Same-Day Office Visits and Surgery: Getting Paid

Information to help make sense of coding and reimbursement nuances in billing for preoperative office visits and related procedures.

BY RIVA LEE ASBELL

One of the most frequent issues encountered in coding and reimbursement is engendering payment for an office visit plus a surgical procedure when the same provider performs both on the same day. Certain parameters that differentiate Medicare definitions of major procedures versus those considered minor procedures have to be met, none of which relate to the complexity of the procedure (see "The Global Period," next page).

MAJOR VS MINOR PROCEDURES

Major Procedures

Medicare defines a major surgical procedure as one with a global period (ie, the period after the surgery for which care is included except for returns to the OR) of 90 days after the surgery and 1 day before.

When can you bill for the preoperative visit for a major procedure, and how should you code to engender payment?

Chapter 12, Section 30.6.6 of the Medicare Claims Processing Manual contains the following payment instructions:

> ***"Decision for Surgery Made Within Global Surgical Period*** *Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90 day global surgical period if the physician uses CPT modifier '57' to indicate that the service resulted in the decision to perform the procedure. Carriers may no [sic] pay for an evaluation and management service billed with the CPT modifier '57' if it was provided on the day of or the day before a procedure with a 0 or 10 day global surgical period."*

The Current Procedural Terminology (CPT) book lists the following definition for modifier 57:

> "Do not use modifier 57 for examination services performed within 24 hours of preplanned or prescheduled surgery."

> ***"Decision for Surgery:*** An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of [evaluation and management] service."

Noteworthy:

- The key word in this description is *initial*. The examination must be the first time surgery was recommended and must be performed within 24 hours of the surgery. If a patient returns for a quick checkup before surgery, the visit would not be separately reimbursable.
- Append modifier 57 to the office visit code, not the surgery code.
- Do not use modifier 57 for examination services performed within 24 hours of preplanned or prescheduled surgery.
- When an evaluation and management (E/M) service resulting in the initial decision to perform major surgery is furnished during the postoperative period of another unrelated procedure, then the E/M service must be billed with both the 24 and 57 modifiers.
- Modifier 57 may be used with the eye codes (CPT codes 92002-92014) or any of the E/M codes (99201-99499) at various places of service.

The Global Period*

How is Global Surgery Classified?

There are three types of global surgical packages based on the number of postoperative days.

1) Zero-Day Postoperative Period (endoscopies and some minor procedures)
- No preoperative period
- No postoperative days
- Visit on day of procedure is generally not payable as a separate service

2) 10-Day Post-operative Period (other minor procedures)
- No preoperative period
- Visit on day of the procedure is generally not payable as a separate service
- Total global period is 11 days (the day of the surgery and 10 days following the day of the surgery)

3) 90-Day Postoperative Period (major procedures)
- One day preoperative included
- Day of the procedure is generally not payable as a separate service
- Total global period is 92 days (1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery)

*From the MLN Global Surgery Fact Sheet

Minor Procedures

The Centers for Medicare and Medicaid Services (CMS) defines a minor surgical procedure as one that has a global period of either 0 or 10 days. The most important difference between a major and minor procedure in terms of getting paid for both the examination visit and surgery on the same day is this: For *major* procedures, the examination visit is included in the fee for the surgery if it is performed within 24 hours of the procedure—unless the *initial* determination for the surgery is made at this visit. For *minor* procedures, the office visit is always packaged with the surgery unless a significant, separately identifiable condition is present.

The Medicare Learning Network (MLN) Global Surgery Fact Sheet states that "The initial evaluation for minor surgical procedures and endoscopies is always included in the global surgery package. Visits by the same physician on the same day as a minor surgery or endoscopy are included in the global package, unless a significant, separately identifiable service is also performed."

> "A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

This is a packaging issue—in other words, think of the examination as part of the calculation for pricing and payment of a minor procedure. One should not interpret this as being denied payment for the office visit, but rather as its being included in the fee. The MLN Global Surgery Fact Sheet states also states that "When the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure."

CPT defines modifier 25 as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service." It may be necessary to indicate that, on the day a procedure or service identified by a CPT code is performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Service Guidelines, available at www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf or by searching CMS 1997 E/M Guidelines, for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure or service was provided. As such, different diagnoses are not required for reporting E/M services on the same date.

Resources & References

MLN Global Surgery Fact Sheet:
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalISurgery-ICN907166.pdf

WPS Medicare Modifier 57 Fact Sheet:
wpsmedicare.com/j5macpartb/resources/modifiers/modifier-57.shtml

WPS Medicare Modifier 25 Fact Sheet:
www.wpsmedicare.com/j5macpartb/resources/modifiers/modifier-25.shtml

Noteworthy:

- When the decision to perform a minor procedure is made immediately before a surgical service, it is considered a routine preoperative service and is not billable in addition to the procedure.
- Of all the misunderstood issues in retinal reimbursement, modifier 25 is the most serious because most practices believe that it can be appended to most office visits on the day of intravitreal injection (CPT code 67028). Proper use of modifier 25 dictates that this is usually not warranted.
- The packaging of the office visit with a surgical procedure designated as minor is not connected to any National Correct Coding Initiative (NCCI) bundles. It is important not to confuse NCCI bundling with the CMS definition of inclusion/packaging (the latter includes the fee for the office visit).

CPT defines modifier 24 as "Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period." The physician may need to indicate that an E/M service was performed during a postoperative period for reasons unrelated to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E/M service.

Noteworthy:

- Modifier 24 is appended to an office visit when the patient is in a global period and indicates that the E/M service (or the eye code) is not related to the surgical procedure. It can be used in combination with modifier 57 or 25.

MEDICAL NECESSITY AND SELECTION OF THE LEVEL OF AN EXAMINATION SERVICE

Medical necessity is the driving force of Medicare. For every service billed there must be medical necessity. There must also be medical necessity for examinations as well as for the required elements for the level of service billed. This applies to E/M services and the eye codes. Caution is warranted, however, because there may be medical necessity for an office visit but not for the choice of code (E/M or eye code) or the level billed. For patients being followed with frequent intravitreal injections, it is generally not medically necessary to perform confrontation visual fields and extraocular muscle balance examinations, which are required elements of a comprehensive eye code (CPT code 92004/92014) in the absence of no new symptoms. If you document more than medical necessity would dictate, either manually or by using the electronic health record, the code selected will be at a higher level than warranted. Repetitive routine performance of elements may not be counted nor considered medically necessary.

Clinical Examples

Case No. 1

An established patient being treated on a treat-and-extend basis for wet age-related macular degeneration (AMD) in the right eye returns for optical coherence tomography (OCT). It is decided that an intravitreal injection will be given in the right eye that day. An examination is performed prior to the injection, and the OCT performed earlier that day is reviewed. *Coding: Modifier 25 should not be used to engender payment for the office visit.*

Case No. 2

A new patient is referred as an emergency by a retina specialist for a recent onset of retinal branch vein occlusion in the right eye. There were no other complaints or findings in either eye. The surgeon performs an intravitreal injection of bevacizumab (Avastin, Genentech) in the right eye after examining both of the patient's eyes. There were no other significant ocular findings warranting treatment. *Coding: The office visit is included with the procedure.*

Case No. 3

An established patient presents for a scheduled intravitreal injection of ranibizumab (Lucentis, Genentech) in the left eye for wet AMD. The patient complains of flashes and floaters in the *right* eye, accompanied by decreased vision. An inferior retinal detachment is observed in the right eye. *Coding: This is a significantly separate condition that is new to the examiner. Use modifier 25 on the office visit.*

Case No. 4

A new patient presents with a retinal detachment in the right eye and is scheduled for surgery using pars plana vitrectomy the next day. *Coding: Append modifier 57 to the office visit because this is a major surgical procedure and this is the initial determination for surgery.*

Case No. 5

A patient is in the global period after repair of tractional retinal detachment in the right eye. He comes in for an emergency examination with sudden loss of the inferior field of vision in his left eye. The patient is scheduled for repair of the newly found retinal detachment in his left eye the next day. *Coding: Append modifiers 24 and 57 to the appropriate examination code. Modifier 24 engenders payment in the global period and modifier 57 engenders payment for the initial determination for performing the retinal detachment repair.*

CONCLUSION

To really understand the nuances of this important topic, I strongly urge you to read the MLN's Global Surgery Fact Sheet (see "Resources & References"). ■

Riva Lee Asbell is the principal of Riva Lee Asbell Associates, an ophthalmic reimbursement consulting firm located in Fort Lauderdale, Fla. Ms. Asbell may be reached at rivalee@rivaleeasbell.com.