The Global Surgery Package
Part I

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Introduction

One of the least understood concepts in surgical coding concerns the details involved in the Global Surgery Package. Some of the rules were modified in 2002, so let's take a look at the new requirements.

CPT (Current Procedural Terminology) Definition

CPT provides the following information in its introductory remarks in the section entitled "Surgery Guidelines".

"The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services 'included' in a given CPT surgical code, the following services are always included in addition to the operation per se:

- ☐ local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
- ☐ subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
- ☐ immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
- ☐ writing orders;
- ☐ evaluating the patient in the postanesthesia recovery area;
- ☐ typical postoperative follow-up care...

Follow-up care for diagnostic procedures (eg, endoscoopy, arthroscopy, injection procedures for radiography) includes only that

care related to the recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

Follow-up care for therapeutic surgical procedures includes only that care which is usually part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be separately reported."

Medicare Global Package

Medicare has slightly different rules and this is from where a lot of confusion originates. Let's now examine Medicare's definitions.

Section 4821 of the Medicare Coverage Manual reports the following information.

The Medicare approved amount for these procedures **includes**

- Preoperative Visits - Preoperative visits **after the decision is made to operate** beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.
- Intraoperative Services - Intraoperative services that are normally a usual and necessary part of a surgical procedure.
- Complications Following Surgery - 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.

Miscellaneous services such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; et cetera are included.

Services not included in the global surgical package are as follows:

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery;

- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care or as specified in §§4822.A.2. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery. See §§4821.A for further guidance on billing for complications;
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in 2 or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure.
- Treatment for postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR). See §§4824.C for payment rules on postoperative complications;

If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.

The Global Period

For Medicare, the global period (defined as the period of time for which one may not bill related office visits/consultations is one of the following: 90 days, 10 days, or 0 days. Major surgery is defined as

those procedures that have a global period of 90 days. Minor procedures are those that have a global period of 10 or 0 days. Thus, in the case of laser trabeculoplasty, which now has a global period of 10 days, the procedure would be classified as minor as would be Ophthalmic Photodynamic Therapy.

The differentiation is important because if the **initial** decision for surgery is made on the same day or the day before a procedure is performed, application of a modifier is necessary in order to get paid for the office visit or consultation. The modifier chosen depends on whether the procedure is a major or minor one. For minor procedures (10 or 0 global period days) use modifier –25. For major procedures, use modifier –57. The modifier is always applied to the office visit/consultation. So technically, modifier –25 would be used for the officer visit or consultation when scheduling a laser trabeculoplasty (CPT code 65855) since the global period was reduced to 10 days effective January 1, 2002.

Also, note that Medicare states that "Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed."

The Global Fee

Many physicians question why there is no compensation for dealing with related problems treated in the office during the postoperative period. The global fee for ophthalmic surgical procedures is divided into three portions: (1) 10 per cent of the allowable is allotted for preoperative care; (2) most often 70 per cent of the fee is allotted for intraoperative care; (3) 20 per cent of the fee is designated for postoperative care. So, if a complication occurs, such as hyphema after cataract surgery, you cannot charge additionally for the medical management of that problem unless the management requires a return to the operating room.

By the same token, if a patient schedules surgery rather far in advance and the surgeons just wants to take a quick look the day before surgery, that visit is not billable since it is part of the global package (the *initial* decision for surgery is not being made).

Furthermore, if a surgical intervention for a related problem is performed in the global period, but does not require a return to the operating room (such as needling of the bleb after trabeculectomy),

then it is included in the surgical global fee and cannot be billed additionally.

Conclusion

In next month's column we will review some important reimbursement issues and coding techniques in order to assure proper payment.

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