Empire BlueCross and BlueShield
Professional Reimbursement Policy

Subject: Global Surgery	
NY Policy: 0012	**Effective: 4/01/2013 – 1/31/2014**

Coverage is subject to the terms, conditions, and limitations of an individual member's programs or products and policy criteria listed below.

DESCRIPTION

The Global Surgery Concept is based on the understanding that reimbursement for a surgical procedure includes the work value of an established Evaluation and Management service (E/M) and other services as defined in the policy section. The global period is derived from the Centers for Medicare & Medicaid Services (CMS) designations.

A surgical procedure is usually assigned one of three global periods depending on whether the procedure performed is classified as major or minor. Major procedures have a 90-day global surgical period. Minor procedures have either a 0-day global or a 10-day global surgical period based on complexity.

- CMS does not list all *Current Procedural Terminology* (CPT®)′ codes in one of these three categories. (There is a separate 45 day global period assigned to certain maternity delivery codes.) Procedures that are not placed in these major categories are listed in supplemental categories of 'MMM', 'XXX', 'YYY', and 'ZZZ'. Please refer to the coding section for clarification.

POLICY

Surgical procedures are subject to preoperative, same day, and postoperative care edits. Evaluation and Management (E/M) services rendered within the applicable global period will not be eligible for separate or additional compensation when reported by the surgeon or by providers of the same group with the same specialty. The Health Plan's global surgical reimbursement includes all E/M services rendered after the decision for surgery has been made, including but not limited to history and physical required for surgical clearance, unless there is a high risk of comorbidity which requires surgical clearance from other than the treating physician. Please refer to the Evaluation and Management Services and Related Modifiers -25 & -57 Reimbursement Policy for additional information.

Services included in the global surgical package may be furnished in any setting (e.g., Hospital, Ambulatory Surgical Center, or Physician's Office). Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon or by providers of the same group with the same specialty. However, there are times when the global surgical package may not apply. Critical care services (99291-

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99292), as well as other select E/M services are payable separately in some situations. (Refer to the Exceptions section of this policy for additional information.)

The following services will not be eligible for separate reimbursement when identified as services that are included in the global surgical package when they are reported by the surgeon or by providers of the same group with the same specialty. Please refer to the Bundled Services and Supplies Policy for additional information:

- E/M visits beginning the day before a major surgical service
- E/M visits occurring on the same day as a surgical procedure or substantial diagnostic or therapeutic procedure or service (such as dialysis, chemotherapy and osteopathic manipulative treatment)
- Intraoperative services (such as monitoring) that are a usual and necessary part of a surgical procedure
- Intraoperative pain management by the surgeon, including moderate sedation and intraoperative pain management devices
- Fluid and drug administration services such as therapeutic, prophylactic, and/or local anesthetic injections (e.g., J2001 and 96372)
- Follow-up E/M visits during the postoperative period that relate to recovery from the surgery (e.g., postoperative pain management, including patient controlled analgesia). The postoperative period begins on the next day following the surgical service.
- Any additional medical or surgical services by the surgeon during the postoperative period because of complications that do not require a return trip to the operating room. See below if a return trip to the operating room is required during the postoperative period.
- Miscellaneous services the Health Plan considers to be routine post surgical care, including but not limited to:
  - dressing changes
  - local incision care
  - removal of sutures, staples, lines, wires, tubes, drains, catheters, and/or casts
- The following services are also not eligible for separate reimbursement when performed during the global postoperative period of the related surgical procedure, except as noted below*:
  - incision and drainage of abscess, simple/single/complicated or multiple (10060-10061)*
  - incision and drainage of hematoma, seroma, or fluid collection (10140)*
  - puncture aspiration of abscess, hematoma, bulla, or cyst (10160)*
  - incision and drainage, complex postoperative wound infection (10180)*
  - adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline (S2083)

***** Typically, the procedures asterisked above are performed in an office setting. However, if such an asterisked procedure requires a return to the operating room during the postoperative period,

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modifier 78 should be appended to the code for the procedure. Please refer to Exceptions Section #5 for information on modifier 78.

In addition, the Health Plan considers local infiltration, anesthetic blocks, or topical anesthesia as part of the surgical package. Therefore anesthetic agents (e.g., lidocaine, Xylocaine, marcaine (bupivacaine)), including those reported with unspecified/unclassified Healthcare Common Procedure Coding System Level II (HCPCS)″ drug codes such as J3490 administered by the operating provider, are considered part of the global surgical package and not eligible for separate reimbursement**.**

Exceptions: There are times when the global surgical package may not apply.

1. The following E/M services are described by CPT′ guidelines as applying to a new or established patient and are excluded from the global surgical package when billed on the same day as a procedure with a zero (0) day postoperative follow-up period. These E/M services include but are not limited to:
    a. Initial observation care 99218-99220
    b. Observation care 99234-99236
    c. Initial hospital care 99221-99223
    d. Office or other outpatient consultations 99241-99245
    e. Initial inpatient consultations 99251-99255
    f. Confirmatory consultations 99271-99275
    g. Critical Care 99291-99292

2. Critical care services provided by the surgeon for a seriously injured or burned patient are eligible for reimbursement during the global period when the critical care is above and beyond, and in most cases unrelated to, the specific anatomic injury or general surgical procedure performed. (Modifier 24 and/or 25 is required.)

3. An E/M visit code reported with a one day preoperative date of service and a diagnosis unrelated to the surgical procedure is excluded from global surgery editing, and is eligible for reimbursement. (Modifier 25 is required.)

4. An E/M visit code with the appropriate modifier appended is eligible for separate reimbursement when reported within the global aftercare period with a diagnosis unrelated to the surgical procedure. (Modifier 24 is required.) The Health Plan considers the evaluation and treatment of post operative pain to be related to the surgical procedure.

5. Related surgical services (not identified as global in the last bullet point in the Policy section above) performed during a postoperative surgical period are eligible for separate

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reimbursement at 70% of the applicable surgical reimbursement allowed amount. A surgical service reported with modifier 78 will not start a new global surgery period.

- Modifier 78 – return to the operating room for a related procedure during the postoperative period.

6. Post surgical procedures and services, unrelated to the prior surgery, are eligible for separate reimbursement in the assigned post operative period. However, it is recommended to append modifier 79 to indicate these services are unrelated to the prior surgery.
    - Modifier 79 – unrelated procedure or service by the same physician during the postoperative period.

Note: Documentation to support the use of the modifiers listed above is not required with claim submission, but may be requested.

E/M services should be billed following the American Medical Association (AMA) standards set forth in the current edition of CPT′. The member's medical records should legibly and accurately reflect the services that warranted the use of a specific CPT′ /HCPCS″ code.

CODING

The following tables show applicable postoperative days assigned by the Health Plan for the supplementary categories of 'MMM', 'XXX', 'YYY' and 'ZZZ':

MMM	"0" postoperative days except the following: • "45" days for codes: 59400, 59410, 59510, 59515, 59610, 59614, 59618, and 59622.
XXX	"0" postoperative days for surgical procedures • 10 postoperative days for anesthesia procedures. Please refer to the Anesthesia Policy for additional information.
YYY	We reserve the right to apply a global period for aftercare based on the postoperative days designated for a similar procedure. Please see the table below for YYY designations.
ZZZ	Same postoperative days as the parent procedure. For example: CPT′ 22585 will be assigned the same 90 day period as the parent code 22554

Applicable Postoperative Days:	YYY codes with a global period for aftercare based on the postoperative days designated for a similar procedure:
10	17999, 38589, 40899, 41899, 68899
45	59898

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90	15999, 19499, 20999, 21089, 21299, 21499, 21899, 22899, 22999, 23929, 24999, 25999, 26989, 27299, 27599, 27899, 28899, 29999, 30999, 31299, 32999, 33999, 36299, 37501, 37799, 38129, 38999, 39499, 39599, 40799, 41599, 42299, 42699, 42999, 43659,43775, 43999, 44238, 44799, 44899, 44979, 45499, 46999, 47379, 47399, 47579, 47999, 48999, 49329, 49659, 49999, 50549, 50949, 51999, 53899, 55559, 55899, 58578, 58679, 58999, 59899, 60659, 60699, 64999, 66999, 67299, 67599, 67999, 68399, 69399, 69799, 69949, 69979

Coding with Modifiers to indicate a Transfer of Care:

Per CPT′, the following modifiers should be used to reflect the appropriate services.

- Modifier 54---surgical care only. Reimbursement will be calculated at 70% of the applicable surgical reimbursement allowed amount.
- Modifier 55---postoperative management only. Reimbursement will be calculated at 20% of the applicable surgical reimbursement allowed amount.
- Modifier 56---preoperative management only. Reimbursement will be calculated at 10% of the applicable surgical reimbursement allowed amount.

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Use of Reimbursement Policy:

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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