Billing and Reimbursement Guideline: Surgical Global Fee Period

Guideline Publication Date: September 1, 2010

Key coding, documentation and reimbursement points include:
Decision for Surgery

- The decision for surgery must be clearly documented within the medical record, hospital or office record.
- If the decision to perform surgery is made at the time of the consultation or other E&M service during the preoperative period, modifier 57 should be used to indicate the decision for surgery. Modifier 57 indicates that the physician provided an evaluation and management service during the preoperative period for a major procedure that resulted in the initial decision for surgery.
- Modifier 25 is used to indicate decision for surgery when a minor procedure is performed (0 or 10 day global period.)

Minor and Major Surgical Procedures:

Neighborhood Health Plan of Rhode considers the following inclusive in a surgical global package:

- Minor procedures and endoscopies have a zero to ten day global period.
- Major surgeries are those procedure codes identified in the Medicare Physician Fee Schedule Data Base with a 90-day postoperative period.
- The preoperative visit on the day before or the day of surgery is not separately reimbursable.
- Local, topical, or other anesthesia when administered by the surgeon is inclusive.
- Associated biopsies performed on the same day.
- Routine intra-operative care performed during the assigned global period.

Version History
Original Publish Date: September 1, 2010
Revision Date (s):
9/1/2013 Format change, minor edits

- Treatment of complications not requiring a return to the operating room.
- Routine post-operative care during the assigned global period.
- Operative notes must clearly document the separate service to be considered for reimbursement.
- Any unrelated service rendered during the global period must be billed with the appropriate modifier and supporting diagnosis to be considered for payment.
- Modifiers 24, 59 or 78 should be used to indicate a separately identifiable service.
- Notes may be requested to review for separate reimbursement of any services denied as inclusive in a surgical package.
- This guideline applies to both CMS-1500 and UB-92 claim submissions.

Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.

This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.

Version History	
Original Publish Date:	September 1, 2010
Revision Date (s):	
9/1/2013	Format change, minor edits