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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Use This Guide To Get A Grip On Global Periods

Learn how modifier 78 breaks all the 'resetting' rules

Ignoring global periods can wreak havoc on your bottom line. We examine the seven global periods Medicare applies to all procedure codes and explain how these assignments should influence the way you append modifiers.

Count Your Days For Major Or Minor

Of the seven different types of globals Medicare has established, three represent the number of days of postoperative care included in the fee for the initial procedure:

000 - This period indicates that zero days of postoperative care are included in the payment, but any related evaluation and management work done on the same day as a procedure with this global is included.

Example: Under Medicare guidelines, 11040 (Debridement, skin, partial thickness) has a global period of 0 days. Therefore you may bill for the procedure as often as it needs to be performed, be it multiple times in one day or once every day for several days in a row. But if you perform a related E/M procedure on that same day, you cannot report it separately.

010 - This period indicates that Medicare includes 10 days of postoperative care in the payment.

Example: An otolaryngologist examines a patient who presents with nasal congestion, headaches, and sinus pressure. The otolaryngologist decides to perform a nasal endoscopy (31231, Nasal endoscopy, diagnostic, unilateral or bilateral), a diagnostic procedure with 0 global days. The scope procedure goes beyond the realm of a normal otolaryngology exam, so you would bill it separately. Because the E/M resulted in the decision to do the procedure, you can consider it separately identifiable as long as the nasal endoscopy was unplanned.

Manage 25 With Minor Procedures

Procedures with global periods of 0 or 10 days are considered "minor procedures." Because of this designation, Medicare and private payers don't pay separately for the E/Ms performed on the same day and consider a small history, exam, and MDM included in the fee for minor procedure. In order to get paid separately for an E/M services performed on the same day as a minor procedure, you have to show that the E/M was documented as separate and significantly identifiable. There are two circumstances that payers will consider 25-worthy:

Scenario 1: Although 25 is not called the "decision for surgery" modifier, in some ways it becomes a decision-for-surgery modifier for minor procedures that are unscheduled, says **Barbara J. Cobuzzi, CPC, CPC-H, CHBME**, president of **CRN Healthcare Solutions** in Shrewsbury, N.J. In these cases you can link the same diagnosis code to the E/M and the minor procedure - just be absolutely sure the minor procedure was not planned prior to the office visit, she adds.

Scenario 2: If a patient presents for a scheduled minor procedure and you have an E/M that is separately identifiable, you will be able to identify this separate service because it will have a different diagnosis code than that linked to the minor procedures. Example: A patient is scheduled for his second synvisc injection for arthritis of the knee. When he arrives at the office, he complains to the physician about sever shoulder pain. The physician does a complete work-up for the new complaint, takes x-rays of the shoulder, and does a full evaluation with medical decision making. In this case, you would report 9921x-25 with diagnosis of shoulder pain, the code for the xray, and the J-code for the synvisc injection.

Rely On 57 For E/Ms With Major Procedures

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090 - Procedures with 90-day global periods have 90 days of postoperative care included in the fee for the initial procedure

Codes with a 90-day global period are considered major surgeries. If decision for surgery E/M is performed on the same day, or the day before and unscheduled surgery, you should append modifier 57 (Decision for surgery) to receive separate payment for the E/M code.

Example: A patient presents to the emergency room with severe pain in her right lower quadrant. The general surgeon is called in for a consultation, and after a comprehensive history exam and MDM, he determines that it's necessary to bring patient into operating room for an emergency appendectomy. An appendectomy procedure has a 90 day global period so it includes all services provided the day of and day before the procedure. But because this was an unscheduled surgery, the surgeon may append 57 indicating that the service was the decision-for-surgery service and therefore separately billable.

Avoid Pigeon-Holing Groups

The remaining 4 global period categories do not have specific time periods for postoperative care attached to them.

MMM - This period describes a service furnished in uncomplicated maternity cases including antepartum care, vaginal delivery and postpartum care. The usual global surgical concept does not apply to uncomplicated vaginal deliveries. A code that would have MMM attached to it is Code 59400 (Routine obstetric care including antepartum care, vaginal delivery [with or without episiotomy and/or forceps] and post-partum care) is an example of a code that would have MMM attached as its global period.

Under MMM, all of a patient's maternity care services are covered during the global period, explains **Maggie Mac, CPC**, a consultant with **Pershing Yoakley & Associates** in Clearwater, FL.

If the delivery is a cesarean, however, it carries a 90-day global so the MMM isn't really applicable, Barbara says.

XXX - Codes assigned "XXX" are not subject to the global period concept. Evaluation and management services and other services performed may be reported separately on the same day as this code. However, NCCI version 7.2 defined that XXX global period procedures, like minor procedures, have a small history, exam and MDM associated included, so some payers may require a 25 modifier on the E/M to indicate that they were significantly separately identifiable in order to get paid.

EKGs, tympanograms and certain other procedures found in the Medicine section of CPT are examples of procedures not subject to the global period concept.

YYY - This designation means that individual carriers determine the global period. YYY usually applies to unlisted procedures, and the global period a carrier assigns will depend on the type of unlisted service. Example: A simple unlisted skin procedure would probably receive a global period of 0-10 days, while 21499 (Unlisted musculoskeletal procedure, head) would most likely be assigned a 90-day global period.

ZZZ - This global period designation means the procedure is related to another primary procedure and falls within the global period of the other service. Only the additional intra-service work to perform this service is included in the work RVU. This global period applies only to add-on codes. This designation is for codes that are a component of a larger service, says Mac.

Important: Never assume all codes within a specific category have the same global period. For example, while the majority of medicine codes have a global period of XXX, there is a handful that doesn't, such as 95144 (Professional services for the supervision of preparation and provision of antigens for allergy immunotherapy, single dose vial[s] [specify number of vials]). The same goes for maternity codes 59400-59622; 59525 (Subtotal or total hysterectomy after cesarean delivery) is an add-on code and therefore has a global period of ZZZ.

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Conquer Coding Complications

Global periods get tricky when you start encountering things such as complications and staged surgeries.

Basically, most major procedure that physicians perform in the postoperative period will reset the global, says **Laureen Jandroep, ORT, CPC, CPC-H, CCS**, **CCS-P**, of the CRN Institute in Absecon, NJ. "For example, if a patient has a hysterectomy and, with 60 days left in the global period, she requires another major surgery with a 90 day global period, then the patient would likely not have any E/Ms billed from that office for another 90 days."

Pitfall: This "reset rule" does not apply to every situation. When you append 78 (Return to the operating room for a related procedure during the postoperative period) to a procedure for a complication of the initial surgery, the global period does not reset - and you get an intraoperative allowance instead of the complete fee for the postoperative procedure.

While Medicare does list the global periods in the its fee schedule database at www.cms.hhs.gov/providers/pufdownload/rvudown.asp, not all payers follow those periods, caution both Jandroep and Mac. Some private payers actually have 45 days for major procedures while Medicare has 90 days, so you should start billing out services to patients who had major procedures on day 46. Best: Ask your carriers for their global periods in writing. Then plot each payer's global periods on a grid so you know the exact length of the postoperative coverage the next time you encounter that service.

Tactic: Check with your top 3 to 5 payers on the global periods they set for your office's most common procedures, Jandroeop advises.

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