SAINT LOUIS UNIVERSITY

OFFICE OF UNIVERSITY COMPLIANCE

Surgery Global Package

November 2015

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)

Surgery Guidelines: Surgery is a medical branch utilizing various operative techniques by manual and instrumental means to diagnos 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)

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Services Included in the Global Package

1. Preoperative Visits – Preoperative visits after the decision is made to operate beginning with the day before the surgery for major procedures and the day of surgery for minor procedures
2. Intraoperative Services – Intraoperative services considered a usual and necessary part of a surgical procedure
3. Complications Following Surgery – All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications, which do not require additional trips to the operating room
4. Postoperative Visits – Follow-up visits within the postoperative period of the surgery related to recovery from surgery
5. Postsurgical Pain Management – By the surgeon
6. Miscellaneous Services – Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples; lines, wires tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes

Services Not Included in the Global Package

1. Initial consultation or evaluation of the problem by the surgeon to determine the need for surgery
2. Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complication of the surgery
3. Treatment for the underlying condition or an added course of treatment that is not part of the normal recovery from surgery
4. Diagnostic tests and procedures, including diagnostic radiological procedures
5. Clearly distinct surgical procedures during the postoperative period that are not re-operations or treatment for complications (A new postoperative period beings with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure
6. Treatment for postoperative complications which requires a return trip to the operating room (OR). The term operating room includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR)
7. If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately
8. For certain services performed in a physician's office
9. Immunosuppressant therapy management for organ transplants
10. Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician
11. For minor surgeries and endoscopies, the Medicare program will not pay separately for an E/M service on the same day as a minor surgery or endoscopy, unless a significant, separately identifiable service is also performed, for example, an initial consultation or initial new patient visit

Modifiers Used To Report Payable Services within the Global Package

Modifier	Description	Appropriate Examples	Examples/Rationale No Modifier
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period	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)	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
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	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	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
57	Decision for Surgery	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)	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

58	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
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	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) 10140-78 is not reported as the procedure did not require a return to the operating room
79	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)	

RESEARCH COMPLIANCE

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.

CODING CORNER

ICD-10-CM Sepsis and Sequencing

ICD-10-CM Code or Scenario	When to code/Sequencing
A41.9	*Type of infection not further specified *Negative or inconclusive blood cultures
R65.2	*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 casual organism not identified – A41.9 with additional codes for acute organ dysfunction
Sepsis/Severe Sepsis w/Localized Infection	*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
Septic Shock (circulatory failure associated w/severe sepsis)	*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)

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