Policy Name | Global Days
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**Summary**

The Centers for Medicare and Medicaid Services (CMS) has established global periods for procedures. The global period for a procedure is the interval of time during which certain preoperative, same day, and postoperative services provided are considered to be included in the global surgical package reimbursement.

**Policy Statement**

Medica follows the global periods published in the CMS National Physician Fee Schedule, except as noted below. The global period assignments are either 0 days or 10 days for minor procedures, or 90 days for major procedures. Other designations assigned to codes indicate that the global period concept does not apply. Note: For 10 or 90-day global periods, the global days are counted starting the day after the surgery.

| National Physician Fee Schedule Global Day Designators |
|---|---|
| 000 | Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only are included in the fee schedule payment amount; E/M services on the day of the procedure are generally not separately reimbursed. |
| 010 | Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period are included in the fee schedule amount; E/M services on the day of the procedure and during the 10-day postoperative period are generally not separately reimbursed. |
| 090 | Major surgery with a 1-day preoperative period and 90-day postoperative period are included in the fee schedule amount; E/M services on the day of the procedure and during the 90-day postoperative period are generally not separately reimbursed. |
| MMM | Maternity codes; the usual global period concept does not apply. Medica assigns a 42-day global period to certain maternity codes. |
| XXX | Global concept does not apply to the code. |
| YYY | Subject to individual pricing and determination whether the global concept applies. Medica assigns a 0-day global period to these codes. |
| ZZZ | The code is related to another service and is always included in the global period of the other service. ZZZ codes are add-on codes that must be billed with another service. There is no post-operative work included in the National Physician Fee Schedule payment for the ZZZ codes. The Global Surgical Package concept does not apply to the code. |
Preoperative Services Included in the Global Period

- Preoperative visits are not separately reimbursable services when performed within the assigned global period by the same physician or other qualified health care professional of the same specialty and federal tax identification number.
- For a procedure with a global period of 0 or 10 days, the decision to perform the procedure is included in the payment for the minor surgical procedure and should not be reported separately as an evaluation and management (E/M) service.
- For a procedure with a global period of 90 days, if an E/M service is performed one day before or on the same date of service as a major surgical procedure, it is included in the global payment for the procedure and is not separately reimbursable unless the decision to perform surgery was made during the visit. If the decision to perform surgery was made during the E/M visit, the E/M would be separately reimbursable with modifier 57 appended to the code.

Postoperative Services included within the Global Period

- Postoperative visits, including follow-up E/M visits that occur within the designated global period that are related to the patient recovery following surgery.
- Complications following surgery, including all additional medical and/or surgical services required of the physician or other qualified health care professional (not resulting in a return trip to the operating room) that occur within the designated global period.
- Post-surgical pain management by the physician or other qualified health care professional.
- Supplies (except for select procedures).
- Miscellaneous services related to the procedure:
  - dressing changes
  - local incisional care
  - removal of cutaneous sutures/staples, lines, wires, tubes, drains, or casts and splints
  - insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes
  - changes and removal of tracheostomy tubes

Return Trips to the Operating/Procedure Room During the Postoperative Period

Modifier 78 should be reported with procedure codes for treatment of postoperative complications that require a return trip to the operating/procedure room.
According to CMS, only the intraoperative portion of the procedure having a global day value of 10 or 90 and reported with modifier 78 should be reimbursed. Multiple procedure reduction and bilateral reduction rules do not apply to a procedure or procedures reported with modifier 78, whether performed on the same day as the original procedure or on a subsequent day.

Medica will allow reimbursement at 84 percent of the physician fee schedule for eligible procedure codes appended with modifier 78.

**Definitions**

**Modifier 24** – Unrelated E/M service by the same physician or other qualified health care professional during a postoperative period. The physician or other qualified health care professional 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.

**Modifier 25** – Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the day of a procedure or other service. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual pre-and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier 25 to the appropriate level of E/M service.

*Note:* This modifier is not used to report an E/M service that resulted in a decision to perform surgery; see modifier 57.

**Modifier 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).

**Modifier 58** – Staged or related procedure or services by the same physician or other qualified health care professional 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
c) for therapy following a diagnostic surgical procedure

Note: This modifier should not be used for treatment of a problem that requires a return to the operating/procedure room (e.g., unanticipated clinical condition); see modifier 78.

**Modifier 78** – Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period. It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this subsequent procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding the modifier 78 to the related procedure.

**Modifier 79** – Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period. The individual 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.

**Same Physician** – Physicians and/or other qualified health care professionals of the same group and same specialty reporting the same federal tax identification number.

**Code Lists**

- Global Days Assignments List
- E/M Services Included in Global Period Code List
- Modifier 78 Code List

**Resources**

- Centers for Medicare and Medicaid Services (CMS)
- Healthcare Common Procedure Coding System (HCPCS)
- National Physician Fee Schedule (NPFS)
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