Regence

**Note: This policy is not effective until 01/01/2027. To view the current policy, click here.**

# Reimbursement Policy

Reimbursement Policy: **Global Days**
Policy No: **Adm 101**
Section: **Administrative**
Original Effective Date: **11/01/2008**
Last Reviewed: **09/01/2026**
Revision Effective Date: **01/01/2027**
Policy Applies To: **Commercial & Medicare Advantage**

This policy applies only to physicians and other qualified health care professionals.

## DEFINITIONS

| Code/Term | Code Description/Term Definition |
|---|---|
| **Global Period** | The timeframe surrounding a surgical procedure where related services are bundled into the payment for the procedure itself. For non-surgical procedures or services, the concept of a global period exists and reflects the period of time where follow-up care related to the procedure or service is included in the initial payment.<br><br>Centers for Medicare & Medicaid (CMS) global surgery indicators are found in the CMS National Physician Fee Schedule Relative Value Files.<br><br>000 Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.<br><br>010 Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.<br><br>090 Major surgery with a 1 day preoperative period and 90 day postoperative period included in the fee schedule amount.<br><br>XXX The global concept does not apply to the code. |

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| | YYY The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.<br><br>ZZZ The code is related to another service and is always included in the global period of the other service. |
| **Major Procedure** | Surgical procedures with a 1-day preoperative period and 90-day postoperative period. |
| **Minor Procedure** | Surgical procedures with a 0 or 10-day postoperative period. |
| **Preoperative Evaluation and Management (E&M) Denial** | E&M codes when provided on the day of or the day before a surgical procedure. |
| **Postoperative E&M Denial** | E&M codes when provided during the global period of the surgical procedure. |
| **Same Day E&M Denial** | E&M codes when provided on the same day as a surgical procedure or service with:<br>• A CMS assigned global period of 0, 10, 90 or XXX days<br>A global period established by our health plan for codes for which CMS has not established a global period and has not indicated that a global period is inappropriate, i.e codes with a CMS status indicator of C – Carrier priced codes |

## POLICY STATEMENT

Our health plan follows the CMS published global period as documented in the current year CMS National Physician Fee Schedule Relative Value File. Our health plan reserves the right to establish a global period for codes for which CMS has not established a global period but has not indicated that a global period is inappropriate.
Unlisted codes and/or codes with no CMS established relative value may be assigned the same global period as the most closely comparable Current Procedural Terminology (CPT®) code for which an allowance is determined.

When multiple procedures are performed at the same operative session, the procedure with the longer global period will take precedence.

### Components of a Global Surgical Package

Reimbursement for surgical procedures includes payment for all related services and supplies that are necessary and/or related to that procedure. Appending a modifier will not bypass these denials. These components of the surgical package are not eligible for separate reimbursement when provided within the global period. This applies to services performed in all places of service including, but not limited to, physician office, hospital, ASC, etc.

Providers within the same provider group with the same or similar specialty are subject to the same global period rules when covering for another provider.

### Preoperative Services

The reimbursement for a surgical procedure includes payment for all E&M services that are related to that procedure:

- A minor surgical procedure (0 or 10 day) includes the day of surgery.

- A major surgical procedure (90 day) includes the day before and the day of surgery.

Our health plan does not separately reimburse preventive and/or preventive like visits (99391-99397, G0402, G0438, G0439, G0513, G0514, S0285, S0612, S0621) when billed the same day as a minor surgical procedure (0 day), unless the services are unrelated and separately identifiable.

Additional preoperative services:

- Anesthesia codes: Preoperative denials will apply to anesthesia services

**Intra-operative Services**

The reimbursement for a surgical procedure includes payment for all intraoperative services that are a normal, usual, and necessary part of that surgical procedure. This includes but is not limited to:

- Cleansing, shaving and prepping of skin
- Draping and positioning of patient
- Insertion of intravenous access for medication administration
- Insertion of urinary catheter
- Sedative administration by the physician performing a procedure
- Local, topical or regional anesthesia administered by the physician performing the procedure
- Surgical approach including identification of anatomical landmarks, incision, evaluation of the surgical field, debridement of traumatized tissue, lysis of adhesions, and isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring
- Surgical cultures
- Wound irrigation
- Insertion and removal of drains, suction devices, and pumps into same site
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional)
- Application of TENS unit
- Institution of Patient Controlled Anesthesia
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription as necessary to document the services provided
- Surgical supplies, except for specific situations where CMS policy permits separate payment

**Postoperative Services**

The reimbursement for a surgical procedure includes payment for all professional services that are related to that procedure and are provided during the postoperative period.

This includes but is not limited to:

- Dressing changes
- E&M services related to the original surgery, all settings (including home postpartum visits)
- Incisional care
- Postoperative pain management by the surgeon
- Removal of staples, tubes, drains, lines, wires, casts, splints, and cutaneous sutures
- Postoperative care or treatment (including complications) that are related to the original surgery but do not require a return trip to the operating room
- Insertion, irrigation and removal of catheters
- Removal of operative pack
- Removal of peripheral intravenous lines
- Removal of nasogastric and rectal tubes
- Changes and removal of tracheostomy tubes

NOTE: The removal of sutures is not eligible for separate reimbursement regardless of the surgical global period.

Additional postoperative services:

- Anesthesia codes: Postoperative denials will apply to anesthesia codes one day after the anesthetic was provided

A procedure or service performed within the global period solely to confirm the success or to exclude a complication of the initial procedure is not eligible for separate reimbursement.

The reimbursement for a surgical procedure with '0' postoperative days as assigned by CMS, includes a global period of the first 24 postoperative hours.

Treatment of surgical complications that are related to preventable adverse events(as defined in Reimbursement Policy Adm 106 - Preventable Adverse Events) are not eligible for separate reimbursement regardless of modifier used.

**Services Not Included in the Global Surgical Package**

Some professional services are not included in the reimbursement for a surgical procedure and therefore may be eligible for separate reimbursement. It may be necessary to append an appropriate modifier to the code for the service to identify the circumstances which make the code eligible for separate reimbursement.

These services include but are not limited to:

- Evaluation of the problem by the surgeon to determine the need for surgery
    - An E&M service the day before or the day of a major surgical procedure *only* if the initial decision to perform the surgery was made during that visit. Modifier 57 must be appended to the E&M code to indicate decision for surgery.
    - An E&M service provided on the same day as a minor procedure *only* if the E&M service is unrelated to the procedure performed. Modifier 25 must be appended to the E&M code to indicate the E&M is significant and separately identifiable.
- An E&M service during the surgical postoperative period *only* if the visit is unrelated to the surgical procedure. Modifier 24 must be attached to the E&M code to indicate the E&M is unrelated to the procedure performed.
- A repeat surgical procedure by the same surgeon performed on the same day as the original surgery, requiring a return trip to the operating room. Modifier 76 must be attached to the procedure code to indicate a repeat surgical procedure.
- A repeat surgical procedure by a different surgeon, on the same day as the original surgery, requiring a return trip to the operating room. Modifier 77 must be attached to the procedure code to indicate a repeat surgical procedure by a different surgeon.
- A procedure or treatment that is related to the original surgery that requires an unplanned return to the operating room. Modifier 78 must be attached to the surgical code to indicate an unplanned return to the OR.
- A procedure or service that is unrelated to the original surgery. Modifier 79 must be attached to the procedure code to indicate the surgery is unrelated to the original procedure.
- A staged surgical procedure (one that was planned at the time of the original surgery) performed during the postoperative period of the original surgery. Modifier 58 must be attached to the procedure code to indicate a staged procedure.

**Non-Surgical Procedures**

Separate reimbursement for E&M services will not be allowed for non-surgical services (e.g., Chemotherapy Administration) that already include payment for the E&M service. If the E&M

service is documented to be unrelated and separately identifiable, modifier 25 appended to the E&M code may allow separate reimbursement for the E&M service.

Procedure codes with a CMS “XXX” global period have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed, therefore separate reimbursement for E&M service will not be made. However, if the E&M service was for a significant and separately identifiable service modifier 25 should be appended to the E&M code for reimbursement consideration.

Reimbursement for medical procedures (i.e. Chiropractic and Osteopathic Manipulative Treatment, Acupuncture) includes payment for all related supplies that are necessary and/or related to that procedure. Appending a modifier will not bypass these denials.

**One or More Sessions Codes**
Codes in CPT with descriptors that include the phrase ‘one or more sessions’ are eligible for reimbursement only once within their own global period, regardless of the number of sessions necessary to complete the treatment and regardless of the modifier attached.

## REFERENCES

American Medical Association. “Appendix A: Modifiers”. Current Procedural Terminology (CPT). Current year version

CMS National Physician Fee Schedule Relative Value File

Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners

## CROSS REFERENCES

Adm 105 - Bundling Edits
Adm 106 - Preventable Adverse Events
Ane 102 - Anesthesia Reimbursement and Services Reporting
Mod 103 - Modifier 25; Significant Separately Identifiable Service
Mod 104 - Modifier 57; Decision for Surgery
Mod 112 - Modifier 78; Unplanned Return to the Operating/Procedure Room By the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period

## DISCLAIMER

Your use of this Reimbursement Policy constitutes your agreement to be bound by and comply with the terms and conditions of the Reimbursement Policy Disclaimer.

## HISTORY

| Date | Updates |
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