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Global Surgical Days for Critical Access Hospital (CAH) Method II

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Related Change Request (CR) Number: 10425
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Related CR Transmittal Number: R2096OTN
Implementation Date: July 2, 2018

Note: This article was revised on June 25, 2018, to reflect a revised CR10425 issued on June 22. In the article, we removed terminated HCPCS codes from edits for visits which are included in the global package. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for Critical Access Hospital (CAH) Method II providers submitting claims to A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10425 which discusses the global surgical days for Method II Critical Access Hospital (CAH) providers. CR 10425 contains no new policy. It improves the implementation of existing Medicare payment policies. Make sure that your billing staffs are aware of these changes.

BACKGROUND

CR10425 is for the global surgical periods for Critical Access Hospital (CAH) Method II providers to mirror the logic historically applied to physicians and non-physician practitioners that bill their own services to Medicare's Multi-Carrier System (MCS).

Physicians and non-physician practitioners billing on Type of Bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (using revenue codes 96X, 97X, or 98X) based on the Medicare Physician Fee Schedule (MPFS) supplemental file.

The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services

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routinely performed by the surgeon or by members of the same group with the same specialty.

Position 13-15 of the MPFS Data Base provides the postoperative periods that apply to each surgical procedure.

The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY, and are defined below. This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

- 000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

- 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

- 090 = Major surgery with a (one) 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

- XXX = Global concept does not apply.

- YYY = A/B MAC (Part A) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

  Codes with "YYY" are A/B MAC (Part B)-priced codes, for which A/B MACs (Part B) determine the global period (the global period for these codes will be 0, 10, or 90 days). Note that not all A/B MAC (Part B)-priced codes have a "YYY" global surgical indicator; sometimes the global period is specified.

CAH Method II providers should follow the same guidelines as per Part B physician services that are available in the Medicare Claims Processing Manual (Pub. 100-04, Chapter 12; (Physicians/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)).

Note that Medicare will reject line items that contain an E/M CPT code (92012, 92014, 99211-99215, 99217-99223, 99231- 99236, 99238, 99239, 99291, 99292, 99315, 99316, and 99347-99350) that is covered by the global period using the following remittance codes:

- Group code of CO - Contractual Obligation
- Claim Adjustment Reason Code 97 – Payment is included in the allowance for another service/procedure

- Remittance Advice Remark Code M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

MACs, however, will allow E/M services rendered during the global period when submitted with modifier 24 or 25, as appropriate.

ADDITIONAL INFORMATION

The official instruction, CR10425, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2096OTN.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
June 25, 2018	This article was revised to reflect a revised CR10425 issued on June 22. In the article, we removed terminated HCPCS codes from edits for visits which are included in the global package. Also, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.
January 26, 2018	Initial article released.