The Global Surgical Package

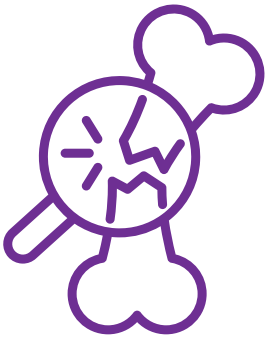
On December 21, 2023, the Centers for Medicare & Medicaid Services (CMS) released their MLN Connects Newsletter addressing a compliance topic of correctly billing services rendered during the global surgical period. This comes as a result of a recent Office of Inspector General (OIG) report citing that providers do not always comply with federal requirements when they bill for surgical services, focusing on co-surgeon (modifier -62) and assistant-at-surgery modifiers (modifiers -80, -81, -82, & -AS).

Let's first define what the "global surgical package" is. When a patient undergoes a minor or major procedure, there is typically a 10- or 90-day global period, respectively. This period is sometimes called the post-op period and covers all related services before, during, and after a procedure for a set number of days. The Medicare Claims Processing Manual (Chapter 12, Sections 40-40.1) informs that the following services are considered components of the global surgical package:

- Preoperative visits
- Intra-operative services that are considered a usual and necessary part of a surgical procedure
- Complications Following Surgery
- Postoperative visits
- Postsurgical pain management
- Supplies
- Miscellaneous Services
    - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Finding the global surgical package challenging to work with?
LW Consulting, Inc. can help! Our team of experts can help you establish an audit plan to add to your current compliance program. Learn more on our website.

LET'S DIG INTO SOME OF THESE A LITTLE DEEPER.



Pre-op visits – this is speaking to the surgeon and other QHP from the same practice, with the same specialty or sub-specialty. If a physician or other QHP from a different group sees the patient on the day prior to, or the day of the surgery, they should have no problems getting their claims paid.

Post-op complications – this inclusion is for treatment that does not require a return trip to the OR. For example, if an incision is oozing and the complication can be handled bedside, without a return to the OR, this is included and cannot be separately billed.

Follow-up visits – All related follow-up visits related to the recovery and healing from said procedure are included for the 10 or 90 days following the day of surgery.

Pain management after surgery – again, this is speaking to the surgeon and other QHP from the same practice, with the same specialty or sub-specialty. If a pain management physician is consulted for management of the post-surgical pain, this provider can bill for services rendered and should have no problems getting claims paid.

Now let's move on to what is NOT included in the global surgical package. Turning, once again, to The Medicare Claims Processing Manual (Chapter 12, Sections 40-40.1), the following services are NOT part of the global surgical package, and may be paid for separately:

- 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.
- Visits unrelated to the diagnosis for which the surgical procedure is performed unless the visits occur due to complications of the surgery.
- Treatment for the underlying condition or an added course of treatment that is not part of normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Distinct surgical procedures, during the postoperative period, that are not reoperations or treatment for complications.
- Treatment for postoperative complications that requires a return trip to the operating room (OR).
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Certain services performed in a physician's office, such as splints and casting supplies are payable separately under the reasonable charge payment methodology.
- Immunosuppressive therapy for organ transplants; and
- Critical care services (CPT codes 99291 and 99292) unrelated to the surgery.

Services Not Included in the Global Surgical Package That May Require Modifiers

The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery – This is typically done in the office several weeks or days prior to the surgery, can be billed, and is payable. Should this happen to occur within the confines of the days considered as included in the global period (the day prior to surgery), the -57 modifier can be applied to indicate the decision for surgery was made on this date. *As a side note, not all payers will accept the -57 modifier as a bypass for payment on a decision for a surgery visit*

This only applies to 90-day global periods. A modifier cannot be used on same-day visits for a minor procedure, unless a separate identifiable problem, unrelated to the procedure, is also treated. In this case, you would use modifier -25.

Visits unrelated to the diagnosis. – Any visits unrelated to the procedure can be billed and paid. Modifier -24 may need to be appended to indicate the visit is being performed during the postoperative global period but is not related to the procedure. Some payers may recognize a different ICD-10-CM code as an indicator, however, most will require the -24 modifier.

Treatment for postoperative complications that requires a return trip to the operating room (OR) - When the complication requires a return trip to the OR, for example, if the incision requires a washout and/or Incision & Drainage (I&D), there is a modifier that can be used to submit a claim for services rendered. It is important to note a claim with a post-op modifier typically does not reimburse at 100% of the allowed amount. Reimbursement is generally reduced by 10-30%, depending on the payer. If the procedure is unrelated, or related and staged, there are also modifiers that would be used.

About Those Modifiers:

- Modifier -78 - This is used for an unplanned return to the operating/procedure room by the same physician or other qualified health care professional following the initial procedure for a related procedure during the postoperative period.
  - Examples include surgical site infection, I&D, or hemorrhage.
  - The global period does NOT reset.
  - Has a reimbursement reduction of 10-30%.

- Modifier -79 - This is used for an unrelated procedure or service by the same physician/surgeon during the postoperative period of another procedure.
  - Typically for a different diagnosis.
  - Global period DOES reset.
  - Should pay at 100%.

- Modifier -58 - Used for a staged or related procedure or service whether at the time of the first surgery or a subsequent surgery that was more expensive than the first surgery and was performed by the same physician during the postoperative.
    - Planned Staged Procedures: ie: Debridement of burns, surgeon pre-plans and schedules for this, AND documents additional debridement will be needed.
    - Anticipated Staged Procedures: Excision of a breast lesion, pathology comes back as malignant, second procedure is planned to perform a mastectomy.
  - Global period DOES reset with each subsequent procedure/surgery.
  - Should pay at 100%.

An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures, including a cardiac catheterization suite, a laser suite, and an endoscopy suite. 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) are not to be considered an "OR".

Post-Op Period

There are three classifications of the global period, they are 0-Day, 10-Day, 90-Day. The determination is based on whether the procedure is an endoscopic, minor, or major surgical procedure. The reimbursement rate includes all the pre-operative (the day prior), intra-operative (the day of), and the post-op follow-up visits (10 or 90 days). This is why there is a global surgical package and trying to figure out what the actual global period timeframes are can be a bit tricky. Knowing where to find the information can help a great deal.

Decoding the "Post-Op Period"

0-Day Postoperative Period (000 codes) – This is for endoscopic procedures and some minor procedures (like some hernia repairs). This means there are no pre-operative or postoperative days to worry about, and typically covers all visits the day of the procedure (there are exceptions to every rule, of course).

10-Day Postoperative Period (010 codes) – Most minor procedures carry a 10-day post-op period. This means there are no pre-operative days to contend with, and typically covers all visits the day of the procedure and the 10 days immediately following. The total global period is 11 days.

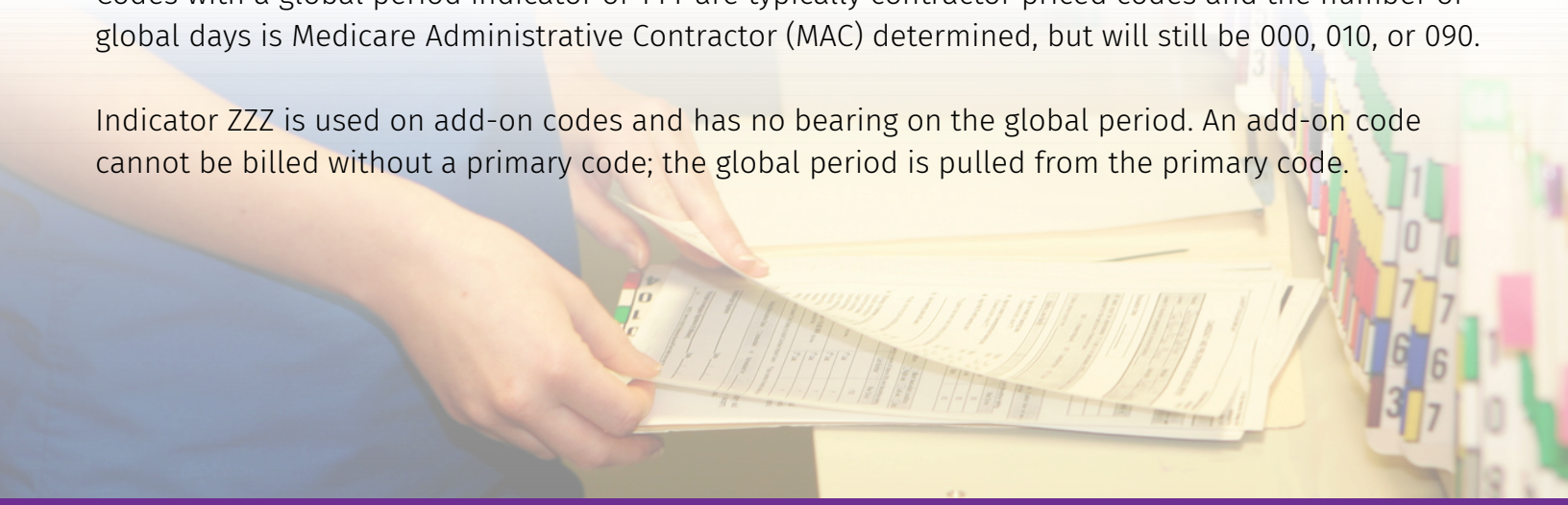
90-Day Postoperative Period (090 codes) – This is for major procedures. Included is 1-day preop, and typically covers all visits the day of the procedure and the 90 days immediately following. The total global period is 92 days.

Your next question is most likely, "But WHERE do I turn to determine WHICH procedures are 000, 010, or 090 global days?" First, there are 3 more codes that must be acknowledged: XXX, YYY, and ZZZ codes.

Codes with XXX indicate the global period concept does not apply.

Codes with a global period indicator of YYY are typically contractor priced codes and the number of global days is Medicare Administrative Contractor (MAC) determined, but will still be 000, 010, or 090.

Indicator ZZZ is used on add-on codes and has no bearing on the global period. An add-on code cannot be billed without a primary code; the global period is pulled from the primary code.

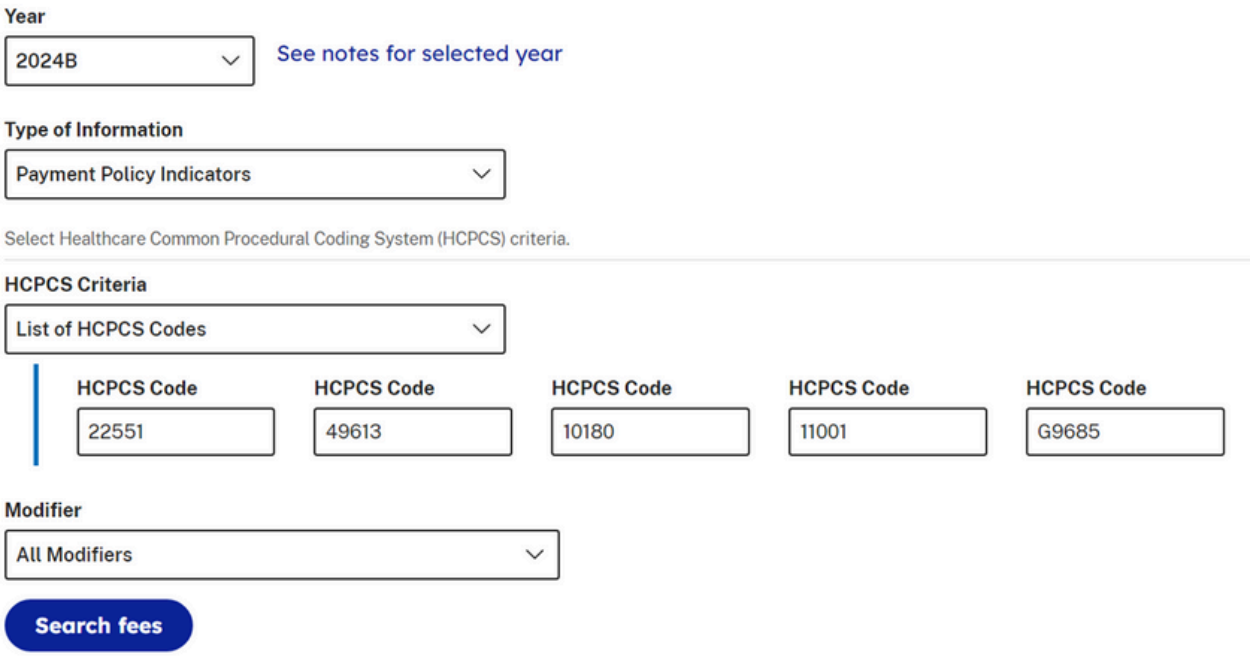


Where Do I Find This Information?

This information is available by utilizing the Physician Fee Schedule Tool offered on CMS' website.

To search you'll:

- Select the year you are inquiring about (the online tool currently goes back to 2000).
- Select the type of information you need. In this case you'll select "Payment Policy Indicators."
- Next, you will enter your HCPCS (CPT) Criteria. Here you can select a single HCPCS (CPT) code, a list (multiple), or a range of HCPCS codes.
- You can also choose modifiers. In this scenario, modifiers don't factor in, so you can leave it at the default of "All Modifiers."

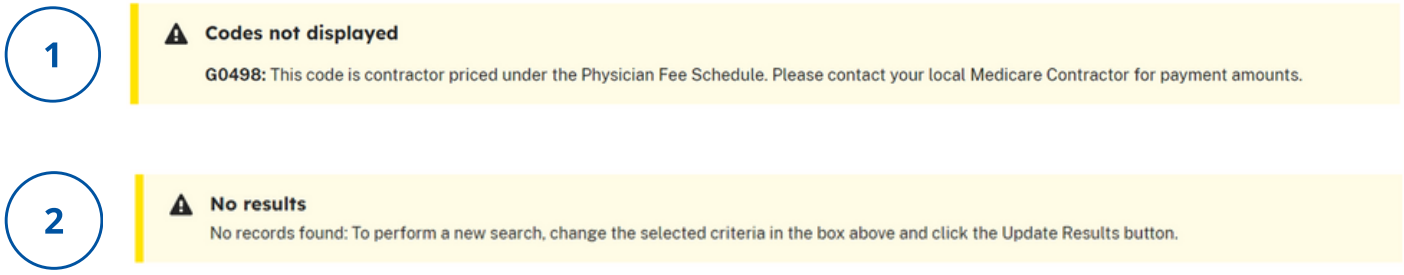


- Then click "Search Fees," and your results will populate.

HCPCS Code	Modifier	Short Description	Proc Stat	PCTC	Global	MULT SURG	BILT SURG	ASST SURG	CO SURG	Team SURG	PHYS SUPV
49613		Rpr aa hrn rcr < 3 rdc	A	0	000	2	0	2	1	0	09
10180		I&d complex po wound infctj	A	0	010	2	0	1	0	0	09
22551		Arthrd ant ntrbdy cervical	A	0	090	2	0	2	2	0	09
G9685		Acute nursing facility care	A	0	XXX	0	0	0	0	0	09
11001		Dbrdmt ecz/infct skn ea addl	A	0	ZZZ	0	0	1	0	0	09

*Note – search results were exported to a spreadsheet for sorting and formatting purposes

When you enter a code that is contractor priced, you'll see one of two results come up. The first one displayed below will show up when you enter multiple HCPCS (CPT) codes, and the second one will show up when you enter the code in a single code search.



You can find 90-Day Global Period Calculators on some of the MAC's website (like this one from the National Government Services (NGS)**.** This makes it easy for you to determine when the global period ends for major surgeries, in the event your billing/coding software does not do this for you.

What to Do if the Surgeon Only Provides a Portion of the Global Surgical Package

There may be situations where a surgeon does not provide the follow-up care. When this happens, the care is split with a transfer of care to another physician. To ensure proper reimbursement is received, the following steps must be taken:

- The agreement to split care must be in a written form; both the surgeon and the physician handling the postoperative care must keep a copy of the written transfer agreement in the patient's medical record.
- The surgeon would bill the appropriate CPT code for services rendered and append modifier -54 to indicate the surgical care was the only portion provided. The physician taking over the follow-up care would also bill the appropriate CPT code for services rendered (by the surgeon) and append modifier -55 to indicate management of the postoperative care.
- The surgeon and the physician would both bill the same DOS, which would be the date the surgical procedure was performed.

Additional Important Information:

- Modifiers -54 and -55 do not get appended to assistant-at-surgery claims or ASC's facility claims.
- The physician accepting the transfer of care must provide at least one service prior to billing for the postoperative care management.
- More information can be found on the Medicare Claims Processing Manual (sections 40.2 & 40.4) via the CMS website (Medicare Claims Processing Manual, 2024).
- There're always exceptions to the rules, modifiers -54 and -55 are no different.
  - If a transfer of care does not happen, the physician who did not perform the surgery can report the follow-up services with an appropriate E/M code, without modifiers.
  - If a physician is seeing a patient as a follow-up to an ED visit, the services can be reported with an appropriate E/M code, without modifiers.

Critical Care Services Received During the Pre- and Postoperative Period

Critical care services (CPT codes 99291 and 99292) unrelated to the surgery

Critical care services can be billed and may be reimbursed when the following criteria are met:

- The patient is critically ill and requires constant physician attendance.
- The critical care is typically unrelated to the specific anatomic injury or general surgical procedure performed and goes beyond the normal procedure.

It is important to note that both items must be met for payment consideration, in addition to the following coding and documentation requirements:

- Use CPT codes 99291/99292 and modifier –25 for pre-operative care or –24 for postoperative care.
- Document the critical care unrelated to the specific anatomic injury or general surgical procedure; add an ICD-10-CM code for a disease or separate injury that clearly indicates the unrelated critical care to surgery. This is acceptable documentation.

It is also important to note other critical care guidelines for bundling services and exclusions should be reported as they would normally be, outside of a global surgical package.

The following services are included in "critical care clock time" when performed during the critical period by the same physician(s) providing critical care and should not be reported separately:

- Interpretation of cardiac output measurements (CPT 93598)
- Pulse oximetry (CPT 94760, 94761, 94762)
- Chest x-rays, professional component (CPT 71045, 71046)
- Blood gases, and collection and interpretation of physiologic data (e.g., ECGs, blood pressures, hematologic data)
- Gastric intubation (CPT 43752, 43753)
- Transcutaneous pacing (CPT 92953)
- Ventilator management (CPT 94002-94004, 94660, 94662)
- Vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)

Any services performed that are not listed above may be reported separately.

Modifier – FT - Unrelated evaluation and management (e/m) visit on the same day as another e/m visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (report when an e/m visit is furnished within the global period but is unrelated, or when one or more additional e/m visits furnished on the same day are unrelated)

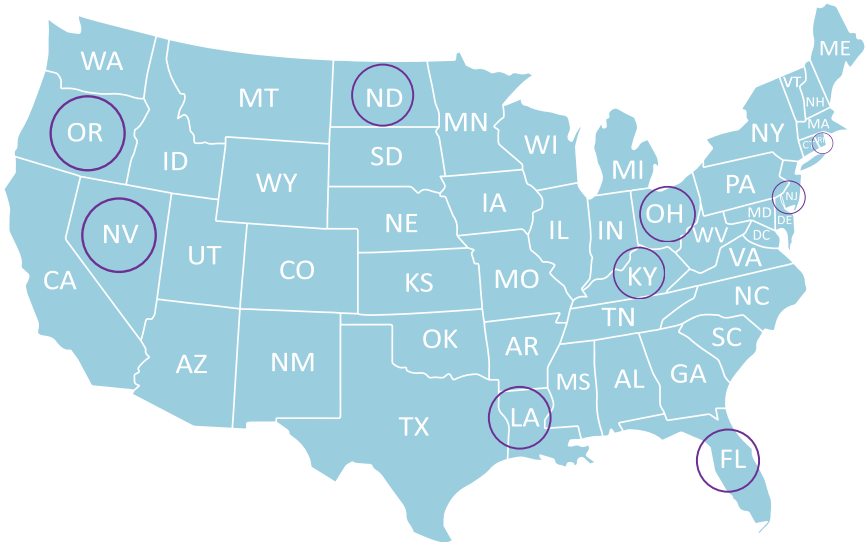
- Modifier – FT must also be appended to the critical care codes to indicate the services are unrelated to the surgical procedure and were performed postoperatively.
- This modifier is a confusing one, as it is not well defined. There are varying responses to using this modifier, for example:
  - A CMS spokesperson explained in response to a question from Part B News "As discussed in our CY 2022 PFS final rule, the modifier should be included on a claim in circumstances when critical care services are performed during the global surgical period of an unrelated procedure."
  - Other payers may have other requirements, it is advised to check with your individual payers to ensure you are reporting these services and using the modifier appropriately

Critical Care Services information: (Evaluation and Management Services Guide, 2023)

Postoperative Claims-Based Reporting Requirements

You may be required to submit a claim to CMS with the post-op CPT code 99024 if you practice in a group with 10 or more providers. This was mandated under MACRA for CMS to collect data to reevaluate and assess the valuation of the global surgical package. This began July 1, 2017, for 9 states:

- Florida
- Kentucky
- Louisiana
- Nevada
- New Jersey
- North Dakota
- Ohio
- Oregon
- Rhode Island



Resources

Medicare Claims Processing Manual. (2024). Medicare Claims Processing Manual. In Chapter 12 - Physicians/Nonphysician Practitioners. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Medicare Learning Network. (2023, August). Evaluation and Management Services Guide. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf