Global Surgical Package and Split Surgery

Reimbursement Policy ID: RPC.0012.2400

Recent review date: 10/2025

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Select Health of South Carolina reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Select Health of South Carolina may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes payment for both the global surgical package and split surgical care to providers contracted with Select Health of South Carolina.

Exceptions

N/A

Reimbursement Guidelines

I. Global Surgical Package

Select Health of South Carolina, SC DHHS Surgical Package Codes (Class S and Class T) and National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits to prevent payment outside of the global surgical package. The global surgical package, also called global surgery, includes all necessary services normally provided by a physician (or members of the same group practice with the same specialty) before, during, and after a procedure. Physicians in the same group practice with the same specialty must bill and accept payment as though they are a single physician. Once a surgery has been submitted and processed for reimbursement, any other services or supplies furnished by the surgeon during the pre-operative period, on the day of surgery, or during the postoperative period of surgery are considered global to the surgery and will be denied if submitted for separate payment.

The global payment indicator reflects the number of postoperative days included in the global surgical package for a surgery. Codes classified as surgical procedure codes can be found on the SC DHHS website in the global surgery list. Diagnostic and therapeutic non-surgical CPT codes are not reimbursed as surgeries by Medicaid.:

- "0" day or Class S codes **do not** have a 30-day global period. The multiple surgical procedure reduction for procedures performed on the same date of service applies.
    - For minor surgeries with the "000" global payment indicator, there are no days after the surgery that are considered the postoperative period.
- "30" day or Class T codes have a 30-day global period. The multiple procedure reduction for procedures performed on the same date of service applies.is the global payment indicator for all major surgeries with the following exceptions:
    - Initial hospital care codes are exempt from the surgical package.
    - Critical Care services are not included in the surgical package.
    - ER services are not part of the surgical package.
    - Hospital and office E&M visits are not part of the surgical package up to and including the day of surgery.
- The 30 days immediately after the day of surgery are considered the postoperative period for major surgery. Services and supplies furnished during these 30 days are considered postoperative, and therefore are included in the global surgical package.

The most comprehensive CPT/HCPCS code(s) for the surgery performed must be submitted for reimbursement. Any services and supplies that have their own CPT/HCPCS codes but are considered integral to the surgery being performed should not be submitted for separate payment. This includes surgical approach and imaging guidance.

Services furnished on the day of surgery, or during the postoperative period of surgery that are not normally furnished for the surgery may be reimbursable if separately reported with the appropriate modifier. Examples of these are:

- Distinct, unrelated procedures performed during the same operative session
- Procedures and E/M services unrelated to the surgery during the postoperative period, including treatment of the underlying condition for which the surgery was performed
- Staged procedures performed during the postoperative period
- Treatment of postoperative complications that require a return to the operating room

Refer to CPT/HCPCS manuals for complete descriptions of procedure codes and their modifiers, NCCI manuals for correct coding policies, the CMS MPFS files for indicators, and Select Health of South Carolina billing resources for fee schedules and guidelines.

II. Split Surgical Care

Select Health of South Carolina will reimburse according to applicable Select Health of South Carolina Fee Schedule(s), the provider's contract, and CMS Guidelines for split surgical care.

Reimbursement for split surgical care applies only to procedures with a 30-day global period as specified. In the DHHS Surgical Package Class T List.

Definitions

Global surgical package
Payment for a surgical procedure includes the preoperative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. Claims for services considered to be directly related to pre-procedure, intra-procedure, and post-procedure work are included in the global reimbursement and will not be paid separately.

Minor surgery
A minor surgery is a procedure with a 0 global postoperative period.

Major surgery
A major surgery is a procedure with a 30-day global postoperative period.

Modifier 54 – Surgical Care Only
When one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

Modifier 55 – Postoperative Care Only
When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

Modifier 56 – Preoperative Care Only
When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

Modifier 57- Decision for Surgery
An evaluation and management (E/M) service that resulted in the initial decision to perform the surgery may be identified by adding this modifier to the appropriate level of E/M service.

Split Surgical Care
Split Surgical Care occurs when different providers furnish either the pre-operative, intra-operative or post-operative portions of a global surgical package.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. South Carolina Medicaid Fee Schedule(s).
VII. SC DHHS Physician Services Provider Manual
VIII. SC DHHHS Surgical Package Codes

Attachments

N/A

Associated Policies

RPC.0033.2400 Multiple Procedure Payment Reduction
RPC.0026.2400 National Correct Coding Initiative (NCCI)

Policy History

10/2025	Reimbursement Policy Committee approval
08/2025	Annual review • No revisions
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
01/2025	Added definition for modifier 57
12/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by Select Health of South Carolina from Policy History section
01/2023	Template revised Revised preamble Removal of Applicable Claim Types table Coding section renamed to Reimbursement Guidelines Added Associated Policies section