Coding Policy

Global Surgical Package: Pre- and Post-Operative Care

CODING POLICY NUMBER: 12

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Next Annual Review: 2026

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SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies"). **The full Company portfolio of current coding policies is available online and can be accessed here.**

POLICY APPLICATION

☒ Providence Health Plan Participating Providers ☒ Non-Participating Practitioners

☒ Commercial ☒ Medicaid/Oregon Health Plan ☒ Medicare

POLICY STATEMENT

I. Reimbursement for surgical procedures is administered as a global surgical package. The global surgical package includes all necessary services normally furnished by the surgeon before, during, and after the procedure.

II. Global periods include the following:

   A. All major surgeries have a 90-day global period.

   B. All minor surgeries have a 10-day global period.

   C. Unless determined otherwise by medical review, all unlisted codes in the range 10000-69999 are assigned a 90-day global period.

1. When an unlisted code is used to report a minor procedure, providers may submit an appeal requesting that a 10-day global period be assigned for that procedure.

PROCEDURE

GENERAL

Major Surgical Services

Major surgical services are procedures listed with a 90-day global period on the Medicare Physician Fee Schedule (MPFS). The global period begins one day prior to the procedure and includes the day of the procedure and 90 days following the day of the procedure.

The global surgical package for major surgical services includes:

- **Preoperative Visits**
  Preoperative visits beginning the day before the day of surgery. If a preoperative visit occurs prior to the day before surgery, and it is clear that the sole purpose of the visit is preoperative and there is no documented medical necessity for performing the preoperative visit prior to the day before surgery, this preoperative visit will also be considered part of the global surgical package.
- **Preoperative History and Physical**
  The admitting history and physical is included in the global package when performed by the surgeon. An H&P performed during an initial consultation or by a physician other than the surgeon is not included in the global package.
- **Consultation Visits**
  Consultation services are included as a component of the global surgery payment except when performed for the purpose of determining the need for surgery. The surgeon may designate and be paid for the consultation in which the decision for surgery is made by using modifier -57. Modifier -57 is only to be used when reporting a visit or consultation before a major surgical procedure (procedures with 90 postoperative days). See Coding Policy 65.0 for instructions on the codes to use for billing consults.
- **Intraoperative Services**
  Intraoperative services that are normally a usual and necessary part of the primary operation.
- **Complications Following Surgery**
  All additional medical or surgical services required of the surgeon within 90 days of the surgery due to complications which do not require additional trips to the operating room.
- **Postoperative Visits**

Follow-up visits within 90 days after the surgery that are related to recovery from the surgery. Services on the day of surgery that are performed following the surgery are considered post-operative.

- **Postoperative Pain Management**
  When performed by the surgeon.
- **Supplies**
  Office medical supplies, except for drugs and specified supplies, are considered a practice expense to the physician, and payment is included in the practice expense portion of the payment for the medical or surgical services to which they are incidental.
- **Miscellaneous Services**
  Items such as dressing changes; local incisional 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.

Minor Surgical Services

Minor surgical services are procedures listed with a 0-day or 10-day global period on the Medicare Physician Fee Schedule (MPFS). The global period includes the day of the procedure for both the 0-day and 10-day global periods and continues for 10 days for codes with a 10-day global period.

The global surgical package for minor surgery includes:

- **Visits on the Same Day**
  It is understood that taking a brief history and performing a brief exam is necessary prior to performing a diagnostic, screening, or minor procedure with a 0-day or 10-day global period. This Evaluation and Management service may not be billed separately with modifier 25. Even if this E&M service is provided several days before the procedure, it does not warrant separate reimbursement, as a minimal preoperative exam is included in the surgical package for minor procedures.
- **Intraoperative Services**
  Intraoperative services that are normally a usual and necessary part of the primary operation including local infiltration, metacarpal/digital block or topical anesthesia.
- **Postoperative Period**
  A post-operative period of 0-10 days applies to minor procedures and endoscopies. Services following the surgery on the same day are considered postoperative. Complications related to a procedure with a 10-day global period are included in payment for the procedure.
- **Certain Supplies**
  Office medical supplies, except for drugs and specified supplies, are considered a practice expense to the physician and payment is included in the practice expense portion of the payment for the medical or surgical services to which they are incidental.

The global surgical package for minor surgery does **not** include:

- Visits not related to the diagnosis for which the minor procedure or endoscopy is performed.

Services/Supplies Not Included in the Global Surgical Package for Major or Minor Procedures

- Casting materials, splints and other devices used to treat fractures
- Critical care services
- Diagnostic tests and procedures, including diagnostic radiology
- Immunosuppressive therapy for organ transplants
- Treatment for postoperative conditions that require a return trip to the operating room (See Coding Policy 72.0)
- Visits for unrelated conditions (indicate with modifier -24)

Services Included in the Global Surgical Package for Both Major and Minor Procedures

Services that are part of the global surgical package and which may not be reported separately include, but are not limited to, the following:

- All work necessary for surgical approach, achieving hemostasis and/or homeostasis, and surgical closure.
- Coincidental elimination of diseased tissue or other pathology at the surgical site is considered incidental to the primary procedure and may not be reported separately. This includes, but is not limited to, the following:
    - Any procedure (endoscopic, open, radiologic, etc.) performed to ensure no intraoperative injury occurred or to verify the definitive procedure was performed correctly.
    - Aspiration of fluid collection at the site of the definitive surgical procedure or on an operative joint.
    - Evacuation of a hematoma, unless the procedure required a return to the operating room specifically to evacuate the hematoma and other procedures were not performed at the same time.
    - Excision or debridement of necrosis, debris, etc. in the incisional and/or operative site.
    - Hernia repair at the site of the incision.
    - Improvement and/or repair of scar at the incisional site.
        - Codes for complex repair, flap, adjacent tissue transfer or rearrangement, etc. may be reported only when the express purpose of the incision at that location is the scar revision or repair.
        - Integumentary repair codes may not be reported when performing another definitive procedure when the incision is made through, or in the area of, the scar, and the surgeon improves or repairs the scar while closing the incision.
    - Incision and drainage of an abscess at the site of the definitive surgical procedure.
    - Injection of substances to reduce inflammation and/or promote healing into the operative site or joint.

- Treatment and repair of intraoperative injury that occurs during the same operative session as the surgery is included in payment for the primary procedure and may not be reported separately. The National Correct Coding Initiative (NCCI) Policy Manual, Chapter I, Section C-14 states: “Treatment of complications of primary surgical procedures is separately reportable with some limitations. 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. Thus, treatment of a complication of a primary surgical procedure is not separately reportable (1) if it represents usual and necessary care in the operating room during the procedure or (2) if it occurs postoperatively and does not require return to the operating room. For example, control of hemorrhage is a usual and necessary component of a surgical procedure in the operating room and is not separately reportable. Control of postoperative hemorrhage is also not separately reportable unless the patient must be returned to the operating room for treatment. In the latter case, the control of hemorrhage may be separately reportable with modifier 78.”

Split Global Surgical Package

See also Coding Policy 20

Commercial Plans:
When one physician performs a surgical procedure and another provides postoperative management, the global surgical package may be broken down to two components. Report the same date of service and surgical procedure code on the surgical care and postoperative care bill. The date of service is the date the surgical procedure happened.

- Surgical services may be identified by adding the modifier -54 to the usual procedure code. The surgery will be reimbursed at 80% of the usual allowable for the procedure.
- Postoperative management may be identified by adding modifier -55 to the usual procedure code. Postoperative care will be reimbursed at 20% of the usual allowable for the procedure.
- Modifier -56 may be appended to the surgery code for preoperative care, but this is considered informational only. There will be no separate payment for preoperative care.

Medicare Plans:
Modifiers -54, -55, and -56 are used when a transfer of care occurs during the global period. Report the same date of service and surgical procedure code on the surgical care and postoperative care bill. The date of service is the date the surgical procedure happened.

- Surgical services may be identified by adding modifier -54 to the usual procedure code. The surgery will be reimbursed at 80% of the usually allowable for the procedure. Modifier –54 shows the surgeon gave all or part of the post-operative care to another provider and is used in any case when a practitioner plans to provide only a part of a global package (including but not limited to when there’s a formal, documented transfer of care or an informal, non-documented but expected, transfer of care).

- Postoperative management may be identified by adding modifier -55 to the usual procedure code. Postoperative management will be reimbursed at 20% of the usual allowable for the procedure.
- Modifier -56 may be appended to the surgery code for preoperative care, but this is considered informational only. There will be no separate payment for preoperative care.

If there is no transfer of care, report occasional post-discharge provider services other than the surgeon using the appropriate E/M code supported by the documentation. Modifiers are not required.

- HCPCS code G0559 may be used when criteria listed in the code description are met and documented in the medical record and postoperative care services are provided by a practitioner other than the one who did the surgical procedure (or another practitioner in the same group practice).

CROSS REFERENCES

- Split Global Surgical Package, Coding Policy 20.0
- Exception Pricing for New or Unlisted Codes, Coding Policy 27.0
- Modifier 25, Coding Policy 31.0
- Modifier 57, Coding Policy 32.0
- Guidelines for Billing Consultations, Coding Policy 65.0
- Modifiers 58, 78, and 79, Coding Policy 72.0

REFERENCES

1. CMS/Medicare Rules and Regulations
2. Medicare Physician Fee Schedule
3. Current Procedural Terminology (CPT)
4. Providence Health Plan Coding Edits

POLICY REVISION HISTORY

Date	Revision Summary
1/2023	Annual review (converted to new template 5/2023). Original policy effective date: 11/1998
1/2025	Annual review. Added Medicare guidelines for modifiers -54, -55, and -56 and information about HCPCS code G0559, which is allowed only for Medicare lines of business. Added information about date of service for split global surgical package.