Part B Insider (Multispecialty) Coding Alert

Surgical Coding: Your 5 Biggest Global Period Questions Answered

Unlisted global? Ask the payer.

With the recent news that CMS may be preparing to practically eliminate global periods by 2017 (see the Insider Vol. 15, No. 25 for more), the spotlight is on these pre- and post-surgical days, which can often confuse even the most seasoned coders. To ensure that you're properly billing your services in the face of global packages, check out the following five questions, along with answers that can help ensure that your global codes are on the straight and narrow.

Prepare for Varying Unlisted Globals

Question 1: Does Medicare assign a global period for unlisted-procedure codes? For instance, if the neurologist performs qualitative sensory testing (QST) and we report 95999, can we charge for a follow-up office visit 10 days later?

Answer: National Medicare policy, as reflected in the Physician Fee Schedule database, does not establish a formal global period for unlisted-procedure codes, such as 95999 (Unlisted neurological or neuromuscular diagnostic procedure). Rather, national Medicare assigns most unlisted codes an "XXX" or "YYY" global period, meaning that the "global concept does not apply" to the code or that the individual carrier "is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing," according to CMS guidelines.

Other payers may base the global period on the "compare code" that you use for pricing. In other words, the payer holds all the cards and can determine whether and what kind of global period to impose when you submit an unlisted-procedure code.

In most cases, the payer will assign an "XXX" global period for diagnostic procedures such as QST - which means the procedure includes no global period. You can attempt to influence the payer's decision by noting the global period for similar procedures when submitting your claim.

If the payer does institute a global period, however, you should not report follow-up visits during that time as separate services.

Don't make assumptions about your payer's rules: Get your payer's guidelines in writing and follow them consistently. Like everything else involving unlisted- procedure claims, this will require extra effort, but it will also ensure the best reimbursement and prevent you from facing fraudulent-coding charges.

Is 'XXX' the same as '0' Global Days?

Question 2: What's the difference between an "XXX" global period and a "000" global period?

Answer: There is a distinct difference between these two global periods. The classification XXX (Global surgical rules do not apply) means the service is truly free of global surgical bundling issues. You can separately report services, such as E/M visits, that you perform on the same date as a surgical procedure with an XXX global period.

The 000 classification means the procedure adheres to bundling rules only on the date of the service. Medicare will therefore bundle all services that you perform on the surgery date into codes with this 000 global period.

Example: Puncture aspiration of a breast cyst (19000) includes a 000 global period. So if you perform an E/M service on the same date as the aspiration, Medicare will typically bundle the E/M into 19000.

By contrast, 32855 (Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including

dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral) has an XXX global period. So if the physician provides a related E/M visit on the same day as this service, Medicare should not bundle the E/M code into 32855.

Best practice: Some coding analysts recommend that you should still append modifier 25 (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) to the E/M code if you report it on the same day as a procedure with an XXX global period. Modifier 25, along with physician documentation, proves the E/M service was "significant" and therefore more in-depth than the typical E/M component the procedure code already includes.

Consider Pricing for Modifier 78

Question 3: For a related procedure done during the global period with modifier 78 attached, should we expect 100 percent allowable payment or it is less being related to the previous procedure? If it is less, how much is it compared to the actual allowable amount?

Answer: 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) is for an unplanned return to the procedure room during the postoperative period. When reporting modifier 78, you will only receive reimbursement for the surgical portion of the code. You'll get no payment for the postoperative care as the patient is already in a global postoperative period for the original surgery for which you were or will be reimbursed. The global period will remain related to the initial procedure performed.

Typical Care Included in Global

Question 4: Our ED doctors have patients with abscess I&Ds come back multiple times during the 10 day treatment period. When asked why this was a routine process, the physician said "he wasn't sure the patient would keep it clean and it would heal, so he wanted the ED nursing staff to take care of it." He himself seldom looks at the wound, unless asked to do so by the nurse. According to CMS, this has a 10 day global period. I have not given the professional side any billing. The doctors are disagreeing with this; what would do you do?

Answer: For codes such as an I&D with a 10-day global period, dressing changes and wound checks would be included in that global period so you would not be able to bill again for the physician services. If the follow up care was atypical non-routine care, such as for curetting, changes of medications, or additional treatments, then you would consider reporting an additional service.

Typical Post-Operative Care is included in the global period. Packing removals may represent "typical care," as the packing removal is an inherent and expected component of the original incision and drainage.

Preexisting Vs. New Matters During Global

Question: If I see a patient after his radical prostatectomy within the global period, and I evaluate and manage his incontinence and ED, can I bill a separately identifiable E/M within the global period? Or, would this be considered included in the global period?

Answer: The answer will depend upon whether your patient had the incontinence and erectile dysfunction (ED) prior to his prostatectomy or if these problems are complications of the prostatectomy.

If these are past conditions, and you have clear documentation that incontinence and ED were existing conditions unrelated to the prostatectomy, you should bill the appropriate evaluation and management code, such as 99214 (Office or other outpatient visit for the evaluation and management of an established patient ...). You should append modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period).

If the conditions are complications directly resulting from the prostatic surgery, and were not present before the radical prostatectomy, you may not be able to bill for the office visit. That said, some commercial payers would allow

reimbursement for treatment of complications. Medicare, however, does not. You need to know your payer.