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Global Surgery Package

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DESCRIPTION:

The global surgery package includes all necessary services normally furnished by a surgeon before, during, and after a procedure. This policy identifies the services included and excluded in the global surgical package. Florida Blue's allowance of a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services performed by the same physician and/or other health professional of the same group and same specialty. The services included in the global surgical package may be furnished in any setting (e.g., in hospitals, ambulatory surgical centers, or physician offices).

This policy applies to billing for services on a CMS-1500 or equivalent claim form. Same provider for the purposes of this policy includes all physicians and/or other health care professionals reporting under the same Federal Tax Identification number.

REIMBURSEMENT INFORMATION:

The global period is defined as the number of days which all necessary services normally furnished by the physician is included in the reimbursement for the procedure performed. Florida Blue utilizes the National Physician Fee Schedule Relative Value File published by the Centers for Medicare & Medicaid Services (CMS) to determine the global period. Listed below are the global time frames for each indicator status.

Global Day Status	Description
000	Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule

	payment amount; evaluation and management (E/M) services on the day of the procedure generally not payable.
010	Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day post-operative period included in the fee schedule amount; E/M services on the day of the procedure and during the 10-day postoperative period generally are not payable.
090	Major surgery with a 1-day preoperative period and 90-day post-operative period included in the fee schedule amount. E/M services on the day before the procedure and the day of the procedure and during the 90-day postoperative period generally are not payable.
MMM	Maternity codes; Florida Blue applies a 45-day global period to these codes
XXX	The global period policy does not apply to procedure code.
YYY	Unlisted procedure codes; subject to individual consideration.
ZZZ	These procedure codes are related to another service and are always included in the global period of the other service.

The following services, when provided within the global period, are included in the global package and are not separately reimbursable except as specified.

Services Included in Global Package:

- Preoperative Visits – Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- The hospital admission work-up;
- Intraoperative Services – Intraoperative services that are normally a usual and necessary part of a surgical procedure;
- The primary operation;
- Selected supplies;
- Writing orders;
- Evaluating the patient in the recovery room;
- Postoperative follow-up care on the day of the surgery;
- Postoperative hospital visits, including the postoperative pain management – by the surgeon;
- Postoperative Visits – Follow up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Complications Following Surgery – All additional medical and surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- Miscellaneous Services – Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, cast, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; changes and removal of tracheostomy tubes; and subsequent gastric restrictive device adjustment(s).

Services Not Included in Global Package:

- The initial consultation or evaluation of the problem by the surgeon to determine the need for major surgery (see modifier 57);
- The initial evaluation for minor surgical procedures and endoscopies, by the same physician on the same day, are included in the global package, unless a significant, separately identifiable service is also performed (see modifier 25);

- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care;
- Visits unrelated to the diagnosis for which the surgical procedure was performed; clinical records must clearly document that the diagnosis is unrelated to the surgical procedure;
- Critical care performed by a surgeon during a global period when the critical care is unrelated to the surgical procedure. Medical records must clearly document that the critical care service is unrelated to the procedure/surgery (see modifier FT);
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the postoperative period, which are not reoperations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done on two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnosis and treat epilepsy (codes 61533, 61534-61536, 61539, 61541, and 61543), which may be performed in succession within 90 days of each other;
- Treatment for postoperative complications, which requires a return 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 cardiac catheterization suite, a laser suite, and an endoscopy suite. The OR 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). The intraoperative component of the surgical procedure is reimbursed separately from the global package; however, the pre-operative and post-operative components are not paid separately, as they are a part of the global package due to an unplanned return to the operating room by the same physician for related procedures with 10- and 90-day global periods only. When modifier 78 is reported, Florida Blue will reimburse the intraoperative portion of the procedure at 70% of the fee schedule allowance. A new global period will not be assigned for a procedure reported with modifier 78.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately, if multiple surgical guidelines apply and it is the same day same session;
- Immunosuppressive therapy for organ transplants.

BILLING/CODING INFORMATION:

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

Modifier	Modifier Description
24	**Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period** The physician or other qualified health care professional may need to indicate that an E/M service was performed during a post-operative period for a reason(s) unrelated to the original procedure. Clinical records may be required to establish appropriate use of modifier 24.
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** It may be necessary to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient's condition required 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 procedure that was performed. A significant, separately identifiable E/M service is

	defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.
57	**Decision for surgery** An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.
58	**Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period** It may be necessary to indicate that the performance of a procedure or service during the post-operative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for the therapy following a surgical procedure. A new postoperative period begins when the next procedure in the series is performed. **Note:** Do not report **modifier 58** for the treatment of a problem that requires a return to the OR. Refer to **modifier 78.**
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** It may be necessary to indicate that another procedure was performed during the post-operative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of the operating/procedure room, it may be reported by adding **modifier** 78 to the related procedure. Florida Blue reimburses modifier 78 at 70% of the fee schedule amount allowance for the procedure.
79	**Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period** The individual may need to indicate that the performance of a procedure or service during the post-operative period was unrelated to the original procedure. This circumstance may be reported by using **modifier 79**.
FT	Unrelated evaluation and management (E/M) visit on the same day as another e/m visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable) (report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated)

RELATED POLICIES

Split Surgical Package – Payment Policy 10-020

REFERENCES:

1. American Medical Association, Current Procedural Terminology (CPT®), Professional Edition
2. Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 12, Section 40, Surgeons and Global Surgery https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf
3. Centers for Medicare and Medicaid Services, "National Physician Fee Schedule (NPFS) Relative Value File" found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

GUIDELINE UPDATE INFORMATION:

Date	Description
02/24/2010	New payment policy
12/19/2011	Updated Policy
01/01/2012	Modifier 78 revision effective
05/31/2012	Name change to Florida Blue
12/30/2013	Update “same physician” definition and global days for MMM procedures
07/24/2014	Update “same physician” to also include, other health professional of the same group and same specialty.
10/11/2016	Annual Review
10/12/2017	Annual Review
10/18/2018	Annual Review; minor verbiage changes to modifier descriptions
10/17/2019	Annual Review
10/08/2020	Annual Review-Modifier 57 descriptor revised.
10/14/2021	Annual Review – no changes
01/01/2022	Revised – Modifier FT (Unrelated E/M visit during a postoperative period) added to the “Services Not Included in Global Package” and “Billing and Coding” sections of the policy.
10/20/2022	Annual Review – References reviewed and updated.
10/19/2023	Annual Review – Descriptor for modifier FT revised. References reviewed and updated.
10/17/2024	Annual Review – Clarifying language added to indicate this policy applies to billing for services on a CMS-1500 or equivalent claim form. References reviewed and updated.

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