Subject: Global Surgery

NY Policy: 0012  Effective: 10/01/2016

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 units 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. For example, Critical care
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services (99291-99292), 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 Health Plan has identified the following services to be included in the global surgical package and not eligible for separate reimbursement when they are reported by the operating surgeon or by providers in the same group with the same specialty. Non-physician providers (NPPs), including but not limited to, physician assistants (PAs) and nurse practitioners (NPs, APRNs, etc.) in the same group as the operating surgeon are considered to be of the same specialty as the operating surgeon:

1. E/M visits beginning the day before a major surgical service

2. E/M visits occurring on the same day as a major or minor surgical procedure or substantial diagnostic or therapeutic procedure or service (such as dialysis, chemotherapy and osteopathic manipulative treatment)

3. Intraoperative services (such as monitoring) that are a usual and necessary part of a surgical procedure

4. Intraoperative pain management by the operating surgeon, including moderate sedation and intraoperative pain management devices

5. Fluid and drug administration services such as therapeutic, prophylactic, and/or local anesthetic injections (e.g., J2001 and 96372)

6. Follow-up E/M visits and aftercare following surgery 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 day following the surgical service.

7. 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/procedure room. (See Exceptions section below if a return trip to the operating/procedure room is required during the postoperative period.)

8. Services the Health Plan considers to be routine post-surgical care, include, but are not limited to:
   - dressing changes
   - local incision care
   - removal of sutures, staples, lines, wires, tubes, drains, catheters, and/or casts
   - adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline (S2083)
9. The Health Plan considers the following procedures not eligible for separate reimbursement when performed during the global postoperative period of the related surgical procedure as these procedures are typically performed in an office setting.
   - incision and drainage of abscess, simple/single/complicated or multiple (10060-10061)
   - incision and drainage of hematoma, seroma, or fluid collection (10140)
   - incision and drainage, complex postoperative wound infection (10180)
   - puncture aspiration of abscess, hematoma, bulla, or cyst (10160)

However, if such procedures require a return to the operating/procedure room during the postoperative period please refer to Exceptions Section #6 for information on modifier 78.

10. 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 (HCPCS Level II) 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. Critical care services provided by the surgeon for a seriously injured or burned patient may be 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, 25, or 57 is required.)

2. When a significant, separately identifiable E/M service performed on the same day as a minor surgical procedure or an endoscopic, diagnostic, or therapeutic procedure, the E/M service may be eligible for separate reimbursement. (Modifier 25 is required.)

3. When an E/M service is reported with a date of service the day prior to or the day of a major surgical procedure and the E/M service results in the initial decision for surgery, the E/M service may be eligible for separate reimbursement. (Modifier 57 is required.)

4. When an E/M service is reported within the global aftercare period with a diagnosis unrelated to the surgical procedure, the E/M service may be eligible for separate reimbursement. (Modifier 24 is required.) However, the Health Plan considers the evaluation, management, and treatment of postoperative pain to be related to the surgical procedure and not eligible for separate reimbursement.
5. Related surgical services that require a return trip to the operating/procedure room performed during a global postoperative surgical period by the same provider may be eligible for separate reimbursement at 70% of the applicable surgical reimbursement allowed amount when such surgical service is reported with modifier 78. The use of modifier 78 will not start a new global surgery period.

- Modifier 78 – unplanned return to the operating/procedure room for a related procedure during the postoperative period by the same provider.

Note: When a return to the operating/procedure room during a global postoperative surgical period is required for incision and drainage codes 10060, 10061, 10140, or 10180 or puncture aspiration code 10160, these procedures may be eligible for separate reimbursement when reported with modifier 78.

6. Post-surgical procedures and services performed by the same provider, unrelated to the prior surgery, may be eligible for separate reimbursement in the assigned postoperative period. Surgical services reported with modifier 79 are considered unrelated to the prior surgery.

- Modifier 79 – unrelated procedure or service by the same provider during the postoperative period.

Note: Documentation to support the use of the modifiers listed above is not required with claim submission however supporting documentation may be requested at a future time.

E/M services should be reported 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 for the following maternity care and delivery procedures:  
|         | • “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 our Anesthesia Services reimbursement policy for additional information. |
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<table>
<thead>
<tr>
<th>YYY</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZZ</td>
<td>Same postoperative days as the parent procedure. For example, CPT add-on code 22585 will be assigned the same 90 day period as the parent code 22554.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Applicable Postoperative Days:</th>
<th>YYY codes with a global period for aftercare based on the postoperative days designated for a similar procedure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>17999, 38589, 40899, 41899, 68899, 0336T</td>
</tr>
<tr>
<td>45</td>
<td>59898</td>
</tr>
<tr>
<td>90</td>
<td>15999, 19499, 20999, 21089, 21299, 21499, 21899, 22899, 22999, 23929, 24999, 25999, 26989, 27299, 27599, 27899, 28899, 29999, 30999, 31299, 32999, 33999, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 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, 0335T, and 0345T</td>
</tr>
</tbody>
</table>

Coding with Modifiers to indicate a Transfer of Care:
According to CPT, the following modifiers should be used with surgical procedure codes to reflect the appropriate services when only part of the global surgical care is rendered. (See also our Modifier Rules reimbursement policy.)

- Modifier 54---surgical care only. Reimbursement will be calculated at 70% of the applicable surgical reimbursement allowed amount.
- Modifier 55---postoperative management only. Postoperative care begins on the next day following the surgical procedure. Reimbursement will be calculated at 20% of the applicable surgical reimbursement allowed amount.
  - When postoperative management only care is rendered for a time frame which is less than the published postoperative global period, report modifier 52 (reduced services) in addition to modifier 55. This will reduce the calculated reimbursement for modifier 55 by 50%.
  - When modifier 55 is reported with procedures that have zero post-operative care days the service will not be eligible for reimbursement.
• Modifier 56—preoperative management only. Preoperative care begins on the day before and/or the same day as the surgical procedure. Reimbursement will be calculated at 10% of the applicable surgical reimbursement allowed amount.

Use of Reimbursement Policy:
State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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