Payment Policy: Visits On Same Day As Surgery

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See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The global surgical reimbursement package includes E/M services, anesthesia, immediate postoperative care, written orders, evaluating the patient in the post anesthesia recovery area and typical postoperative follow-up care provided by a physician before, during and after a procedure.

Evaluation and Management (E&M) services performed *on the same day* as a surgical procedure are included in the global surgical reimbursement package for the surgery and therefore are not separately reimbursable. Specific Current Procedural Terminology (CPT®) modifiers are taken into consideration prior to a denial determination.

For purposes of this policy, "same day visits" address evaluation and management services that occur on the same day as the surgical procedure.

The global surgical reimbursement package includes evaluation and management services, anesthesia, immediate post-operative care, written orders, evaluating the patient in the post anesthesia recovery area and typical postoperative follow-up care.

The global surgical reimbursement package includes:
1. Pre-operative visits *after* the decision for surgery. Major procedures include visits that occur the day prior to and the day of surgery.
2. Minor procedures include visits that occur *on the day of* surgery.
3. Post-operative visits related to the patient's recovery from the procedure.
4. Intra-operative services that are a routine part of the surgical procedure during surgery.
5. Additional medical or surgical services that require the surgeon's attention during the post-operative period of the surgery. This includes complications of surgery, but does not include return trips to the operating room.
6. Post-surgical pain management by the surgeon.
7. Supplies
8. Dressing changes, local incision care, removal of operative pack, cutaneous staples, sutures, etc.

The global surgical period does not include:
1. The initial consultation or evaluation by the surgeon to determine the need for surgery. This is billed separately using Modifier 57, "*Decision for Surgery"*. This modifier may only be used for major surgical procedures.
2. Services required by other physicians related to the surgery, except when the primary surgeon and other physician agree to transfer the patient's care. Modifiers -54 and -55 should be used to identify each physician's participation in the patient's surgical care. Modifier -54 denotes surgical care only, while modifier -55 denotes post-operative management only.

3. Treatment for the underlying condition that was the cause for surgery or for an added course of treatment which is not considered part of the normal recovery from the surgery process.
4. Diagnostic tests and procedures including diagnostic radiologic procedures. However, if the surgical procedure results in an inpatient admission, outpatient diagnostic testing and therapeutic services are bundled into the payment for the inpatient admission.
5. Distinct surgical procedures that occur during the post-operative period but are not related to treatments for complications from the original surgery or the need for a second operation related to the original surgery.
6. Treatment for post-operative complications requiring a return trip to the operating room.
7. Failure of a less extensive procedure that requires a more extensive procedure.
8. Immunosuppressive therapies for organ transplants.
9. Critical care services (CPT code 99291 & 99292) that are unrelated to the surgery.

See the Centers for Medicare and Medicaid Servicers (CMS) for definition of a Global Surgical Package, for additional information.

The purpose of this policy is to define payment criteria for E&M services when billed with surgical procedures having a 000, 010 or 090, MMM, and ZZZ global period to be used in making payment decisions and administering benefits.

Application
E&M services billed within the global surgical period applies to the following services:

a. Inpatient hospital
b. Outpatient hospital
c. Ambulatory surgical centers
d. Physician's E&M services

Policy Description
According to the Centers for Medicare and Medicaid Services (CMS), certain evaluation and management services are not separately reportable when billed *on the same day* as a minor, major or maternity procedure. Instead, these evaluation and management services are subsumed in the reimbursement for the surgical procedure. Necessary services performed before, during or after a surgical procedure are considered components of the surgical procedure.

The global surgical period is determined by *the number of post-operative days* allowed for the surgical procedure. This policy refers to the following types of global surgical periods:

Minor Surgeries and Endoscopies: 000-Zero Day Post-Operative Period. For minor surgeries and endoscopies with a 000 day global period, the global period applies only to *visits and other services that occur on the same day as the surgery*. Visits that occur on the same day as the surgery are not reimbursed as a separate service unless the visit is significant and separately identifiable from the reason for the surgery. The appropriate modifier (-25) must be appended to the E&M service when this occurs. The 000-day post-operative period is defined as:

a. No Pre-operative period. The global concept does not apply to visits and other services rendered the day prior to a surgical procedure.
b. Same Day Visits Included. This means E&M Services that occur on the same day as a minor surgery or endoscopy are included in the global surgery reimbursement package and therefore are not payable as a separate service.
c. No Post-operative period – These procedures have no post-operative days assigned. This means that post-operative visits beyond the day of the minor surgery or endoscopy are not included in the payment amount for the surgery. Thus, they are separately reimbursable.
d. Separate and Distinct Same Day Visits-Since an inherent E&M component is considered included in the reimbursement of a minor surgical procedure with a 000 day global period; it is not separately reimbursable. However, if the reason for the visit that occurred on the same day as a minor procedure or endoscopy is separate and distinct from the procedure, the provider may append the appropriate modifier (-25) to the E&M procedure code to document this occurrence.

Minor Surgeries: 10-Day Post-operative Period. This includes other minor surgeries and some endoscopies. For minor surgeries and endoscopies with a 10 day global period, the global period applies to visits and other services that occur *on the same day as surgery and the 10 days following the surgical procedure*. Visits that occur *on the same day* as the surgery are not reimbursed as a separate service unless the visit is significant and separately identifiable from the reason for the original surgery. The appropriate modifier (-25) must be appended to the E&M service. The 10-day post-operative period is defined as:

a. No pre-operative period. The global concept does not apply to visits and other services rendered the day prior to a surgical procedure.
b. Same Day Visits Included. This means E&M Services that occur on the same day as a minor surgery or endoscopy are included in the global surgery reimbursement package and therefore are not payable as a separate service.
c. 10-Day post-operative period. This means E&M services that occur within 10 days of the surgery are not payable as a separate service.
d. The total global period is 11 days; the day of the surgery counts as day one and the 10 days following surgery.
e. Diagnostic Biopsy Prior to Major Surgery. If a diagnostic biopsy with a 10-day global surgical period occurs before a major surgery, on the same day, or in the 10-day period; the major surgery is reported as a separate service.

Major Surgeries: 90-Day Post-operative Period-this includes major surgical procedures. Visits on the day prior to the major surgery or *on the same day* as the major surgery are not reimbursed as a separate service. The 90-day post-operative period is defined as:

a. One Day Pre-operative Period. This means the day immediately before the day of surgery is not payable as a separate service.
b. Same Day Visits Included. This means E&M Services that occur on the same day as a major surgery are included in the global surgery reimbursement package and therefore are not payable as a separate service.

c. Decision for Surgery (Modifier -57). This means E&M services on the day before or on the day of the major surgery are reimbursable when those visits result in the *decision to perform surgery*. The appropriate "decision for surgery" modifier must be appended to the E&M service to document the decision for surgery.
d. 90-Day Post-operative Period. This means E&M services which occur within the 90-days immediately following surgery are not payable as a separate service.
e. The Total Global Period is 92 days; the one day prior to the surgery, the day of the surgery and the 90 days following surgery.

Maternity Procedures: MMM-this includes maternity visits that occur during the period before childbirth (antepartum) and on *the same day* of the delivery procedure. Visits that occur during the antepartum period, on the same date of service, or during the post-operative period of 45 days are not recommended for separate reimbursement if the procedure includes antepartum or postpartum care.

a. 270-Day antepartum. Preoperative period.
b. Same Day Visits Included. This means visits that occur on the same date of delivery are included in the global maternity package and are not reimbursed as a separate service.
c. 45-Day Post-partum period. This means E&M services which occur within the 45 days immediately following the delivery are not payable as a separate service.

ZZZ Procedures-this includes surgical add-on procedure codes that must be billed with the primary surgical procedure and are defined as:

a. Add-on surgical procedure codes.
b. Must be billed with another primary service and cannot stand alone.
c. When separate payment is made for an E&M service billed with a ZZZ surgical code, the provider is reimbursed for both the primary code and the add-on.
d. The global surgical period is based off of the primary procedure code. If the primary procedure code includes an inherent E&M code, separate reimbursement is not allowed.
e. The professional component modifier -26 may be appropriate for use with some procedures with a ZZZ global surgery indicator.

The Medicare Physician Fee Schedule Data Base (MFSDB) is the source for the postoperative periods that apply to each surgical procedure.

Reimbursement

Louisiana Healthcare Connections code editing software will:

1. Evaluate claim lines, procedure codes, diagnosis codes and modifiers to determine if an evaluation and management service was billed *on the same day* as a surgery with a global surgical period of 000, 010, 090, MMM, and ZZZ days.
2. Claim lines containing E&M codes billed on the same day as a minor, major or maternity procedure will be denied. These services are considered included in the payment for the surgical procedure.
3. Modifiers -25, and -57 are considered prior to a denial determination.

4. This rule reviews claim lines billed on the same claim and across claims in patient's history.
5. This rule reviews claims billed across multiple dates of service.
6. LHCC will not reimburse providers for outpatient surgical procedures provided on the same day as observation services.

Providers who do not adhere to the requirements above may be subject to a post payment medical record review and payment recoupment.

Documentation Requirements

Modifier 25

Claim lines with modifier 25 appended to the E/M are subject to prepayment clinical claims validation. Use of this modifier indicates that a significant, separately identifiable E/M service occurred on the same day as the surgery when the patient's condition required a visit beyond the normal pre-operative and post-operative care. Use of the modifier is substantiated by documentation that satisfies the relevant criteria for the E/M service reported. If documentation supports that a significant and separately identifiable E/M service was performed, the E/M service is reimbursed; otherwise, the E/M is denied. To avoid incorrect denials, all applicable diagnosis codes should be assigned that indicate the need for additional E/M service.

Modifier 57

Claim lines with modifier 57 appended to the E/M are subject to prepayment clinical claims validation. This involves analysis of E/M and surgical dates of service, diagnosis codes, procedure codes billed and other claim information to determine if the initial decision to perform surgery occurred on the day before or the day of a major surgery. If documentation supports the initial decision to perform surgery, the E/M service is reimbursed; otherwise, the E/M is denied.

Appeals/Reconsiderations

In the event the provider disagrees with the prepayment claims edit determination, the provider has an opportunity to submit an appeal or reconsideration request for reconsideration of payment. All medical record supporting documentation must accompany the request.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

ICD-10 Codes	Descriptor
Not Applicable	Not applicable

Definitions:

Global Surgical Package

- All necessary services normally furnished by a surgeon before, during and after a procedure. The payment for the surgical procedure includes all pre-operative, intra-operative and post-operative services performed routinely by a surgeon or from members of the same surgical group with the same specialty. Physicians in the same group practice, with the same specialty must be paid as though they were a single physician.

Evaluation and Management Service (E&M)

- Physician-patient encounters that are represented by five digit Current Procedural Terminology (CPT®) codes used for billing and reimbursement. Specific documentation guidelines apply to these codes. The physician is responsible for documenting the patient's medical history, physical examination, medical decision-making, counseling, coordination of care, nature of the presenting problem and time spent with the patient. CPT® codes are used for Medicare, Medicaid, Marketplace or private insurance encounters.

Major Procedure

- A major procedure is defined as one with a 90-day global surgical period.

Minor Procedure

- A minor procedure or endoscopy is defined as one with a 000 or 10-day global surgical period.

Pre-operative Period

- The day before or the day of the procedure. The pre-operative period for a major surgery includes visits that occur the day before and the day of the major surgery. For minor or endoscopic procedures, this includes the E&M services the day of surgery.

Post-operative Period

- The care received that begins at the end of the operation, in the recovery room, throughout the hospitalization and the outpatient period.

Intra-operative Period

- Services that are carried out as part of a normal and necessary surgical service during the course of surgery.

Antepartum Period

- The period occurring before childbirth.

Related Policies

Policy Name	Policy Number
"Pre-operative Visits"	LA.PP.041
"Post-operative Visits"	LA.PP.042

References

1. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched
2. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
3. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
4. https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf
5. *Current Procedural Terminology (CPT®,)* 2025

Revision History	Revision Date	Approval Date	Effective Date
Converted corporate to local policy.	08/15/20		
Annual Review; Updated dates in the reference section from 2019 to 2021 Removed clinical and added payment policy in "Important Reminder" section	08/30/22		
Annual review; removed CPT code table since this information can be found in the CPT resources. Removed modifier table, to eliminate redundancy. Update reference section	7/27/23	1/9/24	
Annual review completed; updated policy details to explain the global surgery package prior to edit for clarification; added Global Surgery Booklet link for reference. Remove prepayment clinical review verbiage and added a statement, "providers may be subject to post payment review; Removed "clinical validation policy" under related policies, this policy is retired.	8/20/24	12/2/24	1/1/25
Annual review; dates updated	7/25	7/29/25	

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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