CODING Q&A

# Modifiers for E/M Codes During Global Periods

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**Q. What is the official definition of "global period" as it applies to procedures in the urgent care center? When can we code an E/M in addition to the procedure?**

A. The actual definition of the global period differs slightly when it is defined by the AMA (CPT) and when it is defined by CMS (Medicaid/Medicare).

CPT codes are published and copyrighted by the AMA. According to CPT as it applies to services rendered in urgent care centers (i.e., this definition is slight abbreviated to fit the urgent care situation), the services included in the global period for a "surgical package" include:

- the surgical procedure
- local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- immediate postoperative care, including procedure note documentation, patient instructions, and discussions with the family and/or other physicians
- typical follow-up care during the global period.

CPT states that "typical postoperative follow-up care" includes only that care which is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services are not included in the "surgical package" and should be coded in addition to the code for the procedure.

CPT does not define specific (0-, 10-, or 90-day) global surgical periods, so theoretically this period can extend for the duration of the "typical" postoperative follow-up care to be completed. Thus, CPT leaves the theoretical postoperative period as open-ended.

Section 4821 of the *Medicare Carriers Manual* (available online at *cms.hhs.gov/manuals/14_car/3b4820.asp#_1_2*) provides a definition of Medicare's global surgical package.

CMS has designated a 0-, 10- or 90-day global period for every CPT code. The specific global period for every CPT code is available online at *cms.hhs.gov/physicians/mpfsapp/ stepo.asp*. CMS has given a slightly different definition of the global surgical period. Medicare includes:

1. intraoperative services that are a usual and necessary part of a surgical procedure
2. all additional medical or surgical services required of the physician during the postoperative period
3. evaluation and treatment of complications, as long as those complications do not require additional trips to the operating room
4. follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery
5. postsurgical pain management
6. certain supplies
7. miscellaneous services (e.g., dressing changes; local incision care; removal of operative packs; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts and splints…).

In summary, there are two important distinctions bet-ween the definitions given by CPT and CMS for the global package:

- **Complications.** Unlike CPT, Medicare includes in the surgical package treatment of complications that do not require additional trips to the operating room. Note: many payors other than Medicare do not take this restrictive view and will pay for evaluation and treatment of complications to the procedure, even if these complications occur during the defined global period for the procedure.
- **Defined periods.** Unlike CPT, the postoperative part of Medicare's global period is not open-ended. Medicare assigns postoperative global periods of 90 days to major procedures and either 0 or 10 days to minor procedures. Services that occur beyond the Medicare postoperative global period, even if related to the procedure, are separately reportable.

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The specific global period for every CPT code is available for download at *cms.hhs.gov/physicians/ mpfsapp/stepo.asp*.

As a practical matter, almost all payors recognize the global period designations as specified by CMS. ■

**Q. A consultant has instructed us to never code an E/M code on the same day as a procedure. Our consultant states that the E/M on the day of surgery is bundled into the reimbursement for the procedure code. What is your opinion?**

A. Your consultant is correct that the CPT code for most procedures does include an E/M code on the same day as the procedure. In the urgent care situation, however, the physician's evaluation and management is actually a "decision for surgery," i.e., the patient presents with an acute problem, such as a fracture, laceration, or abscess, and the physician needs to perform a full evaluation of the patient's condition and determine what procedure (if any) is appropriate.

This so-called decision for surgery is not part of the global surgical package, so a separate E/M code should be coded.

When the decision for surgery occurs more than one day before the day of the procedure, you can typically report the E/M code without any modifier, since the global surgical package does *not* include preoperative services that occur more than one day before the date of the procedure. In this case, you would not code another E/M on the day of the procedure.

In the typical urgent care context, the decision to perform a procedure and the procedure itself both take place on the same date during the same patient visit.

For example, a patient presents with a laceration. After taking a full patient history and relevant physical exam, the physician performs a laceration repair.

If the physician documents a significant and separately identifiable evaluation and management in the patient chart, then the E/M service should be reported with modifier -25 ("*Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service*") in addition to the code for the procedure itself.

Note: If the global surgical package for the procedure is defined by CMS as major surgery with a 90-day global period, then most payors will deny an E/M with modifier -25 appended. Instead, most payors require modifier -57 ("decision for surgery") to be appended to the E/M. ■




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