In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC) ,Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Global Surgical Package

Policy Number: CPCP014

Version: 4.0

Clinical Payment and Coding Policy Committee Approval Date: 02/15/2019

Effective Date: 02/15/2019

This policy was created to serve as a general reference guide regarding the global surgical package. Health care providers (physicians and other health care professionals) are expected to exercise independent medical judgement in providing care to patients. This policy is not intended to impact care decisions or medical practice.
This policy does not address all situations that may occur and in certain circumstances these situations may override the criteria within this policy.

Modifications to this policy may be made at any time. Any updates will result in an updated publication of this policy.

Description:

The global surgical package includes all the services that a surgeon performs before, during, and after a procedure. The global surgical package applies in any setting.

Reimbursement Information:

Global surgery includes all the necessary services normally furnished by a surgeon or by members of the same group with the same specialty, before, during, and after a procedure. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. These services include:

- Evaluation and management services subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical) This can include codes ranging from 99201-99499. (Visits to a patient in the intensive care or critical care unit are also included if made by the surgeon. However, critical care services 99291-99292 are payable in some situations.)
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia.
- Immediate post-operative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals.
- Writing orders.
- Evaluating the patient in the post-anesthesia recovery area.
- Typical post-operative follow-up care.
- Surgical Suite or anesthesia equipment.
- Postsurgical Pain Management - By the surgeon;
- Supplies – All necessary equipment supplies. Except for those identified as exclusions; and
- Miscellaneous Services - Items such as dressing changes; local incisional 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.

The global periods are maintained by CMS and are in the Medicare Physician Fee Schedule. Claims payment systems utilize the same global periods, which vary according to the procedure being performed. The global periods for surgical procedures are:

0 Days - Minor surgery (endoscopies and some minor procedures) (Code 000)

These procedures have no pre-operative period, no post-operative days, and the visit on the day of the procedure is generally not payable as a separate service.

10 Days - Minor surgery (other minor procedures) (Code 010)

These procedures have no pre-operative period and the visit on the day of the procedure is generally not payable as a separate service. The total global period is 11 days. Count the day of the surgery and the 10 days immediately following the day of the surgery.

90 Days - Major surgery (Code 090)

The visit on the day of the procedure is generally not payable as a separate service. The global surgical package includes one preoperative day, the day of the procedure, and 90 days immediately following the day of the surgery, for total period of 92 days.

References:

American Medical Association. Current Procedural Terminology (CPT). https://www.ama-assn.org/practice-management/cpt

Centers for Medicare and Medicaid Services (CMS). Physician Fee Schedule Relative Value Files. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.html

Centers for Medicare and Medicaid Services (CMS). Global Surgery Booklet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

CMS Manual 100-04, Chapter 12, section 40.1 A.

Policy Update History:

Approval Date	Description
02/08/2018	New Policy
02/15/2019	Annual review