Commercial Reimbursement Policy

Subject: **Global Surgical Package - Professional**	
Policy Number: **C-08007**	Policy Section: **Surgery**
Last Approval Date: **06/14/2023**	Effective Date: **06/14/2023**

Disclaimer

These reimbursement 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 an Anthem member's 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. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. 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. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem allows reimbursement for the global surgical package unless provider, state, or federal contracts and/or requirements indicate otherwise. The Health Plan follows CMS Global Surgery indicator codes, including the supplementary indicators MMM, XXX, YYY, and ZZZ. The global surgery package may be furnished in any setting and reimbursement applies to both minor and major surgical procedures as defined by their postoperative periods of 0, 10, or 90 days.

Included in the Global Surgical Package

Reimbursement for the following components is included within 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:

- Preoperative services rendered after the decision for surgery is made to operate.
  - Beginning with the day before surgery for major procedures
  - Beginning with the day of surgery for minor procedures
- E/M services rendered after the decision for surgery has been made
- Intraoperative services that are normally a usual and necessary part of a surgical procedure
  - Miscellaneous surgical services and supplies used during the surgery
    - Surgical kits
  - Fluid and drug administration services
    - Therapeutic drugs
    - Prophylactic drugs
    - Local anesthetic injections
    - Anesthetic blocks or agents
    - Topical anesthesia
    - Unspecified/unclassified drug codes administered by the operating provider
    - Intraoperative pain management & devices
    - Moderate sedation
- Visits during the postoperative period, that are related to recovery from the surgery regardless of place of service
- Medical or surgical services due to postoperative complications which do not require additional trips to the operating room and that are not categorized as a Hospital-Acquired Condition (HAC) or Present on Admission (POA)
- Postsurgical pain management by the surgeon
- Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline: HCPCS Code S2083
- Incision and drainage: CPT® Codes 10060, 10061, 10140, 10160, 10180

Separately Reimbursable from Global Surgical Package

The following services are not included in the reimbursement for the global surgery and are separately reimbursable expenses:

- The initial consultation or evaluation by the surgeon to determine the need for a major surgical procedure
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement must be in the form of a letter or an annotation in the discharge summary, hospital record, or Ambulatory Surgical Center (ASC) record
- Visits during the postoperative period of surgery that are unrelated to the diagnosis of the surgery, unless the visits occur due to complications of the surgery
- Treatment for an underlying condition or an added course of treatment which is not part of the normal recovery from surgery
- Diagnostic tests and procedures
- Clearly distinct surgical procedures during the postoperative period that are not re-operations or treatment for complications
- Treatment for postoperative complications which require a return trip to the operating room

- The second procedure if a less extensive procedure fails, and a more extensive procedure is required
- Immunosuppressive therapy for an organ transplant
- Critical care services, unrelated to the surgery, where a seriously injured or burned member is critically ill and requires constant attendance of the physician
- Physical Therapy, Occupational Therapy and Speech Therapy
- Surgical clearance from provider other than the treating physician when there is a high risk of comorbidity

Providers must use applicable HIPAA-compliant modifiers for any services provided during the postoperative period.

Related Coding

Supplementary Indicator Code	Codes
MMM 45 postoperative days	59400, 59410, 59510, 59515, 59610, 59614, 59618, and 59622
YYY 10 postoperative days	17999, 38589, 40899, 41899, 68899, 0440T, 0441T, 0442T, 0444T, 0445T, 0567T, 0568T, 0583T, 0600T, 0601T, 0622T, 0627T, 0629T, 0647T, 0673T, 0699T
YYY 45 postoperative days	59898
YYY 90 postoperative days	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, , 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, 0345T, , 0510T, 0511T, 0571T, 0572T, 0573T, 0574T, 0580T, 0585T, 0588T, 0594T, 0596T, 0597T, 0614T, 0619T, 0621T, 0644T, 0655T, 0660T, 0661T, 0672T, 0677T, 0679T, 0680T, 0681T, 0682T, 0714T, 0730T, 0737T, G0308, G0309

Policy History

06/14/2023	Review approved and effective: updated YYY codes per CMS updates, revised language for items Included in Surgical Package; updated Definitions and Related Policy section; removed Bladder Irrigation from Included list; removed Bladder Irrigation exemption New York. Removed language on Modifiers 54, 55, 56 from this policy and created

	a new policy titled Split-Care Surgical Modifiers-Professional (C-23004).
04/28/2021	Review request approved and effective: added Physical Therapy, Occupational Therapy and Speech Therapy to the Separately Reimbursable section of the policy body; added codes 0621T, 0622T, 0627T and 0629T to the YYY section.
09/15/2020	Revised: Added supplementary category codes to YYY section: 0594T, 0596T, 0597T, 0600T, 0601T, 0614T, 0619T
04/22/2020	Updated policy language: Retained Anthem considerations in the policy language, coding with modifiers to indicate transfer of care and the related coding section regarding the MMM, YYY and ZZZ codes and per request received, added codes to YYY section for 10 days (0440T, 0441T, 0442T, 0444T, 0445T, 0467T, 0468T, 0567T, 0568T, 0583T) and 90 days (0446T, 0447T, 0448T, 0466T, 0510T, 0511T, 0571T, 0572T, 0573T, 0574T, 0580T, 0585T and 0588T)
06/01/2019	New policy template: removed description section and added definition section
08/03/2018	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
08/01/2017	Revised: Updated policy language for what Anthem considers routine post-surgical care
11/01/2016	Revised: Updated policy language regarding modifier 55 and disclaimer language regarding Medicare Advantage Employer Group Retiree
05/03/2016	Review with Revisions: Updated policy language to identify services included in the global surgical package identified by Anthem
05/05/2015	Revised: Updated policy language in opening paragraph; added words major and minor in bullet B
03/03/2015	Annual Review: No changes to the policy criteria; removed deleted codes for 2015: 0343T and 0344T
03/04/2014	Revised: Updated policy language for modifiers 24, 25 and 57; added new codes to YYY table
12/03/2013	Revised: Updated modifier language; replaced bullets with letters; updated definition of modifier 78; minor grammatical errors
05/07/2013	Revised: Update policy language in the paragraph prior to exceptions; added language referencing modifiers 24 and 25
11/06/2012	Revised: Updated policy language; added code to YYY table and removed codes from MMM table
09/11/2012	Review with revision: Updated policy language; minor punctuation corrections; correct code for laparoscopy
09/13/2011	Revised: Updated policy language; shortened sentences and combined bullets; revised language in #3 and #4 exception section
09/07/2010	Revised: Updated policy language due to a request; language added in the inclusive services list
08/12/2010	Annual review: Updated policy language clarified in bullets #5 and #7
06/03/2010	Revised: Updated policy language in the exception section #5

05/04/2010	Revised: Policy language updated in the policy section under exception #3; added XXX table for anesthesia codes
11/03/2009	Revised: Updated policy language in bullet #8 to indicate that the removal of a cast was part of after care and references to supplies was removed
10/06/2009	Revised: Policy language updated; added procedure codes in the 9th bullet, under the 3rd paragraph
05/13/2009	Review with Revisions: Policy language updated under global surgery exceptions #4
11/08/2008	Revised: Policy language updated; removed numeral #6 since it is not an exception
10/21/2008	Revised: Policy language updated; added a note to XXX that 0 post op days applies to surgical procedures
09/22/2008	Revised: Policy language updated regarding modifier 78
07/15/2008	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2022

Definitions

Global Surgery	The global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure.
Major procedures	Codes that have a 90-day global surgical period
Minor procedures	Codes that have either a 0-day global or a 10-day global surgical period based on complexity
MMM	Maternity care and delivery procedure codes; usual global period does not apply. • 45-day global period • 0 postoperative days
XXX	Codes that the global surgery concept does not apply. • 0 postoperative days for surgical procedures • 10 postoperative days for anesthesia procedures
YYY	The Health Plan/MAC determines the global period. The global period for these codes will be 0, 10, 45, or 90 days
ZZZ	Code related to another service (add-on code) and is always included in global period of primary service
Preoperative care	Preparation and management of a patient prior to surgery
Postoperative care	Care received after the surgery that is related to recovery from the surgery
General Reimbursement Policy Definitions	

Related Policies and Materials

Bundled Services and Supplies - Professional
Clinic Charges - Facility
Evaluation and Management Services and Related Modifiers 25 and 57 - Professional
Expenses Included in Facility Services - Professional
Maternity Services - Professional
Moderate (Conscious) Sedation - Professional
Modifier Rules - Professional
Professional Anesthesia Services
Split-Care Surgical Modifiers - Professional

Use of Reimbursement Policy
State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.