

	Reimbursement Policy Manual		Policy #:	RPM011
Policy Title:	Global Surgery Package for Professional Providers			
Section:	Surgery	Subsection:	None	
Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:				
Companies:	<input checked="" type="checkbox"/> All Companies: Moda Partners, Inc. and its subsidiaries & affiliates <input type="checkbox"/> Moda Health Plan <input type="checkbox"/> Moda Assurance Company <input type="checkbox"/> Summit Health Plan <input type="checkbox"/> Eastern Oregon Coordinated Care Organization (EOCCO) <input type="checkbox"/> OHSU Health IDS			
Types of Business:	<input checked="" type="checkbox"/> All Types <input type="checkbox"/> Commercial Group <input type="checkbox"/> Commercial Individual <input type="checkbox"/> Commercial Marketplace/Exchange <input type="checkbox"/> Commercial Self-funded <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Short Term <input type="checkbox"/> Other: _____			
States:	<input checked="" type="checkbox"/> All States <input type="checkbox"/> Alaska <input type="checkbox"/> Idaho <input type="checkbox"/> Oregon <input type="checkbox"/> Texas <input type="checkbox"/> Washington			
Claim forms:	<input checked="" type="checkbox"/> CMS1500 <input type="checkbox"/> CMS1450/UB (or the electronic equivalent or successor forms)			
Provider Types:	<input checked="" type="checkbox"/> Physicians & other qualified health care professionals, even those billed under professional revenue codes 096x – 098x in a CMS1450/UB claim form. The global surgery package concept does not apply to facilities.			
Date:	<input checked="" type="checkbox"/> All dates <input type="checkbox"/> Specific date(s): _____ <input type="checkbox"/> Date of Service; For Facilities: <input type="checkbox"/> n/a <input type="checkbox"/> Facility admission <input type="checkbox"/> Facility discharge <input type="checkbox"/> Date of processing			
Provider Contract Status:	<input checked="" type="checkbox"/> Contracted directly, any/all networks <input checked="" type="checkbox"/> Contracted with a secondary network <input checked="" type="checkbox"/> Out of Network			
Originally Effective:	1/1/2000	Initially Published:	7/6/2011	
Last Updated:	7/12/2023	Last Reviewed:	3/13/2024	
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No				
Last Update Effective Date for Texas:		3/13/2024		

Reimbursement Guidelines

A. General

Reimbursement for surgical procedures includes payment for all related services and supplies that are routine and necessary to perform the procedure. These components of the surgical package are not eligible for separate reimbursement and will be denied if billed within the global period of the associated procedure. This applies to services performed in all settings (office, hospital, ambulatory surgery center, etc.).

B. Global period settings

1. CMS-defined global periods are used for all procedure codes with global period indicators of 000, 010, and 090.
2. For procedure codes with a global period indicator of MMM (maternity procedures):
 - a. For claims processed on or after July 1, 2018 (regardless of service date):

- i. The global maternity period for vaginal delivery is 49 days (59400, 59410, 59610, & 59614).
 - ii. The global maternity period for cesarean delivery is 90 days (59510, 59515, 59618, & 59622). A cesarean delivery is considered a major surgical procedure. This is strictly for establishing the follow-up period for post-partum and post-operative care; it does not conflict with or change our policies for modifier 22 as outlined in RPM007, "[Modifier 22 – Increased Procedural Services.](#)" (Moda^D)
- b. For claims processed prior to July 1, 2018, the Maternity Global Period is 45 days.
- 3. For unlisted surgical codes (non-maternity) with a global period indicator of YYY, the global period assigned is 090 days. These unlisted codes are most frequently used to report procedures that are as complex as, or more complicated than, the surrounding surgical CPT codes that also have a global period indicator of 090.

C. Calculating Global Period Date Span

- 1. The longest global period for any procedure code from the original date of surgery applies to the entire surgical session and all subsequent services until the global period is complete.
- 2. When calculating the end of the global period, the day of the surgery is *day zero*. The day after the surgery is day one.
 - a. When the global period indicator = 000 days, the global period includes the day of surgery only. Services included in the global surgery package (e.g., related office visits) become eligible for separate reimbursement on the first day after surgery.
 - b. When the global period indicator = 010 days, the global period includes the day of surgery and the ten days following. Services included in the global surgery package become eligible for separate reimbursement on day 11 after surgery.
 - c. When the global period indicator = 090 days, the global period includes the day *prior* to surgery, the day *of* surgery, and 90 days following (a total of 92 days). Services included in the global surgery package become eligible for separate reimbursement on day 91 after surgery.

D. The Global Surgical Package

- 1. Services included in the global surgical package may be furnished in any setting (e.g., in hospitals, ASCs, physicians' offices).
- 2. The Resource-based Relative Value Unit (RBRVU) for the primary procedure codes includes payment for services performed:
 - a. During the global period.
 - b. Related to the surgery or the original condition for which the surgery was performed.
 - c. Related to complications of the surgery not requiring a return to the operating room.
 - d. By the physician who performs the surgery.

- e. By members of the surgeon's same group (Tax ID Number, TIN) with the same specialty. All statements of "by the surgeon" below also include all call-share surgeons and members of the same group/TIN with the same specialty.
3. The following is a more detailed list of global period services:
- a. Preoperative services
 - i. The evaluation and management (E/M, E&M) service when the decision is made to perform a minor surgical procedure is included in the payment for the minor surgical procedure.
 - ii. 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. Includes the history and physical (S0260).
 - b. Intraoperative services
 - i. The reimbursement for a surgical procedure includes payment for all intraoperative services that are a normal, usual, and necessary part of that surgical procedure.
 - ii. Treatment of any intraoperative complications or injuries are considered a normal, usual, and necessary part of the surgical procedure, and are not eligible to be separately coded or reported on the claim. (CMS⁵)
 - iii. Lysis of adhesions. (CMS¹¹)
 - iv. Control of bleeding during an invasive procedure. (CMS¹¹)
 - v. Verifying the procedure was successful and no intraoperative injury has occurred.
 - vi. Any anesthesia or monitoring services performed by the same physician performing the surgical procedure are included in the reimbursement for the surgical procedure(s) itself.
 - c. Postoperative services
 - i. Visits by the surgeon to a patient in an intensive care or critical care unit.
 - ii. Immediate postoperative care, including dictating operative notes, talking with the family and other physicians.
 - iii. Writing orders.
 - iv. Evaluating the patient in the post-anesthesia recovery area.
 - v. Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery (including 99024).
 - vi. 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. (CMS^{5, 15})
 - vii. Postsurgical pain management by the surgeon (including but not limited to: nerve blocks, joint aspirations, Kenalog injections, CPT code 20610, etc.). (RPM010^A)
 - viii. Surgical trays and supplies (with the exception of surgical implants).
 - ix. Miscellaneous Services
 - 1) Dressing changes.

- 2) Local incisional care.
- 3) Removal of operative pack.
- 4) Removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints.
- 5) Insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

E. Services Included in the Global Surgical Package, Not Separately Reportable

1. All work associated with and necessary for incision, surgical approach, achieving hemostasis and/or homeostasis, and surgical closure is included in the global surgical package. Coincidental elimination of diseased tissue or other pathology at the incisional site is considered incidental and is not separately reportable (procedure codes should not appear on the claim) and will be denied if identified. This includes, but is not limited to:
 - a. Any procedure (endoscopic, open, radiologic, etc.) performed to ensure no intraoperative injury occurred or verify the definitive procedure was performed correctly. (CMS¹⁰) Examples:
 - i. Chromotubation of oviduct (58350) to verify patency & no transection at conclusion of procedure.
 - ii. Cystourethroscopy with irrigation, etc. to check for evidence of injury or bleeding at the end of a procedure.
 - iii. Irrigating the abdominal cavity to check for bleeding.
 - iv. Running the intestines/bowel to check for injury or lacerations.
 - b. Improvement/repair of a scar at the incisional site. (CMS^{7,8})
 - i. Codes for complex repair, flap, adjacent tissue transfer or rearrangement, etc. may only be reported when the express purpose of the incision at that location is the scar revision or repair.
 - ii. Integumentary repair codes may not be reported when performing another definitive procedure and the incision is made through or in the area of the scar and the surgeon improves or repairs the scar while closing the incision.
 - c. Excision or debridement of necrosis, debris, etc. in the incisional and/or operative site. (CMS⁷)
 - d. Evacuation of a hematoma (unless the patient was taken to the operating room specifically to evacuate the hematoma and other procedures were not performed as well). (CMS⁷)
 - e. Incision and drainage of an abscess at the site of the definitive surgical procedure. (CMS⁸)
 - f. Aspiration of fluid collection at the site of the definitive surgical procedure or on an operative joint.
 - g. Injection of substances to reduce inflammation and/or promote healing into the operative site or joint.
 - h. Hernia repair at the site of the incision. (CMS⁹)
2. Treatment and repair of any intraoperative injury is also not separately reportable. Per CMS/CCI, "...treatment of a complication of a primary surgical procedure is not separately reportable (1) if it represents usual and necessary care in the operating room during the procedure..." (CMS⁵) Any

injury during the surgery is necessary to be repaired before the conclusion of the surgery, and thus may not be reported as a separate code. This includes, but is not limited to:

- a. Repair of a perforated intestine.
- b. Abdominal/peritoneal lavage after a perforated intestine.
- c. Control of bleeding.
- d. Repair of nick, laceration, or other injury to bladder, tendon, liver, or other body parts, organs, or structures.
- e. Splenectomy for spleen injury occurring during another procedure (whether due to freeing adhesions or another mechanism of injury).

F. Services Not Included in the Global Surgical Package

1. Some professional services are not included in the reimbursement for a surgical procedure and therefore may be eligible for separate reimbursement.
2. It may be necessary to append an appropriate modifier to the code for the service to identify the circumstances which make the code eligible for separate reimbursement.
3. These services include but are not limited to:
 - a. An E/M service the day before or the day of a major surgical procedure *only* if the initial decision to perform the surgery was made during that visit. Modifier -57 must be attached to the E/M code to indicate decision for surgery.
 - b. An E/M service provided on the same day as a minor procedure *only* if the E/M service is unrelated to the procedure performed. The decision for surgery evaluation is always included in the allowance for a minor surgical procedure. Modifier -25 must be attached to the E/M code to indicate the E/M is significant and separately identifiable.
 - c. An E/M service during the surgical postoperative period *only* if the visit is unrelated to the surgical procedure. Modifier -24 must be attached to the E/M code to indicate the E/M is unrelated to the procedure performed.
 - i. The primary diagnosis code for the E/M service needs to indicate the chief reason for the visit that is unrelated to the surgical procedure.
 - ii. If there is any overlap between the diagnosis codes for the E/M procedure and those for the surgical procedure, the E/M service will be denied as [treatment of complications at the E/M visit](#) and included in the surgical global package. (CMS^{5, 15})
 - 1) Supporting documentation is required for reconsideration of the denial as being unrelated to the surgical procedure.
 - 2) The medical records submitted for review must clearly show the visit was for treatment of the underlying condition or an added course of treatment which was not treating a complication of the original surgery (CMS^{5, 15}) or treating an exacerbation of the original condition due to the surgery or the recovery process requirements (for example physical therapy, use of crutches, etcetera).
 - d. A repeat surgical procedure by the same surgeon performed on the same day as the original surgery, requiring a return trip to the operating room. Modifier -76 must be attached to the procedure code to indicate a repeat surgical procedure

- e. A repeat surgical procedure by a different surgeon, on the same day as the original surgery, requiring a return trip to the operating room. Modifier -77 must be attached to the procedure code to indicate a repeat surgical procedure by a different surgeon.
- f. A procedure or treatment that is related to the original surgery that requires an unplanned return to the operating room (e.g., for treatment of postoperative complications or other related reasons). Modifier -78 must be attached to the surgical code to indicate unplanned return to the OR. (RPM010^A)
 - iii. An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures.
 - iv. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite.
 - v. It 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). (CMS⁴)
 - vi. A procedure room in a physician office or clinic is not considered an OR to support the use of modifier 78.
- g. A procedure or service that is unrelated to the original surgery (not treatment for complications). Modifier -79 must be attached to the procedure code to indicate the surgery is unrelated to the original procedure. (RPM010^A)
- h. A staged surgical procedure (one that was planned or anticipated at the time of the original surgery) performed during the postoperative period of the original surgery. Modifier -58 must be attached to the procedure code to indicate a staged procedure. (RPM010^A)
- i. After application of the first cast or traction device, subsequent replacement of casts and/or traction devices and the associated splints and casting supplies.
- j. Implants supplied by the surgeon (rather than supplied by the facility or billed directly by the implant vendor).
- k. Diagnostic tests and procedures, including diagnostic radiological procedures.
- l. Immunosuppressive therapy for organ transplants.
- m. Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

G. Decision for Surgery

1. If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure.
 - a. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. (CMS³)
 - b. Modifier 57 is not valid to be used for minor surgery procedures. If an evaluation and management (E/M, E&M) service for a decision is billed with modifier 57 and is identified as related to a minor surgery procedure, the service will be denied as included in the global surgery package despite the use of the modifier.
2. If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable

with modifier 57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. (CMS¹⁴)

H. Trays and Supplies for Surgical Procedures Performed in the Office Setting

An allowance for surgical trays and other office and medical supplies is included in the practice expense portion of the relative value unit for each medical or surgical procedure code. Surgical trays, surgical supplies, and office medical supplies should not be reported separately, and are not eligible for separate reimbursement. Payment for these items is included in the allowance for the associated surgical procedure codes.

I. Typical Postoperative Follow-up Care During the Global Period

1. The work associated with returning a patient to the appropriate post-procedure state is included in the post-procedure work. (CMS¹⁵)
2. The global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Thus, treatment of a complication of a primary surgical procedure is not separately reportable:
 - a. if it represents usual and necessary care in the operating room during the procedure or
 - b. if it occurs postoperatively and does not require return to the operating room. (CMS⁵)
3. The RBRVU and fee allowance for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. (CMS⁴) Thus, some patients will require more postoperative follow-up monitoring and care than others, but the standard or contracted fee allowance for the global surgery package covers these clinical variations.
4. If an unplanned return to the operating room is required, that procedure is separately billable in addition to the global surgery package (see Services Not Included in the Global Surgery Package.)

J. One or More Sessions Codes

Codes in CPT with descriptors that include the phrase 'one or more sessions' are eligible for reimbursement only once within their own global period, regardless of the number of sessions necessary to complete the treatment and regardless of the modifier attached. Payment for multiple sessions is included in the RBRVU for those procedure codes.

K. Follow-up Procedure Edits

Procedure codes on a list of normal surgical follow-up services, as determined by clinical and billing practices, will be denied as included in the global surgical procedure when reported by the surgeon for dates of service during a surgical global period. These follow-up procedure codes might include surgical wound checks for infection, evaluation of pain or fever, and/or suture removal.

L. CMS Global Surgery Data Collection

1. CMS has identified a group of surgical codes with Relative Value Units (RVUs) that appear to be overvalued in the pre- and –postoperative care components. (Ollapally¹²) In Section 523 of MACRA, Congress required CMS to gather and analyze data on the actual care, visits, and resources used in order to assign updated global surgery package RVU values to these procedure codes. (CMS¹³)
2. The 2017 Physician Fee Schedule Final Rule requires some practitioners to report on postoperative visits furnished during global periods for specific surgical procedures using CPT code 99024 (*Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure*).
 - a. Although reporting is required for global procedures furnished on or after July 1, 2017, CMS encourages all practitioners to begin voluntary reporting as soon as possible.
 - b. Bill 99024 with a zero-dollar amount.

M. Reporting S0260 History and physical (outpatient or office) related to surgical procedure

1. HCPCS code S0260 is accepted for data collection, reporting, and tracking only; it is not eligible for separate reimbursement.
2. S0260 is never eligible for separate reimbursement; it will deny to provider liability as bundled.
3. Bill S0260 with a zero-dollar amount; reimbursement has already been received through the single global surgery allowance and/or the related E/M service (if eligible for separate reimbursement in addition to the global surgery package).

N. Reporting 99204 Postoperative follow-up visit

1. CPT code 99024 is accepted for data collection, reporting, and tracking only; it is not eligible for separate reimbursement.
2. 99204 applies to surgical procedures with 10- or 90-day global periods.
3. Bill 99204 with a zero-dollar amount; reimbursement has already been received through the single global surgery allowance.
4. CPT code 99024 is not eligible for a fee value or separate reimbursement. Per CMS, assigned a status indicator “B” (bundled) and denies to provider liability.
5. CPT 99024 does not have the same key-component documentation requirements as standard evaluation and management services. Documentation should describe the patient’s recovery from the surgical procedure and continued treatment plan.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASC	=	Ambulatory Surgery Center
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MACRA	=	Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RBRVU	=	Resource-based Relative Value Unit (see also RVU)
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
TIN	=	Tax Identification Number
UB	=	Uniform Bill

Procedure codes (CPT & HCPCS):

Code	Code Description
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

Code	Code Description
59515	Cesarean delivery only; including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
S0260	History and physical (outpatient or office) related to surgical procedure (list separately in addition to code for appropriate evaluation and management service)

CMS Global period indicators

Global period indicator		Definition
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 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 postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.
090	=	Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.
MMM	=	Maternity codes; usual global period does not apply.
XXX	=	Global concept does not apply.
YYY	=	Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.
ZZZ	=	Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

“The work associated with returning a patient to the appropriate post-procedure state is included in the post-procedure work.” (CMS¹⁵)

“Treatment of complications of primary surgical procedures is separately reportable with some limitations. The global surgical package for an operative procedure includes all intra-operative services that are normally a usual and necessary part of the procedure. Additionally the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Thus, treatment of a complication of a primary surgical procedure is not separately reportable (1) if it represents usual and necessary care in the operating room during the procedure or (2) if it occurs postoperatively and does not require return to the operating room. For example, control of hemorrhage is a usual and necessary component of a surgical procedure in the operating room and is not separately reportable. Control of postoperative hemorrhage is also not separately reportable unless the patient must be returned to the operating room for treatment. In the latter case, the control of hemorrhage may be separately reportable with modifier 78.” (CMS⁵)

“If a definitive surgical procedure requires access through diseased tissue (e.g., necrotic skin, abscess, hematoma, seroma), a separate service for this access (e.g., debridement, incision and drainage) is not separately reportable. For example, debridement of skin to repair a fracture is not separately reportable.” (CMS⁷)

“If removal, destruction, or other form of elimination of a lesion requires coincidental elimination of other pathology, only the primary procedure may be reported. For example, if an area of pilonidal disease contains an abscess, incision and drainage of the abscess during the procedure to excise the area of pilonidal disease is not separately reportable.” (CMS⁸)

“If a hernia repair is performed at the site of an incision for an open or laparoscopic abdominal procedure, the hernia repair (e.g., CPT codes 49560-49566, 49652-49657) is not separately reportable. The hernia repair is separately reportable if it is performed at a site other than the incision and is medically reasonable and necessary. An incidental hernia repair is not medically reasonable and necessary and should not be reported separately.” (CMS⁹)

“If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.” (CMS¹⁰)

“By contrast, incidental services that are necessary to accomplish the primary procedure (e.g., lysis of adhesions in the course of an open cholecystectomy) are not separately reportable with an add-on code. Similarly, complications inherent in an invasive procedure occurring during the procedure are not separately reportable. For example, control of bleeding during an invasive procedure is considered part of the procedure and is not separately reportable.” (CMS¹¹)

Cross References

- A. [“Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures”](#), Moda Health Reimbursement Policy number RPM010.
- B. [“Postoperative Sinus Debridement Procedures.”](#) Moda Health Reimbursement Policy Manual, RPM009.
- C. [“Maternity Care.”](#) Moda Health Reimbursement Policy Manual, RPM020.
- D. [“Modifier 22 – Increased Procedural Services.”](#) Moda Health Reimbursement Policy Manual, RPM007.

References & Resources

1. CMS Manual System, Medicare Claims Processing Manual (Pub. 100-4), Chapter 23, § 30 – 30.2.2, Addendum 2010 File Layout.
2. "Coding Update: Surgery Guidelines - 2002." *CPT Assistant*, September 2002: 3-5.
3. CMS. Topic = Decision to perform a minor surgical procedure. *National Correct Coding Initiative Policy Manual*, Chapter 1 General Correct Coding Policies, § D, ¶ 5.
4. CMS Manual System, Medicare Claims Processing Manual (Pub. 100-4), Chapter 12, § 20.4.4, 20.4.6.
5. CMS. “Medical/Surgical Package.” *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, §C.14.
6. CMS. “Global Surgery Fact Sheet.” *Medicare Learning Network (MLN)*. <<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf>>.
7. CMS. “Medical/Surgical Package.” *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, §C.6.
8. CMS. “Medical/Surgical Package.” *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, §C.7.
9. CMS. “Abdominal Procedures.” *National Correct Coding Initiative Policy Manual*. Chapter 6 Digestive System, §E.4.
10. CMS. “Medical/Surgical Package.” *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, §C.3.
11. CMS. “Medical/Surgical Package.” *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, §R.

12. Ollapally, Vinita, JD. "Changes on the Horizon for Global Services Payment." *The Bulletin*. 1 Sept. 2015, American College of Surgeons. 19 Oct. 2016. <<http://bulletin.facs.org/2015/09/changes-on-the-horizon-for-global-services-payment/>>
13. CMS. "Global Surgery Data Collection." 3 Feb. 2017. <<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-.html>> .
14. CMS. Topic = E&M service performed on the same date of service as a major surgical procedure. *National Correct Coding Initiative Policy Manual*, Chapter 1 General Correct Coding Policies, § D, ¶ 4.
15. CMS. *National Correct Coding Initiative Policy Manual*, Chapter 1 General Correct Coding Policies, § C.1.

Background Information

The Centers for Medicare and Medicaid Services (CMS) has established global periods for certain procedure codes. The assigned global periods can be found in the National Medicare Physician Fee Schedule Database (MPFSDB) "global days" field. This global period indicator field provides the postoperative time frames that apply to payment (RVU, fee allowance) for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
3/13/2024	Annual review: Last reviewed field: Date updated. No changes.
7/12/2023	Clarification/Update: Section B.2.a.ii: Clarification of how this section relates to recent clarification/update on Modifier 22 policy for maternity codes. Cross References: 1 entry added.
12/14/2022	Clarification/Update: Section F.3.c: Clarification of global surgery follow-up visit bundling & documentation requirements. Cross References: Hyperlinks added. References & Resources: item # 3 was too broad. Changed to more specific & added xx additional entries broken out from this. Footnotes updated to new listing numbers as needed.
10/12/2022	Formatting/Update: Policy name: "Professional Claims" changed to "Professional Providers." Change to new header. Includes Idaho. Moved from Administrative to Surgery section. Cross References: 1 entry added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
7/6/2011	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on AMA global surgery package guidelines & CMS global surgery package policy.