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.

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.

“Although the Centers for Medicare and Medicaid Services 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.”

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Percentage of payment</th>
<th>Does a new global period begin?</th>
<th>Uses and notes</th>
</tr>
</thead>
</table>
| 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.
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.

Riva Lee Asbell is the principal of Riva Lee Asbell Associates, an ophthalmic reimbursement consulting firm located in Fort Lauderdale, Florida. Ms. Asbell may be reached at rivalee@rivaleeasbell.com.

CPT codes copyrighted 2013 American Medical Association.