Documentation of services provided in the postoperative global period

by Linda Barney, MD, FACS; Jenny J. Jackson, MPH, CPC; Vinita M. Ollapally, JD; Mark T. Savarise, MD, FACS; and Christopher K. Senkowski, MD, FACS

Over the last year, the U.S. Department of Health and Human Services (HHS) has gradually increased its analysis of the value of global surgical packages. In particular, HHS has focused on the evaluation and management (E/M) services provided within the postoperative period, which are included in the value of the global surgical package. This article offers suggestions on how Fellows of the American College of Surgeons (ACS) may document services provided during the global period and explains why HHS is interested in the measurement of postoperative work.

What is the global period, and how do I determine the global period for a Current Procedural Terminology (CPT)* code?

Surgical procedures may be categorized as major or minor surgery. The inclusion of postoperative care services varies according to the procedure’s global period of 0, 10, or 90 postoperative days, as assigned by the Centers for Medicare & Medicaid Services (CMS). The global period for a given CPT code in the Medicare physician fee schedule is available at www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.

How do CPT and Medicare define the surgical package?

CPT codes for surgical procedures typically include a variety of services. In CPT, the following services are always included in addition to the operation:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical)
- Immediate postoperative care (including dictating operative note(s), talking with the family and other physicians or other qualified health care professionals writing orders; and evaluating the patient in the postanesthesia recovery area)
- Typical postoperative follow-up care

Medicare and CPT definitions differ in that Medicare also includes all additional medical or surgical services that surgeons must provide to

*All specific references to CPT (Current Procedural Terminology) codes and descriptions are © 2012 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.
treat complications during the postoperative period, except those requiring additional trips to the operating room.

**Do postoperative visits require the same documentation as standard E/M services?**
For billing purposes, postoperative visits do not require the same documentation as E/M services provided outside of the global period because no claim is submitted; it is, nevertheless, important to describe the medical necessity for the visit, including the patient’s recovery from the surgical procedure and continued treatment plan. The American College of Medical Quality defines medical necessity as “accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness, or injury.” It is also important to document the face-to-face time spent with the patient and/or family—for example, in counseling. In addition, any diagnostic tests ordered, referrals, or consults recommended should be documented. The nature of the patient’s original presenting problem, underlying medical problems, and the severity of the original symptoms all influence the level of medical necessity and follow-up and should be documented postoperatively.

Although these reasons address the recent concerns regarding documentation for purposes of billing and valuation, it is also important to maintain thorough documentation for purposes of quality reporting efforts and to support good communication of the patient’s medical condition for the medical record.

**Do I need to submit an insurance claim for services provided in the postoperative period?**
No. The surgeon typically is not required to submit a claim for visits in the postoperative period. They are included in the global period, as discussed previously in this article.

However, the ACS recommends tracking all office E/M services provided in the postoperative period by recording CPT code 99024 (postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason[s] related to the original procedure) in your practice management system. This code should be applied to all surgeries with 90-and 10-day global periods, thereby indicating that a postoperative visit has occurred. It should be assigned a zero dollar amount because all payment has been received through the single global surgical payment.

**What should I do if only some of the postoperative visits included in a CPT code are provided?**
The surgical package was developed based on the typical case; hence, a physician may furnish more or fewer postoperative visits. In either case the global package covers the period of time for 10 or 90 days. However, the physician is prohibited from billing for E/M services in the global period, unless the service is separately identifiable—for example, related to different diagnosis.

Additionally, if you do not plan to provide any of the medically necessary postoperative visits, bill the original surgery CPT code with modifier 54 (surgical care only). The physician who takes responsibility for the postoperative visits would bill the same original surgery CPT code with modifier 55 (postoperative management only).

**How do I bill for an E/M service unrelated to the global surgical package?**
Modifier 24 (unrelated evaluation and management service by the same physician or other qualified health care professional during the postoperative period) is appended to an E/M service during the global period to indicate that the E/M service is unrelated to the surgery. For example, a surgeon performs a hernia operation that has a 90-day global period on June 15. On July 29, the patient

---

The use of different methodologies for valuing the global surgical package has prompted HHS to examine whether all of the postoperative services considered part of the global surgical package are actually furnished to Medicare beneficiaries.

calls the office, concerned about a breast lump. The office visit for that service is correctly reported as an established patient visit with modifier 24 and a diagnosis of breast lump, clearly unrelated to the hernia operation. Modifier 24 is only used when the original procedure had a 10- or 90-day global period. There would be no reason to use it for an E/M service after a procedure with zero global days because no postoperative services are valued into these procedures.

What if my physician’s assistant provides services during my global period?
The ACS advises against reporting separately those services related to the surgical procedure performed by the surgeon, but provided by a nonphysician provider as part of the surgeon’s global period. However, appropriate documentation of medical necessity is required, including the patient’s recovery from the surgical procedure and continued treatment plan.

What if my fellow, resident, or intern sees my patient during the postoperative period?
The services provided by a resident or intern in a teaching setting are considered part of the global surgical package and may not be billed. However, most medical staff and hospital polices require, and the ACS recommends, that the surgeon see the patient even if the fellow, resident, or intern is involved. Postoperative care may not be abdicated solely to the fellow, resident, or intern. Additionally, appropriate documentation of medical necessity is required, including the patient’s recovery from the surgical procedure and continued treatment plan.

How is the global surgical package valued?
CMS first applied the concept of payment for a global surgical package in 1992. For each global surgical procedure, a single payment is established for the operation and related pre- and postoperative services that the surgeon provides during the global period. Global surgical packages have been valued in various ways. Typically, the global surgical package has been valued using a method known as “magnitude estimation,” which does not factor in the specific relative value units (RVUs) associated with the postoperative services in the global period. In some cases, however, the global surgical package has been valued by roughly adding the RVUs of the surgical procedure to the RVUs associated with all the pre- and postoperative services provided during the global period, based on the typical case.

Regardless of whether a global surgical package has been developed to include a typical number of postoperative services, a physician may furnish more or fewer postoperative visits. However, the physician
may not bill for E/M services in the global period unless the service is separately identifiable—for example, related to a different diagnosis.

**Why the increased interest from HHS?**
The use of different methodologies for valuing the global surgical package has prompted HHS to examine whether all of the postoperative services considered part of the global surgical package are actually furnished to Medicare beneficiaries. The HHS Office of Inspector General (OIG) published a report in 2012 titled *Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided* indicating that surgeons provide fewer postoperative services in the postoperative period than are identified in the global surgical package.¹

The report recommended that CMS adjust the number of visits identified in the global surgical package to reflect the number of visits that actually occur.¹ The 2013 fee schedule indicated that the report’s finding was cause for concern. The ACS comment letter on the proposed 2013 fee schedule questioned the reliability of the OIG report, noting that an insufficient number of claims were reviewed to draw conclusions that could fairly apply to all global surgical packages. The OIG report fails to acknowledge that the number of visits included in the valuation of a global surgical package was never intended to be exact, and instead is based on an estimate of the “typical” patient and expected number of postoperative visits.

CMS also acknowledged that because surgeons are not required to document the related postoperative E/M services in the global period, documentation on the number and level of postoperative services provided is limited. Accordingly, CMS requested comments on methods of obtaining accurate and current data on services furnished as part of a global surgical package. In response, the ACS supported the process that the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) established to collect data on the number and level of services provided. The RUC process values procedures based on the typical patient and typical visit. The visit data (for example, the typical number of hospital visits and office visits for a particular code) are gathered via a survey of the surgeons who typically perform the procedure. Because the RUC is a peer-review group, all specialties participate and judge the data as presented for billing purposes. Given that surgeons are not required to document postoperative services provided during the global period, the most accurate and generalizable information available is the data that the RUC collects, and this system should be retained.

At this time, CMS has not proposed to modify the current rules in a way that would require surgeons to submit claims for related postoperative services during the global period; however, given the backdrop of the HHS reports and CMS’ stated concerns, the ACS continues to encourage surgeons to maintain documentation on the medical necessity of all office visits conducted in the postoperative period.

If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain time, excluding holidays.

---
