Commercial Reimbursement Policy

Subject: Global Surgery

Policy Number: C-08007

Policy Section: Surgery

Last Approval Date: 08/03/2018

Effective Date: 08/03/2018

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member’s Anthem Blue Cross and Blue Shield (Anthem) benefit plan. 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 as well as to the member’s state of residence. 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 both participating and non-participating providers and facilities. This reimbursement policy also applies to Employer Group Retiree Medicare Advantage programs.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem 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These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.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 recover claims payment to the effective date, in accordance with the policy. Anthem 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.

Policy

Surgical procedures are subject to preoperative, same day, and postoperative care edits. Anthem does not allow separate reimbursement 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.

Anthem’s global surgical reimbursement 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 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.

Anthem has identified the following services to be included in the global surgical package and not eligible for separate reimbursement 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. Anthem considers procedures, typically performed in an office setting, to be routine post-surgical care and not eligible for separate reimbursement 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. Anthem 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 eligible for separate reimbursement.

10. Anthem considers surgical kits to be included in the global surgical reimbursement and are not eligible for separate reimbursement. However, Anthem may consider separate reimbursement 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 eligible for reimbursement 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 eligible for separate reimbursement. (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 eligible for separate reimbursement. (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 eligible for separate reimbursement. (Modifier 24 is required.) However, Anthem considers the evaluation, management, and treatment of postoperative pain to be related to the surgical procedure and not eligible for separate reimbursement.

5. 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 eligible for separate reimbursement at 70% of the applicable surgical reimbursement allowed 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 eligible for separate reimbursement when reported with modifier 78.

6. Post-surgical procedures and services performed by the same provider, unrelated to the prior surgery, may be eligible for separate reimbursement 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. Reimbursement will be calculated at 70% of the applicable surgical reimbursement allowed.
   • Modifier 55---postoperative management only. Postoperative care begins on the next day following the surgical procedure. Reimbursement will be calculated at 20% of the applicable surgical reimbursement allowed.

   o 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 reimbursement for modifier 55 by 50%.

   o When modifier 55 is reported with procedures that have zero post-operative care days, the service will not be eligible for reimbursement.

   • Modifier 56---preoperative management only. Preoperative care begins on the day before and/or the same day as the surgical procedure. Reimbursement will be calculated at 10% of the applicable surgical reimbursement allowed.

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

| Related Coding |

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| Related Coding |

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<table>
<thead>
<tr>
<th>Supplementary Categories</th>
<th>Code(s)</th>
<th>Verbiage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMM</td>
<td>Maternity care and delivery procedure codes: 59400, 59410, 59510, 59515, 59610, 59614, 59618, and 59622.</td>
<td>“0” postoperative days. “45” days for codes for maternity care and delivery procedure codes listed to the left.</td>
</tr>
<tr>
<td>XXX</td>
<td></td>
<td>“0” postoperative days for surgical procedures. “10” postoperative days for anesthesia procedures.</td>
</tr>
<tr>
<td>YYY</td>
<td>10 postoperative days</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>45 postoperative days</td>
<td>17999, 38589, 40899, 41899, 68899</td>
</tr>
<tr>
<td></td>
<td>90 postoperative days</td>
<td>59898</td>
</tr>
<tr>
<td></td>
<td>15999, 19499, 20999, 21089, 21299, 21499, 21899, 22899, 22999, 23929, 24999, 25999, 26989, 27299, 27599, 27899, 28899, 29999, 30999, 31299, 32999, 33999, 34814, 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, 49399, 49659, 49999, 50549, 50949, 51999, 53899, 53899, 55559, 55899, 58578, 58679, 58999, 59899, 60659, 60699, 64999, 66999, 67299, 67599, 67999, 68399, 69399, 69799, 69949, 69979, 0335T, and 0345T</td>
<td>17999, 38589, 40899, 41899, 68899</td>
</tr>
<tr>
<td>ZZZ</td>
<td></td>
<td>Same postoperative days as the parent procedure</td>
</tr>
</tbody>
</table>
### Exemptions

<table>
<thead>
<tr>
<th>State</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>California, Colorado, Connecticut, Georgia, Maine, New Hampshire, Nevada, and Virginia</td>
<td>Simple bladder irrigation post bladder surgery (51700) is eligible for separate reimbursement when performed during the global post-operative period of the related surgery</td>
</tr>
</tbody>
</table>

### Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/01/2019</td>
<td>New policy template: removed description section and added definition section</td>
</tr>
<tr>
<td>08/03/2018</td>
<td>Biennial review: Updated policy language; removed correct coding edits and retained customized edits in #8; Added language in #10; Added market exemption for bladder irrigation code 51700</td>
</tr>
<tr>
<td>08/01/2017</td>
<td>Revised: Updated policy language for what Anthem considers routine postsurgical care</td>
</tr>
<tr>
<td>11/01/2016</td>
<td>Revised: Updated policy language regarding modifier 55 and disclaimer language regarding Medicare Advantage Employer Group Retiree</td>
</tr>
<tr>
<td>05/03/2016</td>
<td>Annual Review with Revisions: Updated policy language to identify services included in the global surgical package identified by Anthem</td>
</tr>
<tr>
<td>05/05/2015</td>
<td>Revised: Updated policy language in opening paragraph; added words major and minor in bullet B</td>
</tr>
<tr>
<td>03/03/2015</td>
<td>Annual Review: No changes to the policy criteria; removed deleted codes for 2015: 0343T and 0344T</td>
</tr>
<tr>
<td>03/04/2014</td>
<td>Revised: Updated policy language for modifiers 24, 25 and 57; added new codes to YYY table</td>
</tr>
<tr>
<td>12/03/13</td>
<td>Revised: Updated modifier language; replaced bullets with letters; updated definition of modifier 78; minor grammatical errors</td>
</tr>
<tr>
<td>05/07/2013</td>
<td>Revised: Update policy language in the paragraph prior to exceptions; added language referencing modifiers 24 and 25</td>
</tr>
<tr>
<td>11/06/2012</td>
<td>Revised: Updated policy language; added code to YYY table and removed codes from MMM table</td>
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<tr>
<td>09/11/2012</td>
<td>Annual review with revision: Updated policy language; minor punctuation corrections; correct code for laparoscopy</td>
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<tr>
<td>09/13/2011</td>
<td>Revised: Updated policy language; shortened sentences and combined bullets; revised language in #3 and #4 exception section</td>
</tr>
<tr>
<td>09/07/2010</td>
<td>Revised: Updated policy language due to a request; language added in the inclusive services list</td>
</tr>
<tr>
<td>08/12/2010</td>
<td>Annual review: Updated policy language clarified in bullets #5 and #7</td>
</tr>
<tr>
<td>06/03/2010</td>
<td>Revised: Updated policy language in the exception section #5</td>
</tr>
</tbody>
</table>
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References and Research Materials
This policy has been developed through consideration of the following:
- CMS

Definitions
Global Surgery Concept: Based on the understanding that reimbursement 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 Reimbursement Policy Definitions

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

Use of Reimbursement 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. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.
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