Global Surgical Package and Split Surgery

Reimbursement Policy ID: RPC.0012.DEDS

Recent review date: 01/2024

Next review date: 11/2025

AmeriHealth Caritas VIP Care reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas VIP Care may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy describes payment for both the global surgical package and split surgical care to providers contracted with AmeriHealth Caritas VIP Care.

Exceptions

N/A

Reimbursement Guidelines

I. Global Surgical Package

AmeriHealth Caritas VIP Care utilizes CMS Medicare Physician Fee Service (MPFS) global payment indicators and National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits to prevent

payment outside of the global surgical package. Once a surgery has been submitted and processed for reimbursement, any other services or supplies furnished by the surgeon during the pre-operative period, on the day of surgery, or during the postoperative period of surgery are considered global to the surgery and will be denied if submitted for separate payment.

The global payment indicator reflects the number of postoperative days included in the global surgical package for a surgery:

- "000" is the global payment indicator for some minor surgeries (e.g., endoscopies).
    - Services and supplies furnished on the day of surgery, including the decision for surgery, are included in the global surgical package for minor surgery.
    - There is no day before the surgery that is considered the pre-operative period for minor surgery.
    - For minor surgeries with the "000" global payment indicator, there are no days after the surgery that are considered the postoperative period.
- "010" is the global payment indicator for other minor surgeries.
    - Services and supplies furnished on the day of surgery, including the decision for surgery, are included in the global surgical package for minor surgery.
    - There is no day before the surgery that is considered the pre-operative period for minor surgery.
    - For minor surgeries with the "010" global payment indicator, the 10 days immediately after the day of surgery are considered the postoperative period. Services and supplies furnished during these 10 days are considered postoperative, and therefore are included in the global surgical package.
- "090" is the global payment indicator for all major surgeries.
    - Services and supplies furnished on the day of surgery are included in the global surgical package for major surgery. (See below regarding the decision for major surgery.)
    - Services performed on the day before surgery are considered pre-operative and are therefore included in the global surgical package for major surgery. (See note below regarding the decision for major surgery.)
    - The 90 days immediately after the day of surgery are considered the postoperative period for major surgery. Services and supplies furnished during these 90 days are considered postoperative, and therefore are included in the global surgical package.

The most comprehensive CPT/HCPCS code(s) for the surgery performed must be submitted for reimbursement. Any services and supplies that have their own CPT/HCPCS codes but are considered integral to the surgery being performed should not be submitted for separate payment. This includes surgical approach and imaging guidance.

Services furnished during the pre-operative period, on the day of surgery, or during the postoperative period of surgery that are not normally furnished for the surgery may be reimbursable if separately reported with the appropriate modifier. Examples of these are:

- The decision for major surgery on either the day before surgery or the day of the surgery. (See note further below)
- An Evaluation and Management E/M service unrelated to a minor surgery on the same day as the surgery
- Distinct, unrelated procedures performed during the same operative session
- Procedures and E/M services unrelated to the surgery during the postoperative period, including treatment of the underlying condition for which the surgery was performed
- Staged procedures performed during the postoperative period
- Treatment of postoperative complications that require a return to the operating room

Note: Per AMA CPT Assistant (May 2008/Volume 19), once the decision for major surgery has been made, any pre-operative visits by the surgeon are included in the global surgical package and should not be submitted for payment, even before the start of the global period. This includes the History & Physical (H&P).

Refer to CPT/HCPCS manuals for complete descriptions of procedure codes and their modifiers, NCCI manuals for correct coding policies, the CMS MPFS files for indicators, and AmeriHealth Caritas VIP Care billing resources for fee schedules and guidelines.

II. Split Surgical Care

AmeriHealth Caritas VIP Care will reimburse according to applicable AmeriHealth Caritas VIP Care Fee Schedule(s), the provider's contract, and CMS Guidelines for split surgical care.

Reimbursement for split surgical care applies only to procedures with a 10-day or 90-day global period as specified on the MPFS.

CMS has established percentages for each of the three portions of surgical care for all 10-day and 90-day procedure codes. These percentages are located on the Medicare Physician Fee Schedule Relative Value (MPFSRV) file, which is updated quarterly by CMS. The sum of these portions represents the total global surgical package. Each provider may be reimbursed according to the portion (as established by the MPFSRV) of surgical care they provide.

The three portions of surgical care and their respective reimbursement percentages are as follows:

- Pre-operative care only
- Surgical care only
- Post-operative care only

Definitions

Global surgical package
Payment for a 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. Claims for services considered to be directly related to pre-procedure, intra-procedure, and post-procedure work are included in the global reimbursement and will not be paid separately.

Minor surgery
A minor surgery is a procedure with a 0- or 10-day global postoperative period.

Major surgery
A major surgery is a procedure with a 90-day global postoperative period.

Modifier 54 – Surgical Care Only
When one physician or other qualified health care professional performs a surgical procedure and another

provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

Modifier 55 – Postoperative Care Only
When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

Modifier 56 – Preoperative Care Only
When one 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.

Modifier 57- Decision for Surgery
An evaluation and management (E/M) service that resulted in the initial decision to perform the surgery may be identified by adding this modifier to the appropriate level of E/M service.

Split Surgical Care
Split Surgical Care occurs when different providers furnish either the pre-operative, intra-operative or post-operative portions of a global surgical package.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. CMS Schedule(s).

Attachments

N/A

Associated Policies

RPC.0033.DEDS Multiple Procedure Payment Reduction

RPC.0026.DEDS National Correct Coding Initiative (NCCI)

Policy History

01/2025	Added definition for modifier 57
04/2024	Revised preamble
01/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas VIP Care from Policy History section
01/2023	Template revised

	• Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section