Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Guest Columnist: Alice Marie Reybitz, RN, BA, CPC, CPC-H - Apply These Surefire Tips for 90-Day Global Period Sucess

Think there really are 90 days in this period? Find out the truth As Medicare has proven time and time again, you can never brush up on your global period skills too much.

The 90-day global surgical package has gotten quite a lot of press recently, and there still seems to be some confusion and misinformation out there.

So let's look at what that -global package- is all about.

The global period rule reads, -To determine the global period for major surgeries, carriers count the day immediately before surgery, the day of surgery and the 90 days immediately following the surgery.- This does, in fact, give you 92 days.

The actual 90-day countdown does not start until the day after the surgery took place, not the day of surgery. This can make tracking days tricky for the staff.

Reap Proper Reimbursement

All of this global period information is extremely important in pre- or postoperative care. You must be very careful to compare diagnosis information with each visit in this period. If the same diagnosis is the primary reason for the visit as was the primary for the surgery, payers consider this to be in the global period, and they would deny an E/M visit under the global rule.

Good news: Modifiers allow us to bill for these services during these periods, if the modifier chosen is correct for our documentation:

- Modifier 54 (Surgical care only) allows for billing only the procedure and the associated care.

- Modifier 55 (Postoperative management only) allows us to follow the patient after the procedure but nothing else.

- Modifier 56 (Preoperative management only) allows you to bill for the patient's care before the provider initiates the surgery or procedure.

- Modifier 57 (Decision for surgery) allows for a visit the day immediately before the surgery, and payers will reimburse this E/M.

Coordinate With All Physicians

In today's mobile society, these modifiers are wonderful--but there is a caveat. The total paid to all providers involved cannot and will not exceed the full reimbursement for that 90-day global package care.

For example: Mrs. Green, who lives in Pennsylvania, is visiting her daughter, who lives in Florida. While there, Mrs. Green falls and breaks her arm. She goes to the hospital, has an x-ray, and has a consultation with an orthopedist who per forms an open reduction with internal fixation on her right wrist.

Mrs. Green's return plane tickets are for two weeks from now, so some of her follow-up care will most certainly be done

by her doctor in Pennsylvania.

What does this mean to the biller? Your office must complete all coordination of all care prior to the procedure. All medical providers involved must be aware of what the care will be from each, and each must bill accordingly.

Why? Because the first bill to hit the carrier's desk will be paid, the carrier will deny the other bills hitting later as duplicate(s) or already paid in full to another provider. This can flag an account for fraud. Then you will have to communicate so that whoever re-ceived the first payment returns it, everyone gets the codes right and everything gets resubmitted.

Remember: The total payments made to the individual practitioners cannot exceed the total paid to one for a global service.

For this reason, the surgical coordinators in any office have so much more to do than just schedule the procedures. They really should be coordinating these efforts, and to do that they need to interview the patient extensively and ask about her plans for all that needs to be done regarding care and payment.

The most frustrating bills to collect are those for which you happen to be the last practitioner to get your bill to the carrier. Coordinating on the back end to get all the bills from all participants in the patient's care on track for all of you to be paid is a huge headache.

Size Up Medicare's Definition

In Medicare's view, surgical packages include the following services when completed by the physician who performs the surgery:

- Preoperative visits after the physician decides to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures

- Intraoperative services that are a usual and necessary part of the surgical procedure

- All additional medical or surgical services required of the physician during the postoperative period because of complications not requiring additional trips to the operating room

- Follow-up visits during the postoperative period

- Postoperative pain management

- Certain supplies, especially those needed for the procedure

- Miscellaneous services, such as dressing changes, local incision care, suture removal, insertion, irrigation and removal of catheters and routine peripheral IV lines, and other potential related services.

You can bill separately any service after that 90-day period that is still related to the procedure.

Alice Marie Reybitz, RN, BA, CPC, CPC-H, a healthcare coding and billing consultant based in Belleair, Fla., has been in the medical field for more than 20 years. She has worked as a receptionist, assistant, aide, biller, coder, office manager, director and nurse, and serves as medical billing and coding program coordinator for Keiser Career College in St. Petersburg, Fla.