Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Avoid Giving Care Away for Free During Global With These Quick Tips

Keep modifiers, separate services in mind when offering postoperative care.

If you aren't capturing services that your surgeon performs during the global such as return to the OR for an unanticipated bleed after evacuation of a hematoma, you could be flushing money away. Follow these simple steps to identify all post-surgical complications or unrelated procedures that your physician performs.

Know the Global Period Parameters

You can check a procedure's global period by identifying the day of the surgery, but you don't want to omit any preliminary services provided beforehand. Make sure to include within the global package all care performed the day before the surgery as well as the preop visits that the patient made after the surgeon decided to operate.

On the day of the surgery, any intraoperative services that are a part of the surgical procedure are included in the global period. Following the day of the surgery, anticipated complications of a particular surgical procedure, and services like the observation during recovery from anesthesia, counseling of the family, and other postoperative orders for routine care are part of the global period. The global period for major surgical procedures is 90 days. "In major procedures, count one day immediately before the day of surgery (Preoperative), the day of surgery (Intraoperative), and the 90 days immediately following the date of surgery (Postoperative/ follow ups)," says **Gwendolyn M. Flaherty, CPC,** with NeuroScience Associates, Idaho.

Pay Attention to the Partial Payments

If your physician performs only part of a procedure's surgical package, you should keep modifiers 54 (Surgical care only.....), 55(Postoperative management only.....), and 56 (Preoperative management only.....) at hand to specify the extent of services offered by your surgeon for a particular procedure.

"Modifiers 54, 55, and 56 are important in the global period," says **Michelle L. Benz**, business manager with Neurosurgery and Spine in Milwaukee. Your surgeon may only have performed the surgical procedure and not rendered any extensive preoperative or postoperative care. In this case, you would select the procedure code and append modifier 54. On the other hand, you may encounter instances where another surgeon provides the preoperative and postoperative care.

"These modifiers inform the insurance company that separate providers performed the preoperative, intraoperative, and/or postoperative work," Flaherty says. "If the surgeon performs the preoperative and intraoperative work, but a rural family doctor performs the postoperative follow-up, each provider gets a portion of the surgical CPT® code allowable by appending the appropriate modifier to the surgical CPT® code."

You'd use modifier 55 to indicate that payment for the postoperative, post-discharge care is split between two or more physicians when the physicians agree on the transfer of postoperative care. Lastly, modifier 56 applies when one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, explains Benz.

Keep in mind that two providers sharing components of the preoperative, surgical and postoperative work of a CPT® code must coordinate which codes are used as well as the appropriate modifiers to ensure that both are paid their appropriate components of the work performed, says **Gregory Przybylski, MD**, director of neurosurgery with New Jersey Neuroscience Institute at JFK Medical Center in Edison.

Example: If your neurosurgeon only repairs the encephalocele and the postoperative care is provided by another surgeon, you would report code 62120 (Repair of encephalocele, skull vault, including cranioplasty) and append modifier 54.

"If your neurosurgeon performs the postoperative care for the surgical treatment of a cervical spine injury sustained while the patient was at a resort location andwas subsequently transferred from that local hospital, you would append modifier 55 to the surgical procedure codes used by the other surgeon to designate that your neurosurgeon is performing the postoperative care related to the cervical surgery," says Przybylski. If you perform the preoperative management of a patient who subsequently undergoes a surgical procedure by another surgeon, you may append modifier 56 to all of the procedure codes to designate the performance of the preoperative management component only. "However, payers including CMS may not consider payment for the preoperative services alone," warns Przybylski.

Medicare Requires Return to OR for Postop Payment

When you read in the documentation that the patient was returned to the operating room following the original surgical procedure, you should carefully interpret why the patient was returned and what was done in the subsequent procedure.

You'll append modifier 78 (Unplanned return to the operating/ procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period.....) when the surgeon takes the patient to the operative room again after a previous procedure for a complication or unanticipated clinical condition that follows in the postoperative period. "

When a patient returns to the operating room for an unplanned procedure that is related to the first surgery and they are still in the global period of the first surgery, you report modifier 78. However, you report modifier 58 instead if the performance of a procedure or service during the postoperative period was planned or anticipated, more extensive than the original procedure, or for therapy following a diagnostic surgical procedure, explains Flaherty.

Modifier 58 applies if the return of the patient to the operative room during the global period meets any of the following criteria:

1. The procedure is staged, i.e. it was planned by the surgeon prior to or with the previous procedure;

2. The procedure is more extensive than the original procedure; or

3. The procedure is meant for therapy following a diagnostic surgical procedure.