Surgery Global Package

The global surgical package comprises a host of responsibilities that include knowing if the procedure or surgery has a global period, what services are included in the procedure or surgery, and knowing when a service can be billed separately. Outlined below are the surgical global package guidelines to take into consideration when billing for a procedure or surgery. (Resource: AAPC Medical Coding Training: CPC)

Surgical Guidelines: Surgery is a medical branch utilizing various operative techniques by manual and instrumental means to diagnose and/or treat injury, deformity, and disease. The condition of the patient determines which medical procedure is performed, including all variables or comorbidities. CPT surgical codes represent a wide variety of services. When defining specific services that are included in a given CPT surgical code, the following services are inclusive, not separately billable.

Global Package as Defined by CPT: Payment for surgical procedures includes a standard package of preoperative, intraoperative, and postoperative services. Preoperative and postoperative periods will differ based on the classifications of the service as a major or minor surgery.

The services included in a global surgical package may be furnished in any service location, e.g., a hospital, an ambulatory surgical center (ASC), or physician office. Visits to a patient in an intensive care or critical care unit are also included when made by the surgeon. Under some circumstances, critical care services (99291-99292) are not considered part of the global package and are reimbursed separately.

Surgery as Defined by Medicare: Medicare has classified major and minor surgeries and has determined what services are included and not included with the global package. Medicare has also determined the preoperative and postoperative days allowed for each type of surgery.

The preoperative period included in the global fee for major surgery is 1 day with 90 days for the postoperative period. The preoperative period for minor surgery is the day of the procedure with a postoperative period of either 0 or 10 days depending on the procedure. For endoscopic procedures (except procedures requiring an incision), there is no postoperative period. Global period days are available on the CMS website.

Each CPT also has a global period status indicator as per the CMS payment policies. Surgical CPT codes (10000-69999) have a global surgery status indicator determining classification for minor or major surgery as determined by RVU calculations. Per the Federal Register, Vol. 74, No. 132, surgical status indicators are assigned based on risk factors associated with medical specialties.

Status Indicators:

000 Endoscopies or minor procedures with preoperative and postoperative relative values on the day of the procedure only are reimbursable. Evaluation and management services on the same day of the procedure are generally not payable (e.g., CPT 43255, 53020, 67346)

010 Minor procedures with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period are reimbursable services. Evaluation and management services on the same day of the procedure and during the 10 day postoperative period are not reimbursable (e.g., CPT 17261, 40800, 64612)

090 Major procedures with one day preoperative period and 90-days postoperative period are considered to be a component of global package of the major surgery. Evaluation and management services on the day prior to the procedure, the day of the procedure, and during the 90-day postoperative period are not reimbursable (e.g., CPT 21048, 32664, 49582)

MMM Maternity codes; the usual global period concept does not apply (e.g., CPT 59400, 59612)

XXX The global concept does not apply to this code (e.g., E/M services, Anesthesia, Laboratory, and Radiology procedures) (CPT 10021, 36593, 38220, 44720)

YYY These are unlisted codes, and subject to individual pricing (e.g., CPT 19499, 20999, 44979)

ZZZ These represent add-on codes. They are related to another service and are always included in the global period of the primary service (e.g., CPT 27358, 44955, 67335)

(cont. page 2)
Modifiers Used To Report Payable Services within the Global Package

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Appropriate Examples</th>
<th>Examples/Rationale No Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period</td>
<td>A patient was seen in the global period by his physician for a postoperative check after colon surgery. During the visit, the patient asked for medication for his sinus condition. This throat and nose were checked and a prescription was written (egg, 99212-24)</td>
<td>A patient is seen in the office for a post-op evaluation after removal of a face lesion. Proper reporting would be the code 99024 - Postoperative follow-up visit</td>
</tr>
<tr>
<td>25</td>
<td>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</td>
<td>A patient was seen by an emergency room physician after an automobile accident and a laceration repair of the face was required. The patient was examined for possible head injury. The E/M code (with modifier) and laceration repair codes would be billed</td>
<td>A patient was seen in a physician’s office for a planned wart destruction and the physician discusses the procedure again briefly with the patient and then performed the removal. Proper coding would be 17110 The code 17110 already had minimal E/M included in the code</td>
</tr>
<tr>
<td>57</td>
<td>Decision for Surgery</td>
<td>A patient was seen by a surgeon in an emergency room with severe abdominal pain. The surgeon admitted the patient and performed a laparoscopic cholecystectomy the same day (eg, 99221-57, 47562)</td>
<td>A patient was seen in the provider’s office where the surgery was planned for a week in the future. Report the appropriate E/M service code. It would be inappropriate to append a 57 modifier since the surgery is outside the 24-hour period</td>
</tr>
</tbody>
</table>
### Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

- Patient had a breast biopsy and five days later the same surgeon performed a modified radical mastectomy for breast cancer (19307-58).
- Patient had debridement of the open wound of the leg. Two days later another debridement was performed (11043-58).
- A patient returned to the surgeon’s office five days after a breast biopsy for drainage of a seroma. Report 99024 (post op visit). Do not report 10160-58 or 10160-78 as a seroma can occur after a breast biopsy. The procedure was performed in the office and is bundled with the breast biopsy.

### 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

- A patient returns to surgery for possible abdominal bleeding on the same day following a colon resection performed earlier by the same physician (49002-78).
- Patient is in a global period of a laceration repair of the thigh has developed a small hematoma. The incision is opened 1 inch and the hematoma is drained in the office (99024-78). 10140-78 is not reported as the procedure did not require a return to the operating room.

### Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

- A patient returned to surgery for a closed reduction of a left ankle fracture while the patient was recovering from an open reduction to the right ankle by the same surgeon (27808-79).

---

### Registries versus Repositories

There are distinct, important differences between registries and repositories, which must be acknowledged and adhered to by all investigators. A registry is used for the collection and maintenance of information on individuals who have a similar condition and who will consent to being contacted for future studies or who agreed to allow their data to be used for future studies in a specific area of research. A repository is used for the collection and storage of identifiable specimens. By participating in the repository, the subjects consent to be contacted for possible participation in future studies or who agreed (in advance) to allow their data to be used for future studies in a specific area of research.

Both types of studies require IRB review. IRB approval and consent is required if:

- There is planned collection of additional tissue beyond what is needed for the clinical procedure.
- Discarded tissue is obtained with identifiable information for analysis. Note: Secondary analysis of de-identified specimens does NOT require IRB review and approval. However, federally funded studies may need some documentation of an IRB determination.

In addition to registries and repositories, data use agreements are allowable at Saint Louis University, but will also require IRB review and approval, as PHI is involved. Data use agreements are written contracts that govern the sharing of data between research collaborators at different institutions, i.e., universities, government agencies, other non-profits, for-profit companies.

If there are any questions on any of the above mentioned information you may contact SLU’s IRB at 977-7744 or Research Compliance Auditor Hannah Halstead at 977-5887.

### ICD-10-CM Sepsis and Sequencing

<table>
<thead>
<tr>
<th>ICD-10-CM Code or Scenario</th>
<th>When to code/Sequencing</th>
</tr>
</thead>
<tbody>
<tr>
<td>A41.9</td>
<td>*Type of infection not further specified *Negative or inconclusive blood cultures</td>
</tr>
<tr>
<td>R65.2</td>
<td>*Only assigned when severe sepsis or associated acute organ dysfunction is documented *Requires minimum of 2 codes: underlying systemic infection and severe sepsis R65.2 *If causal organism not identified – A41.9 with additional codes for acute organ dysfunction</td>
</tr>
<tr>
<td>Sepsis/Severe Sepsis w/Localized Infection</td>
<td>*Underlying systemic infection followed by: localized infection AND R65.2 if severe sepsis present *List localized infection first followed by sepsis code(s) if admitted with localized infection and sepsis/severe sepsis doesn’t develop after admission</td>
</tr>
<tr>
<td>Septic Shock (circulatory failure associated w/severe sepsis)</td>
<td>*Systemic infection followed by: R65.21 severe sepsis with septic shock OR T81.12 post procedural septic shock AND any additional codes for other acute organ dysfunction(s)</td>
</tr>
</tbody>
</table>

Reference: Chapter 1: Certain Infectious and Parasitic Diseases, Sepsis, Severe Sepsis, and Septic Shock Coding Guidelines (Section I.C.1d.1)