Global Surgical Modifiers billed with Evaluation and Management Services

The following modifiers are billed along with the applicable evaluation and management service procedure code when performed during the global surgical period:

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| 24       | **Unrelated evaluation and management service by the same physician during a postoperative period:** The physician may need to indicate that an evaluation and management (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 24 modifier to the appropriate level of E/M service.  
**Example:** The patient had a cholecystectomy (90-day global period). One month following the surgery the patient gets into some poison ivy and develops cellulitis of the arm. The same physician who performed the surgery sees the patient. The physician should submit the claim with the 24 modifier added to the E/M code. |
| 25       | **Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service:** The physician may need to indicate that the patient required a significant, separately identifiable E/M service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the 25 modifier to the appropriate level of E/M service.  
**Example:** An established patient presents for a previously planned minor procedure. During the course of the visit, the patient complains of another problem totally unrelated to the minor surgical procedure. The physician does an evaluation and management of the new complaint. The physician should submit the claim with the 25 modifier added to the E/M code. |
| 57       | **Decision for surgery:** An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the 57 modifier to the appropriate level of E/M service. This modifier is used for major surgery only. The question to be asked is: When did the physician decide to do the surgery? If the decision was made the day of the surgery, or the day before surgery, the 57 modifier would be added to the E/M service.  
**Example:** An orthopedic surgeon is called in on consult for a patient with a suspected fractured hip. After the physician completes the evaluation and management service of the patient's condition, the surgeon decides the hip must be repaired that same day. The physician should submit the claim with the 57 modifier added to the E/M code to show that the decision for surgery was made that same day. |
Global Surgical Modifiers billed with surgical procedures

The following modifiers are used when billing for additional surgical procedures performed during the postoperative period of another surgical procedure:

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| 58       | **Staged or related 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:  
  a. Planned prospectively at the time of the original procedure (staged)  
  b. More extensive than the original procedure, or  
  c. For therapy following a diagnostic surgical procedure.  
These circumstances may be reported by adding the 58 modifier to the staged or related procedure.  
**Example:**  
**Staged** - The patient has a resection of the bowel with a temporary colostomy (90-day global period). Eighty days later, the colostomy is closed by the same physician. The physician should submit the claim for the closure with the 58 modifier. There is no reduction in reimbursement.  
**Related** - The patient has a breast biopsy (10-day global period) that is malignant. On the third postoperative day the patient decides to have a mastectomy by the same physician. The physician should submit the claim for the mastectomy with the 58 modifier. There is no reduction in reimbursement. |
| 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 procedure and requires the use of the operating room, it may be reported by adding the 78 modifier to the related procedure. Reimbursement is made for the intra-operative portion only.  
**Example:** The patient has by-pass surgery. Two days postoperative the patient develops hemorrhages and is taken back to the operating room by the same physician. The physician should submit the claim for the return to surgery with the 78 modifier. |
| 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 adding the 79 modifier to the unrelated procedure.  
**Example:** The patient had a hip replacement (90-day global period). Two months later, the patient falls and fractures his or her arm and is seen by the same physician. The physician performed fracture care. The physician should submit the claim for the new surgical procedure with the 79 modifier. There is no reduction in reimbursement. |
Split Care
There are occasions when more than one physician provides the services included in the global surgical package. Payment for these services may be made to each physician when the physicians agree on the transfer of care of the patient. Sometimes, more than one physician may assume the postoperative care. When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed the allowance for the global package.

Appropriate Modifiers

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| **54** | Surgical Care Only: When one physician performs a surgical procedure and another physician provides preoperative and/or postoperative management, surgical services may be identified by adding the 54 modifier.  
Example: 66984-54, provider performs surgical procedure only. |
| **55** | Postoperative Management Only: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the 55 modifier.  
Example: 66984-55, provider performs post op days only, remember to indicate the assumed and relinquished dates in block 19 on CMS 1500 claim form or electronic equivalent. |
| **56** | Preoperative Management Only: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the 56 modifier.  
Example: 66984-56, provider performs pre-op only. |
## Other Important Surgical Modifiers

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| 76       | **Repeat procedure by same physician**: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the 76 modifier to the repeated procedure. This applies only to services repeated on the same day of service.  
  
  **Example**: The patient has a debridement of the arm, leg, and trunk (3 separate areas of the body). The physician should submit the claim with the debridement code 11040 for the arm, 11040-76 for the leg, and 11040-76 for the trunk. (Medicare will read the claim as a duplicate unless the 76 modifier is added to show debridement was performed on separate parts of the body.) |
| 59       | **Distinct procedural service**: The physician may need to indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries). |