If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Global Surgical Package-Professional Providers

Policy Number: CPCP014

Version: 1.0

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Plan Effective Date: June 13, 2022 (Blue Cross and Blue Shield of Texas Only)

This policy was created to serve as a general reference regarding the global surgical package for claim submissions by professional health care providers. Health care providers (physicians and other qualified health care professionals) are expected to exercise independent medical judgement in providing care to eligible members. This policy is not intended to impact care decisions or medical practice.

Health care providers should inform members on how and where to access postoperative care as part of the hospital discharge planning. Payment for postoperative services is included in the global professional reimbursement rate and follow up care should be accessed in the professional health care provider office setting.

This policy does not address all situations that may occur. In certain circumstances, there are situations which may override the criteria within this policy.

Description:

The global surgical package includes all the related services and supplies that are routine and necessary for a provider or by another same specialty provider within the same group before, during, and after a procedure. The global surgical package applies in any setting including inpatient hospital, outpatient hospital, Ambulatory Surgery Center (ASC) or professional health care provider office.

Reimbursement Information:

Global surgical services may include, but are not limited to, the following:

- Pre-operative visits after the decision is made to operate on the eligible member starting with the day before the surgery for a major procedure and the day of surgery for a minor procedure.
- Evaluation and management services for minor surgery on the day of the minor surgery is included in the Global Days Value 000-010.
- Local infiltration, tumescent anesthesia, metacarpal/metatarsal/digital block or topical anesthesia.
- Intra-operative services that are normally a usual and necessary part of the surgical procedure.
- Complications following surgery that includes all medical or surgical services by the surgeon during the post-operative period because of complications that do not require additional trips to the operating room.
- Immediate post-operative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals.
- Writing orders.
- Evaluating the member in the post-anesthesia recovery area.
- Post-operative follow-up care during the post-operative period that are related to the recovery of the surgery.
- Surgical Suite or anesthesia equipment.
- Postsurgical Pain Management - By the surgeon;
- Supplies – Except for those identified as exclusions; and

Miscellaneous Services - Items such as dressing changes; local incisional 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.

Global Period

The global periods are maintained by CMS and are located in the Medicare Physician Fee Schedule. The Plan recognizes and agrees with the services that are included and excluded from the Global Surgical Package that are referenced in the Medicare Claims Processing Manual, Chapter 12- Physicians/Non-physician Practitioners.

For a list of all required CPT/HCPCS codes that should be reported for Global Services refer to the CMS website. The Plan's claims payment systems utilize the CMS defined global periods, which vary according to the procedure being performed.

GLOBAL SURGICAL PACKAGE TYPE	CALCULATION	CRITERIA
MINOR SURGERY Endoscopies and some minor procedures Global Surgery Indicator 000	• Day of surgery= Day 0	• No pre-operative period • No post-operative days • The visit on the day of the procedure is generally not payable as a separate service.
MINOR SURGERY Other minor procedures Global Surgery Indicator 010	• Day of surgery and 10 days immediately after	• No pre-operative period • The visit on the day of the procedure is generally not payable as a separate service. • The total global period is 11 days. Count the day of the surgery and the 10 days immediately following the day of the surgery.
MAJOR SURGERY Global Surgery Indicator 090	• Day before surgery= Day 0 • Day of surgery= Day 1 • 90 days immediately after	• One day pre-operative period • The visit on the day of the procedure is generally not payable as a separate service. • The global surgical package includes one preoperative day, the day of the procedure, and 90 days immediately following the day of the surgery, for a total global period of 92 days.

Services included in the global surgical package may become eligible for separate reimbursement after the global periods based on the post-operative days noted above.

Services not included in the Global Surgical Package

- Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries.
- Services performed by other physicians with the exception where the surgeon and the other physician(s) agree on the transfer of care. In the event a member's care is transferred, documentation should be submitted for eligible reimbursement.
- Visits unrelated to the diagnosis for the surgical procedure performed unless the services are performed due to complications of the surgery.
- Treatment of the underlying condition or an added course of treatment which is not part of the normal recovery from surgery.
- Diagnostic tests and procedures including diagnostic radiological services.
- Clearly distinct surgical procedures during the post-operative period which are not a repeat operation or treatment for complications.
- Treatments for postoperative complications that require a return trip to the operating room.
- If a less extensive procedure has failed and a more extensive procedure is required. The second procedure may be eligible for separate reimbursement.
- Surgical trays are not eligible for separate reimbursement when certain services are performed in a professional health care provider's office.

- Immunosuppressive therapy for organ transplants
- Critical care services that are not related to the surgical procedure where a seriously injured or burned member is critically ill and requires constant attendance of the physician.

Reimbursement for Procedures when Appending a Modifier

Modifiers should be appended to CPT/HCPCS codes to indicate the service **is or is not** part of the global period. Several modifiers have claims logic that may impact claim reimbursement.

Claim submissions may be denied if a claim contains an inappropriate modifier-to-procedure code combination. In this case, a corrected claim submission with the correct modifier-to-procedure code combination will be necessary to be considered for reimbursement. Medical records or other supporting documentation should accompany the claim to be reviewed to ensure appropriateness of claim reimbursement.

Modifier 24 and/or 25 should not be appended to codes for services rendered during the global period when the medical records do not support the visits were separate and unrelated.

Professional health care providers may append an appropriate modifier to a CPT/HCPCS code to indicate the service is not part of a global surgical package for consideration of separate reimbursement. The below may not contain all applicable modifiers:

MODIFIER	DESCRIPTION
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
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
54	Surgical Care Only
55	Postoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional
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
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
FT	Unrelated critical care evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit (within the global surgical period but, is unrelated to the procedure, or when one or more additional E/M visits furnished on the same day are unrelated). The members medical records must clearly document critical care rendered was unrelated to the procedure. (Note, modifier -FT may only be appended to critical care code(s).)

References:

Centers for Medicare and Medicaid Services (CMS). Physician Fee Schedule Relative Value Files. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.html

Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 12. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

CMS Manual 100-04, Chapter 12

Policy Update History:

Approval Date	Description
02/08/2018	New Policy
02/15/2019	Annual review
04/30/2020	Annual Review, Disclaimer update
05/11/2021	Annual Review
03/01/2022	Annual Review