

Policy Memo – Policies and Procedures

2027 Policy Memo

09 – Surgery

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Please note: any timeframe listed in days refers to calendar days unless otherwise specified.

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1. Global Fee Concept

The concept of a global fee for a surgical procedure is a concept under which a single fee is billed and paid for all necessary services normally furnished by the surgeon before, during and after the procedure. Payment may be affected when someone other than the surgeon provides follow-up care as outlined in this policy memo.

To determine the global period for major procedures, count one day immediately before the day of the procedure, the day of the procedure and 42 days immediately following the day of the procedure.

To determine the global period for minor procedures, count the day of the procedure and ten days immediately following the day of the procedure.

To determine the global period for zero day procedures, count the day of the procedure only.

Complete Major and Minor and Zero Day Procedure listings can be found under Medicare listings:
<http://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx>.

The global maximum allowable payment (MAP) for a surgical procedure includes all services listed in Section A below related to that procedure. These services will not be separately reimbursed. The services included in the global surgical package may be furnished in any setting (e.g., hospitals, ASCs, physicians' offices). Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon.

1.2. Components of a Global Surgical Package

Appeals that you can make as the member's authorized representative according to the terms of the member's contract are claims for which the member is financially responsible. When you act as the member's authorized representative, you are not separately entitled to any appeals pursuant to this Contracting Provider Agreement.

- A. Preoperative Visits - Preoperative visits begin one day before the day of the procedure for major procedures and the day of the procedure for minor and zero day procedures.
- B. Intraoperative Services - Intraoperative services (including intraoperative monitoring) are all usual and necessary aspects of a procedure.
- C. Moderate (Conscious) Sedation - CPT defines moderate sedation as a drug induced depression of consciousness during which patients respond purposefully to verbal commands, whether alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Costs associated with the medically necessary moderate sedation performed in a separately billing facility are part of the all-inclusive facility MAP and are not reimbursed separately to the surgeon.

Documentation must support the necessity of the anesthesia service and care provided. Blue Cross and Blue Shield of Kansas (BCBSKS) will monitor the appropriate use of the guidelines

- D. Local Infiltration or Topical Application of Anesthesia - No additional fee is acknowledged for these services or supplies. The procedures are considered content of service of the surgical or anesthetic procedure.

- E. Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the procedure because of complications which do not require additional trips to the operating room.
- F. Postoperative Visits - Follow-up visits during the postoperative period of the procedure that are related to recovery are 42 days for major and ten days for minor procedures. Postoperative visits may be billed for zero day procedures.
- G. Post-Surgical Pain Management - By the surgeon.
- H. Supplies- Initial casting, splints, and materials used.
- I. Miscellaneous Services – Items such as dressing changes, local anesthesia, incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, routine peripheral intravenous lines, and postoperative pain control are considered content of service of the global fee.

Blue Cross and Blue Shield of Kansas, Inc., (BCBSKS) through its Place of Service Differential Program will recognize the additional cost of supplies, personnel and time for selected procedures done in the office setting. Such additional charges are to be included in the surgery fee and are not eligible for reimbursement if itemized separately. It is understood that the fee for these designated outpatient procedures may be higher than those for the same procedure performed on an inpatient basis

1.3. Moderate (Conscious) Sedation

When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider, other than the provider of the primary service, who is authorized under state law to administer general anesthesia. Moderate sedation, when performed in an office setting, is considered content of service to the office procedure rendered by the rendering provider and will be denied as a provider write-off. (Dental providers please refer to Dental Provider manual).

1.4. Services Not Included in the Global Surgical Package

These services may be paid for separately. In some instances, the procedure code will need to be billed with the appropriate modifier.

- A. For major surgeries, the initial consultation or evaluation of the problem by the surgeon to determine the need for the procedure, is allowed as separate from the global. To report, add modifier 57 to the evaluation and management (E/M) code.
- B. New patient office or outpatient services (codes 99202-99205) will be allowed on the day of the procedures.
- C. Visits unrelated to the diagnosis for which the procedure is performed, unless the visits occur because of complications of the procedure. To report, add modifier 24 or 25 for E/M, or modifier 79 for unrelated procedure or service and include additional supportive diagnoses.

- D. Treatment for the underlying condition or an added course of treatment that is not part of the normal recovery from the procedure. To report, add modifier 24 or 25 for E/M, modifier 79 for surgery procedures and additional supportive diagnoses or modifier 22 for individual consideration (see Section 7).
- E. Diagnostic tests and procedures, including diagnostic radiological procedures.
- F. Clearly distinct surgical procedures during the postoperative period that are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Payment for laser eye surgery; e.g., code 67141 states that the code represents one or more sessions of a procedure. BCBSKS will pay for that service only once during the established period.
- G. Modifier 78 is used to identify a separate but related procedure being rendered during a postoperative period of another procedure. When appending modifier "78", the original postoperative period ends and a new postoperative period begins, (e.g., major surgery is performed, on day 35 a second related procedure is performed).
- H. BCBSKS will deny payment if one of the modifiers (22, 24, 25, 78) is not billed with a service furnished during a global period. These modifiers were established to facilitate physician billing and processing of services that are not included in the global package.
- I. When a service performed is considered a lesser service and billed with a modifier 52, reimbursement may be reduced to an allowance reflective of the service performed.

2. Physicians Who Furnish Entire Global Package

Physicians who perform the procedure and furnish all of the usual pre and postoperative work bill for the global package by entering the appropriate American Medical Association Current Procedural Terminology (CPT) code for the procedure only.

3. Physicians in Group Practice

The following requirements are necessary to permit the BCBSKS payment policy to support the group practice's accounting arrangements.

3.2. Physicians Re-Assigning Benefits to the Group

When different physicians in a group practice participate in the care of the patient, the group must bill for the entire global package. The physician who performed the procedure is shown as the performing physician.

3.3. Physicians Not Re-Assigning Benefits to the Group

When different physicians furnish the entire postoperative care, the group must bill for the surgical care and the postoperative care as separate line items with the appropriate modifiers.

4. Providers Furnishing Less Than the Full Global Package

- A. Except for physicians in group practice, there may be occasions when more than one physician provides services included in the global package. The physician who performs the procedure may not furnish the follow-up care. Payment for the postoperative, post-discharge care shall be split evenly between two or more physicians in those instances in which those physicians agree on transfer of care.

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services. Where physicians agree on the transfer of care during the global period, the appropriate modifier should be reported with the corresponding surgical code.

- 54 for surgery only
- 55 for postoperative management only
- 56 for preoperative management only

B. Exceptions:

1. When a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate E/M code. The services of a physician other than the surgeon may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case.
2. In some instances, the itinerant surgeon and the physician providing pre and/or postoperative care may make different arrangements than indicated in Section IV. A. above. In such cases, only the itinerant surgeon would submit one global fee for the services to BCBSKS. The other physician would look to the itinerant surgeon for payment of the pre and/or postoperative services. This would allow them to divide the global fee differently than the Medicare percentages, which will normally be used by BCBSKS.

5. Date(s) of Service

- A. Physicians who bill for the entire global package must enter the date on which the procedure was performed in the "from date of service" field. This will enable us to relate all appropriate billings to the correct surgery.
- B. Physicians who share the out-of-hospital postoperative management with another physician are to submit the date on which the procedure was performed in the "from date of service" field. The date assumed/relinquished care along with the actual number of postoperative days being managed should be in box 19 or the equivalent electronic field.
- C. If the physician who performed the procedure relinquishes care during the post-operative period, he or she need only report the date of the procedure in the "from" field on the claim.

6. Reimbursement

BCBSKS will pay each physician direct for the portion of the global surgery services furnished to the insured. Generally the surgeon furnishes the usual and necessary pre and intraoperative services, and also, with a few exceptions, in-hospital postoperative services. In most cases, the surgeon also furnishes the postoperative office services necessary

to assure normal recovery from the procedure. Recognizing that there are cases when the surgeon turns over the out-of-hospital recovery care to another physician, percentages have been determined for families of procedures for paying usual out-of-hospital postoperative care if furnished by someone other than the surgeon.

7. Unusual Circumstances

Surgeries for which the services performed are significantly greater than usually required may be billed with the modifier 22 added to the CPT code for the procedure. Please provide:

- A. A concise statement about how the service differs from the usual, and
- B. An operative report or any other medical record documentation necessary to explain or describe the patient's condition with the claim.

8. Discharge Procedures by Someone Other Than the Surgeon

When a physician other than the surgeon performs discharge procedures at the request of the surgeon, these services are considered content to the global fee, and no additional payment will be made. BCBSKS will assume that discharge services are related to the procedure.

9. Additional Policy Clarification

Up to 20 percent of the initial surgeon's fee may be allowed for postoperative bleeding for cardiac pulmonary bypasses and after use of the heart/lung machine. Other surgical postoperative complications may be eligible subject to individual consideration.

Important Note: Other policies exist with respect to specific surgical situations. Providers specializing in surgery should check with the BCBSKS professional field representative whenever detailed questions arise.

10. Adverse Events

The BCBSKS list of "Adverse Events" shall automatically include all future CMS adopted "Never Events" that pertain to physicians. The updates become effective immediately upon adoption even if the addition occurs mid-year. The CMS "Never Events" updates do not constitute a change in policy and neither the patient nor BCBSKS shall pay for the medical errors.

Adverse events A, B, and C are not billable to BCBSKS:

- A. Surgery performed on the wrong body part or tooth.
- B. Surgery performed on the wrong patient.
- C. Wrong surgical procedure on a patient.

When one of these three adverse events occurs, no payment will be made to the provider for that error or correction of that error. The patient shall be held harmless and may not be billed for any adverse event. The provider shall refund payments to BCBSKS made for an adverse event if a claim is filed in error. If the surgical error is corrected by a different provider, payment for that procedure will be made.

D. RETENTION OF FOREIGN OBJECT IN SURGICAL PATIENT – In cases where a foreign object is mistakenly left in the patient during a surgical procedure the following applies:

1. If the same provider also removes the object, then no payment for the correcting surgery will be made and the patient will be held harmless.
2. If a provider other than the original provider removes the foreign object, that provider shall receive payment.

The Provider shall cooperate with BCBSKS in initiatives designed to help prevent or reduce such events and ensure that appropriate payments are made with no additional charges incurred for any condition which was not present on admission.



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