Kansas City

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Payment Policy POL-PP-106	
Subject: Global Surgical Package	
Effective Date: 7/01/2019	Committee Approval Obtained: 07/01/2019 Last Review: 11/3/2023 Next Review: 07/1/2024
The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.bluekc.com/ContactUs/PaymentPolicies**	
Provider Payment policies are written to provide an overview of coding and payment guidelines as they pertain to claims submitted to Blue KC. These guidelines are not intended to provide billing or coding advice but to serve as a reference for facilities and providers. **Covered services and payment** are based on the member's benefit plan and provider agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our providers page for information on member eligibility and benefits. Member liability may include, but is not limited to, co-payments, deductibles, and co-insurance. Members' costs depend on member benefits. Certain services require prior authorization or referral. **Blue KC reimburses** health care providers based on your contracted rates and member benefits. Claims are subject to payment edits, which Blue KC updates regularly.	
Policy	Blue KC enforces pre-and post-operative global days based on, but not limited to, CMS standards. Reimbursement for surgical procedures includes payment for all related services and supplies that are routine and necessary for performing the procedure and recovery. Most medical and surgical procedures include preprocedure, intra-procedure, and post-procedure work and have either a 0, 10 or 90 day global package. Claims for services considered to be directly related to pre-procedure, intra-procedure, and post procedure work are included in this global reimbursement and will not be paid separately This ''package'' typically begins the day before surgery. When the package is split between practitioners in different practices or providers with different taxonomy codes, the surgical procedure is billed with the 54, 55, and/or 56 modifiers. Surgeries should be billed globally if the surgery itself, pre- and post-op services are performed by either the same practitioner or by different practitioners from the same practice/under the same tax ID. If different practitioners under different tax IDs perform different portions of the surgical package, the pre-, intra-, and post-op services should be split and billed appropriately.

	Minor Surgery- 0-day global period includes: • Related E&M services performed the same day to a 0-day procedure • Preventive and preventive-like visits performed the day prior to the same day of a 0-day procedure • All anesthesia and anesthetic services performed by the surgeon • Post operative pain management, including epidural management or subarachnoid drug administration • All related supplies **Minor Surgery- 10-day global period includes:** • Related E&M services performed the same day to a 10-day procedure • Related E&M services performed within 10 postoperative days of a 10-day procedure • Preventive and preventive-like visits performed the day prior to the same day of a 10-day procedure • Care management and transitional care services performed within 10 postoperative days of a 10-day procedure • Any additional medical or surgical services provided within 10 postoperative days due to complications of the original minor surgery • All anesthesia and anesthetic services performed by the surgeon • Post operative pain management, including epidural management or subarachnoid drug administration • All related supplies **Major Surgery- 90-day global period includes**: • Related E&M services performed the day prior or the same day to a 90-day procedure • Related E&M services performed within 90 postoperative days of a 90-day procedure • Preventive and preventive-like visits performed the day prior or the same day to a 90-day procedure. • Care management and transitional care services performed within 90 postoperative days of a 90-day procedure • Any additional medical or surgical services provided within 90 postoperative due to complications of the original major surgery • All anesthesia and anesthetic services performed by the surgeon • Post operative pain management, including epidural management or subarachnoid drug administration • All related supplies Global surgery guidelines apply to both professional and facility claims and apply to the primary surgeon and co-surgeon. To determine the surgical global period for a procedure or surgery, refer to the CMS physician fee schedule or CMS list of Global Codes. Physician Fee Schedule

	CMS List of Global Codes **Surgical Care Only Modifier 54** When billing for the surgery only, submit the surgical procedure code with a modifier -54 and an appropriately reduced charge to reflect that post-operative care was not provided. **Pre- or Post-Op Management Modifiers 55 and 56** When billing for pre- and/or post-operative services only, submit the surgical procedure code with the modifier 55 or 56 as appropriate. Pre and/or post-operative services are billed only one time and include all visits within the designated period. Thus, only one payment will be made for the pre- and/or post-op care. If care during the post-operative period is relinquished to another practitioner from a different practice, both practitioners should bill for their portion of post-operative care also with the surgical procedure code and the -55 modifier. However, both practitioners must report the date the care was relinquished. The reimbursement for the post-op care will be divided between the practitioners based on each practitioner's portion of their post-op care. **Unrelated E/M Modifier 24** If the same physician performs an unrelated Evaluation and Management (E/M) service during a postoperative period, modifier 24 should be append to that E/M code. By appending the modifier 24 to an unrelated E/M service you are indicating that the patient's condition requires a significant, separately identifiable E/M service beyond the other service provided, or beyond the usual pre-operative and postoperative care associated with the procedure that was performed. Services appended with modifier 24 must be sufficiently documented in the patient's medical record that the visit was unrelated to the post-operative care of the procedure. An ICD-10-CM that clearly indicates that the reason for the encounter was different and unrelated to the post-operative care may provide sufficient documentation. **Significant Unrelated Procedure or Service Modifier 25** If the same physician performs a significant, separately identifiable evaluation and management (E/M) service during a postoperative period, modifier 25 should be appended to that E/M code. By appending modifier 25 to an unrelated E/M service you are indicating that the patient's condition requires a significant, separately identifiable E/M service beyond the other service provided, or beyond the usual pre-operative and postoperative care associated with the procedure that was performed. Services appended with modifier 25 must be sufficiently documented in the patient's medical record that the visit was unrelated to the post-operative care of the procedure. An ICD-10-CM diagnosis code that clearly indicates the reason for the encounter was different and unrelated to the post-operative care may provide sufficient documentation. **Decision for Surgery Modifier 57** Modifier 57 is appended to indicate that the E/M service resulted in the initial decision to perform surgery either the day before or the day of a major surgical

	procedure (90- day global period). Do not append this modifier when a minor surgical procedure (0- or 10-day global period) is performed. Modifier 57 should not be used to report an E/M service that was pre-planned or prescheduled the day before or the day of surgery, as the E/M would be included as part of the global surgical package. Modifier 57 may not affect edits or payment. However, if applicable, the modifier should be appended to the E/M. Services denied may be considered on subsequent appeal. **Repeat Procedure by Same Physician Modifier 76** Modifier 77 is appended to indicate that a basic procedure or had to be repeated by the same physician. Use of this modifier indicates the procedure is a repeat and not a duplicate. **Repeat Procedure by Another Physician Modifier 77** Modifier 77 is appended to indicate that a basic procedure or service performed by one physician has been repeated by a second physician. This modifier usually is used during the postoperative period of the basic procedure. The second physician adds the modifier to the procedure code used by the first physician. **Return to the Operating Room Modifier 78** If a procedure needs to be repeated on the same day or in postoperative, due to complications, modifier 78 is to be used. Reimbursement for this modifier will be intra-operative percentage only. This modifier will not apply to AS, Assistant Surgeons. Modifier 78 will need to be supported with documentation to verify the need to return to the operation room. **Unrelated Procedure or Service Modifier 79** If the same physician performs an unrelated procedure or service during a postoperative period of another procedure, the modifier 79 should be submitted. Services appended with a 79 modifier must be sufficiently documented in the patient's medical record that the visit was unrelated to the post-operative care of the procedure. **Same Physician** Blue KC defines the "same physician" as the same physician(s) or qualified health care practitioner(s) of the same or similar specialty within the same clinical practice. **CPT 99024 Postoperative follow-up visit** This is used when the service that is being provided is normally included in the surgical package, to indicate that an E&M service was performed during a postoperative period for a reason(s) related to the original procedure. This service would be provided by the "same physician."
History	Effective date 7/01/2019 Approval date 7/01/2019
Review	7/01/2020 – Annual review with no changes. 7/01/2021 – Annual review with no changes. 7/01/2022 – Removed table with pricing percentages. 7/1/2023 – Annual review with no changes 11/3/2023 – Added statement saying, Blue KC enforces pre-and post-operative global days based on, but not limited to, CMS standards. Added additional language identifying minor and major surgeries, and added link to CMS list of Global Codes.

References and Research Materials	AMA CMS
Related Policies	N/A

This document is for informational purposes only and is not an authorization, an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical Technology is constantly changing, and Blue KC reserves the right to review and update policies as needed.