Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Global Surgical Package for Professional Providers		
Effective Date: **04/21/20**	Committee Approval Obtained: **04/21/20**	Section: **Surgery**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.amerigroup.com**. Under Quick Tools, select Reimbursement Policies > Medicaid. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

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

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows reimbursement for the global surgical package unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

	Amerigroup follows CMS global surgery values. 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. **Included in the Global Surgical Package** Reimbursement for the following components is included within the global surgical package: • Preoperative services rendered after the decision is made to operate, beginning with the day before major procedures and the day of surgery for minor procedures • Intraoperative services that are normally a usual and necessary part of a surgical procedure • Visits during the postoperative periods that are related to recovery from the surgery regardless of location • Treatment for all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications, which do not require additional trips to the operating room and that are not categorized as a hospital-acquired condition or present on admission • Postsurgical pain management by the surgeon • Miscellaneous surgical services and supplies used during the surgery **Unlisted Surgical Procedures Included in Global Package** Reimbursement for an unlisted surgical procedure is based on the review of the unlisted code on an individual claim basis. Claims submitted with unlisted codes must contain the following information and/or documentation describing the procedure or service performed for consideration during review: • A written description • Office notes • An operative report **Add-On Surgical Procedures Included in Global Surgical Package** The global surgical period for an add-on surgical procedure will be based on the primary surgical code. **Separately Reimbursable from Global Surgical Package** The following services are not included in the payment amount for the global surgery and are separately reimbursable expenses: • The initial consultation or evaluation by the surgeon to determine the need for a major surgical procedure

	• Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care — the agreement must be in the form of a letter or an annotation in the discharge summary, hospital record or Ambulatory Surgical Center (ASC) record • Visits during the postoperative period of surgery that are unrelated to the diagnosis of the surgery unless the visits occur due to complications of the surgery • Treatment for an underlying condition or an added course of treatment, which is not part of the normal recovery from surgery • Diagnostic tests and procedures • Clearly distinct surgical procedures during the postoperative period that are not reoperations or treatment for complications • Treatment for postoperative complications which require a return trip to the operating room • The second procedure if a less extensive procedure fails, and a more extensive procedure is required • Immunosuppressive therapy for an organ transplant • Critical care services unrelated to the surgery where a seriously injured or burned member is critically ill and requires constant attendance of the physician. Providers must use applicable HIPAA-compliant modifiers for any services provided during the postoperative period.
History	• Biennial review approved and effective 04/21/20: Updated policy language, 2nd bullet under separately reimbursable from Global Surgical Package • Reviewed 12/28/17 and effective 12/31/17: Policy language updated • Review approved 10/26/17: Policy template updated • Biennial review approved 05/01/17: Policy language updated • Biennial review approved 12/29/15: Policy template updated • Biennial review approved and effective 12/31/13: Disclaimer updated; policy language updated • Review approved 11/21/11: Background section and policy template updated; policy language updated • Review approved 10/11/10: Policy language updated; Ohio exemption added; Background section/policy template updated • Review approved 09/21/09: Background section/policy template updated • Initial policy approved and effective: 07/17/06
References and Research Materials	This policy has been developed through consideration of the following:

	• CMS • State Medicaid • Amerigroup state contracts
Definitions	• **Reimbursement Policy Definitions**
Related Policies	• Claims Requiring Additional Documentation • Duplicate or Subsequent Services on the Same Date of Service • Modifier 24: Unrelated Evaluation and Management Service by the Same Physician During the Postoperative Period • Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service • Modifier 57: Decision for Surgery • Modifier 78: Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period • Modifier Usage • Other Provider Preventable Conditions (OPPC) • Split-Care Surgical Modifiers • Unlisted, Unspecified and Miscellaneous Codes
Related Materials	• None