Professional Pricing Policy

Subject: **Global Surgery**	
Policy Number: HLSP-0002	Policy Section: **Surgery**
Last Approval Date: September 1, 2020	Effective Date: October 17, 2020

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

Surgical procedures are subject to preoperative, same day, and postoperative care edits. HealthLink does not separately allow for Evaluation and Management (E&M) services rendered within the applicable global period when reported by the surgeon or by providers of the same group with the same specialty.

A surgical procedure is usually assigned one of three global periods depending on whether the procedure performed is classified as major or minor. Major procedures have a 90-day global surgical period. Minor procedures have either a 0-day global or a 10-day global surgical period based on complexity.

HealthLink's global surgical allowance includes all E&M services rendered after the decision for surgery has been made unless there is a high risk of comorbidity, which requires surgical clearance from a physician other than the treating physician.

Services included in the global surgical package may be furnished in any setting. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon or by providers of the same group with the same specialty.

HealthLink has identified the following services to be included in the global surgical package and not separately allowed when they are reported by the operating surgeon or by providers in the same group with the same specialty. Non-physician providers (NPPs) in the same group as the operating surgeon are considered to be of the same specialty as the operating surgeon:

1. E&M visits beginning the day before a major surgical service.
2. E&M visits occurring on the same day as a major or minor surgical procedure or substantial diagnostic or therapeutic procedure or service.
3. Intraoperative services (such as monitoring) that are a usual and necessary part of a surgical procedure.
4. Intraoperative pain management by the operating surgeon, including moderate sedation and

intraoperative pain management devices.

5. Fluid and drug administration services such as therapeutic, prophylactic, and/or local anesthetic injections.
6. Follow-up E&M visits and aftercare following surgery during the postoperative period that relate to recovery from the surgery. The postoperative period begins on the day following the surgical service.
7. Any additional medical or surgical services by the surgeon during the postoperative period because of complications that do not require a return trip to the operating/procedure room.
8. HealthLink considers procedures, typically performed in an office setting, to be routine post-surgical care and not separately allowed when performed during the global postoperative period of the related surgical procedure:
    a) adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline (S2083)
    b) simple bladder irrigation post bladder surgery (51700)
    c) incision and drainage of abscess, simple/single/complicated or multiple (10060-10061)
    d) incision and drainage of hematoma, seroma, or fluid collection (10140)
    e) incision and drainage, complex postoperative wound infection (10180)
    f) puncture aspiration of abscess, hematoma, bulla, or cyst (10160)
9. HealthLink considers local infiltration, anesthetic blocks or agents, or topical anesthesia and unspecified/unclassified drug codes administered by the operating provider as part of the surgical package and are not separately allowed.
10. HealthLink considers surgical kits to be included in the global surgical allowance and are not separately allowed. However, HealthLink may consider separate allowance for the injectable steroid pain medication**.**

Exceptions: There are times when the global surgical package may not apply.

1. Critical care services provided by the surgeon for a seriously injured or burned patient may be allowed during the global period when the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed. (Modifier 24, 25, or 57 is required.)
2. When a significant, separately identifiable E&M service performed on the same day as a minor surgical procedure or an endoscopic, diagnostic, or therapeutic procedure, the E&M service may be separately allowed. (Modifier 25 is required.)
3. When an E&M service is reported with a date of service the day prior to or the day of a major surgical procedure and the E&M service results in the initial decision for surgery, the E&M service may be separately allowed. (Modifier 57 is required.)
4. When an E&M service is reported within the global aftercare period with a diagnosis unrelated to the surgical procedure, the E&M service may be seprately allowed
5. . (Modifier 24 is required.) However, HealthLink considers the evaluation, management, and treatment of postoperative pain to be related to the surgical procedure and not separately allowed.
6. Related surgical services that require a return trip to the operating/procedure room performed during a global postoperative surgical period by the same provider may be separately allowed at 70% of the applicable surgical allowance when such surgical service is reported with modifier 78.

The use of modifier 78 will not start a new global surgery period.

- Modifier 78 – unplanned return to the operating/procedure room for a related procedure during the postoperative period by the same provider.

Note: When a return to the operating/procedure room during a global postoperative surgical period is required for incision and drainage codes 10060, 10061, 10140, or 10180 or puncture aspiration code 10160, these procedures may be separately allowed when reported with modifier 78.

7. Post-surgical procedures and services performed by the same provider, unrelated to the prior surgery, may be separately allowed in the assigned postoperative period. Surgical services reported with modifier 79 are considered unrelated to the prior surgery.

    - Modifier 79 – unrelated procedure or service by the same provider during the postoperative period.

Note: Documentation to support the use of the modifiers listed above is not required with claim submission however, supporting documentation may be requested at a future time.

E&M services should be reported following the American Medical Association (AMA) standards set forth in the current edition of CPT. The member's medical records should legibly and accurately reflect the services that warranted the use of a specific CPT /HCPCS code.

Coding with Modifiers to indicate a Transfer of Care:

According to CPT, the following modifiers should be used with surgical procedure codes to reflect the appropriate services when only part of the global surgical care is rendered:

- Modifier 54---surgical care only. Allowance will be calculated at 70% of the applicable surgical allowed amount.
- Modifier 55---postoperative management only. Postoperative care begins on the next day following the surgical procedure. Allowance will be calculated at 20% of the applicable surgical allowed amount.
    - When postoperative management only care is rendered for a time frame which is less than the published postoperative global period, report modifier 52 (reduced services) in addition to modifier 55. This will reduce the calculated allowance for modifier 55 by 50%.
    - When modifier 55 is reported with procedures that have zero post-operative care days, the service will not be allowed.
- Modifier 56---preoperative management only. Preoperative care begins on the day before and/or the same day as the surgical procedure. Allowance will be calculated at 10% of the applicable surgical allowed amount.

The following table shows applicable postoperative days assigned by HealthLink for the supplementary categories of 'MMM', 'XXX', 'YYY' and 'ZZZ':

Related Coding		
Supplementary Categories	**Code(s)**	**Verbiage**
MMM	Maternity care and delivery procedure codes: 59400, 59410, 59510, 59515, 59610, 59614, 59618, and 59622.	"0" postoperative days. "45" days for codes for maternity care and delivery procedure codes listed to the left.

XXX		"0" postoperative days for surgical procedures. "10" postoperative days for anesthesia procedures.
YYY 10 postoperative days 45 postoperative days 90 postoperative days	17999, 38589, 40899, 41899, 68899 59898 15999, 19499, 20999, 21089, 21299, 21499, 21899, 22899, 22999, 23929, 24999, 25999, 26989, 27299, 27599, 27899, 28899, 29999, 30999, 31299, 32999, 33999, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 36299, 37501, 37799, 38129, 38999, 39499, 39599, 40799, 41599, 42299, 42699, 42999, 43659, 43775, 43999, 44238, 44799, 44899, 44979, 45499, 46999, 47379, 47399, 47579, 47999, 48999, 49329, 49659, 49999, 50549, 50949, 51999, 53899, 55559, 55899, 58578, 58679, 58999, 59899, 60659, 60699, 64999, 66999, 67299, 67599, 67999, 68399, 69399, 69799, 69949, 69979, 0335T, and 0345T	We reserve the right to apply a global period for aftercare based on the postoperative days designated for a similar procedure. YYY codes with a global period for aftercare based on the postoperative days designated for a similar procedure.
ZZZ		Same postoperative days as the parent procedure

Exemptions

Definitions

Global Surgery Concept	Based on the understanding that allowance for a surgical procedure includes the work value of an established Evaluation and Management service (E&M) and other services as defined in the policy section. The global period is derived from the Centers for Medicare & Medicaid Services (CMS) designations.
General Professional Pricing Policy Definitions	

Related Policies and Materials

Anesthesia Services
Bundled Services and Supplies
Evaluation and Management Services and Related Modifiers 25 and 57
Modifier Rules

References and Research Materials

This policy has been developed through consideration of the following

- CMS
- American Medical Association (AMA) Current Procedural Terminology (CPT)

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.