Global Surgical Periods to Change for Texas Medicaid

Information posted March 5, 2010

Effective for dates of service on or after May 1, 2010, the global surgical period and the usage of certain modifiers will change for Texas Medicaid.

Providers who perform surgical procedures before May 1, 2010, must continue to bill services using the current process.

The following changes apply to surgical procedures that are performed on or after May 1, 2010.

Texas Medicaid uses global surgical periods to determine reimbursement for services that are related to surgical procedures. Medicaid global periods will align with the Medicare global periods that are set by the Centers for Medicare & Medicaid Services (CMS). For information about global surgical periods for individual procedure codes, providers can refer to the Medicare Physician Fee Schedule Database (MPFSDB), which is located on the CMS website at www.cms.hhs.gov/PhysicianFeeSched.

The following services are included in the global surgical period:

- Preoperative care, including history and physical.
- Hospital admission work-up.
- Anesthesia (when administered and monitored by the primary surgeon).
- Surgical procedure (intraoperative).
- Postoperative follow-up and related services.
- Complications following the surgical procedure that do not require return trips to the operating room.

Texas Medicaid will adhere to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows:

- 0-day Global Period—Reimbursement includes the surgical procedure and any associated services that are provided on the same day.
- 10-day Global Period—Reimbursement includes the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 10 days after the surgical procedure.
- 90-day Global Period—Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 90 days after the surgical procedure.

Procedure codes that are designated as "Carrier Discretion" will have their global periods determined by HHSC.

Modifiers

Texas Medicaid will add certain modifiers that are related to surgical services, in alignment with CMS. For the correct reimbursement of services that are rendered in the preoperative, intraoperative, or postoperative period, providers must use the appropriate
modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

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<th>Modifiers</th>
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If a physician provided all of the preoperative, intraoperative, and postoperative care, claims may be considered for reimbursement when they are submitted without a modifier.

**Documentation Requirements**

For services that are billed with any of the listed modifiers to be considered for reimbursement, providers must maintain in the client's medical record documentation that supports the medical necessity of the services. Acceptable documentation includes, but is not limited to, progress notes, operative reports, laboratory reports, and hospital records.

On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed.

**Note:** Retrospective review may be performed to ensure that the submitted documentation supports the medical necessity of the surgical procedure and any modifier used to bill the claim.

**Authorization**

There are no changes to authorization requirements. Providers can refer to the 2009 Texas Medicaid Provider Procedures Manual for additional information about surgical procedures.

**Reimbursement**

The global surgical fee period will apply to both emergency and non-emergency surgical procedures. Physicians in the same group practice and specialty must bill, and will be reimbursed, as if they were a single provider.

**Evaluation and Management (E/M) Services**

E/M services that are rendered on the day of the surgical procedure are generally not payable for procedures that have a 0-day global period.

E/M services that are rendered on the day of the surgical procedure or during the 10-day postoperative period are generally not payable for procedures that have a 10-day global period.

E/M services that are rendered on the day before the surgical procedure, on the day of the surgical procedure or service, or during the 90-day postoperative period are generally not payable for procedures that have a 90-day global period.
Preoperative Services

Preoperative physician E/M services (such as office or hospital visits) that are provided during the preoperative limitation period and are directly related to the planned surgical procedure will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a significant, separately identifiable service may be billed with modifier 25 if they are provided on the same day by the same provider as the surgical procedure.

Modifier 25 is not used to report an E/M service that results in a decision to perform a surgical procedure. Medical record documentation must substantiate the use of modifier 25.

If the decision to perform a minor procedure is made during an E/M visit immediately before the surgical procedure, the E/M visit is considered a routine preoperative service and is not separately billable.

Physicians who provide only preoperative services for surgical procedures with a 10- or 90-day global period may submit claims using the surgical procedure code with the identifying modifier 56. Reimbursement will be limited to a percentage of the Medicaid fee for the surgical procedure.

E/M services that are provided during the preoperative period (one day before or on the same day) of a major surgical procedure (90-day global period) and result in the initial decision to perform the surgical procedure may be considered for reimbursement when they are billed with the modifier 57. The client's medical record should clearly indicate when the initial decision to perform the procedure was made.

Intraoperative Services

Physicians who performed a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with the modifier 54. Modifier 54 indicates that the surgeon is relinquishing all of the postoperative care to a physician outside of the same group. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

Co-surgeons may be reimbursed for surgical procedures that are billed with modifier 62 if the CMS fee schedule indicates that the procedure allows for cosurgeons. Claims will be suspended for manual review of the documentation of medical necessity. Reimbursement will be calculated at 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure’s fee.

Postoperative Services

Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not separately reimbursed. Postoperative services include, but are not limited to, all of the following:

- Follow-up visits (any place of service).
- Pain management.
• Miscellaneous services, including:
  o Dressing changes.
  o Local incision care.
  o Platelet gel.
  o Removal of operative packs.
  o Removal of cutaneous sutures, staples, lines, wires, drains, casts, or splints.
  o Replacement of vascular access lines.
  o Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes.
  o Changes or removal of tracheostomy tubes.

Note: Removal of postoperative dressings or anesthetic devices is not eligible for separate reimbursement as the removal is considered part of the allowance for the primary surgical procedure.

Staged or related surgical procedures or services that are performed during the postoperative period may be reimbursed when they are billed with modifier 58. A postoperative period will be assigned to the subsequent procedure. Documentation must indicate that the subsequent procedure or service was not the result of a complication or any of the following:

• It was planned at the time of the initial surgical procedure.
• It is more extensive than the initial surgical procedure.
• It is for therapy following an invasive diagnostic surgical procedure.

Note: Modifier 58 does not apply to procedure codes that are already defined as staged or sessioned services in the Current Procedural Terminology (CPT) Manual (e.g., 65855 or 66821).

E/M services that are provided by the same provider for reasons that are unrelated to the operative surgical procedure may be considered for reimbursement if they are billed with modifier 24. The submitted documentation must substantiate the reasons for providing E/M services.

• Modifier 24 must be billed with modifier 25 if a significant, separately identifiable E/M service that was performed on the day of a procedure falls within the postoperative period of another unrelated procedure. The postoperative modifier should always be billed before any other modifiers.
• Modifier 24 must be billed with modifier 57 if an E/M service that was performed within the postoperative period of another unrelated procedure results in the decision to perform major surgery.

Preoperative, Intraoperative, and Postoperative Periods

If the surgeon provides both the surgery and the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:
• The surgical procedure, date of the surgery, and modifier 54, which indicates that he or she was the surgeon.

• The surgical procedure, date of service, and modifier 55 to denote the postoperative care.

**Note:** Providers must not submit a claim for a procedure until after the client has been seen during a face-to-face follow-up visit.

If the surgeon provides both the surgery and the preoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

• The surgical procedure, date of the surgery, and modifier 54, which indicates that he or she was the surgeon.

• The surgical procedure, date of service, and modifier 56 to denote the preoperative care.

If the surgeon provides both the preoperative care and the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

• The surgical procedure, date of service, and modifier 55 to denote the postoperative care.

• The surgical procedure, date of service, and modifier 56 to denote the preoperative care.

For postoperative care that is rendered by physicians other than the surgeon for procedures that have a 10- or 90-day global period, the following conditions apply:

• When transfer occurs immediately after surgery, the physician who assumes in-hospital postoperative care must bill subsequent care code 99231, 99232, or 99233.

• Physicians who provide post-discharge care must bill the appropriate surgical code with modifier 55. Reimbursement will be limited to a percentage of the Medicaid fee for the surgical procedure.

• Documentation in the medical record must include all of the following:
  ○ A copy of the written transfer agreement.
  ○ The dates the care was assumed and relinquished.

• The claim must indicate in the comments field of the claim form the dates on which care was assumed and relinquished, and the units field must reflect the total number of postoperative care days provided. Claims that are submitted on the CMS-1500 paper claim form must include the date of surgery in Block 14 and the dates on which care was assumed and relinquished in Block 19.

Postoperative care may be billed only once by the same provider.

Claims that are submitted by an assistant surgeon will not be considered for reimbursement under the following conditions:

• When billed with modifier 58.

• When billed with modifier 78 as a return trip to the operating room for a related procedure during the postoperative period.
- When billed with modifier 79 as an unrelated procedure or service by the same provider during the postoperative period.

**Return Trips to the Operating Room**

Return trips to the operating room for a repeat surgical procedure on the same part of the body may be considered for reimbursement when billed with modifiers 76 and 77 to indicate that it is a repeat procedure. Billing with modifiers 76 and 77 initiates the beginning of a new global period. Medical record documentation must support the need for a repeat procedure.

All surgical procedure codes with a predefined limitation (e.g., once per lifetime or one every 5 years) must not be submitted with modifier 76 or 77.

For modifiers 76 and 77, the repeated procedure must be the same as the initial surgical procedure. The repeat procedure should be billed with the appropriate modifier. The reason for the repeat surgical procedure should be entered in the narrative field on the claim form.

Return trips to the operating room for surgical procedures that are related to the initial surgery (i.e., complications) may be considered for reimbursement when they are billed with modifier 78 by the same provider.

- When a surgical procedure has a "000" global period, the full value of the surgical procedure will be paid since these codes have no preoperative, postoperative, or intraoperative values.
- When an unlisted procedure is billed because no code exists to describe the treatment for the complications, reimbursement is a maximum of 50 percent of the value of the intraoperative services that were originally performed.

**Note:** Only the intraoperative portion of the global surgical fee for the subsequent procedure will be reimbursed.

Reimbursement for the postoperative period of the first surgical procedure includes follow-up services from both surgical procedures, and no additional postoperative reimbursement is allotted. The global period will be based on the first surgical procedure.

Billing with modifier 78 does not begin a new global period.

Surgical procedures that are performed by the same provider during the postoperative period may be considered for reimbursement when billed they are with modifier 79 for any of the following:

- When the same procedure is performed with a different diagnosis.
- When the same procedure is performed on the left and right side of the body in different operative sessions and that procedure is billed with the RT or LT modifier.
- When a different procedure is performed with the same diagnosis.
- When a different procedure is performed with a different diagnosis.

Billing with Modifier 79 initiates a new global surgical period.

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the physician who provide preoperative or postoperative care. Where a transfer of postoperative care occurs, the receiving
physician cannot bill for any part of the global services until at least one service has been provided. The claim must reflect the date of the surgery and the appropriate modifiers. The physician who provides the postoperative care must also include the date on which care was assumed until it was relinquished.

Reimbursement for claims associated with modifiers 54, 55, or 56 is limited to the same total amount as would have been paid if only one physician provided all of the care, regardless of the number of physicians who actually provide the care.

Unless otherwise stated in the Texas Medicaid Provider Procedures Manual, no additional reimbursement is provided to physicians who elect to use special instruments or advanced technology to accomplish a surgical procedure.