JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Reimbursement Policies** **Reimbursement Policies**	*Policy Number*	RPC.041
		Effective Date	12/27/2024
		Approval Date	09/11/2024
	Subject **Global Surgical Services**	*Supersedes Date*	N/A
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This document applies to the following Participating Organizations:

EHP	Johns Hopkins Advantage MD	Priority Partners	US Family Health Plan

Keywords: Global Days, Post-Operative Period, Surgical Services

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory

mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

To provide basic reimbursement guidance of global surgical services. All procedures on the Medicare Fee Schedule Data Base (MFSDB) are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. Providers must bill for the reimbursement of services that are within the provider's scope of practice under state and federal law. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

III. POLICY STATMENT

JHHP follows CMS global surgery indicators codes. 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. JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. Physicians or other qualified healthcare providers in the same group practice, who are in the same specialty, must bill and be paid as though they were a single physician.
2. Physicians who perform the entire global package which includes the surgery and the pre- and post-operative care should bill for their services with the appropriate CPT code only. Do not bill separately for visits or other services that are included in a global package.
3. The global surgical package consists of preoperative services, surgical procedures, and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care. When more than one physician performs services that are included in the global surgical package, the total amount reimbursed for all physicians may not be higher than what would have been paid if a single physician provided all services.

4. Correct coding guidelines require that the same surgical procedure code (with the appropriate modifier) must be used by each physician to identify the services provided when the components of a global surgical package are performed by different physicians.
5. JHHP will process claims on a "first in/first out" approach. When applicable, JHHP will cross-reference both professional and facility claims for our members when billed for the same date of service.
6. Services included in the global surgical package may be furnished in any setting (e.g., in hospitals, Ambulatory Surgical Centers (ASCs), physicians' offices).
7. With very few exceptions, the payment for a surgical procedure includes payment for all dressings, supplies, and local anesthesia. Inappropriate unbundling of a procedure or service will result in a denial.
8. Since NCCI Procedure-to-Procedure (PTP) edits are applied to same day services, by the same provider/supplier, to the same member, certain Global Surgery Rules are applicable to the NCCI program rules.
9. An E/M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 days under limited circumstances and when the appropriate modifier is correctly appended to the E/M code.
10. In accordance with CMS guidance, JHHP will not reimburse services rendered by a practitioner who is unlicensed or if the practitioner is identified as a medical student healthcare provider (taxonomy code 390200000X) reported on the claim.
11. Appropriate documentation must support all codes billed. Claims for some services may be pended for further review.
    i. As supported by Section 1815(a) and Section 1833(e) of the Social Security Act, Section 422.214(a)(2) of Title 42 of the Code of Federal Regulations, contract provisions and other relevant guidance, JHHP reserves the right to request itemized bills in order to confirm proper billing, prior to payment, when necessary. Any improper billing may result in payment reduction or denial for specific charges.
    ii. JHHP may conduct medical record documentation reviews on a randomly selected sample of practitioners or on providers who render services outside their regular scope of practice or assigned specialty.
    iii. Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.

V. EXCLUSIONS and EXEMPTIONS

PPMCO: JHHP will process claims submitted for global surgical services, and will reimburse in accordance to the Code of Maryland Regulations (COMAR) and Maryland Department of Health (MDH). Please consult the authoritative guidance found in these manuals to obtain additional, specific information on policy, benefits, and coverage not outlined in this policy.

- JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
- Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

USFHP: JHHP will process and reimburse global surgical services claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional, specific information on policy, benefits, and coverage not outlined in this policy.

VI. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition

Evaluation and Management (E/M) Services	Per the CPT manual, E/M services (CPT 99202-99499) guidelines have sections that are common to all E/M categories and sections that are category specific. These guidelines are to be used by the reporting physician or other qualified healthcare professional to select the appropriate level of service. The E/M section of the CPT manual is divided into broad categories and further divided into sub-categories of E/M services.
Global Period	The global period represents the period of time during which all necessary services normally furnished by a physician (before, during, and after the procedure) are included in the reimbursement for the procedure performed.
Global Surgical Package	The global surgical package for an operative procedure includes all intra-operative services that are normally a usual and necessary part of the procedure. Additionally, the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. The Global surgical package also includes the administration of fluids and drugs during the operative procedure.
Major Procedure	A procedure having a Global Days Value of 090. To determine the global period for major surgeries, JHHP counts 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.
Medically Unlikely Edit (MUE)	MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same member on the same date of service.
Medicare Fee Schedule Data Base (MFSDB)	The MFSDB provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.
Minor Procedure	A procedure having a Global Days Value of 010. To determine the global period for minor surgeries, JHHP counts the day of surgery, and the 10 days immediately following the day of surgery.

Pre-operative Care	Preparation and management of a patient prior to surgery. Pre-operative care rendered in a hospital when the admission is expressly for the surgery is normally included in the global surgery charge. The admitting history and physical is included in the global package. This also applies to routine examinations in the surgeon's office where such examination is performed to assess the patient's suitability for the subsequent surgery.
Post-operative Care	The care and management of a patient provided after the surgery and is related to recovery from the surgery. All services provided by the surgeon for post-operative complications (e.g., replacing stitches, servicing infected wounds) are included in the global package if they do not require additional trips to the operating room. All visits with the primary surgeon during the 90-day period following major surgery are included in the global package.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN).
Split Care Surgical Package	A split surgical package occurs when a component of the surgical package is rendered by a physician other than the physician performing the surgical service.

Global Day Values/Global Period

Global Days Designator	Definition
000	Endoscopic or minor procedures with related preoperative and postoperative relative values on the day of the procedure only are included in the fee schedule payment amount; E/M services on the day of the procedure are generally not separately reimbursed.
010	A minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period are included in the fee schedule amount; E/M services on the day of the procedure and during the 10-day postoperative period are generally not separately reimbursed.
090	Major surgery with a 1-day preoperative period and 90-day postoperative period are included in the fee schedule amount; E/M services on the day of the procedure and during the 90-day postoperative period are generally not separately reimbursed.

MMM	Maternity codes; usual global period doesn't apply.
XXX	Global concept does not apply. Modifiers 58, 78, and 79 are not considered valid, for procedures with this Global Days indicator.
YYY	Subject to individual pricing and determination whether the global concept applies, as determined by JHHP. Modifiers 58, 78, and 79 are not considered valid, for procedures with this Global Days indicator.
ZZZ	The code is related to another service and is always included in the global period of the other service. ZZZ codes are add-on codes that must be billed with another service. There is no post-operative work included in the National Physician Fee Schedule payment for the ZZZ codes. The Global Surgical package concept does not apply to the code. Modifiers 58, 78, and 79 are not considered valid, for procedures with this Global Days indicator.

Modifiers

Modifier	Definition
24	Unrelated Evaluation and Management (E/M) service by the same physician during a post-operative period.
25	Significant, separately identifiable Evaluation and Management (E/M) by the same physician or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. Non-E/M codes reported with modifier 25 will be denied.
54	Used to indicate that a surgeon performed only the surgical component of a global surgical package (i.e., another physician provides postoperative care).
55	Used to indicate that a physician other than the surgeon performed only the postoperative management component of a global surgical package.
56	Used to indicate that a physician other than the surgeon performed only the preoperative evaluation component of a global surgical package.

57	Decision for surgery. An Evaluation and Management (E/M) service that resulted in the initial decision to perform the surgery may be defined by adding this modifier to the appropriate level of E/M service.
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. Note: *For treatment of a problem that required a return to the operating or procedure room (e.g., unanticipated clinical condition), see modifier 78.*
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating room, it may be reported by adding modifier 78 to the related procedure.
79	Unrelated Procedure by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79.

Medicare Physician Fee Schedule Database (MFSDB) Status Codes

Status	Definition

B	These codes, whether covered services or not, are ***always bundled*** into payment for other services they are incident to. If relative value units (RVUs) are shown on the fee schedule, they are **not** used for payment.
E	These codes are ***excluded*** from the MPFS by regulation.
I	These codes are not valid for Medicare purposes. To prompt payment, another code must be reported.
M	These codes are used for reporting only.
N	These codes are ***not*** covered by Medicare.
Q	These codes are used for reporting only.
X	These codes have been assigned PC/TC indicator 9 and are not considered physician services for MFSDB payment purposes.

VII. REFERENCES

This policy has been developed through consideration of the following:

- CMS MLN907166– Global Surgery
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Maryland Medicaid Professional Services Provider Manual
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual CH. 12- Physicians/Nonphysician Practitioners
- Medicare Claims Processing Manual CH. 23- Fee Schedule Administration and Coding Requirements
- Medicare Physician Fee Schedule Data Base (MPFSDB)
- NCCI for Medicare | CMS
- TRICARE Reimbursement Manual

VIII. APPROVALS

Date	Review/Revision	Reason For Modification	Approved By
9/11/2024	New	New policy	Reimbursement, Authorization and Coding Committee (RAC)

IX. POLICY NOTIFICATION CHART

	Yes/No	If yes in 2nd column, notify the following department of policy revisions:
Does this policy relate to NCQA?	No	Quality Improvement
Does this policy relate to Qlarant/MDH requirements?	No	Quality Improvement

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Does this policy relate to DHA contractual requirements?	No	USFHP Administration