

Payment Policy

Global Surgical Period	
Original effect date:	Revision date:
01/01/2007	07/14/2024

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This payment policy is intended to serve as a general overview and does not address every aspect of the claims reimbursement methodology. This information is intended to serve only as a general reference regarding Blue Shield’s payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member’s programs benefits.

Application

Blue Shield applies the CMS global surgical concept, which is based on the understanding all necessary services normally furnished by a physician during the preoperative, intra- operative and post-operative are included in the reimbursement for the surgical procedure performed.

For orthopedic and spine procedures, Blue Shield follows the American Academy of Orthopedic Surgeons (AAOS) “Complete Global Service Data for Orthopedic Surgery.”

Policy

Surgical procedures are assigned a global surgical period, which includes the pre-operative, intraoperative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. For purposes of this policy, same specialty physician is defined as physicians and/or other health care professionals of the same group and same specialty reporting the same Federal Tax Identification number (TIN).

Global Surgical periods are evaluated using the CMS' global days as designated on the Medicare Physician Fee Schedule (MPFS). Payment rules for global surgical packages apply to procedure codes with global days 000, 010, 090.

There are three types of global surgical packages based on the number of postoperative days:

- Zero Day Post-Operative Period, (endoscopies and some minor procedures)
 - No pre-operative period
 - No post-operative days
 - Visit on day of procedure is generally not payable as a separate service
- 10-Day Post-Operative Period, (other minor procedures)
 - No pre-operative period
 - Visit on day of the procedure is generally not payable as a separate service
 - Total global period is 11 days. Count the day of the surgery and 10 days following the day of the surgery.
- 90-day Post-Operative Period, (major procedures)
 - One day pre-operative included
 - Visit on day of the procedure is generally not payable as a separate service
 - Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery

CMS does not list all procedure codes in one of the three categories above. Instead, some procedures are assigned supplemental categories identified by Global Surgery indicators of MMM, XXX, YYY and ZZZ.

Blue Shield applies global surgery days as defined in the section below for CMS supplemental categories MMM, XXX, YYY and ZZZ.

- Global Days for MMM Procedures
 - Procedure codes with “MMM” are maternity care and delivery codes. The following table shows applicable pre- and post-operative days assigned by Blue Shield for procedures in this category.

Maternity Care Type	Procedure Codes	Pre-op [40 Weeks]	Post-op [6 Weeks]
Antepartum Care Only	59412, 59425, 59426	280 Days	0 Days
Antepartum, Delivery, & Postpartum Care	59400, 59510, 59610, 59618	280 Days	42 Days
Delivery Only**	59409, 59414, 59514, 59612, 59620	0 Days	0 Days
Delivery including Postpartum Care	59410, 59515, 59614, 59622	0 Days	42 Days
Postpartum Care Only	59430	0 Days	42 Days

** When reporting delivery only services (59409, 59414, 59514, 59612, 59620), report inpatient post-delivery management and discharge services using Evaluation and Management Services codes.

- Global Days for XXX Procedures:
 - Blue Shield of California has not assigned pre-op/post-op period to these procedures, hence medical visit editing is applied for same date of service only.

- Blue Shield of California assigns a pre-op/post-op period of 1 to anesthesia procedures which are assigned global indicator of XXX.
- Global Days for YYY Procedures:
 - Procedure codes with “YYY” are contractor-priced codes, for which contractors determine the global period. Please refer to the “Attachment” section below for a list of procedure codes with global-day customizations.
- Global Days for ZZZ Procedures:
 - Procedures with a global period of ZZZ are typically CPT add-on codes, hence the global period of the parent procedure applies.
 - Evaluation and management services submitted with ZZZ procedures (add-on codes) with the same date of service are not recommended for separate reporting.
 - No pre-op or post-op auditing will occur with ZZZ procedures.

The following services are considered included in the global surgery payment when they provide them in addition to the surgery:

- Pre-operative visits, after the decision is made to operate. For major procedures, this includes preoperative visits the day before the day of surgery.
- For minor procedures, this includes pre-operative visits the day of surgery.
- Intra-operative services that are normally a usual and necessary part of a surgical procedure.
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery.
- Post-surgical pain management by the surgeon.
- Supplies, except for those identified as exclusions.
- Miscellaneous services, such as dressing changes, local incision 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.

Global surgery applies in any setting, including an inpatient hospital, outpatient hospital, Ambulatory Surgical Center (ASC), and physician’s office. When a surgeon visits the patient in an intensive care or critical care unit, Medicare includes these visits in the global surgical package. However, there are times when the global surgical package may not apply. For example, Critical care services (99291-99292), as well as other select E/M services are payable separately in some situations.

The following services are not included in the global surgical payment. These services may be billed and paid for separately:

- Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries. This is billed separately using the modifier -57 (Decision for Surgery). This visit may be billed separate surgical procedures.
- Services of other physicians related to the surgery, except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery.
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Clearly distinct surgical procedures that occur during the post-operative period which are not reoperations or treatment for complications.
- Treatment for post-operative complications requiring a return trip to the Operating Room (OR). An OR, for this purpose, is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite.
- It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR).
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Immunosuppressive therapy for organ transplants; and
- Critical care services (Current Procedural Terminology (CPT) codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

Applicable Modifiers:

To ensure the proper identification of services that are, or are not included in the global package the following modifiers would be reported:

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

Modifier 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

Modifier 54: Surgical Care only

Modifier 55: Post-Operative Management Only

Modifier 56: Preoperative Management only

Modifier 57: Decision for Surgery

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

Modifier 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

Modifier 79: Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

Reimbursement of significant, separately identifiable evaluation and management services during the global surgery period of minor procedures:

Under specific circumstances, E/M visits occurring during the major or minor (90 day or 0/10 day) Global Surgery period may be appropriate and separately payable to the same specialty physician or other health care professional who performed the treatment or surgical procedure. All such E/M services must be billed with the correct Common Procedure Terminology (CPT) modifier to explain the reason the services should be considered separately payable. CPT modifier 25 – significant, separately identifiable evaluation and management service, is used to correctly identify separately payable E/M services performed during global period of minor (0 or 10 day) procedures. Modifier 25 is not recognized as an exception to allow separate payment for E/M services during the major (90 day) global period.

Effective date of service on or after July 14, 2024, when certain office or other outpatient visit E/M procedures (CPT codes: 92002, 92004, 92012, 92014 and 99201-99215) appended with Modifier 25 are billed appropriately during the minor (0 or 10 Day) by the same specialty physician and/or other health care professional performing the 0/10 day Global procedure, Blue Shield of California will reimburse the E/M services at 50% of the Blue Shield Provider Allowance.

Rationale

The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the preoperative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Attachment(s)	
Global Period - YYY	See attached.
Resources	
<ul style="list-style-type: none"> • American Medical Association https://www.ama-assn.org/ama • Medicare Claims Processing Manual”, Chapter 12, Sections 40.2 & 40.4 Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners Guidance Portal (hhs.gov) • CMS Medicare Physician Fee Schedule (MPFS) Relative Value File PFS Relative Value Files CMS • The American College of Obstetrics and Gynecologist Definition of Term Pregnancy ACOG 	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
01/01/2007	New Policy Adoption	Payment Policy Committee
07/08/2017	Policy Revision	Payment Policy Committee
08/03/2018	Maintenance	Payment Policy Committee
01/01/2020	Maintenance: Updated Global Period – YYY content list	Payment Policy Maintenance
04/01/2022	Updated MMM Global period based on gestational weeks	Payment Policy Maintenance
01/01/2023	Updated Global Period – YYY content list	Payment Policy Maintenance
01/01/2024	Updated Global Period – YYY content list	Payment Policy Maintenance
07/14/2024	Update: Reimburse 50% allowance for E&M billed with Mod 25 along with Minor Surgery	Payment Policy Committee

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under an enrollee’s contract.

These Policies are subject to change as new information becomes available.