BlueCross BlueShield Minnesota

MEDICARE REIMBURSEMENT POLICY

Global Surgical Package

Active

Section: Surgery/Interventional Procedure
Policy Number: 007
Effective Date: 04/01/24

Description

This policy addresses the coding and reimbursement of the Global Surgical Package.

Definitions

Same Physician: A physician or other qualified health care professional (QHP) in the same group and same specialty reporting the same federal tax identification number

Major Procedure: A procedure with a 090-day Global Surgery Indicator assignment

Minor Procedure: A procedure with a 000 or 010-day Global Surgery Indicator assignment

Operating Room (OR): As defined by the Centers for Medicare and Medicaid Services (CMS) for the purposes of the Global Surgical Package, an OR is "a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR)."

Policy Statement

The Global Surgical Package, as defined by the Centers for Medicare and Medicaid Services (CMS), includes all services normally provided by the surgeon, or other physician or QHP within the same group and same specialty during the preoperative, intraoperative, and postoperative period of a procedure.

Services Included in the Global Surgical Package
The following services are included in the Global Surgical Package and are therefore not separately reimbursable:

- Preoperative visits after the decision to operate has been made; For Major Procedures, preoperative visits the day before and the day of surgery are included. For Minor Procedures, preoperative visits the day of surgery are included.
- Intraoperative services
- All additional medical or surgical services, not requiring a return to the operating room, that are necessary due to complications during the postoperative global period.
- Follow-up visits during the postoperative period that are related to recovery from the surgery
- Post-surgical pain management by the Same Physician

- Supplies
- Miscellaneous services associated with the surgical procedure, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Services included in the Global Surgical Package may be furnished in any setting, including hospitals, ambulatory surgical centers (ASCs) and physicians' offices.

Services Not Included in the Global Surgical Package
The following services are not included in the Global Surgical Package and will be considered for separate reimbursement. Refer to the Modifier section within this policy when reporting these services:

- Services of other physicians/QHPs with different specialties or in different group practices. For situations involving a transfer of care and split surgical package, refer to *Medicare Surgery/Interventional Procedure – 024 Split Surgical Package Reimbursement Policy.*
- The initial consultation or evaluation by the surgeon to determine the need for a Major Procedure (when reported with modifier 57)
- Visits for a diagnosis unrelated to the reason for which the surgical procedure was performed (Use modifier 25 for the day of procedure and modifier 24 – during the postoperative period.)
- Diagnostic tests and procedures
- Clearly distinct surgical procedures during the postoperative period that are not re-operations or treatment for complications (modifier 79)
- Postoperative complications that require a return to the operating room (See above definition of Operating Room.) (modifier 78)
- Immunosuppressive therapy for organ transplants.
- Critical care services (99291 and 99292) unrelated to the surgery performed, within the global period (modifier FT)
- Staged or related procedures or services during the postoperative period (modifier 58)

Days Included in Global Surgical Package:
The "Global Surgery Indicator", which is assigned by CMS and published in the National Physician Fee Schedule (NPFS) Relative Value File, indicates whether the Global Surgical Package concept applies and if so, the number of preoperative and postoperative days included in the package. The Global Surgery Indicators include: 000, 010, 090, MMM, XXX, YYY and ZZZ:

Global Surgery Indicators	
000	• Endoscopic or Minor Procedure with related preoperative and postoperative relative values on the day of the procedure only included in the payment amount. • Evaluation and management (E/M) services on the day of the procedure generally not payable (except as noted in the Modifier section of this policy).

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 payment amount. • E/M services on the day of the procedure and during the 10-day postoperative period are not payable as a separate service except as noted in the Modifier sections of this policy.
090	• Major Procedure with a 1-day preoperative period and 90-day postoperative period included in the payment amount. • E/M services on the day prior to the procedure, the day of the procedure, and during the 90-day postoperative period are generally not payable as a separate service except as noted in the Modifier section of this policy.
MMM	Maternity codes, usual global period does not apply. Blue Cross has assigned values of 42 days to these codes.
XXX	Per CMS, the Global Surgical Package concept does not apply.
YYY	CMS does not specify the global period for codes with an assigned value of "YYY", which includes most unlisted codes, and instead directs carriers to determine the appropriate value. Blue Cross has, therefore, assigned values consistent with either comparable codes, or codes within the same code range.
ZZZ	Add-on codes that must be billed with another service. The global period is applied to the primary code.

Billing for the Global Surgical Package:
When the entire Global Surgical Package is provided by the Same Physician, the appropriate code for the surgical procedure should be billed on one line with one charge. A modifier is not necessary. Charges for visits or other services included in the global package are not separately reimbursable.

Billing for a Split Surgical Package
For situations involving a transfer of care and split surgical package, refer to *Medicare Surgery/Interventional Procedure - 024 Split Surgical Package Reimbursement Policy.*

Modifiers
In some circumstances, additional services beyond the routine pre- and postoperative care may be necessary. For example, the patient experiences complications and needs to return to the operating room, or an unrelated problem requires treatment. When billing for additional services that should be considered separate from the Global Surgical package, modifiers should be used as appropriate

Evaluation and Management Services within the Global Period	
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period • Used to indicate that an E/M service was provided during the postoperative period for reasons unrelated to the surgical procedure. • Should only be used when the patient's condition requires 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 surgical procedure. • The medical record must contain documentation supporting use of modifier 24. • A diagnosis code that clearly indicates that the reason for the encounter was different and unrelated to the post-operative care should be reported.
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service • Used when an E/M service is rendered on the same day as a Minor Procedure • Use of modifier 25 is appropriate only when the E/M service provided is above and beyond the usual pre- and postoperative service associated with a procedure. • For Commercial and FEP only: A 20% reduction in the allowed amount is applied for E/M codes 99202-99380 and 99401-99498 submitted with modifier 25 on a professional claim.
57	Decision for Surgery • Used to indicate that the E/M service resulted in the initial decision to perform surgery either the day before or the day of a Major Procedure • Do not append this modifier when a Minor Procedure is performed. The initial evaluation is always included in a procedure with a Global Surgery Indicator other than 090. • Should not be used to report an E/M service that was pre-planned or pre-scheduled the day before or the day of surgery, as the E/M would be included as part of the Global Surgical Package. Patients are normally reevaluated on the date of the actual surgery to ensure the service can be performed. That clearance would be included in the global period and should not be reported separately.
FT	Unrelated Evaluation and Management (E/M) Visit During a Postoperative Period, or on the Same Day as a Procedure or Another E/M Visit. (Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated) to the critical care CPT code(s).

	• Should only be used when critical care E/M services are provided during the global period of an unrelated surgery. Refer to *Medicare Evaluation and Management – 007 Critical Care Services Reimbursement Policy.* • Medical records must clearly document that the critical care E/M visit is unrelated to the surgery.

Procedure Performed within the Global Period of Another Procedure
A procedure with a Global Surgery Indicator of 000, 010 or 090 that is performed by the Same Physician during the postoperative period of another procedure with a Global Surgery Indicator of 010 or 090, is considered included in the Global Surgical Package of the initial procedure, unless one of the following modifiers, as appropriate, is used.

Procedure within the Global Period of Another Procedure	

58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
	
	• Used to bill staged or related surgical procedures performed during the postoperative period of the first procedure. This modifier indicates that the procedure or service performed during the postoperative period was:
	  ○ Planned prospectively or at the time of the original procedure.
	  ○ More extensive than the original procedure.
	  ○ For therapy following a diagnostic surgical procedure.
	• A new postoperative period begins with the next procedure in the series.

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 • When treatment for complications requires a return to the operating room, the CPT code that describes the procedure(s) performed during the return trip should be reported with modifier 78. • Procedures with a global day assignment of 10 or 90 that are billed with modifier 78 will be reimbursed at 84 percent of the approved allowance. • A new global period does not apply to a procedure reported with modifier 78.
79	Unrelated Procedure or Service • If an unrelated procedure or service is performed by the Same Physician during a postoperative period of another procedure, modifier 79 should be submitted. • A new postoperative period begins with the subsequent procedure. • The medical record must contain documentation supporting use of the 79 modifier, indicating that the visit was unrelated to the postoperative care associated with the surgical procedure.

Requests to add a required modifier to a denied service must follow the replacement claim process and include supporting medical records. Replacement claims submitted without medical records will be denied and the original claim(s) will remain as originally processed.

Documentation Submission

Documentation must identify and describe the services performed and provide detailed support for the use of modifiers. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	24 25 57 58 78 79 FT
ICD-10 Diagnosis:	N/A
ICD-10 Procedure:	N/A
CPT/HCPCS:	All surgical codes
Revenue Codes:	N/A

Resources

Current Procedural Terminology (CPT ®)
Healthcare Common Procedure Coding System (HCPCS)
Medicare Claims Processing Manual, Chapter 12, Sections 30.6, 40
Medicare Learning Network, MLN907166
National Physician Fee Schedule (NPFS) Relative Value File

BlueCross BlueShield Minnesota

Policy History	
05/19/2015	Initial Committee Approval
07/06/2020	Code Update
01/25/2022	Revised
03/28/2023	Revised
06/27/2023	Annual Policy Review
01/23/2024	Revised