REIMBURSEMENT POLICY

Global Surgical Package

Active

Policy Number:	Surgery/Interventional Procedure – 007
Policy Title:	Global Surgical Package
Section:	Surgery/Interventional Procedure
Effective Date:	05/19/2015

Product: ☒Commercial ☒FEP ☒Medicare Advantage ☒Platinum Blue

Description

This policy addresses Blue Cross and Blue Shield of Minnesota's (Blue Cross) requirements for the coding and reimbursement of the Global Surgical Package when it is provided by the same physician or is split between two or more physicians.

Definitions

Same physician - A physician or other qualified health care professional in the same group and same specialty reporting the same federal tax identification number

Policy Statement

The Global Surgical Package, as defined by the Centers for Medicare and Medicaid Services (CMS), includes all services normally provided during the preoperative, intraoperative, and postoperative period of a procedure.

When the entire Global Surgical Package is provided by the same physician (defined as a physician or other qualified health care professional in the same group and same specialty reporting the same federal tax identification number), 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

In those situations where any of the pre-, intra-, and postoperative services are provided by two or more physicians with different specialties or in different group practices, the Global Surgical Package may be split. The appropriate modifier (54, 55, 56) specific to the component that is being billed, must be appended to the procedure code for separate reimbursement to be considered. See "Modifiers" section of this policy.

Global Days Values

Surgeries are assigned a global period of 0, 10 or 90-days. To determine the global surgical period, refer to the CMS Physician Fee Schedule.

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.
For codes with a value of “MMM” *refer to General Coding - 025 Maternity 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, or when splitting the surgical package, modifiers should be used as appropriate.

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.

Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period – Modifier 24

- Modifier 24 is used to indicate that an E/M service was provided during the postoperative period for reasons unrelated to the surgical procedure.
- Modifier 24 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.

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 – Modifier 25

- Modifier 25 is used when an E/M service is rendered on the same day as a minor surgical procedure (0 or 10-day global period).
- 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.

Note: Effective for dates of service beginning January 1, 2022, Blue Cross will be implementing a 20% reduction in the allowed amount for E/M codes 99202-99380 and 99398-99498 submitted with modifier 25 on a professional claim.

Surgical Care Only – Modifier 54

- Append modifier 54 to the surgical procedure code when one physician performs the intraoperative portion of a surgical procedure while another physician(s) of a different specialty or from a different practice provides preoperative and/or postoperative management.
- Payment is made at 80% of the allowed amount.

- The surgical procedure should be billed globally (no modifier) if the pre-, intra-, and postoperative services are rendered by the same physician or other providers in the same group and same specialty.

Postoperative Management Only – Modifier 55

- Append modifier 55 to the surgical procedure code when postoperative services are provided by a different physician (i.e., different specialty and/or practice).
- Payment is made at 15% of the allowed amount.
- Postoperative services are billed only one time and include all visits within the designated period. Thus, only one payment will be made for the post-op care.
- Do not submit separate, itemized services for uncomplicated surgical follow-up.
- If care during the postoperative period is relinquished to another practitioner from a different practice, both practitioners should bill for their portion of postoperative care with the surgical procedure code and the 55 modifier. However, both practitioners must report the date the care was relinquished. Assumed and relinquished care is reported in the 2300 loop/DTP03 of the electronic claim record. The reimbursement for the post-op care will be divided between the practitioners based on each practitioner's portion of their post-op care.

Preoperative Management Only – Modifier 56

- Append modifier 56 when preoperative services are provided by a physician other than the surgeon (i.e., different specialty and/or practice).
- Payment is made at 5% of the allowed amount.
- Preoperative services are billed only one time and include all visits within the designated period. Thus, only one payment will be made for the pre-op care.
- Patients are normally reevaluated on the date of the actual surgery to assure the service can be performed. That clearance would be included in the global period and should not be reported separately.

Decision for Surgery – Modifier 57

- Modifier 57 is 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 surgical procedure (90-day global period).
- Do not append this modifier when a minor surgical procedure (0- or 10-day global period) is performed.
- Modifier 57 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 assure the service can be performed. That clearance would be included in the global period and should not be reported separately.

Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period – Modifier 58

- Modifier 58 is 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.

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 – Modifier 78

- 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 70 percent of the approved allowance.
- A new global period does not apply to a procedure reported with modifier 78.

Unrelated Procedure or Service – Modifier 79

- If an unrelated procedure or service is performed by the same physician (same group and same specialty reporting the same federal tax identification number) 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.

Unrelated Evaluation and Management (E/M) Visit During a Postoperative Period, or on the Same Day as a Procedure or Another E/M Visit – Modifier FT

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

Note: For additional guidance regarding global surgical billing for Medicare Advantage and Platinum Blue claims, refer to the Medicare Claims Processing Manual, Chapter 12.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, Blue Cross 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 54 55 56 57 58 78 79 FT
ICD-10 Diagnosis:	N/A
ICD-10 Procedure:	N/A
CPT/HCPCS:	All surgical codes
Revenue Codes:	N/A

Cross Reference

Cross Reference:

Evaluation and Management – 001 Evaluation and Management Services

Evaluation and Management – 007 Critical Care Services

General Coding – 025 Maternity

Policy History

05/19/2015	Initial Committee Approval Date
05/02/2018	Annual Policy Review
07/06/2020	Annual Policy Review
01/25/2022	Annual Policy Review – content revisions made for clarity; Modifier FT added.