Global Surgical Package

Background

Payer adheres to the global surgical package rules as defined by CMS. These services include all necessary services normally furnished by a surgeon before, during, and after a surgical procedure. The payment for the surgical procedure performed by the surgeon or by members of the same group with the same specialty will include routine:

- **Pre-Operative Services**
  - Visits after the decision is made for surgery
  - Minor procedures, including the visit the day of the surgery
  - Major Procedures, including pre-operative visits the day before surgery
- **Intra-Operative Services**
  - Services performed as a part of the surgical procedure
- **Post-Operative Services**
  - All additional medical or surgical supplies or services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.
  - Follow-up visits that are related to the recovery from the surgery
  - Post-surgical pain management by the surgeon
- **Supplies**, including the surgical tray, except for those identified as exclusions
- **Miscellaneous services** such as dressing changes, local incision 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

Physicians who are of the same specialty and in the same practice must bill and be paid as if they were a single physician when they are involved in the care of the same surgical case of a patient.

The global surgical package is applied regardless of where the surgeon’s services are rendered. This would include office, inpatient, outpatient, Ambulatory Surgical Centers (ASC’s) and physician’s office.

Calculating Pre-Surgical and Follow-up Care Days Included in Global Surgical Packages

There are three types of global surgical packages.

1. **Zero Day Post-Operative Period** (used for most endoscopic and some minor procedures)
   - Includes no pre-operative days
   - Includes no post-operative days

2. **Ten (10) Day Post-Operative Period** (minor procedure)
   - Includes no pre-operative period
   - Visit on the day of the procedure is generally not payable as a separate service
   - Total global period is 11 days. This includes the day of the surgery and the 10 days following.

3. **Ninety (90) Day Post-Operative Period** (major surgical procedures)
   - One day pre-operative visit included
   - Day of the procedure is generally not payable as a separate services
   - Total global period is 92 days, including 1 day before the surgery, the day of the surgery, and 90 days after the surgery
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- **000** represents the Zero Day Post-Operative Procedures
- **010** represents the 10 Day Post-Operative Procedures
- **090** represents the 90 Day Post-Operative Procedures
- **ZZZ** represents an add on code that must be billed with another service. There is no post-operative payment for ZZZ codes. The global period assigned would be applied to the primary code. (See definition of Add-On Codes.)

Exceptions to the Global Surgical Package

The following are not included in the Global Surgical Package:

- Visits unrelated to the diagnosis for which the surgical procedure is being performed unless due to complications of the surgery.
- Treatment for an underlying condition or added course of treatment that is not a normal part of the recovery from the surgery.
- Diagnostic radiological and laboratory services including pathology.
- Surgical procedures that occur during the post-operative period that are not related to the surgical procedure or for treatment of complications.
- Services of other physicians related to the surgery, except where written transfer of care has occurred. This can be documented in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record.
- The visit where the decision to perform surgery was made by the surgeon. This visit should be billed with Modifier 57 (Decision for Surgery).
- Treatment for post-operative complications requiring a return to the operating room (OR).
- If the surgeon performed a less extensive procedure and it failed and a more extensive procedure is required. The more extensive procedure is payable separately.
- Critical Care Services (99291 and 99292)
- Immunosuppressive Therapy for organ transplants.

Transfer of Care and the Global Surgical Package

When multiple physicians provide services included in the global surgical package, the primary surgeon should bill payment for these services. If an agreement is made to transfer care in writing then the services may be split and billed by each respective physician. This usually occurs when one physician performs the surgery but transfers care to another physician for postoperative care. In this case both providers may bill separately and append the procedure code with the appropriate modifier. Both physicians must bill the same CPT code (the surgical procedure). Written transfer of care must be available if requested.

- **Modifier 54** – Surgery only
- **Modifier 55** – Post-operative management only

The allowable for both physicians cannot be any greater than the total fee the allowed if one surgeon for the global surgical package for the procedure performed.
Multiple Surgeries and the Global Surgical Package

Multiple surgeries are separate procedures performed during the same operative session by the same surgeon or physicians in the same practice for which separate payment may be allowed. This can include co-surgeons, surgical teams, or assistants at surgery who may participate in multiple surgeries on the same patient on the same day. To determine the global surgical package days the rule will apply based on the CMS MPFS Fee Schedule. The more complex procedure will determine which rule is used. The determination is not based on the fee for the surgery but on the medical complexity.

Multiple procedures performed by the same provider at the same session should have the modifier 51 appended to all procedures other than the primary or highest RVU procedure. Modifier 51 triggers the multiple surgery reduction. Payer will allow 100% for the first procedure, 50% for the second and 25% for any additional procedures unless otherwise stated in the contract.

Co-Surgeons and Team Surgeons

When two or more physicians each perform a distinctly separate, unrelated surgery on the same patient on the same day (example: trauma injuries), each may bill for their services separately.

Co-surgeons who are each a different specialty are required to perform a specific procedure, each surgeon bills for the same procedure with a modifier 62 (Two Surgeons).

Team surgeons includes more than two surgeons of different specialties required to perform specific parts of the procedure. Each surgeon will bill the procedure with modifier 66 (Surgical Team). The need for a surgical team must be documented and available if requested to support the need for the team.