Global Fee Periods
What’s Covered, What’s Not

ASCRS-ASOA Symposium & Congress
Practice Management Program
San Diego, California
April 17-21, 2015

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Global Fee Periods

• It is important to understand the concept of global fee periods
• A global fee is defined as:
  – A single fee that involves all necessary services normally furnished by the surgeon before, during and after the surgical procedure

Global Fee Period

• Services included in global fee period:
  – Pre-op visits
  – Intra-operative services
  – Complications following surgery that do not require a return to the OR
  – Follow-up visits during global period
  – Post-surgical pain management by surgeon
  – Supplies
    • Unless excluded

Global Fee Period

• Services not included in global fee period
  – Initial evaluation to determine need for surgery
    • Requires -57 modifier to get paid on day of major surgery
  – New patient evaluations
  – Visits unrelated to the diagnosis for which surgery was performed
  – Treatment for underlying condition or an added course of treatment
  – Diagnostic tests

Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.
### Global Fee Period

- Unrelated surgical procedures
- Treatment for post-op complications requiring return to OR
- More extensive procedure following a failed lesser procedure
  - Example: Retinal repair following focal laser
    - Requires -58 modifier
- An added course of treatment
  - Example: SFU injections following trabeculectomy
    - Requires -58 modifier

### Global Fee Period

- There are two types of global fee periods: Minor and Major
  - **Minor Surgery:**
    - “0” day global fee period
      - Includes day of surgery only:
        - Biopsies
        - A/C tap
        - Subconjunctival or Sub-Tenon injections
    - “10” day global fee period
      - Includes day of surgery and 10 days following surgery

### Global Fee Period

- Punctum plug insertions
- Lesion removals
- Epilation trichiasis
- Argon Laser Trabeculoplasty (ALT)

- **Major Surgery** – 90 day global fee period
  - Includes day before surgery, day of surgery, and 90 days following surgery
    - Blepharoplasty
    - Ectropion/Entropion repair
    - Cataracts
    - YAG laser capsulotomy

### Global Fee Period

- Laser procedures except ALT
- Vitrectomy
- Retinal detachment repair
- Glaucoma filter procedures

- All doctors in group practice of same specialty (ophthalmology)
  - Considered the “same” doctor with regard to providing post-operative care
  - Example: Patient develops edema during global fee of cataract surgery and sent to retina doctor to treat

### Global Fee Period

- Allied staff should monitor the patient’s global fee period
  - Inappropriate billing and fragmentation of services could result in unnecessary denials and/or a Medicare audit
    - i.e., documenting that the visit should be billed with the -24 modifier as unrelated when the patient was scheduled for post-op follow-up visit
    - Can’t bill even if doctor discovers another problem during that visit
Co-Management

• More than one physician may furnish services in global fee package
  – Payment for post-operative care can be split among two or more physicians
    • Physicians must agree on the transfer of care
  – For ophthalmology services, Medicare payment for co-management cannot exceed 20% of allowed amount for surgery

Co-Management

• When physicians agree on transfer of care
  – Services are distinguished by use of appropriate modifiers
    • Modifier -54: Surgical care only
    • Modifier -55: Post-operative management only

Co-Management

• Per CMS, decision to co-manage can only be made between surgeon and patient
  – No pre-arranged date of transfer with co-manager
  • Co-manager cannot submit claim until he/she first sees the patient
    – Can bill from date patient was transferred even if patient not seen for 3 weeks

Co-Management

• Surgeon bills surgical code and -54 modifier (e.g., 66984-54)
• Co-manager bills surgical code and -55 modifier when transfer of care has occurred (e.g., 66984-55)
  – Date of service must be date of surgery
  – Item 19 must contain date care assumed and date care relinquished

Co-Management

Ophthalmologist performing surgery and portion of follow-up care
  - Surgery performed on 03/02/15
  - Follow-up care provided through 03/18/15

<table>
<thead>
<tr>
<th>Item 19</th>
<th>LT EYE Assumed care 03/02; Relinquished care 03/18; Total Days 16</th>
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</table>

<table>
<thead>
<tr>
<th>24a (Dates of Service)</th>
<th>24d (Procedure/Mod)</th>
<th>24g (Units)</th>
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</thead>
<tbody>
<tr>
<td>03/01/12</td>
<td>66984-54LT</td>
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<tr>
<td>03/01/12</td>
<td>66984-55LT</td>
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</tbody>
</table>

Note: Some Medicare contractors require number of post-op days in 24G

Co-Management

Optometrist or other MD providing portion of follow-up care
  - Surgery performed on 03/02/15
  - Follow-up care provided through 03/9/15 by surgeon

<table>
<thead>
<tr>
<th>Item 19</th>
<th>LT EYE Assumed care 03/10; Relinquished care 05/31; Total days 73</th>
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</table>

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Note: Some Medicare contractors require number of post-op days in 24G
**Co-Management**

- **Surgeon** should forward a copy of patient's signed transfer of care form indicating desire to be co-managed
  - Copy of form must be maintained in both the surgeon’s file and the co-manager’s file
  - This is mandated by CMS
  - Implement a procedure to make sure this is done

**Co-Managing Premium IOLs**

- OIG issued favorable advisory opinion
  - OD receiving additional fee from patient for non-covered, post-op care following premium IOL surgery does not violate Anti-Kickback statutes based on following rationale:
    - Requestor has no written or unwritten agreements to co-manage
    - Requestor informs patients if they return to OD for post-operative care, OD may charge additional fee

* OIG Advisory Opinion No. 11-14, September 30, 2011

**Global Fee Modifiers**

**Modifier -24**

- Indicates unrelated service by same physician during post-op period
- Use for office visits unrelated to original surgery
- Example:
  - Complaint of foreign body sensation in fellow eye following cataract surgery

**Modifier -24**

- Glaucoma exam following cataract surgery
- BDR follow-up visit on same eye following ptosis repair
- Do not use modifier -24 for office visits related to complications of surgery
  - Post-op follow-up visits
  - Second eye surgery exam if visit addresses first eye
### Modifier -24

- Post-op care provided to patient in global fee period by non-surgeon
  - With regard to post-op care, Medicare considers all physicians in group practice of same specialty (ophthalmology - 18) to be "one" surgeon
  - *It would be inappropriate for the non-surgeon to append the -24 modifier to an office visit for a complication of the surgery*  

### Modifier -25

- Indicates significant, separately identifiable service by same physician on day of minor procedure
  - Exam is not just incidental to surgery
  - Must be above and beyond usual preoperative and postoperative care associated with procedure performed
  - Not to be used just for decision for surgery

### Modifier -25

- Example:
  - Patient presents with complaint of pain and foreign body sensation after being hit in eye with tree limb
  - Complete exam performed to determine extent of injury and cause of pain – FB removed
    - If only slit lamp performed and foreign body removed without complete eye exam, office visit not billable
  - Modifier -25 on OIG radar again

### Modifier -57

- Exam indicates initial evaluation to determine need for major surgery
  - 90 day global fee period
- Use if decision is made day before or day of major surgery
  - Not to be used for re-examination of patient after surgical decision has been made

### Modifier -57

- Example:
  - Patient presents with complaint of decreased vision after having cataract surgery 10 months ago
  - Cloudy capsule is diagnosed and YAG laser recommended same day or following day

### Modifier -58

- Staged or related procedure by same physician during post-op period
  - Planned or anticipated (staged) before original procedure
  - More extensive than original procedure
  - For therapy following a surgical procedure
  - Does not apply to multiple retinal laser procedures
- Not to be used for treatment requiring “return to OR”
Modifier -58

- Example:
  - Trabeculectomy following a failed ALT or iridotomy/iridectomy
  - Scleral buckle following a pneumatic retinopexy

Modifier -78

- Indicates unplanned return to operating room or procedure room during the post-operative period
- Operating room defined by Medicare as:
  - Hospital OR
  - Ambulatory surgery center OR, or
  - Designated procedure room/OR in physician’s office
- Not to be used for repeat procedures

Modifier -78

- Example:
  - Trabeculectomy following a failed ALT or iridotomy/iridectomy
  - Scleral buckle following a pneumatic retinopexy

Modifier -78

- Example:
  - Revision of operative wound
  - AC tap for elevated pressure following cataract or glaucoma surgery
    - If performed in lane, not billable
  - Reposition of IOL
  - Kenalog injections for CME
    - If performed in lane, not billable

Modifier -79

- Indicates unrelated service or procedure during global fee period
  - Different condition
  - Fellow eye
  - Different day
- A new post-operative period begins when modifier -79 is used

Modifier -79

- Example:
  - PRP on the same eye following YAG surgery
  - PRP on same eye following focal laser
  - Cataract surgery on the fellow eye
  - YAG on fellow eye following cataract surgery, etc.
  - 5-FU injections if Medicare does not permit modifier -58

Global Fee FAQs
### FAQs

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>Does the global surgery payment only apply to physician’s office services?</td>
<td>No</td>
</tr>
<tr>
<td>- If a surgeon visits a patient in the inpatient or outpatient hospital, Medicare includes the visits in the global surgical package as well</td>
<td></td>
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<td></td>
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<tr>
<td>Can a nurse or technician bill code 99211 for assisting patients with bandage changes or IOP drops?</td>
<td>No</td>
</tr>
<tr>
<td>- Considered part of global surgical package when performed in global period of surgical procedure</td>
<td></td>
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<tr>
<td></td>
<td>Not billable separately</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Can we bill an office visit to treat a complication from surgery?</td>
<td>No</td>
</tr>
<tr>
<td>- Complications of surgery are included in the global fee package</td>
<td></td>
</tr>
<tr>
<td>- An office visit to treat the complication is not billable separately</td>
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<td></td>
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<tr>
<td>Can we bill a pre-operative evaluation on a 90-day global surgery procedure if the service is performed more than 1 day prior to surgery?</td>
<td>Yes</td>
</tr>
<tr>
<td>- You can bill the service without any modifiers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The global fee period is day before, day of, and 90 days following major surgery</td>
</tr>
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<td></td>
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<tr>
<td>Patient had surgery last week and is now being admitted to the hospital because of complications from surgery. Can we bill the initial hospital admit visit?</td>
<td>Not if the reason for the admission is due to complication from the surgery</td>
</tr>
<tr>
<td>- Not if the reason for the admission is due to complication from the surgery</td>
<td></td>
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<tr>
<td>- Medicare considers the office visit part of the global surgery package and not separately payable</td>
<td></td>
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<tr>
<td>Can we bill for post-operative suture removal?</td>
<td></td>
</tr>
<tr>
<td>- Medicare considers suture removal included in the surgical package</td>
<td></td>
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<tr>
<td>- This is typical uncomplicated post-op care</td>
<td></td>
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<tr>
<td>- Medicare only pays exams for suture removal when it requires general anesthesia</td>
<td></td>
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<tr>
<td>- Must be outside global fee period</td>
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</tbody>
</table>
FAQs

• Do post-operative exams require the same documentation as standard office visits?
  – While no claim is submitted, must still describe medical necessity for the visit
    • Patient’s recovery
    • Continued treatment plan
    • Any diagnostic tests ordered
    • Referrals should also be documented
    • Nature of patient’s original presenting problem

• Underlying problem
  • Severity of symptoms
    – These all influence medical necessity and follow-up
  – Must still maintain thorough documentation for purposes of quality reporting efforts
  • Also supports good communication of patient’s medical condition
  • Particularly important with EHRs in group practices
    – Also a Risk Management issue

• Are we required to submit a claim for post-operative visits during the global fee period?
  – No
    • Surgeon is not required to submit a claim to Medicare for post-operative care
  – Should track all office visits though
    • Use code 99204 to identify the post-op visit
      – Use zero dollar amount

• How do we bill for an office visit during global fee period that is unrelated to the surgery?
  – Must append modifier -24 to let Medicare know service is unrelated to the surgery
    • Applies to procedures with a 10-day or 90-day global fee period

• Where can we find a listing of the global fee periods for each surgical procedure?
  – Unfortunately, most MACs do not include global fee periods in their fee schedules
    • You can go to CMS website and download the Medicare “national” fee schedules that do include the global fees
      – www.cms.gov
      – Do search for PFS Relative Value Files

Using Modifiers

• Correct use of modifiers can improve reimbursement when medical records are documented properly
  – Without supporting documentation, claim could be denied in post-payment audit
• Overuse or incorrect modifiers could subject practice to:
  – Overpayment and refund requests
  – Penalties for fraudulent billing
  – Possible prepayment scrutiny
Using Modifiers

- Always append modifiers that affect payment first
  - 54, 78, 79
- Informational modifiers are appended next
  - 50, 51
- Anatomical modifiers always appended last
  - LT/RT, E1-E4 (if required)

Questions

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