19499	31599	40899	47399	59898	0253T	0530T	0646T	0737T	0824T
20999	31899	41599	47579	59899	0274T	0531T	0655T	0739T	0825T
21089	32999	41899	47999	60659	0275T	0532T	0656T	0744T	0861T
21299	33999	42299	48999	60699	0308T	0569T	0657T	0745T	0862T

21499	34841	42699	49329	64999	0335T	0571T	0671T	0775T	0863T
21899	34842	42999	49659	66999	0345T	0572T	0672T	0790T	0867T
22899	34843	43289	49999	67299	0449T	0573T	0674T	0793T	0888T
22999	34844	43499	50549	67399	0450T	0574T	0675T	0795T	0908T
23929	34845	43647	50949	67599	0505T	0580T	0677T	0796T	0909T
24999	34846	43648	51999	67999	0510T	0582T	0679T	0797T	0910T
25999	34847	43659	53899	68399	0511T	0584T	0680T	0798T	
26989	34848	43999	54699	68899	0515T	0585T	0681T	0799T	
27299	37501	44238	55559	69300	0516T	0586T	0682T	0800T	
27599	37799	44799	55899	69399	0517T	0594T	0686T	0801T	
27899	38129	44899	55970	69799	0518T	0614T	0714T	0802T	
28899	38589	44979	55980	69949	0519T	0543T	0719T	0803T	
29799	38999	45499	58578	69979	0520T	0544T	0725T	0805T	

The following codes have a Global value of 10 days:

0266T	0441T	0581T	0600T	0643T	0661T	0793T	0786T	0817T	0901T
0267T	0442T	0583T	0601T	0647T	0673T	0784T	0787T	0818T	
0268T	0444T	0587T	0632T	0660T	0699T	0785T	0816T	0819T	
0440T	0445T	0588T							

DEFINITIONS:

Modifier	Definition
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional
57	Decision for surgery
58	Staged or related procedure/service by the same physician or other qualified health care professional during the postop period
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional, following initial procedure
79	Unrelated procedure/service, by the same physician or other qualified healthcare professional during postoperative period
FT	Unrelated evaluation and management (E&M) visit during a postoperative period, or on the same day as a procedure or another E&M visit

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-005: Modifiers 54 and 55
- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- CMS Online Manual Pub. 100-4, Chapter 12, Sections 30.6.9.1 and 30.6.9.2. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 1460, CR 5794. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1460CP.pdf
- CMS Online Manual Pub. 100-04, Chapter 12, 40.0-40.44. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 954, CR 5025. https://chfs.ky.gov/agencies/dph/dafm/Documents/IVMM5025.pdf

POLICY UPDATE HISTORY INFORMATION:

11 / 2018	Implementation
6 / 2021	Added Commercial and Medicare Advantage direction pertaining to services carrying the YYY global day indicator.
7 / 2021	Added additional codes to the YYY section for both Medicare Advantage and Commercial
11 / 2021	Added NY region applicable to the policy
12 / 2021	Added Medicare Advantage note for modifier 78 reduction. Delaware MA added as applicable to the policy. Codes 43499, 0356T, 0444T, 0445T, 0660T, 0661T, G2170, G2171 added to the global YYY codes sections for both MA and Commercial.
1 / 2022	Removed codes 0356T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0466T, 0467T, 0548T, 0549T, 0550T, 0551T, D7220, D7230, D7240, D7241, D7250, and added codes 0671T-0675T, 0677T, 0679T, 0680T-0682T, 0686T, 0699T, to the global YYY codes sections for MA and Commercial. Added modifier FT.
7 / 2022	Added 0714T, 0719T, 0725T, 0726T, 0727T, 0730T, 0737T, to the global YYY codes sections for MA and Commercial. Removed MP S-52 reference.
8 / 2022	Added 0643T to the global YYY codes sections for MA and Commercial.
1 / 2023	Removed codes 0163T, G2170, G2171 and added 0739T, 0744T, 0745T and 0775T to the global YYY code sections for MA and Commercial.
6 / 2023	Administrative policy review with no changes in policy direction
7 / 2023	Added 0793T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0805T, 0809T, 0810T, to the global YYY codes sections for MA and Commercial

1 / 2024	Added 0784T, 0785T, 0786T, 0787T, 0790T, 0816T - 0819T, 0823T - 0825T, 0861T - 0863T, to the global YYY codes sections for MA and Commercial.
7 / 2024	Added 0867T, 0888T, to the global YYY codes sections for MA and Commercial.
1 / 2025	Added 0901T, 0908T-0910T to the global YYY codes sections for MA and Commercial. Removed 0553T, 0567T, 0568T, and 0616T-0618T.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-042		
Subject:	Global Surgery and Subsequent Services		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	July 1, 2024	**Revised Date:**	July 2024
Date Reviewed:	June 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy is to provide direction on The Plan's reimbursement of global surgery services and subsequent hospital visits and hospital discharge day management services. Surgery is classified as either definitive/major or diagnostic/minor. Definitive/major surgical procedures have designated post-operative days (90 days) while diagnostic/minor surgical procedures have ten (10) or zero (0) post-operative days. The post-operative global periods are assigned by The Centers for Medicare and Medicaid Services (CMS) identified by the Global Days indicator on the Medicare Physicians' Fee Schedule (MPFS). Procedures that carry a global period indicator of YYY on the MPFS are at carriers' discretion to determine and apply post-operative periods.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Pre and Post-operative Care

In-hospital, the allowance for a surgical procedure includes payment for routine in-hospital pre-operative care and routine post-operative care, in or out of the hospital, when provided by the surgeon, his assistant, or associate as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days).

***Other than in-hospital**, the allowance for a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days), includes routine post-operative care when provided by the surgeon, his assistant, or associate.

***Note**: As permitted under state license/accreditation and Highmark policies.

Note: Reimbursement may be made for an unrelated Evaluation and Management (E/M) service by the same physician during the post-operative period when modifier 24 is reported with the E/M service.

Surgery and Medical Care on the Same Day

Regardless of place of service, medical care provided on the same day as a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) by the same physician, for the same condition is not eligible for reimbursement.

An E/M visit is included in the global allowance for the surgery and not separately reimbursable and when the medical care is contractually excluded, the visit is not covered.

Note: Reimbursement may be made for a significant, separately identifiable E/M service by the same physician on the same day as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) when modifier 25 is reported with the E/M code. When the 25 modifier is reported, the patients' records must clearly document separately identifiable medical care was rendered. Modifier 25 should only be used on claims for E/M services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. The plan will reimburse for an E/M service provided on the day of a procedure with a global fee period only when the physician indicates the service was for a significant, separately identifiable E/M service above and beyond the usual pre- and post-operative work of the procedure. Both the medically necessary E/M service and the procedure must be sufficiently documented in the patient's medical record by the physician or other qualified non-physician practitioner to support the claim for these services.

Reimbursement may also be made for an E/M service that results in the initial decision to perform the surgery when modifier 57 is reported with the E/M code.

Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  The Plan will reimburse claim lines at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29999	39499	45999	58579	G0186	0525T	0543T	0682T	0800T
15999	30999	39599	46999	58679	0164T	0526T	0544T	0686T	0801T
17999	31299	40799	47379	58999	0165T	0527T	0545T	0714T	0802T
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21299	33999	42299	48999	60699	0308T	0553T	0620T	0727T	0810T
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22899	34843	43289	49999	67299	0449T	0571T	0655T	0739T	0825T
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27599	37799	44799	55899	69399	0517T	0585T	0677T	0796T	
27899	38129	44899	55970	69799	0518T	0586T	0679T	0797T	
28899	38589	44979	55980	69949	0519T	0594T	0680T	0798T	
29799	38999	45499	58578	69979	0520T	0614T	0681T	0799T	

The following codes have a Global value of 10 days:

0266T	0441T	0568T	0588T	0632T	0660T	0699T	0785T	0816T	0819T
0267T	0442T	0581T	0600T	0643T	0661T	0793T	0786T	0817T	
0268T	0444T	0583T	0601T	0647T	0673T	0784T	0787T	0818T	
0440T	0445T	0587T							

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Global Surgery

Certain services are paid for under what are known as “global fees”. These fees incorporate the reimbursement for services performed at different times by the same provider (or group), but all in conjunction with one medical procedure or episode of care.

Standard packages of preoperative, intra-operative and post-operative services are included in the payment for a surgical procedure.

All surgical procedures are classified as one of the following:

1. Major surgery: Procedures have a 90-day post-operative period
2. Minor or Endoscopic surgery: Procedures have either a 10-day post-operative period or a 0-day post-operative period.

Components of a Global Surgical Package

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package.

The approved amount for surgical procedures includes reimbursement for the following services related to the surgery when furnished by the physician who performs the surgery:

Pre-operative Visits: Pre-operative visits beginning with the day before the date of surgery for major procedures (those having a Global Days value of 90) and the day of surgery for minor procedures (those having a Global Days value other than 90).

Intraoperative Services: Intra-operative services normally a usual and necessary part of the surgical procedure, including post-operative work in the hospital.

Complications Following Surgery: All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.

Post-operative Visits: Follow-up visits during the post-operative period of the surgery related to recovery from the surgery.

Post-surgical Pain Management: By the surgeon.

Supplies: See exception to this under "Services not included in the Global Surgical Package."

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.

A surgical tray (A4550) is not separately reimbursable because it is considered a bundled service, therefore, it is non-covered and non-billable to the member.

Services Not Included in the Global Surgical Packages

The following services are not included in the global surgical package and can be paid for separately in addition to the surgical procedure:

- The initial evaluation of the problem by the surgeon to determine the need for surgery. Modifier 57 must be reported with the E/M service if this evaluation is the day before major surgery or the day of major surgery (those procedures having a Global Days value of 90). The initial evaluation is always included in the allowance for a procedure having a Global Days value other than 90.
- A visit on the same day as a minor or endoscopic procedure for a significant separately identifiable service, above and beyond care normally associated with the procedure. Modifier 25 must be reported with the E/M service to identify it as a significant separately identifiable service. Modifier 25 should only be used on claims for E/M services and only when these services are

provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 must be added to the E/M code on the claim. Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the practitioner in the patient's medical record to support the claim for these services.

- Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.
- 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 following the patient's discharge unrelated to the diagnosis for which the surgical procedure is performed (unless due to complications of the surgery). Modifier 24 must be reported with the E/M service to identify it as unrelated. Additionally, sufficient documentation must show that the visit was unrelated to the surgery. A diagnosis code that clearly indicates the reason for the encounter was unrelated to the surgery is sufficient documentation.
- 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.
- Physical therapy.
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatments for complications. Modifier 58 should be used to identify procedures done in two (2) or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Modifier 79 must be reported to identify unrelated procedures performed during the post-operative period.
- Treatment for postoperative complications which require a return trip to the operating room. An operating room for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures, including 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). Modifier 78 must be reported with the subsequent surgical procedure.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately. Modifier 58 must be reported with the second procedure.
- Major surgery performed on the same day or in the postoperative period of a diagnostic biopsy with a 10-day global period is separately payable.
- Splints and casting supplies for fractures or dislocations may be reimbursed when performed in a physician's office (codes A4649 and L0210).
- Recasting's during the global period of the treatment of a fracture. Modifier 58 (staged procedure) or Modifier 79 (unrelated procedure) should be reported with the recasting code.
- Immunosuppressive therapy for organ transplants. Modifier 24 should be reported to identify the care (even if it is during the same hospital stay as the surgical procedure). It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.
- Critical care services (code 99291) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. Modifier 25 must be

reported with code 99291 if rendered in the pre-operative period and modifier 24 for post-operative care. Documentation the critical care was unrelated to the specific anatomic injury or surgical procedure must be submitted. A diagnosis code which clearly indicates the critical care was unrelated to the surgery is acceptable documentation.

Subsequent Hospital Visits During the Global Surgery Period

Reimbursement for surgical procedures includes all the services and visits (e.g., E/M visits) part of the global surgery reimbursement including when such surgical procedures may be fragmented. Subsequent Hospital Care visits (codes 99231, 99232 and 99233) are not separately reimbursed when included in the global surgery payment.

Hospital Discharge Day Management Service

A Hospital Discharge Day Management Service, (codes 99238 or 99239) is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is reimbursed per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (codes 99231, 99232 and 99233) for a final visit.

Reimbursement for general paperwork is included through the pre-and post-service work of evaluation and management (E/M) services.

Applicable codes: 99231 99232 99233 99238 99239

Subsequent Hospital Visit and Discharge Management on Same Day

Payment will only be made for the hospital discharge management code on the day of discharge unless it is also the day of admission.

Physicians shall use the Observation or Inpatient Care Services (Including Admission and Discharge Services) for a hospital admission and discharge occurring on the same calendar date and when the following criteria are met:

1. When the patient was admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care can be reported by the physician. The Hospital Discharge Day Management service shall not be reported for this scenario.
2. When a patient was admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician can report an Initial Hospital Care and a Hospital Discharge Day Management service.
3. When a patient was admitted to inpatient hospital care for a minimum of eight (8) hours but less than twenty (24) hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), can be reported.

A subsequent hospital visit in addition to a hospital discharge day management service reported for the same date of service by the same physician is not eligible for reimbursement.

Applicable codes: 99234 99235 99236 99238 99239

Hospital Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed, even if the paperwork is delayed to a subsequent date.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  PA, WV, DE - will reimburse lines reporting modifier 78 at the code specific intra-op percent (of the approved allowance) as defined on the Medicare Physician Fee Schedule (MPFS). The intra-op rates will be evaluated on an annual basis with the release of the January Medicare Physician Fee Schedule, for changes to existing codes and application to any new codes issued throughout the previous year.

  NY - will reimburse lines reporting modifier 78 at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29999	39499	45999	58579	G0186	0525T	0543T	0682T	0800T
15999	30999	39599	46999	58679	0164T	0526T	0544T	0686T	0801T
17999	31299	40799	47379	58999	0165T	0527T	0545T	0714T	0802T
19499	31599	40899	47399	59898	0253T	0530T	0616T	0719T	0803T
20999	31899	41599	47579	59899	0274T	0531T	0617T	0725T	0805T
21089	32999	41899	47999	60659	0275T	0532T	0618T	0726T	0809T
21299	33999	42299	48999	60699	0308T	0553T	0620T	0727T	0810T

21499	34841	42699	49329	64999	0335T	0567T	0644T	0730T	0823T
21899	34842	42999	49659	66999	0345T	0569T	0646T	0737T	0824T
22899	34843	43289	49999	67299	0449T	0571T	0655T	0739T	0825T
22999	34844	43499	50549	67399	0450T	0572T	0656T	0744T	0861T
23929	34845	43647	50949	67599	0505T	0573T	0657T	0745T	0862T
24999	34846	43648	51999	67999	0510T	0574T	0671T	0775T	0863T
25999	34847	43659	53899	68399	0511T	0580T	0672T	0790T	0867T
26989	34848	43999	54699	68899	0515T	0582T	0674T	0793T	0888T
27299	37501	44238	55559	69300	0516T	0584T	0675T	0795T	
27599	37799	44799	55899	69399	0517T	0585T	0677T	0796T	
27899	38129	44899	55970	69799	0518T	0586T	0679T	0797T	
28899	38589	44979	55980	69949	0519T	0594T	0680T	0798T	
29799	38999	45499	58578	69979	0520T	0614T	0681T	0799T	

The following codes have a Global value of 10 days:

0266T	0441T	0568T	0588T	0632T	0660T	0699T	0785T	0816T	0819T
0267T	0442T	0581T	0600T	0643T	0661T	0793T	0786T	0817T	
0268T	0444T	0583T	0601T	0647T	0673T	0784T	0787T	0818T	
0440T	0445T	0587T							

DEFINITIONS:

Modifier	Definition
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional
57	Decision for surgery
58	Staged or related procedure/service by the same physician or other qualified health care professional during the postop period
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional, following initial procedure
79	Unrelated procedure/service, by the same physician or other qualified healthcare professional during postoperative period
FT	Unrelated evaluation and management (E&M) visit during a postoperative period, or on the same day as a procedure or another E&M visit

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-005: Modifiers 54 and 55
- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- CMS Online Manual Pub. 100-4, Chapter 12, Sections 30.6.9.1 and 30.6.9.2. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 1460, CR 5794. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1460CP.pdf
- CMS Online Manual Pub. 100-04, Chapter 12, 40.0-40.44. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 954, CR 5025. https://chfs.ky.gov/agencies/dph/dafm/Documents/IVMM5025.pdf

POLICY UPDATE HISTORY INFORMATION:

11 / 2018	Implementation
6 / 2021	Added Commercial and Medicare Advantage direction pertaining to services carrying the YYY global day indicator.
7 / 2021	Added additional codes to the YYY section for both Medicare Advantage and Commercial
11 / 2021	Added NY region applicable to the policy
12 / 2021	Added Medicare Advantage note for modifier 78 reduction. Delaware MA added as applicable to the policy. Codes 43499, 0356T, 0444T, 0445T, 0660T, 0661T, G2170, G2171 added to the global YYY codes sections for both MA and Commercial.
1 / 2022	Removed codes 0356T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0466T, 0467T, 0548T, 0549T, 0550T, 0551T, D7220, D7230, D7240, D7241, D7250, and added codes 0671T-0675T, 0677T, 0679T, 0680T-0682T, 0686T, 0699T, to the global YYY codes sections for MA and Commercial. Added modifier FT.
7 / 2022	Added 0714T, 0719T, 0725T, 0726T, 0727T, 0730T, 0737T, to the global YYY codes sections for MA and Commercial. Removed MP S-52 reference.
8 / 2022	Added 0643T to the global YYY codes sections for MA and Commercial.
1 / 2023	Removed codes 0163T, G2170, G2171 and added 0739T, 0744T, 0745T and 0775T to the global YYY code sections for MA and Commercial.
6 / 2023	Administrative policy review with no changes in policy direction
7 / 2023	Added 0793T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0805T, 0809T, 0810T, to the global YYY codes sections for MA and Commercial

1 / 2024	Added 0784T, 0785T, 0786T, 0787T, 0790T, 0816T - 0819T, 0823T - 0825T, 0861T - 0863T, to the global YYY codes sections for MA and Commercial.
7 / 2024	Added 0867T, 0888T, to the global YYY codes sections for MA and Commercial.

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-042		
Subject:	Global Surgery and Subsequent Services		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	January 1, 2024	**Revised Date:**	January 2024
Date Reviewed:	December 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy is to provide direction on The Plan's reimbursement of global surgery services and subsequent hospital visits and hospital discharge day management services. Surgery is classified as either definitive/major or diagnostic/minor. Definitive/major surgical procedures have designated post-operative days (90 days) while diagnostic/minor surgical procedures have ten (10) or zero (0) post-operative days. The post-operative global periods are assigned by The Centers for Medicare and Medicaid Services (CMS) identified by the Global Days indicator on the Medicare Physicians' Fee Schedule (MPFS). Procedures that carry a global period indicator of YYY on the MPFS are at carriers' discretion to determine and apply post-operative periods.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Pre and Post-operative Care

In-hospital, the allowance for a surgical procedure includes payment for routine in-hospital pre-operative care and routine post-operative care, in or out of the hospital, when provided by the surgeon, his assistant, or associate as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days).

***Other than in-hospital**, the allowance for a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days), includes routine post-operative care when provided by the surgeon, his assistant, or associate.

***Note**: As permitted under state license/accreditation and Highmark policies.

Note: Reimbursement may be made for an unrelated Evaluation and Management (E/M) service by the same physician during the post-operative period when modifier 24 is reported with the E/M service.

Surgery and Medical Care on the Same Day

Regardless of place of service, medical care provided on the same day as a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) by the same physician, for the same condition is not eligible for reimbursement.

An E/M visit is included in the global allowance for the surgery and not separately reimbursable and when the medical care is contractually excluded, the visit is not covered.

Note: Reimbursement may be made for a significant, separately identifiable E/M service by the same physician on the same day as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) when modifier 25 is reported with the E/M code. When the 25 modifier is reported, the patients' records must clearly document separately identifiable medical care was rendered. Modifier 25 should only be used on claims for E/M services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. The plan will reimburse for an E/M service provided on the day of a procedure with a global fee period only when the physician indicates the service was for a significant, separately identifiable E/M service above and beyond the usual pre- and post-operative work of the procedure. Both the medically necessary E/M service and the procedure must be sufficiently documented in the patient's medical record by the physician or other qualified non-physician practitioner to support the claim for these services.

Reimbursement may also be made for an E/M service that results in the initial decision to perform the surgery when modifier 57 is reported with the E/M code.

Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  The Plan will reimburse claim lines at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29999	39499	45999	58579	G0186	0525T	0543T	0682T	0800T
15999	30999	39599	46999	58679	0164T	0526T	0544T	0686T	0801T
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19499	31599	40899	47399	59898	0253T	0530T	0616T	0719T	0803T
20999	31899	41599	47579	59899	0274T	0531T	0617T	0725T	0805T
21089	32999	41899	47999	60659	0275T	0532T	0618T	0726T	0809T
21299	33999	42299	48999	60699	0308T	0553T	0620T	0727T	0810T
21499	34841	42699	49329	64999	0335T	0567T	0644T	0730T	0823T
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22899	34843	43289	49999	67299	0449T	0571T	0655T	0739T	0825T
22999	34844	43499	50549	67399	0450T	0572T	0656T	0744T	0861T
23929	34845	43647	50949	67599	0505T	0573T	0657T	0745T	0862T
24999	34846	43648	51999	67999	0510T	0574T	0671T	0775T	0863T
25999	34847	43659	53899	68399	0511T	0580T	0672T	0790T	
26989	34848	43999	54699	68899	0515T	0582T	0674T	0793T	
27299	37501	44238	55559	69300	0516T	0584T	0675T	0795T	
27599	37799	44799	55899	69399	0517T	0585T	0677T	0796T	
27899	38129	44899	55970	69799	0518T	0586T	0679T	0797T	
28899	38589	44979	55980	69949	0519T	0594T	0680T	0798T	
29799	38999	45499	58578	69979	0520T	0614T	0681T	0799T	

The following codes have a Global value of 10 days:

0266T	0441T	0568T	0588T	0632T	0660T	0699T	0785T	0816T	0819T
0267T	0442T	0581T	0600T	0643T	0661T	0793T	0786T	0817T	
0268T	0444T	0583T	0601T	0647T	0673T	0784T	0787T	0818T	
0440T	0445T	0587T							

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Global Surgery

Certain services are paid for under what are known as “global fees”. These fees incorporate the reimbursement for services performed at different times by the same provider (or group), but all in conjunction with one medical procedure or episode of care.

Standard packages of preoperative, intra-operative and post-operative services are included in the payment for a surgical procedure.

All surgical procedures are classified as one of the following:

1. Major surgery: Procedures have a 90-day post-operative period
2. Minor or Endoscopic surgery: Procedures have either a 10-day post-operative period or a 0-day post-operative period.

Components of a Global Surgical Package

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package.

The approved amount for surgical procedures includes reimbursement for the following services related to the surgery when furnished by the physician who performs the surgery:

Pre-operative Visits: Pre-operative visits beginning with the day before the date of surgery for major procedures (those having a Global Days value of 90) and the day of surgery for minor procedures (those having a Global Days value other than 90).

Intraoperative Services: Intra-operative services normally a usual and necessary part of the surgical procedure, including post-operative work in the hospital.

Complications Following Surgery: All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.

Post-operative Visits: Follow-up visits during the post-operative period of the surgery related to recovery from the surgery.

Post-surgical Pain Management: By the surgeon.

Supplies: See exception to this under "Services not included in the Global Surgical Package."

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.

A surgical tray (A4550) is not separately reimbursable because it is considered a bundled service, therefore, it is non-covered and non-billable to the member.

Services Not Included in the Global Surgical Packages

The following services are not included in the global surgical package and can be paid for separately in addition to the surgical procedure:

- The initial evaluation of the problem by the surgeon to determine the need for surgery. Modifier 57 must be reported with the E/M service if this evaluation is the day before major surgery or the day of major surgery (those procedures having a Global Days value of 90). The initial evaluation is always included in the allowance for a procedure having a Global Days value other than 90.
- A visit on the same day as a minor or endoscopic procedure for a significant separately identifiable service, above and beyond care normally associated with the procedure. Modifier 25 must be reported with the E/M service to identify it as a significant separately identifiable service. Modifier 25 should only be used on claims for E/M services and only when these services are

provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 must be added to the E/M code on the claim. Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the practitioner in the patient's medical record to support the claim for these services.

- Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.
- 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 following the patient's discharge unrelated to the diagnosis for which the surgical procedure is performed (unless due to complications of the surgery). Modifier 24 must be reported with the E/M service to identify it as unrelated. Additionally, sufficient documentation must show that the visit was unrelated to the surgery. A diagnosis code that clearly indicates the reason for the encounter was unrelated to the surgery is sufficient documentation.
- 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.
- Physical therapy.
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatments for complications. Modifier 58 should be used to identify procedures done in two (2) or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Modifier 79 must be reported to identify unrelated procedures performed during the post-operative period.
- Treatment for postoperative complications which require a return trip to the operating room. An operating room for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures, including 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). Modifier 78 must be reported with the subsequent surgical procedure.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately. Modifier 58 must be reported with the second procedure.
- Major surgery performed on the same day or in the postoperative period of a diagnostic biopsy with a 10-day global period is separately payable.
- Splints and casting supplies for fractures or dislocations may be reimbursed when performed in a physician's office (codes A4649 and L0210).
- Recasting's during the global period of the treatment of a fracture. Modifier 58 (staged procedure) or Modifier 79 (unrelated procedure) should be reported with the recasting code.
- Immunosuppressive therapy for organ transplants. Modifier 24 should be reported to identify the care (even if it is during the same hospital stay as the surgical procedure). It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.
- Critical care services (code 99291) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. Modifier 25 must be

reported with code 99291 if rendered in the pre-operative period and modifier 24 for post-operative care. Documentation the critical care was unrelated to the specific anatomic injury or surgical procedure must be submitted. A diagnosis code which clearly indicates the critical care was unrelated to the surgery is acceptable documentation.

Subsequent Hospital Visits During the Global Surgery Period

Reimbursement for surgical procedures includes all the services and visits (e.g., E/M visits) part of the global surgery reimbursement including when such surgical procedures may be fragmented. Subsequent Hospital Care visits (codes 99231, 99232 and 99233) are not separately reimbursed when included in the global surgery payment.

Hospital Discharge Day Management Service

A Hospital Discharge Day Management Service, (codes 99238 or 99239) is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is reimbursed per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (codes 99231, 99232 and 99233) for a final visit.

Reimbursement for general paperwork is included through the pre-and post-service work of evaluation and management (E/M) services.

Applicable codes: 99231 99232 99233 99238 99239

Subsequent Hospital Visit and Discharge Management on Same Day

Payment will only be made for the hospital discharge management code on the day of discharge unless it is also the day of admission.

Physicians shall use the Observation or Inpatient Care Services (Including Admission and Discharge Services) for a hospital admission and discharge occurring on the same calendar date and when the following criteria are met:

1. When the patient was admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care can be reported by the physician. The Hospital Discharge Day Management service shall not be reported for this scenario.
2. When a patient was admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician can report an Initial Hospital Care and a Hospital Discharge Day Management service.
3. When a patient was admitted to inpatient hospital care for a minimum of eight (8) hours but less than twenty (24) hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), can be reported.

A subsequent hospital visit in addition to a hospital discharge day management service reported for the same date of service by the same physician is not eligible for reimbursement.

Applicable codes: 99234 99235 99236 99238 99239

Hospital Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed, even if the paperwork is delayed to a subsequent date.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  PA, WV, DE - will reimburse lines reporting modifier 78 at the code specific intra-op percent (of the approved allowance) as defined on the Medicare Physician Fee Schedule (MPFS). The intra-op rates will be evaluated on an annual basis with the release of the January Medicare Physician Fee Schedule, for changes to existing codes and application to any new codes issued throughout the previous year.

  NY - will reimburse lines reporting modifier 78 at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29999	39499	45999	58579	G0186	0525T	0543T	0682T	0800T
15999	30999	39599	46999	58679	0164T	0526T	0544T	0686T	0801T
17999	31299	40799	47379	58999	0165T	0527T	0545T	0714T	0802T
19499	31599	40899	47399	59898	0253T	0530T	0616T	0719T	0803T
20999	31899	41599	47579	59899	0274T	0531T	0617T	0725T	0805T
21089	32999	41899	47999	60659	0275T	0532T	0618T	0726T	0809T
21299	33999	42299	48999	60699	0308T	0553T	0620T	0727T	0810T

21499	34841	42699	49329	64999	0335T	0567T	0644T	0730T	0823T
21899	34842	42999	49659	66999	0345T	0569T	0646T	0737T	0824T
22899	34843	43289	49999	67299	0449T	0571T	0655T	0739T	0825T
22999	34844	43499	50549	67399	0450T	0572T	0656T	0744T	0861T
23929	34845	43647	50949	67599	0505T	0573T	0657T	0745T	0862T
24999	34846	43648	51999	67999	0510T	0574T	0671T	0775T	0863T
25999	34847	43659	53899	68399	0511T	0580T	0672T	0790T	
26989	34848	43999	54699	68899	0515T	0582T	0674T	0793T	
27299	37501	44238	55559	69300	0516T	0584T	0675T	0795T	
27599	37799	44799	55899	69399	0517T	0585T	0677T	0796T	
27899	38129	44899	55970	69799	0518T	0586T	0679T	0797T	
28899	38589	44979	55980	69949	0519T	0594T	0680T	0798T	
29799	38999	45499	58578	69979	0520T	0614T	0681T	0799T	

The following codes have a Global value of 10 days:

0266T	0441T	0568T	0588T	0632T	0660T	0699T	0785T	0816T	0819T
0267T	0442T	0581T	0600T	0643T	0661T	0793T	0786T	0817T	
0268T	0444T	0583T	0601T	0647T	0673T	0784T	0787T	0818T	
0440T	0445T	0587T							

DEFINITIONS:

Modifier	Definition
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional
57	Decision for surgery
58	Staged or related procedure/service by the same physician or other qualified health care professional during the postop period
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional, following initial procedure
79	Unrelated procedure/service, by the same physician or other qualified healthcare professional during postoperative period
FT	Unrelated evaluation and management (E&M) visit during a postoperative period, or on the same day as a procedure or another E&M visit

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-005: Modifiers 54 and 55
- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm
- CMS Online Manual Pub. 100-4, Chapter 12, Sections 30.6.9.1 and 30.6.9.2. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 1460, CR 5794. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1460CP.pdf
- CMS Online Manual Pub. 100-04, Chapter 12, 40.0-40.44. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12
- CMS Transmittal 954, CR 5025. https://chfs.ky.gov/agencies/dph/dafm/Documents/IVMM5025.pdf

POLICY UPDATE HISTORY INFORMATION:

11 / 2018	Implementation
6 / 2021	Added Commercial and Medicare Advantage direction pertaining to services carrying the YYY global day indicator.
7 / 2021	Added additional codes to the YYY section for both Medicare Advantage and Commercial
11 / 2021	Added NY region applicable to the policy
12 / 2021	Added Medicare Advantage note for modifier 78 reduction. Delaware MA added as applicable to the policy. Codes 43499, 0356T, 0444T, 0445T, 0660T, 0661T, G2170, G2171 added to the global YYY codes sections for both MA and Commercial.
1 / 2022	Removed codes 0356T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0466T, 0467T, 0548T, 0549T, 0550T, 0551T, D7220, D7230, D7240, D7241, D7250, and added codes 0671T-0675T, 0677T, 0679T, 0680T-0682T, 0686T, 0699T, to the global YYY codes sections for MA and Commercial. Added modifier FT.
7 / 2022	Added 0714T, 0719T, 0725T, 0726T, 0727T, 0730T, 0737T, to the global YYY codes sections for MA and Commercial. Removed MP S-52 reference.
8 / 2022	Added 0643T to the global YYY codes sections for MA and Commercial.
1 / 2023	Removed codes 0163T, G2170, G2171 and added 0739T, 0744T, 0745T and 0775T to the global YYY code sections for MA and Commercial.
6 / 2023	Administrative policy review with no changes in policy direction
7 / 2023	Added 0793T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0805T, 0809T, 0810T, to the global YYY codes sections for MA and Commercial

1 / 2024	Added 0784T, 0785T, 0786T, 0787T, 0790T, 0816T - 0819T, 0823T - 0825T, 0861T - 0863T, to the global YYY codes sections for MA and Commercial.

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-042		
Subject:	Global Surgery and Subsequent Services		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	July 3, 2023	**Revised Date:**	June 2023
Date Reviewed:	June 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy is to provide direction on The Plan's reimbursement of global surgery services and subsequent hospital visits and hospital discharge day management services. Surgery is classified as either definitive/major or diagnostic/minor. Definitive/major surgical procedures have designated post-operative days (90 days) while diagnostic/minor surgical procedures have ten (10) or zero (0) post-operative days. The post-operative global periods are assigned by The Centers for Medicare and Medicaid Services (CMS) identified by the Global Days indicator on the Medicare Physicians' Fee Schedule (MPFS). Procedures that carry a global period indicator of YYY on the MPFS are at carriers' discretion to determine and apply post-operative periods.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Pre and Post-operative Care

In-hospital, the allowance for a surgical procedure includes payment for routine in-hospital pre-operative care and routine post-operative care, in or out of the hospital, when provided by the surgeon, his assistant, or associate as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days).

***Other than in-hospital**, the allowance for a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days), includes routine post-operative care when provided by the surgeon, his assistant, or associate.

***Note**: As permitted under state license/accreditation and Highmark policies.

Note: Reimbursement may be made for an unrelated Evaluation and Management (E/M) service by the same physician during the post-operative period when modifier 24 is reported with the E/M service.

Surgery and Medical Care on the Same Day

Regardless of place of service, medical care provided on the same day as a surgical procedure, as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) by the same physician, for the same condition is not eligible for reimbursement.

An E/M visit is included in the global allowance for the surgery and not separately reimbursable and when the medical care is contractually excluded, the visit is not covered.

Note: Reimbursement may be made for a significant, separately identifiable E/M service by the same physician on the same day as defined by the CMS Global Days field (e.g. 0, 10, 90, or YYY days) when modifier 25 is reported with the E/M code. When the 25 modifier is reported, the patients' records must clearly document separately identifiable medical care was rendered. Modifier 25 should only be used on claims for E/M services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. The plan will reimburse for an E/M service provided on the day of a procedure with a global fee period only when the physician indicates the service was for a significant, separately identifiable E/M service above and beyond the usual pre- and post-operative work of the procedure. Both the medically necessary E/M service and the procedure must be sufficiently documented in the patient's medical record by the physician or other qualified non-physician practitioner to support the claim for these services.

Reimbursement may also be made for an E/M service that results in the initial decision to perform the surgery when modifier 57 is reported with the E/M code.

Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  The Plan will reimburse claim lines at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29799	38589	44899	55899	69300	0515T	0580T	0671T	0745T
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28899	38129	44799	55559	68899	0511T	0574T	0657T	0744T	

The following codes have a Global value of 10 days:

0266T	0440T	0444T	0581T	0587T	0600T	0632T	0647T	0661T	0699T
0267T	0441T	0445T	0583T	0588T	0601T	0643T	0660T	0673T	0793T
0268T	0442T	0568T							

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

Global Surgery

Certain services are paid for under what are known as “global fees”. These fees incorporate the reimbursement for services performed at different times by the same provider (or group), but all in conjunction with one medical procedure or episode of care.

Standard packages of preoperative, intra-operative and post-operative services are included in the payment for a surgical procedure.

All surgical procedures are classified as one of the following:

1. Major surgery: Procedures have a 90-day post-operative period
2. Minor or Endoscopic surgery: Procedures have either a 10-day post-operative period or a 0-day post-operative period.

Components of a Global Surgical Package

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package.

The approved amount for surgical procedures includes reimbursement for the following services related to the surgery when furnished by the physician who performs the surgery:

Pre-operative Visits: Pre-operative visits beginning with the day before the date of surgery for major procedures (those having a Global Days value of 90) and the day of surgery for minor procedures (those having a Global Days value other than 90).

Intraoperative Services: Intra-operative services normally a usual and necessary part of the surgical procedure, including post-operative work in the hospital.

Complications Following Surgery: All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.

Post-operative Visits: Follow-up visits during the post-operative period of the surgery related to recovery from the surgery.

Post-surgical Pain Management: By the surgeon.

Supplies: See exception to this under "Services not included in the Global Surgical Package."

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.

A surgical tray (A4550) is not separately reimbursable because it is considered a bundled service, therefore, it is non-covered and non-billable to the member.

Services Not Included in the Global Surgical Packages

The following services are not included in the global surgical package and can be paid for separately in addition to the surgical procedure:

- The initial evaluation of the problem by the surgeon to determine the need for surgery. Modifier 57 must be reported with the E/M service if this evaluation is the day before major surgery or the day of major surgery (those procedures having a Global Days value of 90). The initial evaluation is always included in the allowance for a procedure having a Global Days value other than 90.
- A visit on the same day as a minor or endoscopic procedure for a significant separately identifiable service, above and beyond care normally associated with the procedure. Modifier 25 must be reported with the E/M service to identify it as a significant separately identifiable service. Modifier 25 should only be used on claims for E/M services and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier 25 must be added to the E/M code on the claim. Both the medically necessary E/M service and the

procedure must be appropriately and sufficiently documented by the practitioner in the patient's medical record to support the claim for these services.

- Modifier FT may be reported with medical care (e.g. critical care, E/M visits) to identify it as significant and separately identifiable from the other service(s) provided on the same day or within the post-op period. When modifier "FT" is reported, the patient's medical records must clearly document that separately identifiable medical care was rendered and reported at the appropriate level based on the complexity of medical decision making.
- 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 following the patient's discharge unrelated to the diagnosis for which the surgical procedure is performed (unless due to complications of the surgery). Modifier 24 must be reported with the E/M service to identify it as unrelated. Additionally, sufficient documentation must show that the visit was unrelated to the surgery. A diagnosis code that clearly indicates the reason for the encounter was unrelated to the surgery is sufficient documentation.
- 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.
- Physical therapy.
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatments for complications. Modifier 58 should be used to identify procedures done in two (2) or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Modifier 79 must be reported to identify unrelated procedures performed during the post-operative period.
- Treatment for postoperative complications which require a return trip to the operating room. An operating room for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures, including 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). Modifier 78 must be reported with the subsequent surgical procedure.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately. Modifier 58 must be reported with the second procedure.
- Major surgery performed on the same day or in the postoperative period of a diagnostic biopsy with a 10-day global period is separately payable.
- Splints and casting supplies for fractures or dislocations may be reimbursed when performed in a physician's office (codes A4649 and L0210).
- Recasting's during the global period of the treatment of a fracture. Modifier 58 (staged procedure) or Modifier 79 (unrelated procedure) should be reported with the recasting code.
- Immunosuppressive therapy for organ transplants. Modifier 24 should be reported to identify the care (even if it is during the same hospital stay as the surgical procedure). It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.
- Critical care services (code 99291) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. Modifier 25 must be reported with code 99291 if rendered in the pre-operative period and modifier 24 for post-operative care. Documentation the critical care was unrelated to the specific anatomic injury or surgical procedure must be submitted. A diagnosis code which clearly indicates the critical care

was unrelated to the surgery is acceptable documentation.

Subsequent Hospital Visits During the Global Surgery Period

Reimbursement for surgical procedures includes all the services and visits (e.g., E/M visits) part of the global surgery reimbursement including when such surgical procedures may be fragmented. Subsequent Hospital Care visits (codes 99231, 99232 and 99233) are not separately reimbursed when included in the global surgery payment.

Hospital Discharge Day Management Service

A Hospital Discharge Day Management Service, (codes 99238 or 99239) is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is reimbursed per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (codes 99231, 99232 and 99233) for a final visit.

Reimbursement for general paperwork is included through the pre-and post-service work of evaluation and management (E/M) services.

Applicable codes: 99231 99232 99233 99238 99239

Subsequent Hospital Visit and Discharge Management on Same Day

Payment will only be made for the hospital discharge management code on the day of discharge unless it is also the day of admission.

Physicians shall use the Observation or Inpatient Care Services (Including Admission and Discharge Services) for a hospital admission and discharge occurring on the same calendar date and when the following criteria are met:

1. When the patient was admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care can be reported by the physician. The Hospital Discharge Day Management service shall not be reported for this scenario.
2. When a patient was admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician can report an Initial Hospital Care and a Hospital Discharge Day Management service.
3. When a patient was admitted to inpatient hospital care for a minimum of eight (8) hours but less than twenty (24) hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), can be reported.

A subsequent hospital visit in addition to a hospital discharge day management service reported for the same date of service by the same physician is not eligible for reimbursement.

Applicable codes: 99234 99235 99236 99238 99239

Hospital Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed, even if the paperwork is delayed to a subsequent date.

Procedures Reported with Modifier 78

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating room. An operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term operating room 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 operating room.)

Note: A new Global Period will **not** apply to a procedure meeting these requirements and reported with modifier 78.

- **Modifier 78 Reimbursement Adjustments**

  PA, WV, DE - will reimburse lines reporting modifier 78 at the code specific intra-op percent (of the approved allowance) as defined on the Medicare Physician Fee Schedule (MPFS). The intra-op rates will be evaluated on an annual basis with the release of the January Medicare Physician Fee Schedule, for changes to existing codes and application to any new codes issued throughout the previous year.

  NY - will reimburse lines reporting modifier 78 at 70% of the approved allowance.

Services Assigned CMS Global Days Indicator YYY

The plan determines an appropriate post-operative day value and assigns a value of 0, 10, or 90 days for codes assigned the CMS Global Day indicator YYY. Codes listed below are those the Plan has assigned a value greater than zero (0).

The following codes have a Global value of 90 days:

15847	29799	38589	44899	55899	69300	0515T	0580T	0671T	0745T
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17999	30999	39499	45499	55980	69799	0517T	0584T	0674T	0793T
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21499	33999	41899	47579	59898	0165T	0526T	0543T	0681T	0799T
21899	34841	42299	47999	59899	0253T	0527T	0544T	0682T	0800T

22899	34842	42699	48999	60659	0274T	0530T	0545T	0686T	0801T
22999	34843	42999	49329	60699	0275T	0531T	0616T	0714T	0802T
23929	34844	43289	49659	64999	0308T	0532T	0617T	0719T	0803T
24999	34845	43499	49999	66999	0335T	0553T	0618T	0725T	0805T
25999	34846	43647	50549	67299	0345T	0567T	0620T	0726T	0809T
26989	34847	43648	50949	67399	0449T	0569T	0644T	0727T	0810T
27299	34848	43659	51999	67599	0450T	0571T	0646T	0730T	
27599	37501	43999	53899	67999	0505T	0572T	0655T	0737T	
27899	37799	44238	54699	68399	0510T	0573T	0656T	0739T	
28899	38129	44799	55559	68899	0511T	0574T	0657T	0744T	

The following codes have a Global value of 10 days:

0266T	0440T	0444T	0581T	0587T	0600T	0632T	0647T	0661T	0699T
0267T	0441T	0445T	0583T	0588T	0601T	0643T	0660T	0673T	0793T
0268T	0442T	0568T							

DEFINITIONS:

Modifier	Definition
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional
57	Decision for surgery
58	Staged or related procedure/service by the same physician or other qualified health care professional during the postop period
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional, following initial procedure
79	Unrelated procedure/service, by the same physician or other qualified healthcare professional during postoperative period
FT	Unrelated evaluation and management (E&M) visit during a postoperative period, or on the same day as a procedure or another E&M visit

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-005: Modifiers 54 and 55
- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines

REFERENCES:

- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm

- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim. https://www.ssa.gov/OP_Home/ssact/title18/1800.htm

- CMS Online Manual Pub. 100-4, Chapter 12, Sections 30.6.9.1 and 30.6.9.2. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12

- CMS Transmittal 1460, CR 5794. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1460CP.pdf

- CMS Online Manual Pub. 100-04, Chapter 12, 40.0-40.44. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12

- CMS Transmittal 954, CR 5025. https://chfs.ky.gov/agencies/dph/dafm/Documents/IVMM5025.pdf

POLICY UPDATE HISTORY INFORMATION:

11 / 2018	Implementation
6 / 2021	Added Commercial and Medicare Advantage direction pertaining to services carrying the YYY global day indicator.
7 / 2021	Added additional codes to the YYY section for both Medicare Advantage and Commercial
11 / 2021	Added NY region applicable to the policy
12 / 2021	Added Medicare Advantage note for modifier 78 reduction. Delaware MA added as applicable to the policy. Codes 43499, 0356T, 0444T, 0445T, 0660T, 0661T, G2170, G2171 added to the global YYY codes sections for both MA and Commercial.
1 / 2022	Removed codes 0356T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0459T, 0460T, 0461T, 0462T, 0463T, 0466T, 0467T, 0548T, 0549T, 0550T, 0551T, D7220, D7230, D7240, D7241, D7250, and added codes 0671T-0675T, 0677T, 0679T, 0680T-0682T, 0686T, 0699T, to the global YYY codes sections for MA and Commercial. Added modifier FT.
7 / 2022	Added 0714T, 0719T, 0725T, 0726T, 0727T, 0730T, 0737T, to the global YYY codes sections for MA and Commercial. Removed MP S-52 reference.
8 / 2022	Added 0643T to the global YYY codes sections for MA and Commercial.
1 / 2023	Removed codes 0163T, G2170, G2171 and added 0739T, 0744T, 0745T and 0775T to the global YYY code sections for MA and Commercial.
6 / 2023	Administrative policy review with no changes in policy direction
7 / 2023	Added 0793T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0805T, 0809T, 0810T, to the global YYY codes sections for MA and Commercial.