curative

TITLE:	GLOBAL SURGICAL PACKAGE
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	02/20/2026
REVISION DATE:	03/03/2026

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this policy:

3.1. **Evaluation and Management (E/M) Services** Face-to-face and/or non-face-to-face provider work involving history, examination, medical decision-making (MDM), and/or time, as defined by CPT®.

3.2. **Global Period, Global Days** The number of days during which services furnished by the physician performing the procedure before, during and after are included in the reimbursement for the procedure performed.

3.3. **Global Surgical Package** The necessary pre-operative, intra-operative and post-operative services and supplies necessary to a surgery, rendered by a provider or a provider of the same group and same primary specialty in any setting.

3.4. **Major Procedure** A procedure code assigned a global period of 90 days.

3.5. **Minor Procedure** A procedure code assigned a global period of 0 or 10 days.

3.6. **Modifier 24:** Unrelated E/M by the Same Individual Provider or Same Specialty Provider during a postoperative period

3.7. **Modifier 25** Indicates a significant, separately identifiable E/M service by the Same Individual Provider or Same Specialty Provider on the same date as another procedure or service.

3.8. **Modifier 54** Surgical Care Only. Applies to professional billing. Indicates one provider performed a surgical procedure and another provider (not in the same group practice) rendered the preoperative and/or postoperative management.

3.9. **Modifier 55** Postoperative Care Only. Applies only to professional billing. Indicates this provider only rendered the postoperative care. Not valid for 0-day global periods.

3.10. **Modifier 56** Preoperative Care Only. Applies only to professional billing. Indicates this provider only rendered the preoperative care. Not valid for 0-day global periods.

3.11. **Modifier 58** Indicates a return trip to the Operating Room occurred during the postoperative period for a planned or staged procedure and is related to the original surgery.

3.12. **Modifier 78** Indicates a subsequent procedure related to the original which required a return to the operating room and was performed during the global period of the original procedure.

3.13. **Modifier 79** Indicates a subsequent procedure which required a return to the operating room was not related to the original but was performed during the global period of the original procedure.

3.14. **Operating Room** A place of service for the sole purpose of performing procedures. It does not include a recovery room, a patient's room, or a minor treatment room.

3.15. **Preoperative Services** Visits performed after the decision for surgery is made, to include the day before a Major Procedure or the day of a Minor Procedure.

3.16. **Same Individual Provider** The same individual Physician or Other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification number.

3.17. **Same Specialty Provider** Physicians and/or Other Qualified Health Care Professionals of the same group and same primary specialty reporting the same Federal Tax Identification number.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Reimbursement Guidelines

This policy describes how providers are reimbursed for services related to surgical procedures. Curative follows the Centers for Medicare & Medicaid Services (CMS) guidelines and concepts considered the

Global Surgical Package. The Global Surgical Package includes components referred to as preoperative, intraoperative and postoperative.

Global Surgical Package

Reimbursement to providers who perform the surgical procedures include:

- Preoperative visits after the decision is made to do surgery for Major Procedures
- Intraoperative services considered a usual and necessary part of a procedure
- Complications following a procedure that do not require an additional trip to the Operating Room
- Postoperative visits for follow-up related to recovery as assigned by CMS on the National Physician Fee Schedule
- Postoperative pain management by the surgeon
- Supplies required for surgical care, except for excluded items
- Miscellaneous services - dressing changes, incisional care, removal of sutures or drains, application of casts, insertion of urinary catheters, routine peripheral intravenous lines

Evaluation and Management Services Related to the Global Surgical Package

Evaluation and management (E/M) services on the day of the procedure are included as Preoperative Services unless designated as separate by use of a modifier 25 or modifier 57, as appropriate.

- Modifier 25: Indicates a significant, separately identifiable E/M service by the Same Individual Provider or Same Specialty Provider on the same date as another procedure or service.

The work must be above and beyond what is the normal pre-service work for the service. This modifier is appropriate for use on Minor Procedures on the day of the procedure.

- Modifier 57: Decision for surgery. An E/M service that resulted in the initial decision to perform the surgery by the Same Individual Provider or Same Specialty Provider.

This modifier is appropriate for use on Major Procedures on the day before or day of the procedure.

E/M services during a postoperative period may be allowed if designated as unrelated by modifier 24.

- Modifier 24: Unrelated E/M by the Same Individual Provider or Same Specialty Provider during a postoperative period

Global Periods

0 Day Postoperative Period with Global Services Indicator 000 in the CMS National Physician Fee Schedule (NPFS), Minor Procedure

- Preoperative period only includes the day of the procedure
- No postoperative period

10 Day Postoperative Period with Global Services Indicator 010 in the NPFS, Minor Procedure

- Preoperative period only includes the day of the procedure
- Postoperative period includes the 10 days following
- Global Period total is 11 days

90 Day Postoperative Period with Global Services Indicator 090 in the NPFS, Major Procedure

- Preoperative period includes the day before the procedure
- Postoperative period includes the day of the procedure and the 90 days following
- Global Period total is 92 days

MMM Maternity Code Global Period assigned as 42 days in alignment with ACOG (American College of Obstetricians and Gynecologists)

- Postoperative period includes the day of the procedure and 42 days following
- Other maternity codes are assigned 0 or XXX (Global Package does not apply)

YYY No Postoperative Period assigned by CMS and can be determined by carrier

ZZZ No Postoperative Period assigned due to always being billed as add-on code

Procedures during a Global Period

- Modifier 78

If a return trip to the Operating Room during the postoperative period is necessary a modifier 78 should be used if the procedure is unplanned and related to the original procedure performed. The modifier 78 will adjust the reimbursement to only reflect the intraoperative care, which Curative recognizes as 70% of the allowed amount. The postoperative Global Period does not restart in these cases as the service is related to the original.

- Modifier 58

If a return trip to the Operating Room during the postoperative period is a planned or staged procedure and is related, a modifier 58 should be used. The modifier 58 will not adjust the reimbursement and will not restart the postoperative period as the service was planned and is related to the original.

- Modifier 79

If a return trip to the Operating Room during the postoperative period is unplanned and unrelated to the original procedure performed, a modifier 79 should be used. The modifier 79 does not adjust the reimbursement but does start its own postoperative period as the service is unrelated to the original.

Split Global Surgical Package

If there is a transfer of care for the management of the patient during the Global Period the Global Surgical Package is split between the two providers. Claims from both providers require the same date of service and procedure code. The appropriate modifier identifying what component the provider is billing for should be appended and will indicate what portion of the payment will be assigned by Curative.

- Modifier 54: Surgical Care Only 70% Reimbursement
- Modifier 55: Postoperative Management Only 20% Reimbursement
- Modifier 56: Preoperative Management Only 10% Reimbursement

The date of transfer should be included on the claim in the remarks field and documentation of the transfer agreement should be in each provider's medical record for the patient.

5. REFERENCE DOCUMENTS AND MATERIALS

5.1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

5.2. Centers for Medicare and Medicaid Services (CMS), CMS Manual System, Medicare Claims Processing Manual 100-04, Chapter 12 Physician/Nonphysician Practitioners

5.3. Centers for Medicare and Medicaid Services (CMS), Physician Fee Schedule (PFS) Relative Value Files

6. COLLABORATING DEPARTMENTS

6.1. Claims

6.2. Compliance

6.3. Medical Management

6.4. Network

6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
03-03-2026	CJ Wisecarver	002	Remove reference to CMS NPFS intraoperative percent column and add intraoperative percent of 70%.
02-20-2026	CJ Wisecarver	001	Initial Version