Coding for Surgical Procedures in the Global Period

BY RIVA LEE ASBELL

In order to understand Medicare coding for surgery performed during the global period of another surgery, the concepts of the global fee, the global period, and the correlating Medicare definitions of major surgery and minor surgery should be mastered. Although the Centers for Medicare and Medicaid Services (CMS) has published a Proposed Rule for 2015 that would eliminate the global period starting with minor procedures in 2017 and major procedures in 2018, that proposal has not been implemented, and it remains to be seen if any of these proposed guidelines will become final rules.

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THE GLOBAL FEE

The global fee is the amount of money Medicare approves as payment for a given surgical procedure. It is composed of 3 distinct time periods: (1) preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures; (2) intraoperative services that are essentially the surgical procedure(s) itself; (3) postoperative services, which include all additional related medical or surgical services the surgeon provides

TABLE. MODIFIERS FOR SURGICAL PROCEDURES PERFORMED DURING THE GLOBAL PERIOD FOR ANOTHER SURGERY

Modifier	Percentage of payment	Does a new global period begin?	Uses and notes
58	100% of the allowable amount (usually referred to as "the allowable") per the Medicare Physician Fee Schedule Database	Yes	• Used for procedures that are planned prospectively (ie, staged procedures) • Used for procedures that are more extensive than the original surgery • Used for procedures that are therapeutic following a diagnostic procedure
78	70% to 80% of the allowable; the intraoperative value of the allowable varies depending on whether it is a minor or major procedure	No	• Used for related procedures performed when treating a problem or a complication pertaining to the original procedure • This modifier requires that the patient be returned to an operating/procedure/treatment room.
79	100% of the allowable	Yes	• Used for generation of payment for surgical procedures performed in the global period unrelated to the original procedure
Note: When billing Medicare, modifiers facilitate payment for all unusual circumstances.			

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Q: During the postoperative global period for cryopexy repair of a retinal tear, the patient complains of new flashers and floaters. Can I bill for this visit if there are no new tears?

A: No. Because the patient is in the global period for the procedure you cannot bill for any services that would be considered part of the global fee, including postoperative examinations for complaints that might be related to the surgery, as is the case here.

Q: A patient had repair of a retinal detachment performed using vitrectomy/endolaser, photocoagulation, etc., and the procedure was coded 67108. Within the global period, a recurrent retinal detachment occurred and was repaired using the same techniques. This procedure was also coded 67108. Should modifier 58 or 78 be used in this case?

A: Modifier 78 should be used because the surgeon used the same techniques and the diagnoses were the same. Whenever you are at the same level or a lower level of complexity, 78 is the correct modifier.

Q: One physician in a practice examined a patient for a retinal detachment and performed a pneumatic retinopexy (code 67110). The procedure was not successful. Another physician in the practice repaired the retinal detachment using vitrectomy (code 67108). Codes 67110 and 67108 are bundled. Can this second procedure be billed for, and, if so, which modifier should be used?

A: Bundles apply only to procedures performed on the same day at the same session, so they do not apply in this case. To obtain payment, a modifier must be used to bypass the global period edits. In this case, modifier 58 should be used because the second procedure is of greater complexity than the first.

Q: Several years ago a patient underwent repair of a retinal detachment with a scleral buckle. A pars plana vitrectomy for macular pucker was performed on this patient 1 month prior. He was subsequently in a motor vehicle accident, which resulted in displacement of his posterior chamber intraocular lens (subluxated into the vitreous cavity, but still partially attached to zonules) as well as a retinal detachment. The retinal detachment surgery was performed by pars plana vitrectomy with endolaser photocoagulation and injection of gas. After removing the previously placed (and now dislocated) posterior chamber intraocular lens using a pars plana approach, the decision was made not to place a new intraocular lens.

What is the best way to code this? Code 67112 (Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having ipsilateral retinal detachment repair[s] using scleral buckling or vitrectomy techniques)? Or code 67108 (Repair of retinal detachment; with vitrectomy, any method) because the previous surgery was done prior to there being a code 67112?

For the removal of the intraocular lens from the vitreous through a pars plana approach, should code 65920 (Removal of implanted material, anterior segment of the eye) or code 67121 (Removal of implanted material, posterior segment; intraocular) be used, as the implanted material is now mostly in the posterior segment? Also, which modifier should be used?

A: The correct codes would be 67108-79 + 67121-51-59-79. CPT code 67112 pays less than 67108 and was developed for insurers other than Medicare that do not honor the modifiers. CPT code 67121 is bundled with 67108; however, in this case it is used as an exception because it was specifically developed for this set of circumstances. Most important, because the patient is in the global period but the surgery is unrelated in medical terms to the first surgery (it was necessitated by the car accident), modifier 79 should be used so the claim will be paid.

due to complications that do not require additional trips to the OR during the postoperative period.

Many physicians question why there is no compensation for preoperative office visits for minor procedures, such as intravitreal injections, or for related problems treated in the office during the postoperative period. The answer is that physicians are being paid: The global fee, by definition, encompasses payment for all 3 time periods.

THE GLOBAL PERIOD

Medicare defines the global period as that period of time during which a physician may not bill for related office visits. The global period may be 90, 10, or 0 days. According to Medicare, a major surgery has a global period of 90 days, and a minor surgery has a global period of either 10 or 0 days. Thus, the time frame of, not the complexity of, the surgery determines whether a surgery is major or minor.

SURGICAL PROCEDURES PERFORMED IN THE GLOBAL PERIOD

Surgical procedures performed in the global period of another operation may be related or unrelated. In order for a claim for such surgeries to be paid, a modifier must be appended on the claim (Table).

If the additional surgery to be performed during the global period is planned prospectively, is more complex than the original operation, or is a therapeutic surgery following a diagnostic surgery, modifier 58 should be used.

If the operation is for postoperative complications or is related to the original surgery in any way, then modifier 78 should be appended. Modifier 78 requires that the surgery be done in an OR, which Medicare has defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. These include cardiac catheterization suites, laser suites, and endoscopy suites. It does not include patient examination rooms, minor treatment rooms, recovery rooms, or intensive care units.

If a surgical intervention for a related problem is performed during the global period but is performed in-office, the intervention is not reimbursable unless performed in a suitable place of service as defined above.

If the surgery to be performed is in no way related to the original surgery, modifier 79 should be used.

MODIFIERS

In order to be paid for a surgical procedure that is performed within the global period of another procedure, the appropriate modifier must be applied. The choice is among modifiers 58, 78, and 79. Complete descriptions of these modifiers are found in the Current Procedural Terminology handbook. A brief listing is provided in the Table. These modifiers apply to the same surgeon in the same session. ■

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