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: October 1, 2023 (Blue Cross and Blue Shield of Texas Only)

This policy was created to serve as a general reference on the reimbursement for the global surgical package and subsequent services provided within the global surgery days for professional health care provider claims. 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.

The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims are reviewed on a case-by-case basis.

Health care providers are responsible for informing members how and where to access postoperative care as part of the hospital discharge planning. Reimbursement for postoperative services is included in the global professional reimbursement rate. Follow up care is rendered 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, also referred to as global surgery, includes all the related services and supplies that are routine and necessary to the procedure, rendered by a provider or another physician or other qualified health care professional (QHP) within the same group and/or same specialty and sub-specialty, preoperative, intra-operative, and post-operative to the 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 Period

A **global period** is time that is pre-operative, intra-operative, and post-operative.

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

Pre-operative Visits are visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.

Intra-operative Services are services that are normally a usual and necessary part of a surgical procedure.

Post-operative Visits are follow-up visits during the post-operative period of the surgery that are related to recovery from surgery.

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 typically included in the global surgical package may become eligible for separate reimbursement if provided after the global period expires based on the post-operative days noted above. However, a procedure that has a Global Days Value of 000, 010, or 090 that is performed during the post-operative period of another procedure having a Global Days Value of 010 or 090, when both of the procedures are reported by the same surgeon, same specialty provider or another QHP, is considered included in the Global Surgical Package of the initial procedure **unless** an appropriate modifier is appended.

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

- Pre-operative visits 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 usual and necessary to the surgical procedure. E.g., the administration of fluids and drugs during or for an operative procedure are included in the services and are not separately reimbursable. CPT codes 96360-96377 are not reported separately for the operative procedure.
- 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 **related** to the recovery of the surgery. This includes follow-up E/M visits occurring within the designated Global Period **related** to the recovery following surgery. However, a significant and separately identifiable E/M service unrelated to the decision to perform a minor surgical procedure should be reported separately with modifier -25 appended.
- Surgical Suite or anesthesia equipment.
- Postsurgical Pain Management when performed by the surgeon, same specialty/subspecialty physician or other QHP within the same group.
- Supplies – Except for those identified as exclusions.
- 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.
- Surgical trays are not eligible for separate reimbursement when certain services are performed in a professional health care provider's office.

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 requiring 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.
- Immunosuppressive therapy for organ transplants
- Critical care services unrelated to the surgical procedure where a seriously injured or burned member is critically ill and requires constant attendance of the physician.

Split Surgical Package

A split surgical package is when the pre-operative and/or post-operative services are rendered by a physician or QHP other than the surgeon performing the surgical procedure. Appropriate modifiers should be appended to the same surgical procedure code by each physician or QHP to identify who provided the service(s) during the global surgical package.

Eligible reimbursement for a split surgical service must not exceed 100% of the total global surgical allowable amount.

Modifier	Percentage
54	75%
55	12.5%
56	12.5%
TOTAL	**100%**

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 required for reimbursement consideration.

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 following list of modifiers is not an all-inclusive list:

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	Post-operative Management Only
56	Pre-operative 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

MODIFIER	DESCRIPTION
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).)

Additional Resources:

Clinical Payment and Coding Policy

CPCP023 Modifier Reference Policy

References:

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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

Medicare NCCI Policy Manual. Accessed 3/15/2023 https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-policy-manual#:~:text=The%20NCCI%20Policy%20Manual%20should,1%2C%202022.

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
06/21/2023	Annual Review