GLOBAL SERVICES

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THE CONCEPT OF GLOBAL SERVICES

- A “package” of services inherently included within another billable (procedural) service (which may or may not be “surgery”)

"COGNITIVE" VS "PROCEDURAL" SERVICES

- Cognitive Services
  - Performed with your mind, your mouth, and a pen
  - Evaluation and Management ("E/M") Services
- Procedural Services
  - Debridement, Injections, x-rays, "surgery"
  - "hands on"

- Some visits entail *only* procedural services
- Some visits entail *only* cognitive services
- Many visits entail *both*

- “There is a certain (minimal?) component of E/M in any procedural service”
- It has been argued that “there is a certain procedural component in any E/M service”
  - (I’m not so sure…)

GLOBAL SERVICE INCLUDES:

- “Usual and Customary” post-operative global care (0, 10, 90 days for Medicare)
- Supplies and dressings (except for bunionectomies in the office [Medicare])
- Any anesthesia administered by the surgeon
- Use of C-arm, fluoroscopy
- Pre-op evaluation “after decision is made to operate”

GLOBAL SERVICE INCLUDES:

- Removal of any fixation device *intended to be removed*, within the global period
- Post-surgical pain management
- Management of “any” (and all?) complications that do not require return to the O.R.
- Application of first cast or splint in O.R.
- Removal of any cast, splint, or dressing

GLOBAL SERVICE DOES *NOT* INCLUDE:

- E/M services or Procedures *unrelated* (unrelated to the diagnosis?) to the original procedure
- Medically necessary x-rays
- Medically necessary cast changes and associated materials (after initial date of service)
- Pre-op examination “to determine need for surgery”
- Management of complications that *DO* require return to O.R. (staged or related; “-78”)

BILLING FOR SERVICES NOT INCLUDED IN GLOBAL PACKAGE, WITHIN GLOBAL PERIOD

- Unrelated E/M
  - “-24” Modifier
- Unrelated “Procedure”
  - “-79” Modifier (no effect on payment; new global period starts)
- Related/Staged Procedure
  - “-58” modifier (get intraoperative fee only; does not re-set global period)
  - Inc application of cast…

GLOBAL PERIOD BEGINS

- The day *of* a “Minor Procedure”
- The day *before* a “Major Procedure”

- Medicare defines “Minor Procedures” as those with 0 or 10 global days
- Medicare defines “Major Procedures” as those with 90 global days

- Other payers may have different rules

“UNBUNDLING”

- The unethical practice of breaking the “bundled” components of a procedure apart, so as to bill for them separately

- Like billing separately for the integral components parts of a car

EXAMPLE OF UNBUNDLING

- Billing separately for local anesthesia required to perform a matricectomy
- (anesthesia by the operating surgeon is included in the global allowance)

EXAMPLE OF *NOT* UNBUNDLING

- Matrixectomy (CPT 11750); and on same day…
- Injection of neuroma on opposite foot (CPT 64455-59)

ANATOMIC MODIFIERS

- To indicate a separate site, location, or problem
- To argue, “I am *NOT* unbundling”

- Only to be used on procedural service codes (Not E/M codes)

ANATOMIC MODIFIERS

- -59
- -LT
- -RT

- -TA
- -T1
- -T2
- -T3
- -T4
- -T5
- -T6
- -T6
- -T7
- -T8
- -T9

NATIONAL CORRECT CODING INITIATIVE ("CCI")

- History:
  - "Rebundling Edits" (Jan, 1992; MCM Section 4630)
  - 1994 AdminiStar Federal (Indianapolis, IN)
    - Correct Coding Policy (CCI)

- In 1993, the only edits associated with CPT 11750 were CPT 11730 and 64450
  - Now there are well over 100
- There were over 88,000 *changes* in the editing pairs for Q4 2013
- (there are lots of changes being added every year..)

- Medicare is REQUIRED to use the NCCI edits
- Other payers are not required to use the NCCI edits; but many do – or some proprietary equivalent
  - (St. Anthony/Ingenix)

TYPES OF CCI EDITS

- Standards of Medical/Surgical Practice
  - Billing for sterile prep before surgery
  - Billing for creation of your op report
- Comprehensive/Component
  - Override with “-59” modifier, or equivalent
  - (“1” superscript)
- Mutually Exclusive
  - E.g. Billing for New and Established patient visit on same day
  - Can NOT override (“0” superscript)

- INSERT PAGE FROM CODE MANAGER or APMA CODING RC.COM

EXAMPLES OF CCI EDITS

- CPT 28296 with CPT 28285 (1)
- CPT 11050 with CPT 11720 (1)
- CPT 11056 with CPT 11720 (1)
- CPT 11719 with ANY E/M 99XXX code
  - (originally 0; now 1)
- CPT 11721 with CPT 11720 (0)
- CPT 11720 with CPT 11719 (1)
- CPT 11721 with CPT 11719 (0)

EXAMPLE OF CCI EDITS

- CPT 20550 (injection of plantar fascia) with CPT 29540 (supportive taping)

- Originally 0, now 1 (effective July 1, 2005)
  - Rationale: initial splint or cast at time of a procedure included in the global allowance
  - Can bypass this edit if for a separate site/problem (Modifier 59)

- MOST, but not all, Carriers use the CCI edits, or some equivalent (proprietary) edits
- Ask you major payers what edits they use
- (In past, Aetna has agreed to publish their edits as part of class action suit)
- “Black Box edits” (unpublished “secret” edits)

SOURCES OF CCI EDITS

- CMS / MEDICARE (free, but not user-friendly)
- www.APMAcodingrc.com ****
- AMA (CodeManager)
- CodeCorrect
- St Anthony's
- PMIC
- others

GLOBAL FRACTURE CARE

- Two methods to bill for Fracture Care:
- “Global Fracture Care”
  - CPT 27750-CPT 27848
- “”a la carte”

- What is the difference?

GLOBAL FRACTURE CARE

- BOTH billing methods permit you to bill separately for:
  - Medically necessary x-rays
  - Medically necessary cast supplies/materials

THE INCREASED ALLOWANCE FOR GLOBAL FRACTURE CARE INCLUDES

- Initial evaluation (whether in office, or hospital)
  - Remember, global period begins day before a major procedure (90 day global)
  - "-57" Modifier ("Decision for Surgery")
- Any subsequent office visits related to the Fx/dislocation for the global 90 days
- Initial application of cast or splint
- Cast supply is billable, even initially

THE LESSER ALLOWANCE OF A LA CARTE BILLING INCLUDES…

- NOTHING
- Can bill for initial and all subsequent
  - Evaluations, office visits
  - Medically necessary x-rays
  - Initial and all subsequent Medically necessary cast applications and associated supplies

THE GLOBAL SERVICE DOES PAY PRETTY WELL

- So BILL THE GLOBAL FRACTURE CARE IF:
  - No one else has already billed for it
  - You expect to provide all subsequent care, and
  - You are not looking at a nightmare (e.g., diabetic neuropathic fracture with ulceration and infection)

CAST SUPPLY

- HCPCS
  - A4580 (Plaster) (# units billed = # rolls used)
  - A4590 (Fiberglass) (# units = # rolls)
- MEDICARE
  - Q Codes
    - Based upon type of cast, material, and patient age
  - Q4050 (Misc casting material)
  - Get ABN if applying special cast material (i.e. fiberglass)
    - Might not be covered by Carrier
    - But most payers getting more comfortable with fiberglass..

MEDICARE ONLY REIMBURSES CAST SUPPLY FOR..

- “Fracture”
- “Dislocation”
- NOT sprains, strains, edema, off-loading of diabetic ulcer (must have Diagnosis of “fracture” or “dislocation”- NOT Charcot)

- Medicare WILL reimburse for the application of the cast; but NOT the supply

MEDICARE TOTAL CONTACT CAST

- Medicare will reimburse cast application
- Medicare will ONLY reimburse supply if Dx is “fracture” or “dislocation”
- i.e. NOT Charcot; NOT ulcer; NOT neuropathic joint disease

- Call it fracture or dislocation
- Use “Q” codes
- OR dispense a cam walker

TOTAL CONTACT CAST

- CPT 29445 (application of rigid total contact leg cast)
  - Carriers have fairly strict definitions regarding what features must be included to meet the definition of this code
  - And may have their own defined preferred ICD-9 codes
- Supply codes Q4037-Q4040