OWCP Surgical Services – Global Surgery

A global period is a period of time starting with a surgical procedure and ending some period of time after the procedure. Many surgeries have a follow-up period during which charges for normal post-operative care are bundled into the global surgery fee. For the Office of Workers' Compensation (OWCP), no global periods for surgical procedures shall be longer than the period designated by the Centers for Medicare and Medicaid (CMS). Reimbursement for surgical procedures includes payment for all related services and supplies that are routine and necessary to perform the procedure. These components of the surgical package are not eligible for separate reimbursement and will be denied if billed within the global period of the associated procedure.

CMS global surgery indicators are found in the current CMS National Physician Fee Schedule Relative Values Files for which OWCP uses as a primary resource. Historically, this information is found in the current Federal Register which can be assessed online at:
https://www.federalregister.gov/index/2018/centers-for-medicare-medicaid-services

More detailed information is provided in the Medicare Claims Processing Manual, Chapter 12
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

CMS global surgery indicators are found in the CMS National Physician Fee Schedule Relative Value Files. Values which are currently used are:

000 Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the same day of the procedure generally not payable.

010 Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during a 10-day postoperative period generally not payable.

090 Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.

MMM Maternity codes; usual global period does not apply.

XXX The global concept does not apply.

YYY The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ The code is related to another service and is always included in the global period of the other service.

Components of a Global Surgical Package

Preoperative Services:
The reimbursement for a surgical procedure includes payment for all E/M services that are related to that procedure:

- A minor procedure (0-10 post-operative days) includes the day of surgery
- A major procedure (90 post-operative days) includes the day before and the day of surgery unless that E/M service resulted in the initial decision to perform the surgical procedure. In this case, the E/M code may be eligible for separate reimbursement if modifier-57 is attached to the E/M code

Intra-operative Services:
The reimbursement for a surgical procedure includes payment for all intraoperative services that are a normal, usual and necessary part of that surgical procedure.

Postoperative Services:
The reimbursement for a surgical procedure includes payment for all professional services that are related to that procedure and are provided during the postoperative period. This includes but is not limited to:

- Dressing changes
- E/M services related to the original surgery, all settings
- Incisional care
- Postoperative pain management by the surgeon
- Removal of staples, tubes, drains, casts, splints and cutaneous sutures
- Routine, typical postoperative care or treatment (including complications) that are related to the original surgery but do not require a return trip to the operating room
- Insertion, irrigation and removal of catheters

The follow-up period applies to any provider who participated in the surgical procedure. These providers include:

- Surgeon or physician who performs any component of the surgery (e.g., the pre, intra and/or postoperative care of the patient; identified by modifiers -54, -55, and -56)
- Assistant surgeon (identified by modifiers –80, –81, –82, and –AS)
- Two surgeons (identified by modifier –62)
- Team surgeons (identified by modifier –66)
- Anesthesiologists and CRNA

Separate Providers of Pre, Intra, or Post-operative Services:
OWCP will allow separate payment when different physicians or providers perform the preoperative, intraoperative or postoperative components of the surgery. The appropriate modifiers (–54, –55 or –56) must be used.

Minor Surgical Procedures:

For minor surgical procedures, OWCP follows the CMS policy to not allow payment for an E/M office visit during the global period unless:

- A documented, unrelated service is furnished during the post-operative period and modifier -24 is used
  or
- The physician who performs the procedure is seeing the patient for the first time, in which case an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier -25 must be used. Appropriate documentation must be made in the chart describing the E/M service.
- Modifier -57, decision for surgery is not payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered routine preoperative service and a visit or consultation is not paid in addition to the procedure. Modifier -57 is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

Professional inpatient services (CPT codes 99221 – 99223) are only payable during the follow-up period if they are performed on an emergency basis. These services are not payable for scheduled hospital admission.

Supplies:
The reimbursement for a surgical procedure includes payment for all supplies that are a normal, usual and necessary part of that surgical procedure.

Services Not Included in the Global Surgical Package:
Some professional services are not included in the reimbursement for a surgical procedure and therefore may be eligible for separate reimbursement. It may be necessary to append an appropriate modifier to the code for the service to identify the circumstances which make the code eligible for separate reimbursement. These services include but are not limited to:

- Consultations
- New patient E/M services
- An E&M service the day before or the day of a major surgical procedure only if the initial decisio n to perform the surgery was made during that visit. Modifier -
  57 must be attached to the E&M code to indicate decision for surgery.
- An E&M service provided on the same day as a minor procedure only if the E&M service is unrelated to the procedure performed. Modifier -25 must be attached to the E&M code to indicate the E&M is significant and separately identifiable.
- An E&M service during the surgical postoperative period only if the visit is unrelated to the surgical procedure. Modifier-24 must be attached to the E&M code to indicate the E&M is unrelated to the procedure performed.
- A repeat surgical procedure by the same surgeon performed on the same day as the original surgery, requiring a return trip to the operating room. Modifier-76 must be attached to the procedure code to indicate a repeat surgical procedure. The use of modifier-76 must be substantiated by documentation.

- A repeat surgical procedure by a different surgeon, on the same day as the original surgery, requiring a return trip to the operating room. Modifier-77 must be attached to the procedure code to indicate a repeat surgical procedure by a different surgeon. The use of modifier-77 must be substantiated by documentation.
- A procedure or treatment that is related to the original surgery that requires an unplanned return to the operating room. Modifier-78 must be attached to the surgical code to indicate an unplanned return to the operating room.
- A procedure or service that is unrelated to the original surgery. Modifier-79 must be attached to the procedure code to indicate the surgery is unrelated to the original procedure.
- A staged surgical procedure (one that was planned at the time of the original surgery) performed during the postoperative period of the original surgery. Modifier-58 must be attached to the procedure code to indicate a staged procedure.
- Splinting and cast supplies

Appropriate Usage of Modifiers:
As identified in the scenarios above, modifiers may be applicable to billing for services related to the global surgical period. Appropriate modifier usage should be selected based on the CPT and/or HCPCS coding rules.

24 – *Unrelated E/M service by the same physician during a postoperative period*

The physician may need to indicate that an E/M service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E/M service.

25 - *Significant, separately identifiable E/M service by the same physician on the day of a procedure*

The physician may need to indicate that on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual pre-and postoperative care associated with the procedure. This circumstance may be reported by adding the modifier-25 to the appropriate level of E/M.

57 – *Decision for Surgery*

An E/M service that resulted in the initial decision to perform the surgery may be identified by adding the modifier-57 to the appropriate level of E/M service.
Note: This modifier should only be used in cases in which the decision for surgery was made during the preoperative period of a major surgical procedure (90-day global period).

58 - *Staged or related procedure or services by the same physician during the postoperative period*

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding the modifier-58 to the staged or related procedure.

78 - *Return to the Operating Room for a related procedure during the postoperative period*

The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier-78 to the related procedure.

79 - *Unrelated procedure or service by the same physician during the postoperative period*

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier-79. (For repeat procedures on the same day, see modifier-76).