Payment Policy: Global Surgical Package Policy

Policy Number: 3830

Version Number: 2

Form(s): CMS 1500

Global Surgical Package Policy

Payment Policy Disclaimer

Payment policies serve as a guide to assist with accurate claim submission. You are responsible for submission of accurate claims information to Sentara Health Plans. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or Revenue codes with appropriate ICD-10 diagnosis. The codes shall denote the services and/or procedures performed. Subject to applicable law, if appropriate coding/billing guidelines or current payment policies are not followed, Sentara Health Plans may reject/deny the claim or recover and/or recoup claim payments.

The payment policies do not cover all issues related to reimbursement for services rendered to Sentara Health Plans enrollees. Further, legislative mandates, the physician or other provider contract documents, the enrollee's benefit coverage documents, and the Provider Manuals all may supplement or, in some cases, supersede these payment policies.

Sentara Health Plans payment policies may use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), National Uniform Billing Committee (NUBC), or other coding guidelines to determine appropriate payment. The payment policies apply to all health care services billed on CMS 1500 forms and UB04 forms. Additionally, Sentara Health Plans payment policies apply to both participating and non-participating professionals and facilities, unless otherwise indicated. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design, and other factors are considered in developing payment policies.

Sentara Health Plans reserves the right to review and revise payment policies when necessary. The most current version of this payment policy will be published on the website. For clarity, this payment policy applies to claims processed pursuant to Sentara Health Plans provider contracts.

Payment Policy-Global Surgical Package Policy

Product Applicability		
Plan	***Product***	***Applicability***
Sentara Health Plans	Medicaid	X
	Medicare	X
	Commercial (Fully Insured and ASO)	X

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Definitions

Global Period, Global Days Value- The Global Period or Global Days Value represents the period of time during which all necessary services normally furnished by a physician (before, during, and after the procedure) are included in the reimbursement for the procedure performed.

Procedure Codes

10000-69999

G0559- add on code for post-operative care services provided by a practitioner other than the one who did the surgical procedure (or another practitioner in the same group practice). This add-on code shows the time and resources involved in post-operative follow-up visits provided by practitioners who weren't involved in providing the surgical procedure.

Policy- Global Days

Policy Summary- The global surgical package, also called global surgery, includes all necessary services normally provided by a provider (or members of the same group with the same specialty) before, during, and after a procedure. Providers in the same group practice, with the same specialty, must bill and accept payment as though they're a single physician. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, and physicians' offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon.

Zero Day Post-Operative Period (endoscopies and some minor procedures)

- No pre-operative period
- No post-operative days
- Generally, a visit on the procedure day isn't payable as a separate service

Simple Procedures (Zero Global Period) has no preoperative/postoperative period so the global period is only the day of the procedure. Unless special circumstances exist, an evaluation and management (E&M) visit on the same day as surgery is not payable. If the circumstances exist, modifier 25 (significant and separately identifiable

service) must be appended to the E & M code. Services are generally simple minor procedures and some endoscopic procedures.

10-Day Post-Operative Period (other minor procedure)

- No pre-operative period
- Generally, a visit on the procedure day isn't payable as a separate service
- Total global period is 11 days; count the surgery day and the 10 days following the surgery day

90-day Post-Operative Period (major procedure)

- 1-day pre-operative period
- Generally, the procedure day isn't separately payable
- Total global period is 92 days; count 1 day before surgery, the day of surgery, and the 90 days following the surgery day

Note: If the surgeon only performed the intra-operative portion of the services included in the surgical global package and another physician unrelated to the provider group, or in the provider group but a different specialty, performed the pre-op or post-op or both the pre-op and post-op, then review the Modifier Policy.

Global Days Indicated as:
XXX- The global Surgical Package concept does not apply to the code.
YYY-The plan assigns a global period of 0 to these codes
ZZZ-The code is related to another service and is always included in the Global Period of the primary service.

Physicians Who Furnish the Entire Global Package
Physicians who furnish the surgery and furnish all of the usual pre-and post-operative care may bill for the global package by entering the appropriate CPT code for the surgical procedure only. Separate billing is not allowed for visits or other services that are included in the global package.

Physicians Who Furnish Part of a Global Surgical Package
More than one physician may furnish services included in the global surgical package. It is possible that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative, post-discharge care is split among two or more physicians where the physicians agree on the transfer of care.

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provided all services, except where stated policies allow for higher payment. For instance, when the surgeon furnishes only the surgery and a physician other than the surgeon furnishes pre-operative and

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post-operative inpatient care, the resulting combined payment may not exceed the global allowed amount.

The surgeon and the physician furnishing the post-operative care must keep a copy of the written transfer agreement in the member's medical record. Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case. Split global-care billing does not apply to procedure codes with a 0-day postoperative period.

Modifiers 54, 55, and 56

Where physicians agree on the transfer of care during the global period, services will be distinguished by the use of the appropriate modifier:

- Surgical care only (modifier -54)
- Post-operative management only (modifier -55)
- Pre-operative care only (modifier -56)

The physician must use the same CPT code for global surgery services billed with modifiers -54, -55, or -56 in the case of a formal transfer of care. The same date of service and surgical procedure code should be reported on the bill for surgical care only and post-operative care only. The date of service reported is the date the surgical procedure was furnished.

Modifier "-54" indicates that the surgeon is relinquishing all or part of the postoperative care to a physician and is used in any case when a practitioner plans to provide only a part of a global package (including but not limited to when there's a formal, documented transfer of care or an informal, non-documented but expected, transfer of care).

The physician, other than the surgeon, who furnishes post-operative management services, bills with modifier "-55

- Use modifier "-55" with the CPT procedure code for global periods of 10 or 90 days.
- Report the date of surgery as the date of service and indicate the date that care was relinquished or assumed. Physicians must keep copies of the written transfer agreement in the beneficiary's medical record.
- The receiving physician must provide at least one service before billing for any part of the postoperative care.

Modifier 56- When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number

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Modifiers 54 and 55 are not allowable for an Assistant at Surgery (Modifier AS). An assistant at surgery is a Physician Assistant or Nurse Practitioner who is acting in the capacity of a surgical assistant. Assistant at Surgery charges are billed with modifier AS.

Exceptions to the Use of Modifiers "54" and "55"

Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate E&M code. No modifiers are necessary on the claim.

Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of E&M code, without a modifier.

If the services of a physician, other than the surgeon, are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate E&M code. No modifiers are necessary on the claim.

If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using subsequent hospital care codes for the inpatient hospital care and the surgical code with the "-55" modifier for the post-discharge care. The surgeon bills the surgery code with the "-54" modifier

Included Services in Global Surgical Package

- Preoperative visits are not separately reimbursable services when performed within the assigned Global Period. This period begins with the day before surgery for Major Procedures (those having a Global Days Value of 090) and the day of surgery for procedures having a Global Days Value other than 090.Intra-operative care including the performance of the surgery.
- Postoperative Care: All standard postoperative care of the patient including but not limited to removal of sutures, staples, casts, drains, tubes, packs, etc. Wound care or dressing changes. Any care required by the surgeon due to postoperative complications or problems, that do not require the patient to be taken back to the operating room for further procedures. Not applicable to 0-day codes.
- Supplies used to treat any postoperative surgical complications or treatments, unless otherwise stated as exclusive.
- Post-operative pain management.
- A procedure having a Global Days Value of 000, 010 or 090 that is performed during the postoperative period of another procedure having a Global Days Value of 010 or 090, when both procedures are reported by the Same Specialty Physician or Other QHP, is considered included in the

Global Surgical Package of the initial procedure unless an appropriate modifier is appended.

Services Not Included in Global Surgical Package

- A 90-day procedure: An E&M service the day of, or the day before, a major is included in the global package. The exception to the inclusion would be if the outcome of that E & M was that surgery was necessary. Modifier 57 is appended to the E & M code to indicate that the E & M (performed the day of the surgery or the day before the surgery) was the decision for surgery day. With the 57 Modifier, the E&M can be paid outside of the global period.
- A 10-day procedure performed the same day as an E & M would generally not be paid unless a Modifier 25 is appended to the E & M code to identify it as a significant and separately identifiable service.
- Distinct surgical procedures for a different diagnosis during the postoperative period which are not repeat operations or treatment for complications. Providers must report modifier 79 (unrelated procedure or service by the same physician during the postoperative period).
- Return trips to the operating room for complications from the surgery. If a return trip to the operating room is required, then the global surgical period starts over again with the second surgery. Providers must bill modifier 78 (return to the operating room for a related procedure during the postoperative period)
- If a second, more costly procedure is required due to failure of the less expensive procedure; both are billable and payable and are not part of the global period.
- Office visits in which attention to diagnoses or medical conditions that are unrelated to the surgery are payable. Modifier 24 should be appended to the code.
- Diagnostic tests and procedures (including lab and x-rays)
- Medication management for conditions/diagnoses unrelated to the surgical procedure.
- Services with Modifier 58 for a staged or planned procedure
- Critical care services unrelated to surgery where a critically ill patient, seriously injured or burned, needs constant provider attendance. For critical care visits that are unrelated to the surgical procedure and done post-operatively, report modifier –FT.

Policy History

Review Date	Summary of Revisions	Revision Effective Date	Approved By

6/18/2025	Annual Review	08/18/2025	Payment Policy
12/9/2024	Annual Review	12/9/2024	Payment Policy

Resources

Department of Medical Services Assistance (DMAS)

Center for Medicare and Medicaid Services (CMS)

American Medical Association (AMA)