



Global Surgery



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Table of Contents

What’s Changed?	3
Global Surgical Package Definition	4
FAQs	4
Global Surgery Coding & Billing Guidelines	8
Pre-Operative Period Billing.....	9
Procedure Day Billing	10
Assistant-at-Surgery Services	12
Post-Operative Period Billing.....	12
Special Billing Situations.....	15
Resources	17

What's Changed?

For critical care visits that are unrelated to the surgical procedure and performed post-operatively, report modifier –FT (page 7).

Substantive content changes are in dark red.

This booklet explains Medicare's global surgery package components. It covers surgery, endoscopy, and split global surgical packages' billing and payment rules between 2 or more physicians.

Global Surgical Package Definition

We established a national global surgical package to ensure Medicare Administrative Contractors (MACs) consistently pay the same services across all jurisdictions.

This policy helps prevent Medicare payments for more or less comprehensive services than intended. We established uniform payment policies and claims processing requirements for other surgical issues, including bilateral and multiple surgeries, co-surgeons, and team surgeons.

The global surgical package, also called global surgery, includes all necessary services normally provided by a physician (or members of the same group with the same specialty) before, during, and after a procedure. Medicare physicians in the same group practice, with the same specialty, must bill and accept payment as though they're a single physician.

Get more information in Sections 40–40.1 of the [Medicare Claims Processing Manual, Chapter 12](#).

FAQs

Is global surgery payment restricted to hospital inpatient settings?

Global surgery applies in any setting, including an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. When a surgeon visits a patient in an intensive care or critical care unit, we include these visits in the global surgical package.

Get more information in Sections 40–40.1 of the [Medicare Claims Processing Manual, Chapter 12](#).

How does Medicare classify global surgery?

We classify 3 types of global surgical packages based on the number of post-operative days:

0-Day Post-Operative Period (endoscopies and some minor procedures)

- No pre-operative period
- No post-operative days
- Generally, a visit on procedure day isn't payable as a separate service

10-Day Post-Operative Period (other minor procedures)

- No pre-operative period
- Generally, a visit on procedure day isn't payable as a separate service
- Total global period is 11 days; count the surgery day and the 10 days immediately following the surgery day

90-day Post-Operative Period (major procedures)

- 1-day pre-operative included
- Generally, procedure day isn't separately payable
- Total global period is 92 days; count 1 day before surgery, the day of surgery, and the 90 days immediately following the surgery day

NOTE: We let the surgeon or other practitioners separately bill and get paid for a post-discharge home visit according to conditions in the Comprehensive Care for Joint Replacement Model (CJR). Continue applying all other global surgery billing rules during the 90-day post-operative period.

Where can I find the covered surgical procedures post-operative periods?

The [Medicare Physician Fee Schedule \(PFS\) Look-Up Tool](#) outlines each procedure code, including the global surgery indicator.

In the tool, under Modifier, select "Global" (Diagnostic Service) to display the global column. The global surgical payment rules apply to procedure codes with global surgery indicators 000, 010, 090, and sometimes, YYY:

- 000 codes identify endoscopies or some minor surgical procedures (0-day post-operative period).
- 010 codes identify other minor procedures (10-day post-operative period).
- 090 codes identify major surgeries (90-day post-operative period).
- YYY codes identify contractor-priced codes. MACs determine the global period. The global period for these codes is 0, 10, or 90 days.

NOTE: Not all contractor-priced codes have a YYY global surgical indicator. Sometimes we specify the global period as 000, 010, or 090.

Codes with ZZZ are surgical codes. They're add-on codes you must bill with another service. The Medicare PFS payment doesn't include post-operative work ZZZ codes. We pay the primary and add-on codes but apply the global period assigned to the primary code. Sometimes providers can use modifier -26 with global surgery indicator ZZZ. To see specific procedures where it's appropriate to use modifier -26, review Addendum B for the fee schedule year. The [CY 2024 PFS Final Rule Addenda](#) is in the Downloads section.

We set the CPT Category III codes 0437T, 0439T, and 0443T to ZZZ global surgery days and identify other YYY codes:

- 44799: Global Surgery Days = YYY
- G9685 and G9686: Global Surgery Days = XXX
- G0498: Global Surgery Days = YYY

Codes with XXX indicate the global concept doesn't apply.

Get more information in Sections 40–40.1 of the [Medicare Claims Processing Manual, Chapter 12](#).

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What services does Medicare include in the global surgery payment?

We include these services in the global surgery payment when added to surgery:

- Pre-operative visits after the decision to operate. For major procedures, this includes pre-operative visits the day before the surgery. For minor procedures, this includes pre-operative visits on the surgery day.
- Intra-operative services, normally a necessary part of a surgical procedure.
- All additional medical or surgical services the surgeon provides during the post-operative period because the complications don't require additional trips to the operating room.
- Follow-up post-operative recovery period visits.
- Post-surgical patient pain management.
- Supplies (except exclusions).
- Miscellaneous services, like dressing changes, local incision care, operative pack removal, cutaneous sutures and staples removal, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and urinary catheter removal, routine peripheral intravenous lines, nasogastric and rectal tubes; and tracheostomy tube changes and removals.

What services aren't included in the global surgery payment?

We exclude these global surgical payment services. You may bill them separately and get paid:

- Surgeon's initial evaluation to determine the need for major surgeries. Bill this separately using modifier –57 (Decision for Surgery). Only bill this separately for major surgical procedures.

NOTE: Always include the initial minor surgical procedures and endoscopies evaluation in the global surgery package. We include minor surgery or endoscopy visits by the same physician on the same day in the global package unless they perform a significant, separately identifiable service. Use modifier –25 to separately bill an identifiable Evaluation and Management (E/M) service by the same physician on the same procedure day.

- Other physicians' related surgery services, except when the surgeon and the other physicians agree on a transfer of care. Document this agreement through a letter or an annotation in the discharge summary, hospital record, or ASC record.
- Visits unrelated to the surgical diagnosis procedure unless the visits happen because of surgery complications.
- Underlying condition treatment or an added treatment course that's not part of normal surgery recovery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Clearly distinct surgical procedures that happen during the post-operative period that aren't re-operations or complications treatment.

NOTE: A new post-operative period begins with the subsequent procedure. This includes procedures done in 2 or more parts when the decision to stage the procedure comes before the first procedure.

- Treatment for post-operative complications when the patient returns to the operating room (OR). An “OR” is a place of service specifically equipped and staffed solely for performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It doesn’t include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient’s condition is critical so there’s insufficient time for transporting to an OR).
- If a less extensive procedure fails, and the patient needs a more extensive procedure, we separately pay the second procedure.
- Organ transplant immunosuppressive therapy.
- Critical care services (CPT codes 99291 and 99292) unrelated to surgery where a critically ill patient, seriously injured or burned, needs constant physician attendance. **For critical care visits that are unrelated to the surgical procedure and performed post-operatively, report modifier –FT.**

How are minor procedures and endoscopies handled?

Minor procedures and endoscopies have 10-day or 0-day post-operative periods (indicated by 010 and 000, respectively).

10-day post-operative period procedures: We don’t allow separate post-operative visits or service payments within 10 days of surgery related to procedure recovery. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, we separately pay the major surgery. Minor procedure services by other physicians generally aren’t included in the global fee.

0-day post-operative period procedures: Post-operative visits beyond the procedure day aren’t included in the surgery payment. Separately bill and get paid post-operative visits. Get more information in Section 40.1 of the [Medicare Claims Processing Manual, Chapter 12](#).



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Global Surgery Coding & Billing Guidelines

Physicians Who Provide the Entire Global Package

Physicians providing the global package should enter only the appropriate surgical CPT procedure code. We don't allow billing separate visits or other services in the global package.

When different physicians in a group practice participate in the patient's care, the group practice bills the entire global package if the physicians reassign benefits to the group. Report the physician who performs the surgery as the performing physician.

Get more information in Sections 40.2 and 40.4 of the [Medicare Claims Processing Manual, Chapter 12](#).

Physicians Who Provide Part of a Global Surgical Package

More than 1 physician may provide services included in the global surgical package. The physician who performs the surgical procedure can't provide the follow-up care. If the physicians agree on a transfer of care, they normally split post-operative and post-discharge payment among them and any other participating physicians.

When more than 1 physician provides services in the global surgical package, the physicians' approved sum may not exceed what we would pay if a single physician provided all services, except where stated policies allow higher payment. For example, when the surgeon provides only the surgery and another physician provides pre-operative and post-operative inpatient care, the combined payment may not exceed the global amount allowed.

The surgeon and the physician providing the post-operative care must keep a copy of the written transfer agreement in the patient's medical record. Where a transfer of care doesn't occur, we separately pay or deny the other physician's services for medical necessity reasons, depending on the case circumstances. Split global-care billing doesn't apply to procedure codes with a 0-day post-operative period.

Using Modifiers –54 & –55

When physicians agree on a transfer of care during the global period, distinguish the services using the appropriate modifier:

- Surgical care only (modifier –54)
- Post-operative management only (modifier –55)

Physicians must use the same global surgery services CPT code and bill with modifiers –54 or –55. Report the same date of service and surgical procedure code on the surgical care and post-operative care bill. The date of service is the date the surgical procedure happened.

Modifier –54 indicates the surgeon gave all or part of the post-operative care to another physician.

- Modifier –54 doesn't apply to assistant-at-surgery services
- Modifier –54 doesn't apply to an ASC's facility fees

The physician other than the surgeon who provides post-operative management services bills modifier –55.

- Use modifier –55 with the CPT procedure code for global periods of 10 or 90 days.
- The date of surgery is the service date and indicates the date the surgeon transferred the patient to another physician. Physicians must keep written transfer agreement copies in the patient's medical record.
- The physician accepting the patient's care must provide at least 1 service before billing any part of the post-operative care.
- This modifier isn't appropriate for assistant-at-surgery services or for ASC facility fees.

Get more information in Sections 40.2 and 40.4 of the [Medicare Claims Processing Manual, Chapter 12](#).

Exceptions to Using Modifiers –54 and –55

If a transfer of care doesn't happen, report occasional post-discharge physician services other than the surgeon using the appropriate E/M code. You don't need claim modifiers.

Physicians providing minor emergency department follow-up services should bill the appropriate level E/M code without a modifier.

If a physician other than the surgeon must attend to an underlying condition or medical complication during a post-operative period, the other physician reports the appropriate E/M code. Claim modifiers aren't necessary; for example, a cardiologist managing underlying patient cardiovascular conditions. Get more information in Sections 40.2 and 40.4 of the [Medicare Claims Processing Manual, Chapter 12](#).

Pre-Operative Period Billing

Initial E/M Service Decision to Perform Surgery

We don't include the E/M services that result in the initial decision to perform surgery on the day before, or the day of, major surgery in the global surgery payment. You may bill separately these services and get paid.

Use the CPT E/M code, modifier –57 (Decision for surgery) to identify a visit that results in the initial decision to perform surgery.

Don't use modifier –57 with minor surgeries. We don't include minor surgeries the day before the surgery global period. When the decision to perform the minor procedure comes immediately before the service, we consider it a routine pre-operative service and you can't bill a visit or consultation with the procedure. MACs may not pay an E/M service billed with CPT modifier –57 if it's provided on the day of, or the day before, a procedure with a 000- or 010-day global surgical period.

Procedure Day Billing

Same Physician, Significant, Separately Identifiable E/M Service on the Same Procedure Day

Use modifier –25 (Significant, separately identifiable E/M service by the same physician on the day of procedure), which indicates the patient’s condition needed a significant, separately identifiable E/M service beyond the usual procedure or service pre-operative and post-operative care.

- Use modifier –25 with the appropriate level E/M service
- Use modifiers –24 (Unrelated E/M service by the same physician during a post-operative period) and –25 when a significant, separately identifiable E/M service on the procedure day falls within the post-operative period of another unrelated procedure

You don’t need to report different diagnoses when reporting the E/M service on the same date as the procedure or other service. The physician or qualified non-physician practitioner (NPP) must sufficiently document the medically necessary E/M service and procedure in the patient’s medical record to support the billed claim. We don’t expect you to submit the documentation with the claim. Get more information in Section 30.6.6 of the [Medicare Claims Processing Manual, Chapter 12](#).



Multiple Surgeries

We consider multiple surgeries as separate procedures when a single physician or physicians in the same group practice perform on the same patient at the same operative session or on the same day. In these situations, we may allow separate payment. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient the same day.

Surgeries subject to the multiple surgery rules have an indicator of ‘2’ in the [Medicare PFS Look-Up Tool](#).

NOTE: Under Type of Information, select “All” for the multi surg column to display. We apply the multiple procedure payment reduction based on the Medicare PFS-approved amount and not on the providers’ submitted amounts. The larger submitted amount may or may not indicate the major surgery.

Distinguish multiple surgeries from components of, or incidental to, a primary procedure. Don't separately bill these intra-operative services, incidental surgeries, or more major surgery components.

You may find instances when 2 or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (for example, in some multiple trauma cases). When this happens, Medicare's multiple surgeries payment adjustment rules may be inappropriate. You can find payment adjustments for co-surgeons in Table 3 of the [CY 2024 PFS](#).

Get more information in Section 40.6 of the [Medicare Claims Processing Manual, Chapter 12](#).

Co-Surgeons & Team Surgeons

Under some circumstances, it's necessary for 2 or more individual surgeons' skills to perform surgery on the same patient during the same operative session. This may happen because of the complex nature of the procedures or the patient's condition (or both). In these cases, additional physicians aren't acting as assistants-at-surgery.

Use the following billing process when billing a surgical procedure or procedures where the patient's condition needs 2 surgeons or a team of surgeons:

- If 2 surgeons (each in a different specialty) perform a specific procedure, each surgeon bills their procedure with modifier –62 (2 surgeons). Co-surgery also means 2 surgeons performing parts of the procedure simultaneously, like a heart transplant or bilateral knee replacements. We require the 2 surgeons to document certain services' medical necessity in the patient's medical record. Find more information in the [Medicare PFS Look-Up Tool](#).

NOTE: Some procedures need modifier –62. If both surgeons don't use the modifier, we return the claims unpaid.

- If a team of surgeons (more than 2 surgeons of different specialties) perform a specific procedure, each surgeon bills the procedure using modifier –66 (Surgical team). The Medicare Fee Schedule Data Base (MFSDDB) Field 25 identifies certain services submitted with modifier –66. You should sufficiently document the required services to establish the team's medical necessity. All team surgeons' claims must contain sufficient information to allow pricing by report.
- If surgeons of different specialties each perform a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the surgeons perform the procedures through the same incision). If 1 surgeon performs multiple procedures, the multiple procedure rules apply to that surgeon's services.

When billing co-surgeons' claims using modifier –62, the fee schedule amount for each co-surgeon is 62.5% of the global surgery fee schedule amount. We pay the team surgery (modifier –66) on a report basis.

Get more guidance in Section 40.8 of the [Medicare Claims Processing Manual, Chapter 12](#).

Assistant-at-Surgery Services

When physicians perform assistant-at-surgery services, the fee schedule payment equals 16% of the applicable surgical payment.

MACs may not pay assistants-at-surgery surgical procedures when a physician acts as an assistant-at-surgery in less than 5% of the cases for that procedure nationally. We determine this through manual reviews.

You must get prior authorization for us to pay assistant-at-surgery services claims. We only pay authorized procedures with these modifiers:

- –80 (Assistant surgeon)
- –81 (Minimum assistant surgeon)
- –82 (Assistant surgeon (when qualified resident surgeon not available))
- –AS modifier (physician assistants, nurse practitioners, and clinical nurse specialists)

Medicare's assistant-at-surgery services policies on billing patients above the Medicare-allowed amount apply. Physicians who bill a patient for an assistant-at-surgery service knowingly and willfully violate this prohibition and these procedures can become subject to penalties. Penalties vary based on the frequency and seriousness of the violation.

We pay Method II critical access hospitals (CAHs) assistant-at-surgery services provided by a physician or NPP who reassigned their billing rights to a Method II CAH when the CAH bills the procedure on type of bill 85X with revenue codes 96X, 97X, or 98X and an appropriate assistant-at-surgery modifier.

Get more information in Section 20.4.3 of the [Medicare Claims Processing Manual, Chapter 12](#).

Post-Operative Period Billing

Unrelated Procedure or Service or E/M Service by Same Physician During Post-Operative Period

Two CPT modifiers simplify billing visits and other procedures during the surgical procedure post-operative period not included in the surgical procedure payment. These modifiers include:

- Modifier –79 (Unrelated procedure or service by the same physician during a post-operative period). The physician may indicate an unrelated procedure or service during a post-operative period to the original procedure. A new post-operative period begins when the physician bills the unrelated procedure.
- Modifier –24 (Unrelated E/M service by the same physician during a post-operative period). The physician may indicate an unrelated E/M service during the post-operative period to the original procedure. The physician must document the E/M service billed with modifier –24 and must send documentation supporting the unrelated service.

Post-Operative Claims-Based Reporting Requirements – CPT Code 99024

Practitioners **must** report post-operative E/M visits using CPT code 99024 if they:

- Practice in a group of 10 or more practitioners in 1 of these 9 states:
 - Florida
 - Kentucky
 - Louisiana
 - Nevada
 - New Jersey
 - North Dakota
 - Ohio
 - Oregon
 - Rhode Island

NOTE: You're exempt from required reporting if your practice has less than 10 practitioners, but we encourage you to report if possible.

- Provide global services under 1 of the required procedure codes. More than 100 practitioners nationally provide the required procedure codes more than 10,000 times annually or have more than \$10 million in annual allowed charges.

The term “practitioner” means physicians and NPPs who can provide and bill Medicare patient services under the PFS. Get more information in the [Claims-Based Reporting Requirements for Post-Operative Visits FAQs](#).

Medicare Requires Codes When Reporting Post-Operative Visits

Find more information on the [Global Surgery Data Collection](#) webpage. It shows the required reporting codes.

Return to OR for Related Procedure During Post-Operative Period

When treatment for post-operative complications requires an OR return trip, bill the CPT code that describes the procedures during the return trip. If no such code exists, use the unspecified procedure code in the correct series, 47999 or 64999. Don't use the procedure code for the original surgery unless you repeat the identical procedure.

Use the CPT code and report modifier –78 (Unplanned return to the operating or procedure room by the same physician following the initial related procedure during the post-operative period).

The physician may also perform another procedure during the initial procedure post-operative period. When this subsequent procedure relates to the first procedure and requires the operating room, bill it using modifier –78.

NOTE: The CPT modifier –78 definition doesn't limit its complications treatment use.

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Staged or Related Procedure or Service by Same Physician During Post-Operative Period

Modifier –58 (Staged or related procedure or service by the same physician during the post-operative period) helps bill staged or related surgical procedures during the first post-operative period procedure. Modifier –58 indicates the procedure or service during the post-operative period is:

- Planned prospectively or at the original procedure's time
- More extensive than the original procedure
- For therapy following a diagnostic surgical procedure

Report modifier –58 with the staged procedure's CPT. A new post-operative period begins when you bill the next procedure in the series.

Critical Care

We don't consider a seriously injured or burned patient's critical care services during a global surgical period as a surgical procedure. If specific circumstances apply, you can separately bill and get paid.

We may pay pre-operative and post-operative critical care added to a global fee if the services meet both these criteria:

- The patient is critically ill and requires constant physician attendance
- The critical care is typically unrelated to the specific anatomic injury or general surgical procedure performed and goes beyond the normal procedure

These patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

For payment, these services must meet 2 reporting requirements:

1. Use CPT codes 99291/99292 and modifier –25 for pre-operative care or –24 for post-operative care.
2. Document the critical care unrelated to the specific anatomic injury or general surgical procedure; add an ICD-10-CM code for a disease or separate injury that clearly indicates the unrelated critical care to surgery. This is acceptable documentation.

We don't bundle services like endotracheal intubation (CPT code 31500) and flow-directed catheter insertion. For example, we don't bundle Swan-Ganz (CPT code 93503) into critical care codes. We separately pay unrelated critical care with these services if the critical care is a significant, separately identifiable service, and reported with modifier –25. We exclude the time performing the pre-, intra-, and post-procedure work of these unbundled services (for example, endotracheal intubation) from the time providing critical care.

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This policy applies to procedures with a 0-, 10-, or 90-day global period, including cardiopulmonary resuscitation (CPR) (CPT code 92950). CPR has a global period of 0 days and isn't bundled into critical care codes. Bill critical care with CPR if critical care is a significant, separately identifiable service and reported with modifier –25. We exclude CPR time from critical care time. In this instance, the physician who performs the resuscitation must bill this service. Code team members may not each bill Medicare Part B CPR services.

Get more information on global surgery and critical care in Section 30.6.12, Part K, of the [Medicare Claims Processing Manual, Chapter 12](#).



Special Billing Situations

Care Provided in Different Jurisdictions

If you provide a portion of the global surgery package care in different payment jurisdictions, bill the services to the MAC servicing each applicable jurisdiction. For example, if you perform the surgery in 1 state and provide the post-operative care in another, bill the surgery with modifier –54 (Surgical care only) to the MAC where you performed the surgery.

Bill post-operative care with modifier –55 (Post-operative management only) to the MAC servicing the jurisdiction where the post-operative care happened. This is true whether the same physician/group or different physicians performed the services.

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Health Professional Shortage Area (HPSA) Service Payments Subject to Global Surgery Rules

We pay global surgery bonus payments when you provide the services in an HPSA. Use these guidelines for appropriate billing procedures:

- If the physician provides the entire global package in an HPSA, they should bill the appropriate global surgical code with the applicable HPSA modifier
- If the physician provides part of the global package in an HPSA, they should use an HPSA modifier to bill for the portion provided in the HPSA

Billing Wrong Surgical or Other Invasive Patient Procedures; Performing Surgery or Other Invasive Procedures on the Wrong Body Part; and Performing Surgical or Other Invasive Procedures on the Wrong Patient

Providers must append 1 of these HCPCS modifiers to all lines related to any erroneous surgery:

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

Get more information on erroneous surgeries in Sections 140.6–140.8 of the [National Coverage Determination Manual, Chapter 1, Part 2](#) and Section 230 of the [Medicare Claims Processing Manual, Chapter 32](#).

Billing Mohs Micrographic Surgical Procedures

We pay Mohs Micrographic Surgical (MMS) services only when the Mohs surgeon acts as surgeon and pathologist. You can't bill us for these procedures if a physician other than the Mohs surgeon prepares or interprets pathology slides. Get more information in the [MLN Matters® Article SE1318](#).

Billing Bilateral Procedures

The terminology for some procedure codes includes the terms “bilateral” (for example, code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or “unilateral or bilateral” (for example, code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment for bilateral surgery rules doesn't apply to CPT procedures identified as bilateral (or unilateral or bilateral) since the fee schedule reflects additional bilateral surgery work.

If a procedure isn't identified as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure using modifier –50. Report these procedures as a single line item.

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NOTE: This differs from the CPT coding guidelines. They indicate you should bill bilateral procedures as 2-line items.

If codes 27395 and 52290 identify a bilateral (or unilateral or bilateral) procedure, don't use modifier -50 to report it.

Get more information on bilateral surgeries in Section 40.7 of the [Medicare Claims Processing Manual, Chapter 12](#).

Resources

- [Billing Wrong Surgical or Other Invasive Procedures](#)
- [Global Surgery Data Collection](#)
- [MLN Matters Article SE1318, Guidance to Reduce Mohs Surgery Reimbursement Issues](#)
- [Medicare Improperly Paid Physicians for Co-Surgery and Assistant-at-Surgery Services That Were Billed Without the Appropriate Payment Modifiers](#)
- [Surgeons and Global Surgery](#)

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