Global Surgical Payment Policy

Policy

A global surgical package for surgical procedures refers to a payment policy of bundling payment for the various services associated with a surgery into a single payment, covering professional services for preoperative care, the surgery itself, and postoperative care.

Reimbursement

The following professional services, when rendered by a treating surgeon, are considered part of the global surgery package, if applicable:

a) Pre-operative 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).
b) Hospital admission work-up, including pre-admission diagnostic tests and non-diagnostic work.
c) Primary operation.
d) Use of robotic surgical systems (S2900), also known as robotic-assisted surgery.
e) Immediate postoperative care, including dictating operative notes, talking with the family and other physicians.
f) Writing orders.
g) Evaluating the patient in the recovery room.
h) Post-operative follow-up on the day of the surgery.
i) Post-operative hospital including post-operative pain management and office visits.
j) Complications following surgery, including all additional medical or 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 and/or hospital admission.
k) Anesthesia services rendered by the surgeon.

The pre- and post-operative time frames are based on Centers for Medicare and Medicaid Services (CMS) guidelines. Visits to the initiating physician and/or covering physician rendered within the time frame and related to the operation itself will be reimbursed as a bundled component of the total surgical package. This allows for one co-payment per physician or physician practice and one co-payment per outpatient facility to be taken within the global period.

Post-operative services identified as part of the global package, which are not to be reimbursed separately, include but are not limited to:

a) Dressing changes;
b) Local incisional care;
c) Removal of operative packs: Removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints;
d) Insertion, irrigation, and removal of urinary catheters;
e) Routine peripheral intravenous lines and nasogastric and rectal tubes;
f) Change and removal of tracheotomy tubes;
g) Wound complications that do not require additional trips to the operating room or a hospital admission.

Services not included in the global surgical package:

a) Initial consultation or evaluation of the problem by the surgeon to determine the need for surgery;
b) Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care;
c) Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;

d) Treatment for the underlying condition or an added course of treatment that is not part of normal recovery from surgery;
e) Diagnostic tests and procedures, including radiological procedures;
f) Clearly distinct surgical procedures during the postoperative period that are not re-operations or treatment for complications;
g) Treatment for postoperative complications which require a return trip to the operating room;
h) Immunosuppressive therapy for organ transplants;
i) Critical care services (codes 99291, 99292, 99466, 99467) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

Referral/notification/prior authorization requirements

All elective surgeries encompass the pre-operative and post-operative visit within the global period. It is not the intent to require additional pre-authorization for visits relating to complications during the global billing period. No further referrals are required for services provided within the global billing period if they are related to the approved surgery and rendered by the performing physician.

Billing/coding guidelines

To bill for initial decision to perform surgery:
In addition to the evaluation and management code, add modifier 57 (decision for surgery) to identify a visit which results in the initial decision to perform surgery.

To bill for the global surgical allowance when reporting you have performed a complete surgical package: Bill the appropriate code for surgical procedure only.

To bill for surgical care only:

- Add modifier 54 to indicate that only the intraoperative portion of the global surgery was performed. Payment for surgical care only is reimbursed at 70% of the physician's contracted rate.

To bill for pre-operative care only:

- Add modifier 56 to indicate that only the pre-operative portion of the surgery was rendered. (Note: This modifier is valid only for major surgeries). Payment for pre-operative care is only reimbursed at 10% of the physician's contracted rate.

To bill for post-operative care only:

- Add modifier 55 with surgical procedures to indicate that only the post-operative portion of the surgery was rendered. Payment for post-operative care only is reimbursed at 20% of the physician's contracted rate.
- Do not bill CPT code 99024.
- Report post-operative care after all services have been rendered and range the dates of service from the first to last date.

To bill for post-operative care for reporting:

- Use code 99024 when reporting post-operative care that is reimbursed within the global allowance.

To bill for unrelated evaluation and management service:

- Add modifier 24 to indicate that an evaluation and management service was performed during the postoperative period of an unrelated procedure. These services must be sufficiently documented to establish that the visit was unrelated to the surgery via an ICD-10CM code that clearly indicates that the reason for the encounter was unrelated to the surgery. Supporting documentation is required upon request.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	
Previous revision date(s):	06/25/03, 05/25/05, 05/10/06, 5/24/06, 5/9/07, 11/7/07 01/01/09 – Updated in response to CPT code changes. 05/01/2013 - Moved to new format. 09/01/2015 - Annual review and moved to new Plan template. 07/01/2016 – Annual review.
Connection date & details:	May 2017 – Annual review. July 2018 – Annual review, no updates. July 2019 – Clarified billing/coding language.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.